STATE OF FLORIDA
DEPARTMENT OF VETERANS' AFFAIRS

STATE VETERAN HOME NURSING HOME APPLICATION PACKET

INTRODUCTION GENERAL INFORMATION

Thank you for applying to the Florida Department of Veterans' Affairs State Veterans Nursing Home. We offer rehabilitation services such as: Physical, Occupational & Speech therapy and Restorative Programs, all under the direct supervision of trained qualified therapists. Hospice and Respite Services are also available.

There is a three-step applicant qualifying process that is as follows:

- All documents required by the home must be completed before the application can be processed. These documents include VA, Financial and Medical.
- The completed application will be reviewed by our admission team.
- Whether your application is approved or disapproved, you will be notified by telephone or mail.

ADMISSION CRITERIA

The facility will verify the following of an applicant prior to admission:

- That the applicant is a Veteran as determined under Chapter 1.01 (14), Florida Statutes.
- That the applicant has been Honorably Discharged from the most recent period of active duty.
- That the applicant is a resident of Florida at time of application.
- That the applicant needs skilled nursing home care for a medical condition.
- That the applicant is not currently delinquent on any monies due to the Florida Department of Veterans Affairs for a prior skilled nursing facility stay.
- That the applicant has submitted a completed application for admission, and any additional information requested.
- If there is a share of cost (payment) required from the applicant, that payment is made prior to admission.

APPLICATION PROCESS

(Please note that an incomplete application may result in delays or denial)

For the facility to process an application, the following must occur:

- Application must be completed in its entirety and may be submitted via fax, mail, in-person, or emailed.
- All financial information required must be provided (applicants with a 70%-100% service-connected disability is not required to submit financial information, but proof this disability must be submitted with the application).
- All medical forms required must be completed by a health care practitioner (HCP).
- If the facility requests additional medical, financial, of proof of service or disability information, then all information requested must be provided.
- The Admissions Coordinator will review the potential veteran for placement in a skilled nursing facility.
- The application will be reviewed by the Interdisciplinary Team, and the team before an admission is scheduled.
- If after approval the veteran is placed on our waiting list, a reassessment will be scheduled before actually admission to determine if there is a change in the veteran's condition.
- Whether your application is approved or disapproved, either for direct admission or waiting list, you will be notified by telephone or mail.

APPLICATION CHECKLIST

(To assist with completing the packet, the following checklist is provided)

Forms to be completed/submitted by applicant or representative.

☐ A signed and complete application packet must be returned via fax, mail, in-person, or emailed
☐ Form 54 – Application for Admission
☐ Form 10-10 EZ
☐ Medical Information Release From
☐ Medical Provider Contact Information
☐ VA 21-22
☐ VA 10-0460
☐ Activities of Daily Living (ADLs) and Behaviors Questionnaire
☐ Documents showing proof of Veteran status as determined under Chapter 1.01 (14), Florida Statutes.
☐ If applicable, documents showing proof of service-connected disability from the VA
☐ All medical insurance cards for verification of health insurance benefits (copies of front and back)
☐ A government issued identification care (ID) for applicant
☐ Family Questionnaire

Forms to be completed by the Health Care Provider

☐ Form 3008 (signed and dated within 30 days of admission)
☐ AHCA MedServ Form 004 (PASRR)
☐ Most recent History & Physical, or summary of most recent physician visit
☐ Statement that applicant is currently communicable disease status
☐ Current medication list
☐ COVID-19 Card, other proof of vaccination, and included in documentation
☐ Verification of Capacity

These documents must be submitted with application if applicable.

☐ Durable/Power of Attorney Healthcare and Financial
☐ Health Care Surrogate documents
☐ Living Will documents
☐ Guardianship documents
☐ Any court-order documents related to applicant
☐ DO NOT RESUSCITATE ORDER (if applicable)

Financial Information

REQUIRED for all applicants who do not have a service-connected disability, or those with a service-connected disability rating of 60% or below.
NOT REQUIRED by applicants who are have a 70% - 100% service-connected disability rating, (*VA Disability letter required as proof of rating*).

☐ Most recent three months bank statements
☐ Most recent social security statement
☐ Most recent tax return (if applicable)
☐ Proof of all income currently received by applicant
☐ Financial Information Release

SMOKING STANDARD

The Florida Department of Veterans' Affairs adheres to the Clean Air Act of Florida. The department is moving towards becoming 100% tobacco free. That means no smoking on the facility property at all – not in cars, in the grass, porch, etc. Smoking is NEVER permitted in or near areas where oxygen or other gases are being stored or administered.

For the purpose of this standard, smoking and tobacco include any lighted or unlighted cigarette, cigar, pipe, bidi, clove cigarette, cigarillo, hookah, and any other smoking product, and any smokeless or spitless tobacco also known as dip, chew, snuff, snus, orbs and strips, sticks, or any electronic cigarette in any form. Vapor Producing Devices or Non-Lit smoking devices are all considered smoking in this standard. Residents are not permitted to leave the campus to smoke, and residents are not permitted to smoke while on facility sponsored outings/events.

*** Residents admitted to the Emory L Bennet State Veterans' Nursing Home before 07/01/2019 have been "grandfathered" with smoking privileges. Veterans admitted on or after 07/01/2019 do not have smoking privileges. ****

MONTHLY COST OF CARE

For Veterans who have a 70%-100% service connection, there is NO SHARE OF COST to the facility.

For Veterans required to pay a monthly share of cost (monthly payment to the facility):

- The monthly cost of care = NET MONTHLY INCOME minus $ Click or tap here to enter text..
- The Veteran gets to keep $ Click or tap here to enter text. each month as a personal needs allowance.
- Proof of income is required to determine monthly cost of care.
- All Veterans who are required to pay a share of cost must apply for monetary benefits for which they may qualify that will assist in paying for their care at the facility (i.e. Medicaid).
- Should the resident's income exceed the maximum cost per day, other charges may ensue (such as medications).

WHAT IS INCLUDED IN COST OF CARE?

- Room and board
- 24-hour nursing services
- Social services
- Therapeutic activities
- Restorative nursing care
- Daily meals and snacks
- Housekeeping and laundry services
- Prescription medications

Non-routine services, which are not covered in the daily room rate, include but not limited to:

- Dental Care at any level
- Hearing Aide repair / replacements
- X-ray Services
- Laboratory Charges
- Physical, Occupational and Speech Therapy
- Physician visits
- Private Sitters or Personal Care Attendants
- Transportation or non-emergency ambulance travel

Beauty / Barber charges
(Cash or Resident Trust Fund Required)

James S. Hartsell
Executive Director

STATE OF FLORIDA
DEPARTMENT OF VETERANS' AFFAIRS
NURSING HOME PROGRAM

APPLICATION FOR ADMISSION (FORM 54)

(to be completed by applicant or representative)

NO INDIVIDUAL WILL, ON THE GROUNDS OF RACE, COLOR, RELIGIOUS BELIEFS, SEX, GENDER IDENTITY, SEXUAL ORIENTATION, OR NATIONAL ORIGIN BE DENIED ADMISSION, CARE OR ANY OTHER BENEFIT PROVIDED BY THE STATE HOME.

INSTRUCTIONS

- Print or type and answer all items.
- Individuals must meet the criteria required by the U.S. Department of Veterans Affairs for veteran status.
- Must be resident of Florida immediately preceding this application, and in need of institutional long-term care.

SECTION A: PERSONAL INFORMATION
VETERAN'S LAST NAME FIRST NAME MIDDLE NAME *SOCIAL SECURITY # VA CLAIM #
VETERAN'S DATE OF BIRTH VETERAN'S BIRTHPLACE VETERAN'S SEX ☐ Male ☐ Female
VETERANS MEDICARE # VETERANS MEDICAID # VETERANS OTHER INSURANCE #
SPOUSE NAME: SPOUSE'S SSN SPOUSE'S DATE OF BIRTH
PLACE OF RESIDENCE: ☐ Own Home ☐ Hospital ☐ Nursing Home ☐ Retirement Home ☐ Boarding Home ☐ Other, explain: _____
PHONE NUMBERS Home: _____ Work: _____ Other: _____
MAILING ADDRESS: Street, City, State Zip Code Phone Number:
RESIDENCE ADDRESS: (IF DIFFERENT) Street, City, State Zip Code Phone Number:
MARITAL STATUS ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Date of Marriage: _____ Date of Divorce: _____
HAS VETERAN BEEN A PATIENT/RESIDENT IN A HOSPITAL OR NURSING HOME DURING THE PAST YEAR? ☐ YES ☐ NO Name of Facility: _____ Address of Facility: _____
HAS VETERAN EVER BEEN CONVICTED OF A FELONY? ☐ YES ☐ NO If yes, in what state? _____

HAS VETERAN EVER REGISTERED AS A SEX OFFENDER?

☐ YES ☐ NO If yes, in what state? _____

SECTION B: MILITARY INFORMATION - ATTACH A COPY OF MILITARY DISCHARGE PAPERS (DD-214)

BRANCH OF SERVICE	SERVICE NUMBER	DATE ENTERED	DATE DISCHARGED	CHARACTER OF SERVICE

SECTION C: GROSS MONTHLY INCOME INFORMATION

DO NOT COMPLETE SECTION C FOR VETERANS WITH PROOF OF 70%-100% SERVICE-CONNECTED DISABILITY

MONTHLY INCOME	APPLICANT Gross	APPLICANT Net	SPOUSE Gross	SPOUSE Net
VA Pension/VA Compensation				
Social Security				
U.S. Civil Service				
U.S. Railroad Retirement				
Military Retirement				
Employment				
Other Retirement, or Income Source: Attach extra page if more Space is needed	ASSET VALUE/MONTHLY INCOME		ASSET VALUE/MONTHLY INCOME	

SECTION D: LEGAL REPRESENTATIVE FOR HEALTH CARE AND FINANCIAL AUTHORITY

Designated Authority Name _____ Relationship_____

Designated Authority Address _____

Designated Authority Phone Number _____

SECTION E: THIS SECTION MUST BE SIGNED BY THE VETERAN OR DPOA

The Veteran is applying for admission to the State Veterans Nursing Home. The veteran is a resident of the State of Florida immediately preceding the date of this application. All the statements on this application are true and complete. Veteran agrees to follow the rules of conduct and policies and procedures of the Department of Veterans' Affairs and the State Veterans' Nursing Home. VETERAN AGREES TO APPLY FOR ALL FINANCIAL ASSISTANCE AVAILABLE THAT THEY MAY QUALIFY FOR, TO INCLUDE MEDICAID. I agree to the release of all medical and financial information needed to complete this application process.

_____ _____ Applicant's

Signature, or person authorized to sign for applicant Date

The State of Florida Department of Veterans' Affairs (FDVA) is asking you to provide your Social Security Number. If you give FDVA your Social Security Number, we will use it to verify honorable Veteran status, for billing purposes or for other purposes as authorized or required by law. The information you supply may be verified through a computer-matching program. FDVA may disclose the information you put on this form as permitted by law. You do not have to provide the information to FDVA, but if you do not, we will be unable to process your application for admission and serve your medical needs. **FS119.071(5) Personal Information**

APPLICATION FOR BENEFITS VA FORM 10-10-EZ

(to be completed by applicant or representative)

OMB Control No. 2900-0091
Estimated Burden Avg. 30 min.
Expiration Date: 06/30/2024

Department of Veterans Affairs

VA DATE STAMP
(For VHA Use Only)

APPLICATION FOR HEALTH BENEFITS

SECTION I - GENERAL INFORMATION

Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)

TYPE OF BENEFIT(S) APPLYING FOR:

☐ **ENROLLMENT** - VA Medical Benefits Package (Veteran meets and agrees to the enrollment eligibility criteria specified at 38 CFR 17.36)

☐ **REGISTRATION** *(Complete Sections I, II, and III)* - VA Health Services (Veterans meets the "Enrollment not required" eligibility criteria specified at 38 CFR 17.37)

1A. VETERAN'S NAME *(Last, First, Middle Name)*	1B. PREFERRED NAME	2. MOTHER'S MAIDEN NAME

3A. BIRTH SEX	3B. SELF-IDENTIFIED GENDER IDENTITY	4. ARE YOU HISPANIC OR LATINO?
☐ MALE ☐ FEMALE	☐ MAN ☐ WOMAN ☐ TRANSGENDER MAN ☐ TRANSGENDER WOMAN ☐ NON-BINARY ☐ PREFER NOT TO ANSWER ☐ A GENDER NOT LISTED HERE	☐ YES ☐ NO

5. WHAT IS YOUR RACE? *(You may check more than one. Information is required for statistical purposes only.)*	6. SOCIAL SECURITY NO.
☐ ASIAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ WHITE ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ CHOOSE NOT TO ANSWER	

7A. DATE OF BIRTH *(mm/dd/yyyy)*	7B. PLACE OF BIRTH *(City and State)*	8. PREFERRED LANGUAGE	9. RELIGION

10A. MAILING ADDRESS *(Street)*	10B. CITY	10C. STATE	10D. ZIP CODE	10E.COUNTY

10F. HOME TELEPHONE NO. *(optional)* *(Include Area Code)*	10G. MOBILE TELEPHONE NO. *(optional)* *(Include Area Code)*	10H. E-MAIL ADDRESS *(optional)*

11A. HOME ADDRESS *(Street)*	11B. CITY	11C. STATE	11D. ZIP CODE	11E.COUNTY

12. CURRENT MARITAL STATUS

☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED

13A. NEXT OF KIN NAME	13B. NEXT OF KIN ADDRESS	13C. NEXT OF KIN RELATIONSHIP

13D. NEXT OF KIN TELEPHONE NO. *(Include Area Code)*	14A. EMERGENCY CONTACT NAME	14B. EMERGENCY CONTACT TELEPHONE NO. *(Include Area Code)*

15. DESIGNEE - INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH *(Note: This does not constitute a will or transfer of title)*

16. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? *(for listing of facilities visit www.va.gov/find-locations)*	17. WOULD YOU LIKE FOR VA TO CONTACT YOU TO SCHEDULE YOUR FIRST APPOINTMENT? ☐ YES ☐ NO

APPLICATION FOR HEALTH BENEFITS *Continued*	VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

SECTION II - MILITARY SERVICE INFORMATION

1A. LAST BRANCH OF SERVICE	1B. LAST ENTRY DATE *(mm/dd/yyyy)*	1C. FUTURE DISCHARGE DATE *(mm/dd/yyyy)*	1D. LAST DISCHARGE DATE *(mm/dd/yyyy)*

1E. DISCHARGE TYPE	1F. MILITARY SERVICE NUMBER

2. MILITARY HISTORY *(Check yes or no)*	YES	NO		YES	NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?	☐	☐	F. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	☐	☐
B. ARE YOU A FORMER PRISONER OF WAR?	☐	☐	G. DID YOU SERVE IN AN AGENT ORANGE LOCATION BETWEEN JANUARY 9, 1962 AND JULY 31, 1980?	☐	☐
C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?	☐	☐	H. DID YOU SERVE IN AN IONIZING RADIATION LOCATION AND PARTICIPATE IN ANY NUCLEAR TESTING, TREATMENTS, OR CLEAN UP?	☐	☐
D. WERE YOU DISCHARGED OR RETIRED FROM MILITARY FOR A DISABILITY INCURRED IN THE LINE OF DUTY?	☐	☐	I. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	☐	☐
E. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998?	☐	☐	J. DID YOU SERVE ON ACTIVE DUTY AT LEAST 30 DAYS AT CAMP LEJEUNE FROM AUGUST 1, 1953 THROUGH DECEMBER 31, 1987?	☐	☐

SECTION III - INSURANCE INFORMATION *(Use a separate sheet for additional information)*

1. ENTER YOUR HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER *(Include coverage through spouse or other person)*

2. NAME OF POLICY HOLDER	3. POLICY NUMBER	4. GROUP CODE

5. ARE YOU ELIGIBLE FOR MEDICAID? *(Federal health insurance for low income adults)*	6A. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A?	6B. EFFECTIVE DATE *(mm/dd/yyyy)*	6C. MEDICARE NUMBER:
☐ YES ☐ NO	☐ YES ☐ NO		

SECTION IV - DEPENDENT INFORMATION *(Use a separate sheet for additional dependents)*

1. SPOUSE'S NAME *(Last, First, Middle Name)*	2. CHILD'S NAME *(Last, First, Middle Name)*

1A. SPOUSE'S SOCIAL SECURITY NUMBER	2A. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)*	2B. CHILD'S SOCIAL SECURITY NO.

1B. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)*	2C. DATE CHILD BECAME YOUR DEPENDENT *(mm/dd/yyyy)*

1C. SPOUSE'S SELF-IDENTIFIED GENDER IDENTITY

☐ MAN ☐ WOMAN ☐ TRANSGENDER MAN
☐ TRANSGENDER WOMAN ☐ NON-BINARY
☐ PREFER NOT TO ANSWER ☐ A GENDER NOT LISTED HERE

2D. CHILD'S RELATIONSHIP TO YOU *(Check one)*

☐ SON ☐ DAUGHTER ☐ STEPSON ☐ STEPDAUGHTER

1D. DATE OF MARRIAGE *(mm/dd/yyyy)*

2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18?

☐ YES ☐ NO

1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP if different from Veteran's)*

2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR?

☐ YES ☐ NO

2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(e.g., tuition, books, materials)*

3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT?

☐ YES ☐ NO

SECTION V - EMPLOYMENT INFORMATION

1A. VETERAN'S EMPLOYMENT STATUS *(Check one)*.	1B. DATE OF RETIREMENT *(mm/dd/yyyy)*
☐ FULL TIME ☐ PART TIME ☐ NOT EMPLOYED ☐ RETIRED	

1C. COMPANY NAME. *(Complete if employed or retired)*	1D. COMPANY ADDRESS *(Complete if employed or retired - Street, City, State, ZIP)*	1E. COMPANY PHONE NUMBER *(Complete if employed or retired) (Include area code)*

APPLICATION FOR HEALTH BENEFITS *Continued*	VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

SECTION VI - FINANCIAL DISCLOSURE

Disclosure allows VA to accurately determine whether certain Veterans will be charged copays for care and medications, their eligibility for other services and enrollment priority. Veterans are not required to disclose their financial information. Veterans who choose not to disclose financial information may not be eligible for enrollment or may be responsible for any applicable VA copayments, if they are enrolled. **Recent Combat Veterans (e.g., OEF/OIF/OND)** may answer YES in Section VI and complete Sections VII and VIII to have their priority for enrollment and financial eligibility for travel assistance, cost-free medications and/or medical care for services unrelated to military experience.

☐ **No, I do not wish to provide financial information in Sections VII through VIII.** If I am enrolled, I agree to pay applicable VA copayments. Sign and date the form in the Assignment of Benefits section.

☐ **Yes, I will provide my household financial information for last calendar year.** Complete applicable Sections VII and VIII. Sign and date the form in the Assignment of Benefits section.

SECTION VII - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN

(Use a separate sheet for additional dependents)

	VETERAN	SPOUSE	CHILD 1
1. GROSS ANNUAL INCOME FROM EMPLOYMENT *(wages, bonuses, tips, etc.)* EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
3. LIST OTHER INCOME AMOUNTS *(e.g., Social Security, compensation, pension, interest, dividends)* EXCLUDING WELFARE.	$	$	$

SECTION VIII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE *(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home) VA will calculate a deductible and the net medical expenses you may claim.*	$
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES (INCLUDING PREPAID BURIAL EXPENSES) FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD *(Also enter spouse or child's information in Section VI.)*	$
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES *(e.g., tuition, books, fees, materials) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.*	$

SECTION IX - CONSENT TO COPAYS AND TO RECEIVE COMMUNICATIONS

By submitting this application, you are agreeing to pay the applicable VA copayments for care or services (including urgent care) as required by law. You also agree to receive communications from VA to your supplied email, home phone number, or mobile number. However, providing your email, home phone number, or mobile number is voluntary.

ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section 1729 and 42 U.S.C. 2651, the Department of Veterans Affairs (VA) is authorized to recover or collect from my health plan (HP) or any other legally responsible third party for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse. Furthermore, I hereby assign to the VA any claim I may have against any person or entity who is or may be legally responsible for the payment of the cost of medical services provided to me by the VA. I understand that this assignment shall not limit or prejudice my right to recover for my own benefit any amount in excess of the cost of medical services provided to me by the VA or any other amount to which I may be entitled. I hereby appoint the Attorney General of the United States and the Secretary of Veterans' Affairs and their designees as my Attorneys-in-fact to take all necessary and appropriate actions in order to recover and receive all or part of the amount herein assigned. I hereby authorize the VA to disclose, to my attorney and to any third party or administrative agency who may be responsible for payment of the cost of medical services provided to me, information from my medical records as necessary to verify my claim. Further, I hereby authorize any such third party or administrative agency to disclose to the VA any information regarding my claim.

ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS WHICH DEFINE WHO CAN SIGN ON BEHALF OF THE VETERAN.

SIGNATURE OF APPLICANT *(Sign in ink)* _____ **DATE** *(mm/dd/yyyy)* _____

The State of Florida Department of Veterans' Affairs (FDVA) is asking you to provide your Social Security Number. If you give FDVA your Social Security Number, we will use it to verify honorable Veteran status, for billing purposes or for other purposes as authorized or required by law. The information you supply may be verified through a computer-matching program. FDVA may disclose the information you put on this form as permitted by law. You do not have to provide the information to FDVA, but if you do not, we will be unable to process your application for admission and serve your medical needs. **FS119.071(5) Personal Information**

James S. Hartsell Executive Director	**STATE OF FLORIDA** **DEPARTMENT OF VETERANS' AFFAIRS** **NURSING HOME PROGRAM**	**Ron DeSantis** Governor **Ashley Moody** Attorney General **Jimmy Patronis** Chief Financial Officer **Wilton Simpson** Commissioner of Agriculture

MEDICAL RECORDS AND HEALTH INFORMATION RELEASE

(to be completed by applicant or representative)

PATIENT NAME: _____ **DATE OF BIRTH:** _____

I authorize the use or disclosure of the above individual's health information as described below. The following individual or organization is authorized to make the disclosure:

Facility to fill in:

_____

NAME OF HOSPITAL, PHYSICIAN, OR HEALTHCARE FACILITY

This information may be disclosed to and used by the following individual or organization for the purposes of assisting with placement and providing medical care:

Emory L Bennett SVNH
1920 Mason Avenue
☐ **Daytona Beach, FL 32117**
PH: 386-274-3460
FAX: 386-274-3487

Douglas Jacobson SVNH
21281 Grayton Terr.
☐ **Pt. Charlotte, FL 33954 PH: 941-613-0919**
FAX: 941-613-0935

Baldomero Lopez SVNH
6919 Parkway Blvd
☐ **Land O Lakes, FL 34689**
PH: 813-558-5000
FAX: 813-558-5021

Clyde E Lassen SVNH
4650 SR 16
St. Augustine, FL 32092
PH: 904-940-2193
☐ **FAX: 904-940-9913**

Sandy Nininger SVNH
8401 W. Cypress Drive
Pembroke Pines
☐ **PH: 954-985-4824**
FAX: 954-985-4866

Ardie R. Copas SVNH
13000 SW Tradition
Pt. St. Lucie, FL 34987
☐ **PH: 772-241-6132**

Chester Sims SVNH
4419 Tram Road
☐ **Panama City, FL 32404**
PH: 850-747-5401
FAX: 850-747-5301

Lake Baldwin SVNH
5255 Raymond Street
☐ **Orlando, FL 32803**
PH: 407-741-4614
FAX: 407-741-4631

The purpose of the disclosure is to assist with placement and providing medical care and may be shared with other Florida. State Veterans' Homes for placement.

INITIAL BELOW FOR RELEASE OF INFORMATION

_____ 1. The undersigned hereby authorizes the release of copies of all medical records included but not limited to the following: Physician's orders, discharge summary, and History & Physical X-ray/Lab/EKG reports, MDS Physician's progress notes
Nursing notes, Care plans, Medication list

Dietary notes, Activity notes, Social Services assessment
Consultations-specify: _____
Other-specify: _____

_____ 2. I understand and hereby authorize the release of information in my medical record, which may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV).

_____ 3. I understand and hereby authorize the release of information in my medical record, which may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

(Note: Release of psychiatric or substance abuse progress notes require a separate authorization.) I understand that I have a right to revoke this authorization at any time. I understand that if I revoke the authorization, I must do so in writing and present my written revocation to the health information management department.

I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire if my application is denied, or if accepted, upon my permanent transfer or discharge from the facility.
I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to obtain treatment. I understand the potential for the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by the Federal privacy laws.

_____ _____
Signature of Resident or Legal Representative Date

_____
Relationship of Legal Representative to Resident

_____ _____
Signature of Witness Date

ACTIVITIES OF DAILY LIVING (ADLS) AND BEHAVIORS QUESTIONNAIRE

(to be completed by applicant or representative, CHECK ALL THAT APPLY)

AMBULATION (walking) ☐ Ambulates safely w/no physical help ☐ Needs assistance, set-up help, or supervision ☐ Needs 1 person or 2-person physical assist ☐ Does not ambulate	EATING ☐ Can safely eat meals or snacks with no assistance ☐ Needs assistance, set-up help, or supervision ☐ Needs 1 person or 2-person physical assist ☐ Does not eat (other modes of nutrition)
WHEELCHAIR ☐ Can safely propel self in wheelchair ☐ Needs assistance, set-up help, or supervision ☐ Needs 1 or 2 people to physical assist	TOILETING ☐ Can safely toilet with no assistance or supervision ☐ Needs assistance, set-up help, or supervision ☐ Needs 1 person or 2-person physical assist
BOWEL FUNCTION ☐ Continent ☐ Occasional incontinence – once or twice a week ☐ Frequent incontinence – at least once a day ☐ Total incontinence ☐ Ostomy	BLADDER FUNCTION ☐ Continent ☐ Occasional incontinence – once or twice a week ☐ Frequent incontinence – at least once a day ☐ Total incontinence ☐ Catheter
BED MOBILITY ☐ Can safely position and move in the bed alone ☐ Needs assistance, set-up help, or supervision ☐ Needs 1 person or 2-person physical assist	TRANSFERS ☐ Can safely sit to stand or stand to sit with no help ☐ Needs assistance, set-up help, or supervision ☐ Needs 1 person or 2-person physical assist
BATHING ☐ Can safely bathe with no assistance or supervision ☐ Needs assistance, set-up help, or supervision ☐ Needs 1 person or 2-person physical assist	DRESSING ☐ Can safely dress with no assistance or supervision ☐ Needs assistance, set-up help, or supervision ☐ Needs 1 person or 2-person physical assist
PERSONAL HYGIENE / GROOMING ☐ Can safely complete hygiene/ personal grooming with no assistance or supervision ☐ Needs assistance, set-up help, or supervision ☐ Needs 1 person or 2-person physical assist	ALCOHOL USE ☐ Never occurs ☐ Occurs less than daily ☐ Occurs daily or more frequently
TOBACCO USE (CIGARETTES, CIGARS, PIPE) ☐ Never occurs ☐ Occurs less than daily ☐ Occurs daily or more frequently	DRUG USE ☐ Never occurs ☐ Occurs less than daily ☐ Occurs daily or more frequently

BEHAVIORS (circle all that apply)	BEHAVIORS (circle all that apply)
☐ Has current diagnosis of dementia or Alzheimer's ☐ Sundowns" or wanders ☐ Exit seeking or eloping ☐ Verbally abusive ☐ Physically abusive ☐ Resistant to care ☐ Inappropriate toileting habits ☐ Inappropriate sexual behavior ☐ Hallucinations, Delusions, or Paranoia ☐ Resistant to care (stiffening, rigidity, refusal)	Hallucinations (hears or sees things not there) Delusions (tells stories that are not fact based) ☐ Current smoker ☐ Former smoker ☐ Can understand others ☐ Can be understood by others ☐ Verbal ☐ Non-verbal ☐ Wandering ☐ Comments about death of self or others ☐ Verbally abusive (curses, screams, threatens) ☐ Physically abusive (strikes out, grabs)

VETERAN'S HISTORY QUESTIONNAIRE

1. What traumatic events has the veteran experienced in the past 10 years (i.e. death of a loved one, diagnosed with terminal illness, etc.) And how did he/she handle this? What coping skills or resources did they utilize (i.e. help from family, friends, community support, spiritual faith, etc.)? What is an effective intervention that our staff might use during difficult times?

2. Identify a pleasant/fun activity for the veteran which could be implemented right now (i.e. singing a favorite song, watching special tv program, listening to hymns, etc.).

3. Were there unpleasant or sensitive life experiences which the veteran still recalls and which staff needs to be aware? Please indicate how to respond.

4. Is there anything else we should know to help us provide individualized care to the veteran?

.

CURRENT MEDICATION LIST

(written in or list can be attached, must be signed Health Care Provider)

Medication Name	Dose	Instructions for Use	Route

Provider Name (printed): _____
Signature: _____
Office Phone Number: _____
Date of Exam: _____

Place stamp here if available.

James S. Hartsell Executive Director	**STATE OF FLORIDA** **DEPARTMENT OF VETERANS' AFFAIRS** **NURSING HOME PROGRAM**	**Ron DeSantis** Governor **Ashley Moody** Attorney General **Jimmy Patronis** Chief Financial Officer **Wilton Simpson** Commissioner of Agriculture

STATEMENT OF HEALTH

(to be completed by health care provider, must be completed 30 days prior to admission)

Patient/Resident Name: _____

DOB: _____

☐ I have examined the individual named above and to the best of my knowledge, he/she is free of any communicable diseases.

☐ I have examined the individual named above and to the best of my knowledge, he/she has a communicable disease (if so, indicate in the space below).

Indicate communicable disease here:

_____

_____

_____

By signing below, I certify that this information above is true and accurate.

Provider Name (printed): _____
Signature: _____
Office Phone Number: _____ Date of Exam: _____

Place stamp here if available.

MEDICAL PROVIDER CONTACT INFORMATION

PROVIDER TYPE	PROVIDER NAME	PROVIDER PHONE #
PRIMARY CARE		
NEUROLOGY		
CARDIOLOGY		
VA OUTPATIENT CLINIC		
VA SOCIAL WORKER		
HOME HEALTH AGENCY		
HOSPICE		
SKILLED NURSING FACILITY		
ASSISTED LIVING FACILITY		

Hospitalizations & Admission History

List all Hospitalizations, Skilled Nursing Facility, or Assisted Living Facility admissions in the last year.

Name Hospital, SNF, ALF	Date of Admission	REASON FOR ADMISSION	REASON FOR DISCHARGE

OMB Control No. 2900-0321
Respondent Burden: 5 minutes
Expiration Date: 02/28/2022

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

IMPORTANT: Please read the Privacy Act and Respondent Burden Information on Page 3 before completing the form.

NOTE: If you prefer to have an individual assist you with your claim instead of a veterans service organization, please complete VA Form 21-22a, *Appointment of Individual as Claimant's Representative*. See Page 4 for information on how to submit the completed form, either by mail, in person at a VA regional office or electronically. VA forms are available at www.va.gov/vaforms.

SECTION I: VETERAN'S INFORMATION

NOTE: You can either complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly to expedite processing of the form.

1. VETERAN'S NAME *(First, Middle Initial, Last)*

2. VETERAN'S SOCIAL SECURITY NUMBER *(SSN)* — —

3. VA FILE NUMBER *(If applicable)*

4. VETERAN'S DATE OF BIRTH — — Month / Day / Year

5. VETERAN'S SERVICE NUMBER *(If applicable)*

6. INSURANCE NUMBER(S) *(If applicable) (Include letter prefix)*

7. VETERAN'S MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code —

8. VETERAN'S TELEPHONE NUMBER *(Include Area Code)*

9. VETERAN'S EMAIL ADDRESS *(Optional)*

SECTION II: CLAIMANT'S INFORMATION (If other than veteran)

10. CLAIMANT'S NAME *(First, Middle Initial, Last)*

11. CLAIMANT'S MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code —

12. CLAIMANT'S TELEPHONE NUMBER *(Include Area Code)*

13. CLAIMANT'S EMAIL ADDRESS *(Optional)*

14. RELATIONSHIP TO VETERAN

SECTION III: SERVICE ORGANIZATION INFORMATION

15. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS *(See list on Page 3 before selecting organization)*

16A. NAME OF OFFICIAL REPRESENTATIVE ACTING ON BEHALF OF THE ORGANIZATION NAMED IN ITEM 15 *(This is an appointment of the entire organization and does not indicate the designation of only this specific individual to act on behalf of the organization)*

16B. JOB TITLE OF PERSON NAMED IN ITEM 16A

17. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 15

18. DATE OF THIS APPOINTMENT *(MM/DD/YYYY)*

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION IV: AUTHORIZATION INFORMATION

19. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C. - By checking the box below I authorize VA to disclose to the service organization named on this appointment form any records that may be in my file relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia.

☐ I **authorize** the VA facility having custody of my VA claimant records to disclose to the service organization named in Item 15 all treatment records relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. Redisclosure of these records by my service organization representative, other than to VA or the Court of Appeals for Veterans Claims, is not authorized without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the service organization named in Item 15, either by explicit revocation or the appointment of another representative.

20. LIMITATION OF CONSENT- I authorize disclosure of records related to treatment for all conditions listed in Item 19 except:

☐ DRUG ABUSE ☐ INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)

☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

21. AUTHORIZATION TO CHANGE CLAIMANT'S ADDRESS - By checking the box below, I authorize the organization named in Item 15 to act on my behalf to change my address in my VA records.

☐ I **authorize** any official representative of the organization named in Item 15 to act on my behalf to change my address in my VA records. This authorization does not extend to any other organization without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I file a written revocation with VA; or (2) I appoint another representative, or (3) I have been determined unable to manage my financial affairs and the individual or organization named in Item 16A is not my appointed fiduciary.

I, the claimant named in Items 1 *or* 10, hereby **appoint** the service organization named in Item 15 as my representative to prepare, present and prosecute my claim(s) for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 1. I authorize VA to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 19 and 20), to my appointed service organization. I understand that my appointed representative will not charge any fee or compensation for service rendered pursuant to this appointment. I understand that the service organization I have appointed as my representative may revoke this appointment at any time, subject to 38 CFR 20.6. *Additionally, in some cases a veteran's income is developed because a match with the Internal Revenue Service necessitated income verification. In such cases, the assignment of the service organization as the veteran's representative is valid for only five years from the date the claimant signs this form for purposes restricted to the verification match.* Signed and accepted subject to the foregoing conditions.

SECTION V: SIGNATURES

NOTE: THIS POWER OF ATTORNEY DOES NOT REQUIRE EXECUTION BEFORE A NOTARY PUBLIC

22A. SIGNATURE OF VETERAN OR CLAIMANT *(Do Not Print)*	22B. DATE SIGNED *(MM/DD/YYYY)*
23A. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 16A *(Do Not Print)*	**23B. DATE SIGNED** *(MM/DD/YYYY)*

NOTE: As long as this appointment is in effect, the organization named herein will be recognized as the sole representative for preparation, presentation and prosecution of your claim before the Department of Veterans Affairs in connection with your claim or any portion thereof.

VA USE ONLY	COPY OF VA FORM 21-22 SENT TO:	DATE SENT	ACKNOWLEDGED *(Date)*	REVOKED *(Reason and date)*
	☐ VR&E FILE ☐ EDU FILE ☐ LG FILE ☐ INSURANCE FILE			

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement of a material fact, knowing it to be false or for the fraudulent acceptance of any payment to which you are not entitled.

OMB Approval No. 2900-0160
Estimated Burden: 30 minutes

Department of Veterans Affairs	Request for Prescription Drugs from an Eligible Veteran in a State Home

To:	VA Facility	From:	Name and Address of State Home

I am a veteran who was admitted to the _____ State Nursing Home.
I request that I be furnished with prescription drugs by the United States Department of Veterans Affairs as provided for in Title 38 of the Code of Federal Regulations, Section(s) 17.96 and/or 51.42.

I am eligible for this benefit by reason of being (check any of the following):

☐ (1) a veteran in receipt of increased VA compensation, or increased VA pension because I am permanently housebound or in need of regular aid and attendance.

☐ (2) a veteran in need of regular aid and attendance who was formerly in receipt of increased pension but whose pension has been discontinued solely by reason of excess income, and whose annual income does not exceed the maximum annual income limitation by more than $1,000.

☐ (3) a veteran who
(i) Has a singular or combined rating of 50 percent or 60 percent based on one or more service-connected disabilities or unemployability and is in need of such drugs and medicines; and
(ii) Is in need of nursing home care for reasons that do not include care for a VA adjudicated service-connected disability.

☐ (4) a veteran who
(i) Has a singular or combined rating of less than 50 percent, based on one or more service-connected disabilities, and is in need of such drugs and medicines for a service-connected disability, and
(ii) Is in need of nursing home care for reasons that do not include care for a VA adjudicated service-connected disability.

Signature of Veteran Applying for Benefit

Date of Application

Applicant Information

Veteran's Name (last, first, and middle initial):

Veteran's Social Security Number:	Date of Admission to the State Nursing Home:

Date that A&A or Housebound was awarded by VA:

(a copy of this award ☐ is or ☐ is not attached with this request)

Diagnosis/Diagnoses for which the Applicant was Admitted to the State Nursing Home		
Diagnosis Code	**Diagnosis Name**	**Category of Eligibility from page 1** *(1, 2, 3 or 4)*
Name of Prescribing Physician:		**Telephone Number:**

I certify that the following medications are prescribed for _____ .
Veteran's Name

_____
Signature of State Home Representative

James S. Hartsell Executive Director	**STATE OF FLORIDA** **DEPARTMENT OF VETERANS' AFFAIRS** **NURSING HOME PROGRAM**	**Ron DeSantis** Governor **Ashley Moody** Attorney General **Jimmy Patronis** Chief Financial Officer **Wilton Simpson** Commissioner of Agriculture

VERIFICATION OF CAPACITY

MEDICAL VERIFICATION OF CAPACITY OR INCAPACITY TO GIVE INFORMED CONSENT AND / OR MAKE MEDICAL DECISIONS UPON ADMISSION OR FROM A CHANGE IN CONDITION

I, DR. _____, the attending / referring
PHYSICIAN NAME

physician for _____a potential or current resident at the
PATIENT NAME

_____, have evaluated my patient on

_____ and determined that HE / SHE _____ HAS or _____ LACKS
DATE

capacity to make informed consent and / or medical decisions due to the following

conditions: _____.

_____ _____

PHYSICIAN SIGNATURE **DATE**

This determination is being made as part of the medical record for the purpose of:

1. **Initiating the resident's Living Will**
2. **Commencing and delegating the authority of the resident's Health Care Surrogate**
3. **Designating a Health Care Proxy for the resident**
4. **Signing Admission documents to a skilled nursing facility**

FAMILY QUESTIONNAIRE

We request that you complete this form to the best of your ability in order to ensure that we have sufficient and relevant information to care for your loved one. Our sincere intent in asking you to answer these questions is to obtain information in which may help us enhance the quality of his / her life to the greatest extent possible.

VETERAN'S NAME: _____ **NICKNAME:** _____

DATE OF BIRTH: _____ **AGE:** _____ **PLACE OF BIRTH:** _____

CURRENT MARITAL STATUS: ☐ **SINGLE** ☐ **MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐ **SEPARATED**

HIGHEST LEVEL OF EDUCATION COMPLETED: _____

FORMER OCCUPATION(S): _____

NAME OF DURABLE POWER OF ATTORNEY (DPOA) OR GUARDIAN: _____

RELATIONSHIP OF DPOA OR GUARDIAN TO VETERAN: _____

NAME(S) OF VETERAN'S CHILDREN AND RELATIONSHIP

_____ ☐ **DISTANT** ☐ **POOR** ☐**GOOD**

_____ ☐ **DISTANT** ☐ **POOR** ☐**GOOD**

_____ ☐ **DISTANT** ☐ **POOR** ☐**GOOD**

_____ ☐ **DISTANT** ☐ **POOR** ☐**GOOD**

_____ ☐ **DISTANT** ☐ **POOR** ☐**GOOD**

_____ ☐ **DISTANT** ☐ **POOR** ☐**GOOD**

NAME(S) OF VETERAN'S RELATIVES AND RELATIONSHIP

_____ ☐ **DISTANT** ☐ **POOR** ☐**GOOD**

_____ ☐ **DISTANT** ☐ **POOR** ☐**GOOD**

_____ ☐ **DISTANT** ☐ **POOR** ☐**GOOD**

_____ ☐ **DISTANT** ☐ **POOR** ☐**GOOD**

_____ ☐ **DISTANT** ☐ **POOR** ☐**GOOD**

_____ ☐ **DISTANT** ☐ **POOR** ☐**GOOD**

WITH WHOM DOES THE VETERAN HAVE THE BEST RELATIONSHIP AND WHY? _____

VETERAN'S PRIOR LIVING SITUATION:

☐ **HOME** ☐ **ASSISTED LIVING FACILITY (ALF)** ☐ **SKILLED NURSING FACILITY (SNF)** ☐ **OTHER**

ADMITTED TO STATE VETERANS' NURSING HOME FROM: _____

DOES THE VETERAN HAVE A MEMORY PROBLEM? ☐ **YES** ☐ **NO**

HOW LONG HAS THE VETERAN HAD A MEMORY PROBLEM?

☐ 1 YEAR ☐ 1 – 3 YEARS ☐ 3 – 5 YEARS ☐ 5 YEARS OR MORE

WAS THE ONSET OF THE MEMORY PROBLEM: ☐ SUDDEN ☐ GRADUAL

HAVE THERE BEEN ANY CHANGES IN THE VETERAN'S MOOD OR BEHAVIOR IN THE LAST 6 MONTHS?

☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

DOES THE VETERAN HAVE A HISTORY OF PSYCHIATRIC PROBLEMS (DEPRESSION, HOSPITALIZATION, MEDICATION, PSYCHOTHERAPY, ETC) _____

MOOD AND BEHAVIOR

CHECK ALL BEHAVIORS THAT APPLY AND OCCURRENCE OF BEHAVIOR

BEHAVIOR	NEVER OCCURS	OCCURS LESS THEN DAILY	OCCURS DAILY OR MORE FREQUENTLY
Wandering			
Continuous pacing			
Repetitive behaviors (word, actions)			
Withdrawn / depressed (long periods of time inactive			
Anxious, worried			
Crying, tearful			
Comments about death of self or others			
Sleep disturbances (insomnia or frequent napping)			
Mood swings (sudden changes in mood)			
Over-eating			
Under-eating			
Clinging (to caregiver, can't leave sight / needs reassurance)			
Verbally abusive (curses, screams, threatens)			
Physically abusive (strikes out, grabs)			
Rummaging or hoarding			
Inappropriate toileting habits			
Inappropriate sexual behavior			

Sun-downing (difficult behaviors or increased confusion occurs in the late afternoon)			
Hallucinations (hears or sees things that are not there)			
Delusions (tells stories that are not fact based)			
Suspiciousness, paranoia			
Resistant to care (stiffening, rigidity, refusal)			
Repetitive verbalizations or behaviors			
Catastrophic reactions (overacts to stressful situations)			

DOES THE VETERAN HAVE A HISTORY OF USING ANY OF THE FOLLOWING SUBSTANCES:

	YES	**NO**	**TYPES USED**	**AVERAGE USE**	**HOW LONG SINCE LAST TIME USED**
TOBACCO USE (cigarettes, cigars, pipe)					
ALCOHOL USE					
DRUG USE					

DESCRIBE THE BEHAVIOR OF THE VETERAN THAT REFLECTS THEIR:

Anger: _____

Depression / sadness: _____

Other: _____

WHAT TRAUMATIC EVENTS HAS THE VETERAN EXPERIENCED IN THE PAST 10 YEARS (I.E. DEATH OF A LOVED ONE, DIAGNOSED WITH TERMINAL ILLNESS, ETC.) _____

AND HOW DID HE/SHE HANDLE THIS? _____

WHAT COPING SKILLS OR RESOURCES DID THEY UTILIZE (I.E. HELP FROM FAMILY, FRIENDS, COMMUNITY SUPPORT, SPIRITUAL FAITH, ETC.)? _____

WHAT IS AN EFFECTIVE INTERVENTION THAT OUR STAFF MIGHT USE DURING DIFFICULT TIMES? _____
_____

IS THERE A PARTICULAR ANNIVERSARY, HOLIDAY, EVENT OF THE PAST OR SITUATION THAT MAY TRIGGER SADNESS, WITHDRAWAL, AGITATION, OR IN ANY WAY AFFECT THEIR BEHAVIOR IN THEIR NEW ENVIRONMENT?
_____

IDENTIFY A PLEASANT/FUN ACTIVITY FOR THE VETERAN WHICH COULD BE IMPLEMENTED RIGHT NOW (I.E. SINGING A FAVORITE SONG, WATCHING SPECIAL TV PROGRAM, LISTENING TO HYMNS, ETC.) _____

_____

WHAT METHOD OF REINFORCEMENT IS THE MOST SATISFYING FOR THE VETERAN (I.E. SOCIAL, TOUCHING, HUGGING, PATS ON THE BACK, PRAISE, COMPLIMENT)? _____

_____

TANGIBLE – PRIZES, FOOD, ETC: _____

IN YOUR OPINION, HOW WILL THE VETERAN ADJUST / ADAPT TO LIFE IN THIS FACILITY? _____

_____

WHAT CAN OUR STAFF DO TO MAKE THIS TRANSITION EASIER FOR THE VETERAN? _____

IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT THE VETERAN? _____

WHAT TYPE OF LEISURE ACTIVITIES HAS YOUR RELATIVE ENJOYED IN THE PAST 6 MONTHS? _____

_____

WHAT TYPE OF LEISURE ACTIVITIES CAN/DOES YOUR FAMILY MEMBER STILL ENJOY DOING? _____

_____

ARE THERE SITUATIONS THAT UPSET YOUR RELATIVE?

☐ **CAR RIDES** ☐ **BEING ALONE** ☐ **UNFAMILIAR SURROUNDINGS**

☐ **DEMANDS (PERSONAL CARE)** ☐ **BEING TOUCHED**

☐ **OTHER:** _____

DO YOU HAVE APPROACHES YOU USE TO HELP CALM YOUR RELATIVE?

☐ **HUMOR** ☐ **AFFECTION** ☐ **FOOD (SNACK)** ☐ **GOING FOR A WALK**

☐ **LEAVING ALONE**

☐ **OTHER:** _____

DOES YOUR RELATIVE EXPERIENCE ROUTINE OR OCCASIONAL DISCOMFORT DUE TO PHYSICAL CONDITIONS (HEADACHES, JOINT PAIN, ETC.)? _____

CLUES THAT MAY INDICATE YOUR RELATIVE IS EXPERIENCING PAIN OR ILLNESS (VERBAL OR NON-VERBAL). _____

_____

ARE THERE LIFE EXPERIENCES OR ACCOMPLISHMENTS YOUR RELATIVE ENJOYS RECALLING?

CHILDHOOD_____

MIDDLE YEARS _____

RETIREMENT _____

WERE THERE UNPLEASANT OR SENSITIVE LIFE EXPERIENCES WHICH THE VETERAN STILL RECALLS AND WHICH STAFF NEEDS TO BE AWARE? PLEASE INDICATE HOW TO RESPOND.

CHILDHOOD_____

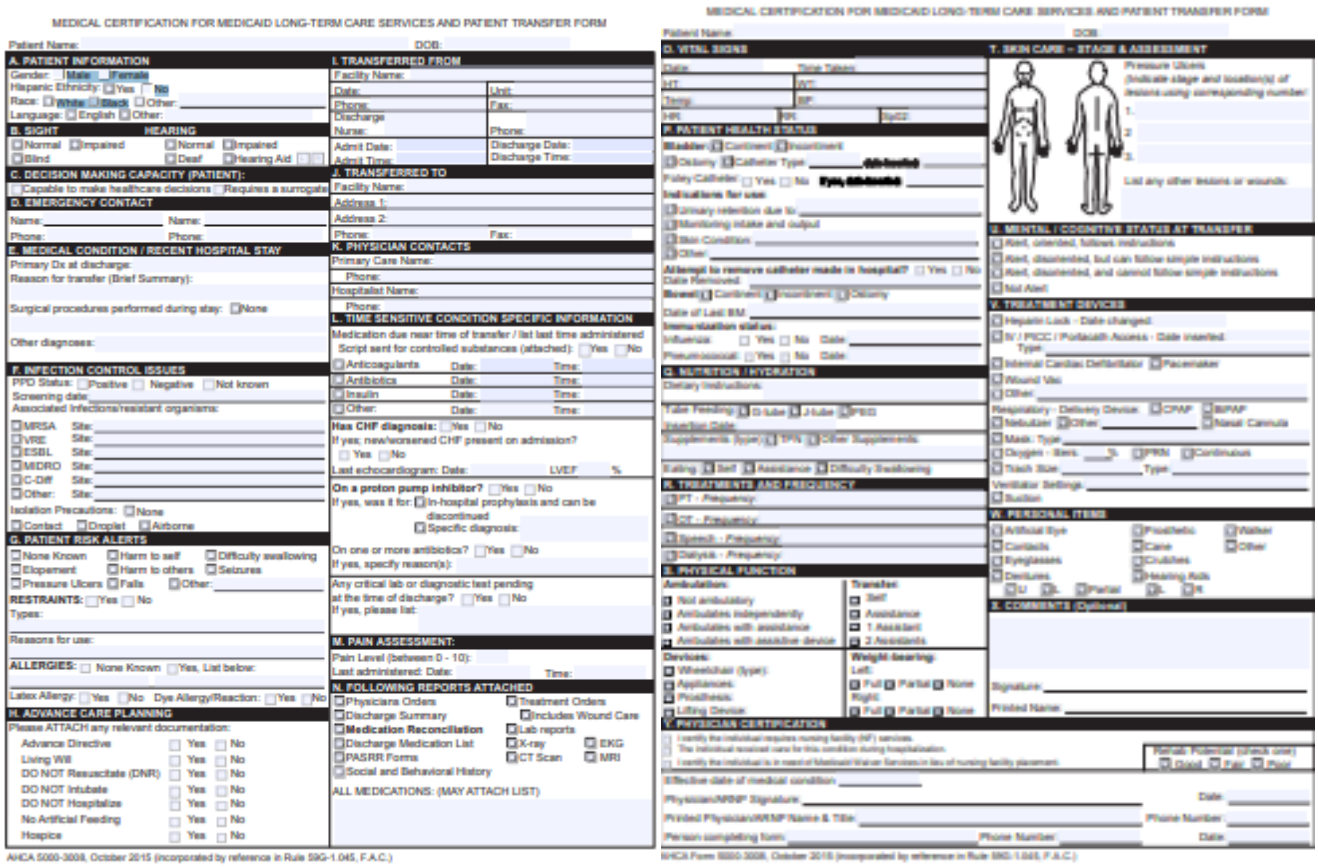
MIDDLE YEARS _____

RETIREMENT _____

THE FOLLOWING DOCUMENTS NEED TO BE OBTAINED PRIOR TO ADMISSION FROM YOUR MEDICAL PROFESSIONAL.

Sample Documents Below

Example 3008



MEDICAL CERTIFICATION FOR MEDICAID LONG-TERM CARE SERVICES AND PATIENT TRANSFER FORM

Patient Name: DOB:

A. PATIENT INFORMATION

Gender: Male Female
Hispanic Ethnicity: Yes No
Race: White Black Other:
Language: English Other:

B. SIGHT / **HEARING**

Normal Impaired / Normal Impaired
Blind / Deaf Hearing Aid

C. DECISION MAKING CAPACITY (PATIENT):

Capable to make healthcare decisions Requires a surrogate

D. EMERGENCY CONTACT

Name: Name:
Phone: Phone:

E. MEDICAL CONDITION / RECENT HOSPITAL STAY

Primary Dx at discharge:
Reason for transfer (Brief Summary):
Surgical procedures performed during stay: None
Other diagnoses:

F. INFECTION CONTROL ISSUES

PPD Status: Positive Negative Not known
Screening date:
Associated Infections/resistant organisms:
MRSA Site:
VRE Site:
ESBL Site:
MDRO Site:
C-Diff Site:
Other: Site:
Isolation Precautions: None
Contact Droplet Airborne

G. PATIENT RISK ALERTS

None Known Harm to self Difficulty swallowing
Elopement Harm to others Seizures
Pressure Ulcers Falls Other:
RESTRAINTS: Yes No
Types:
Reasons for use:
ALLERGIES: None Known Yes, List below:
Latex Allergy: Yes No Dye Allergy/Reaction: Yes No

H. ADVANCE CARE PLANNING

Please ATTACH any relevant documentation:

Advance Directive	Yes	No
Living Will	Yes	No
DO NOT Resuscitate (DNR)	Yes	No
DO NOT Intubate	Yes	No
DO NOT Hospitalize	Yes	No
No Artificial Feeding	Yes	No
Hospice	Yes	No

I. TRANSFERRED FROM

Facility Name:
Date: Unit:
Phone: Fax:
Discharge Nurse: Phone:
Admit Date: Discharge Date:
Admit Time: Discharge Time:

J. TRANSFERRED TO

Facility Name:
Address 1:
Address 2:
Phone: Fax:

K. PHYSICIAN CONTACTS

Primary Care Name:
Phone:
Hospitalist Name:
Phone:

L. TIME SENSITIVE CONDITION SPECIFIC INFORMATION

Medication due near time of transfer / list last time administered
Script sent for controlled substances (attached): Yes No

Anticoagulants	Date:	Time:
Antibiotics	Date:	Time:
Insulin	Date:	Time:
Other:	Date:	Time:

Has CHF diagnosis: Yes No
If yes: new/worsened CHF present on admission?
Yes No
Last echocardiogram: Date: LVEF: %
On a proton pump inhibitor? Yes No
If yes, was it for: In-hospital prophylaxis and can be discontinued
Specific diagnosis:
On one or more antibiotics? Yes No
If yes, specify reason(s):
Any critical lab or diagnostic test pending at the time of discharge? Yes No
If yes, please list:

M. PAIN ASSESSMENT:

Pain Level (between 0 - 10):
Last administered: Date: Time:

N. FOLLOWING REPORTS ATTACHED

Physicians Orders Treatment Orders
Discharge Summary Includes Wound Care
Medication Reconciliation Lab reports
Discharge Medication List X-ray EKG
PASRR Forms CT Scan MRI
Social and Behavioral History
ALL MEDICATIONS: (MAY ATTACH LIST)

AHCA 5000-3008, October 2015 (incorporated by reference in Rule 59G-1.045, F.A.C.)

MEDICAL CERTIFICATION FOR MEDICAID LONG-TERM CARE SERVICES AND PATIENT TRANSFER FORM

Patient Name: DOB:

O. VITAL SIGNS

Date: Time Taken:
HT: WT:
Temp: BP:
HR: RR: SpO2:

P. PATIENT HEALTH STATUS

Bladder: Continent Incontinent
Ostomy Catheter Type:
Foley Catheter: Yes No
Indications for use:
Urinary retention due to:
Monitoring intake and output
Skin Condition:
Other:
Attempt to remove catheter made in hospital? Yes No
Date Removed:
Bowel: Continent Incontinent Ostomy
Date of Last BM:
Immunization status:
Influenza: Yes No Date:
Pneumococcal: Yes No Date:

Q. NUTRITION / HYDRATION

Dietary Instructions:
Tube Feeding: G-tube J-tube PEG
Insertion Date:
Supplements: Type: TPN Other Supplements:
Eating: Self Assistance Difficulty Swallowing

R. TREATMENTS AND FREQUENCY

PT - Frequency:
OT - Frequency:
Speech - Frequency:
Dialysis - Frequency:

S. PHYSICAL FUNCTION

Ambulation:
Not ambulatory
Ambulates independently
Ambulates with assistance
Ambulates with assistive device
Transfer:
Self
Assistance
1 Assistant
2 Assistants
Devices:
Wheelchair (type):
Appliances:
Prosthesis:
Lifting Device:
Weight-bearing:
Left: Full Partial None
Right: Full Partial None

T. SKIN CARE – STAGE & ASSESSMENT

Pressure Ulcers
(Indicate stage and location(s) of lesions using corresponding number)
1.
2
3.
List any other lesions or wounds:

U. MENTAL / COGNITIVE STATUS AT TRANSFER

Alert, oriented, follows instructions
Alert, disoriented, but can follow simple instructions
Alert, disoriented, and cannot follow simple instructions
Not Alert

V. TREATMENT DEVICES

Heparin Lock - Date changed:
IV / PICC / Portacath Access - Date inserted:
Type:
Internal Cardiac Defibrillator Pacemaker
Wound Vac
Other:
Respiratory - Delivery Device CPAP BiPAP
Nebulizer Other: Nasal Cannula
Mask: Type:
Oxygen - liters: L/. PRN Continuous
Trach Size: Type:
Ventilator Settings:
Suction:

W. PERSONAL ITEMS

Artificial Eye Prosthetic Walker
Contacts Cane Other
Eyeglasses Crutches
Dentures Hearing Aids
U L Partial L R

X. COMMENTS (Optional)

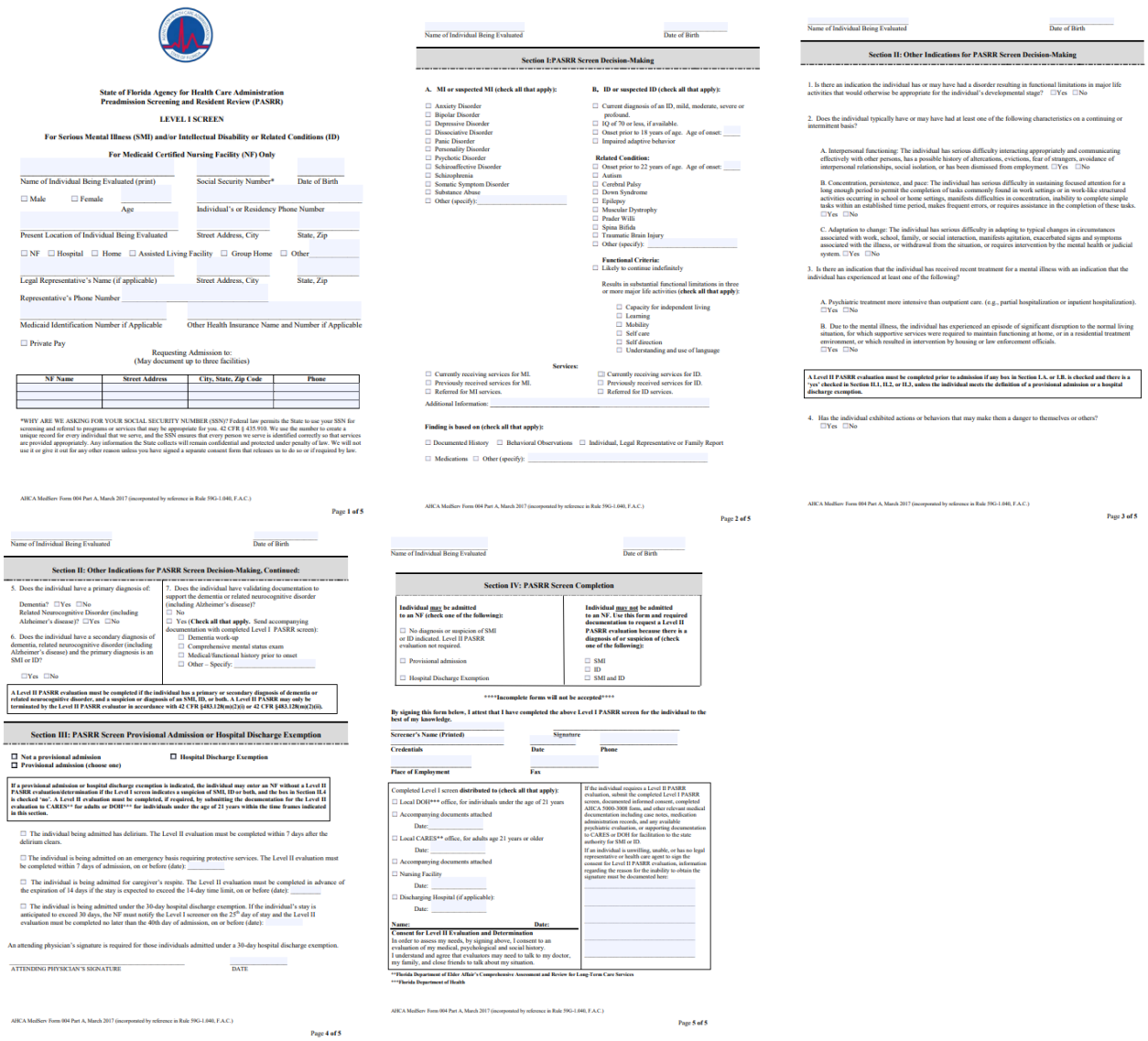
Signature:
Printed Name:

Y. PHYSICIAN CERTIFICATION

I certify the individual requires nursing facility (NF) services.
The individual received care for this condition during hospitalization.
I certify the individual is in need of Medicaid Waiver Services in lieu of nursing facility placement.
Rehab Potential (check one): Good Fair Poor
Effective date of medical condition:
Physician/MRNP Signature: Date:
Printed Physician/MRNP Name & Title: Phone Number:
Person completing form: Phone Number: Date:

AHCA Form 5000-3008, October 2015 (incorporated by reference in Rule 59G-1.045, F.A.C.)

Sample PASSR



State of Florida Agency for Health Care Administration
Preadmission Screening and Resident Review (PASRR)

LEVEL I SCREEN

For Serious Mental Illness (SMI) and/or Intellectual Disability or Related Conditions (ID)

For Medicaid Certified Nursing Facility (NF) Only

Name of Individual Being Evaluated (print) | Social Security Number* | Date of Birth

☐ Male ☐ Female | Age | Individual's or Residency Phone Number

Present Location of Individual Being Evaluated | Street Address, City | State, Zip

☐ NF ☐ Hospital ☐ Home ☐ Assisted Living Facility ☐ Group Home ☐ Other

Legal Representative's Name (if applicable) | Street Address, City | State, Zip

Representative's Phone Number

Medicaid Identification Number if Applicable | Other Health Insurance Name and Number if Applicable

☐ Private Pay

Requesting Admission to:
(May document up to three facilities)

NF Name	Street Address	City, State, Zip Code	Phone

*WHY ARE WE ASKING FOR YOUR SOCIAL SECURITY NUMBER (SSN)? Federal law permits the State to use your SSN for screening and referral to programs or services that may be appropriate for you. 42 CFR § 435.910. We use the number to create a unique record for every individual that we serve, and the SSN ensures that every person we serve is identified correctly so that services are provided appropriately. Any information the State collects will remain confidential and protected under penalty of law. We will not use it or give it out for any other reason unless you have signed a separate consent form that releases us to do so or if required by law.

AHCA MedServ Form 004 Part A, March 2017 (incorporated by reference in Rule 59G-1.040, F.A.C.)

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Name of Individual Being Evaluated | Date of Birth

Section I:PASRR Screen Decision-Making

A. MI or suspected MI (check all that apply):

☐ Anxiety Disorder
☐ Bipolar Disorder
☐ Depressive Disorder
☐ Dissociative Disorder
☐ Panic Disorder
☐ Personality Disorder
☐ Psychotic Disorder
☐ Schizoaffective Disorder
☐ Schizophrenia
☐ Somatic Symptom Disorder
☐ Substance Abuse
☐ Other (specify):

B. ID or suspected ID (check all that apply):

☐ Current diagnosis of an ID, mild, moderate, severe or profound.
☐ IQ of 70 or less, if available.
☐ Onset prior to 18 years of age. Age of onset:
☐ Impaired adaptive behavior

Related Condition:
☐ Onset prior to 22 years of age. Age of onset:
☐ Autism
☐ Cerebral Palsy
☐ Down Syndrome
☐ Epilepsy
☐ Muscular Dystrophy
☐ Prader Willi
☐ Spina Bifida
☐ Traumatic Brain Injury
☐ Other (specify):

Functional Criteria:
☐ Likely to continue indefinitely

Results in substantial functional limitations in three or more major life activities (check all that apply):

☐ Capacity for independent living
☐ Learning
☐ Mobility
☐ Self care
☐ Self direction
☐ Understanding and use of language

Services:

☐ Currently receiving services for MI.
☐ Previously received services for MI.
☐ Referred for MI services.
☐ Currently receiving services for ID.
☐ Previously received services for ID.
☐ Referred for ID services.

Additional Information:

Finding is based on (check all that apply):

☐ Documented History ☐ Behavioral Observations ☐ Individual, Legal Representative or Family Report
☐ Medications ☐ Other (specify):

AHCA MedServ Form 004 Part A, March 2017 (incorporated by reference in Rule 59G-1.040, F.A.C.)

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Name of Individual Being Evaluated | Date of Birth

Section II: Other Indications for PASRR Screen Decision-Making

1. Is there an indication the individual has or may have had a disorder resulting in functional limitations in major life activities that would otherwise be appropriate for the individual's developmental stage? ☐Yes ☐No

2. Does the individual typically have or may have had at least one of the following characteristics on a continuing or intermittent basis?

A. Interpersonal functioning: The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, fear of strangers, avoidance of interpersonal relationships, social isolation, or has been dismissed from employment. ☐Yes ☐No

B. Concentration, persistence, and pace: The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, manifests difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks. ☐Yes ☐No

C. Adaptation to change: The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system. ☐Yes ☐No

3. Is there an indication that the individual has received recent treatment for a mental illness with an indication that the individual has experienced at least one of the following?

A. Psychiatric treatment more intensive than outpatient care. (e.g., partial hospitalization or inpatient hospitalization). ☐Yes ☐No

B. Due to the mental illness, the individual has experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials. ☐Yes ☐No

A Level II PASRR evaluation must be completed prior to admission if any box in Section I.A. or I.B. is checked and there is a 'yes' checked in Section II.1, II.2, or II.3, unless the individual meets the definition of a provisional admission or a hospital discharge exemption.

4. Has the individual exhibited actions or behaviors that may make them a danger to themselves or others? ☐Yes ☐No

AHCA MedServ Form 004 Part A, March 2017 (incorporated by reference in Rule 59G-1.040, F.A.C.)

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Name of Individual Being Evaluated | Date of Birth

Section II: Other Indications for PASRR Screen Decision-Making, Continued:

5. Does the individual have a primary diagnosis of:

Dementia? ☐Yes ☐No
Related Neurocognitive Disorder (including Alzheimer's disease)? ☐Yes ☐No

6. Does the individual have a secondary diagnosis of dementia, related neurocognitive disorder (including Alzheimer's disease) and the primary diagnosis is an SMI or ID?

☐Yes ☐No

7. Does the individual have validating documentation to support the dementia or related neurocognitive disorder (including Alzheimer's disease)?

☐ No
☐ Yes (Check all that apply. Send accompanying documentation with completed Level I PASRR screen):
☐ Dementia work-up
☐ Comprehensive mental status exam
☐ Medical/functional history prior to onset
☐ Other – Specify:

A Level II PASRR evaluation must be completed if the individual has a primary or secondary diagnosis of dementia or related neurocognitive disorder, and a suspicion or diagnosis of an SMI, ID, or both. A Level II PASRR may only be terminated by the Level II PASRR evaluator in accordance with 42 CFR §483.128(m)(2)(i) or 42 CFR §483.128(m)(2)(ii).

Section III: PASRR Screen Provisional Admission or Hospital Discharge Exemption

☐ Not a provisional admission ☐ Hospital Discharge Exemption
☐ Provisional admission (choose one)

If a provisional admission or hospital discharge exemption is indicated, the individual may enter an NF without a Level II PASRR evaluation/determination if the Level I screen indicates a suspicion of SMI, ID or both, and the box in Section II.4 is checked 'no'. A Level II evaluation must be completed, if required, by submitting the documentation for the Level II evaluation to CARES** for adults or DOH** for individuals under the age of 21 years within the time frames indicated in this section.

☐ The individual being admitted has delirium. The Level II evaluation must be completed within 7 days after the delirium clears.

☐ The individual is being admitted on an emergency basis requiring protective services. The Level II evaluation must be completed within 7 days of admission, on or before (date):

☐ The individual is being admitted for caregiver's respite. The Level II evaluation must be completed in advance of the expiration of 14 days if the stay is expected to exceed the 14-day time limit, on or before (date):

☐ The individual is being admitted under the 30-day hospital discharge exemption. If the individual's stay is anticipated to exceed 30 days, the NF must notify the Level I screener on the 25th day of stay and the Level II evaluation must be completed no later than the 40th day of admission, on or before (date):

An attending physician's signature is required for those individuals admitted under a 30-day hospital discharge exemption.

ATTENDING PHYSICIAN'S SIGNATURE | DATE

AHCA MedServ Form 004 Part A, March 2017 (incorporated by reference in Rule 59G-1.040, F.A.C.)

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Name of Individual Being Evaluated | Date of Birth

Section IV: PASRR Screen Completion

Individual may be admitted to an NF (check one of the following):	Individual may not be admitted to an NF. Use this form and required documentation to request a Level II PASRR evaluation because there is a diagnosis of or suspicion of (check one of the following):
☐ No diagnosis or suspicion of SMI or ID indicated. Level II PASRR evaluation not required.	☐ SMI
☐ Provisional admission	☐ ID
☐ Hospital Discharge Exemption	☐ SMI and ID

****Incomplete forms will not be accepted****

By signing this form below, I attest that I have completed the above Level I PASRR screen for the individual to the best of my knowledge.

Screener's Name (Printed) | Signature
Credentials | Date | Phone
Place of Employment | Fax

Completed Level I screen distributed to (check all that apply):

☐ Local DOH*** office, for individuals under the age of 21 years
☐ Accompanying documents attached
Date:
☐ Local CARES** office, for adults age 21 years or older
Date:
☐ Accompanying documents attached
☐ Nursing Facility
Date:
☐ Discharging Hospital (if applicable):
Date:

Name: Date:

Consent for Level II Evaluation and Determination
In order to assess my needs, by signing above, I consent to an evaluation of my medical, psychological and social history. I understand and agree that evaluators may need to talk to my doctor, my family, and close friends to talk about my situation.

If the individual requires a Level II PASRR evaluation, submit the completed Level I PASRR screen, documented informed consent, completed AHCA 5000-3008 form, and other relevant medical documentation including case notes, medication administration records, and any available psychiatric evaluation, or supporting documentation to CARES or DOH for facilitation to the state authority for SMI or ID.
If an individual is unwilling, unable, or has no legal representative or health care agent to sign the consent for Level II PASRR evaluation, information regarding the reason for the inability to obtain the signature must be documented here:

**Florida Department of Elder Affair's Comprehensive Assessment and Review for Long-Term Care Services
***Florida Department of Health

AHCA MedServ Form 004 Part A, March 2017 (incorporated by reference in Rule 59G-1.040, F.A.C.)

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The State of Florida Department of Veterans' Affairs (FDVA) is asking you to provide your Social Security Number. If you give FDVA your Social Security Number, we will use it to verify honorable Veteran status, for billing purposes or for other purposes as authorized or required by law. The information you supply may be verified through a computer-matching program. FDVA may disclose the information you put on this form as permitted by law. You do not have to provide the information to FDVA, but if you do not, we will be unable to process your application for admission and serve your medical needs. **FS119.071(5) Personal Information**