# 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 provide a range of rehabilitation services, including physical, occupational, and speech therapy, as well as restorative programs, all supervised by our qualified therapists. Additionally, we offer hospice and respite services.

The applicant qualifying process consists of three steps:

1. Complete and submit all required documents, including VA, financial, and medical forms, for your application to be processed.
2. Our admissions team will review your completed application.
3. You will be notified by phone or mail regarding the approval or disapproval of your application.

## ADMISSION CRITERIA

Before admission, the facility will verify the following for each applicant:

- The applicant is a Veteran as defined in Chapter 1.01(14) of the Florida Statutes.
- The applicant has been honorably discharged from their most recent period of active duty.
- The applicant is a resident of Florida at the time of application.
- The applicant requires skilled nursing home care for a medical condition.
- The applicant is not currently delinquent on any payments due to the Florida Department of Veterans Affairs from a previous stay in a skilled nursing facility.
- The applicant has submitted a completed application for admission and any additional requested information.
- If a share of cost (payment) is required, the payment must be 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 steps must be completed:

- The application must be fully completed and can be submitted via fax, mail, in-person, or email.
- All required financial information must be provided. Applicants with a 70%-100% service-connected disability are exempt from submitting financial information, but proof of this disability must accompany the application.
- All required medical forms must be completed by a healthcare practitioner (HCP).
- If the facility requests additional medical, financial, or proof of service or disability information, all requested information 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 before admission is scheduled.
- If, after approval, the veteran is placed on our waiting list, a reassessment will be scheduled before actual admission to determine if there has been any change in the veteran's condition.
- You will be notified by telephone or mail whether your application is approved or disapproved, either for direct admission or the waiting list.

# 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 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 and is committed to becoming a 100% tobacco-free facility. This means smoking is prohibited on all facility property, including in cars, on the grass, on porches, etc. Smoking is strictly forbidden in or near areas where oxygen or other gases are stored or administered.**

**For this standard, smoking and tobacco include any lighted or unlighted cigarette, cigar, pipe, bidi, clove cigarette, cigarillo, hookah, and any other smoking product. It also encompasses any smokeless or spitless tobacco, such as dip, chew, snuff, snus, orbs, strips, sticks, and any form of electronic cigarette. Vapor-producing devices and non-lit smoking devices are also considered smoking under this standard. Residents are not allowed to leave the campus to smoke, nor are they permitted to smoke during facility-sponsored outings or events.**

***** Residents admitted to the Emory L. Bennett 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 with 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 is calculated as NET MONTHLY INCOME minus $[amount to be filled in].
- The Veteran retains $[amount to be filled in] each month as a personal needs allowance.
- Proof of income is required to determine the monthly cost of care.
- All Veterans required to pay a share of cost must apply for any monetary benefits for which they may qualify to assist in paying for their care at the facility (e.g., Medicaid).
- If the resident's income exceeds the maximum cost per day, additional charges may apply (such as for medications).

**WHAT IS INCLUDED IN THE 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, not covered in the daily room rate, include but are not limited to: **

- Dental care at any level
- Hearing aid 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)

| | | |
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## ***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:<br><br>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**

| | | |
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# 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:

| | **Skilled Nursing Facilities** | | | **Skilled Nursing Facilities** | |
|---|---|---|---|---|---|
| | **1. Ardie R. Copas, St. Lucie** | | | 6. **Clifford Chester Sims, Panama City** | |
| | Phone: | 772-241-6132 | | Phone: | 850-747-5401 |
| | Fax: | 772-241-6150 | | Fax: | 850-747-5301 |
| | **2. Emory L. Bennett, Daytona Beach** | | | 7. **Douglas T. Jacobson, Port Charlotte** | |
| | Phone: | 386-274-3460 | | Phone: | 941-613-0919 |
| | Fax: | 386-274-3487 | | Fax: | 941-613-0935 |
| | 3. **Alwyn C. Cashe, Orlando** | | | 8. **Clyde E. Lassen, St. Augustine** | |
| | Phone: | 407-741-4614 | | Private | 904-940-2193 |
| | Fax: | 407-741-4631 | | Semi-Private | 904-940-9913 |
| | 4. **Baldomero Lopez, Land O' Lakes** | | | | |
| | Phone: | 813-558-5000 | | | |
| | Fax: | 813-558-5021 | | | |
| | 5. **Alexander Nininger, Pembroke Pines** | | | | |
| | Phone: | 954-985-4824 | | | |
| | Fax: | 954-985-4866 | | | |

The purpose of the disclosure is to assist with placement and providing medical care and may be shared with another 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, including but not limited to the following: physician's orders, discharge summary, history and physical, X-ray/lab/EKG reports, MDS, and 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 to 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 BEHAVIORAL QUESTIONNAIRE

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

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

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

## 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: _____

| | | |
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## STATEMENT OF HEALTH

***(This section must be completed by a healthcare provider within 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 | | |
| | | |
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# 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 |
|---|---|---|---|
| | | | |
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# 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 to provide us with sufficient and relevant information to care for your loved one. Our sincere intent in asking these questions is to gather information that may help us enhance the quality of their life to the greatest extent possible.**

**SPOUSES NAME: _____NICKNAME: _____**

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

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

**VETERAN'S NAME: _____ CURRENT FACILITY RESIDENT: Y or N**

**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**

**_____ ☐ ☐GOOD**
**DISTANT ☐ POOR**

**_____ ☐ ☐GOOD**
**DISTANT ☐ POOR**

**_____ ☐ ☐GOOD**
**DISTANT ☐ POOR**

**_____ ☐ ☐GOOD**
**DISTANT ☐ POOR**

**_____ ☐ ☐GOOD**
**DISTANT ☐ POOR**

**_____ ☐ ☐GOOD**
**DISTANT ☐ POOR**

**NAME(S) OF VETERAN'S RELATIVES AND RELATIONSHIP**

**_____ ☐ ☐GOOD**
**DISTANT ☐ POOR**

**_____ ☐ ☐GOOD**
**DISTANT ☐ POOR**

**_____ ☐ ☐GOOD**
**DISTANT ☐ POOR**

**_____ ☐ ☐GOOD**
**DISTANT ☐ POOR**

**_____ ☐ ☐GOOD**
**DISTANT ☐ POOR**

**_____ ☐ ☐GOOD**
**DISTANT ☐ POOR**

**WITH WHOM DOES THE APPLICANT HAVE THE BEST RELATIONSHIP AND WHY? _____**

**APPLICANT'S PRIOR LIVING SITUATION:**

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

**ADMITTED TO STATE VETERANS' NURSING HOME FROM: _____**

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

**HOW LONG HAS THE APPLICANT 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 APPLICANT'S MOOD OR BEHAVIOR IN THE LAST 6 MONTHS?**

**☐ YES ☐ NO**

**IF YES, PLEASE EXPLAIN: _____**

**DOES THE APPLICANT 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 APPLICANT 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-APPLICANT HAT REFLECTS THEIR:**

**Anger:** _____

**Depression / sadness:** _____

**Other:** _____

**WHAT TRAUMATIC EVENTS HAS THE APPLICANT 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 APPLICANT 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 APPLICANT (I.E. SOCIAL, TOUCHING, HUGGING, PATS ON THE BACK, PRAISE, COMPLIMENT)?** _____

_____

**TANGIBLE – PRIZES, FOOD, ETC:** _____

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

_____

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

---

**IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT THE APPLICANT?**

_____

**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** _____

Department of Veterans Affairs

# INSTRUCTIONS FOR COMPLETING ENROLLMENT APPLICATION FOR HEALTH BENEFITS

## Please Read Before You Start . . . What is VA Form 10-10EZ used for?

For Veterans to apply for enrollment in the VA health care system. The information provided on this form will be used by VA to determine your eligibility for medical benefits and on average will take 30 minutes to complete. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

## Where can I get help filling out the form and if I have questions?

You may use ANY of the following to request assistance:

- Ask VA to help you fill out the form by calling us at 1-877-222-VETS (8387).
- Go to www.va.gov/health-care for information about VA health benefits.
- Contact the Enrollment Coordinator at your local VA health care facility.
- Contact a National or State Veterans Service Organization.

## Definitions of terms used on this form:

- SERVICE-CONNECTED (SC): A VA determination that an illness or injury was incurred or aggravated in the line of duty, in the active military, naval or air service.
- COMPENSABLE: A VA determination that a service-connected disability is severe enough to warrant monetary compensation.
- NONCOMPENSABLE: A VA determination that a service-connected disability is not severe enough to warrant monetary compensation.
- TOXIC EXPOSURE RISK ACTIVITY (TERA): Veterans who were exposed to one or more of the following hazards or conditions during active duty, active duty for training, or inactive duty training (this is not an all-inclusive list): air pollutants, chemicals, occupational hazards, radiation, and warfare agents. For more information visit https://www.publichealth.va.gov/exposures/.
- NONSERVICE-CONNECTED (NSC): A Veteran who does not have a VA determined service-related condition.
- REPORTABLE INCOME: The minimum amount of gross income required to file a Federal income tax return according to the Internal Revenue Code of 1954 Section 6012(a).

**Getting Started:** **ALL VETERANS MUST COMPLETE SECTIONS I - III.**

## Directions for Sections I - III:

**Section I - General Information:** Answer all questions.

**Type of Benefit Applying For:**

- **Enrollment -** Veterans applying for enrollment for the Full Medical Benefits Package provide in 38 C.F.R. 17.38 must meet the eligibility requirements of 38 C.F.R. 17.36.
- **Registration** - For Registrations, only complete Sections I, II, and III. Enrollment not required - Veterans requesting an eligibility assessment, clinical evaluation, care or treatment pursuant to a special treatment authority provided in 38 C.F.R. 17.37:
  - Care for a Veteran with a VA service connected disability rating of 50% or greater
  - Care for a VA rated service connected disability
  - Care for psychosis or other mental illness
  - Care for Military Sexual Trauma treatment (MST)
  - Catastrophically Disabled Examination
  - A veteran who was discharged or released from active military service for a disability incurred or aggravated in the line of duty can receive VA care for the 12-month period following discharge or release
  - Care for a Veteran participating in VA's vocational rehabilitation program under 38 U.S.C. 31

**Section II - Military Service Information:** If you are not currently receiving benefits from VA, you may attach a copy of your discharge or separation papers from the military (such as DD-214 or, for WWII Veterans, a "WD" Form), with your signed application to expedite processing of your application. If claiming a Military Exposure, you may provide us a written statement, or statements from people who witnessed your claimed exposure(s). If you are currently receiving benefits from VA, we will cross-reference your information with VA data.

**Section III - Insurance Information:** Include information for all health insurance companies that cover you, this includes coverage provided through a spouse or significant other. Bring your insurance cards, Medicare and/or Medicaid card with you to each health care appointment.

## Directions for Sections IV-IX:

**Section IV - Dependent Information:** Include the following:

- Your spouse even if you did not live together, as long as you contributed support last calendar year.
- Your biological children, adopted children, and stepchildren who are unmarried and under the age of 18, or at least 18 but under 23 and attending high school, college or vocational school (full or part-time), or became permanently unable to support themselves before age 18.
- Child support contributions. Contributions can include tuition or clothing payments or payments of medical bills.

**Section V - Employment Information:**

- Veterans Employment Status
- Date of Retirement
- Company Name
- Company Address
- Company Phone Number

**Section VI - Financial Disclosure: ONLY NSC AND 0% NONCOMPENSABLE SC VETERANS MUST COMPLETE THIS SECTION TO DETERMINE ELIGIBILITY FOR VA HEALTH CARE ENROLLMENT AND/OR CARE OR SERVICES.**

**Financial Disclosure Requirements Do Not Apply To:**

- a former Prisoner of War; or
- those in receipt of a Purple Heart; or
- a recently discharged Combat Veteran; or
- those who served in a toxic exposure risk activity (TERA); or
- those discharged for a disability incurred or aggravated in the line of duty; or
- those receiving VA SC disability compensation; or
- those receiving VA pension; or
- those in receipt of Medicaid benefits; or
- those who served in an Agent Orange exposure location; or
- those who served in SW Asia during the Gulf War between August 2, 1990 and November 11, 1998; or
- those who served at least 30 days at Camp Lejeune between August 1, 1953 and December 31, 1987.

You are not required to disclose your financial information; however, VA is not currently enrolling new applicants who decline to provide their financial information unless they have other qualifying eligibility factors. If a financial assessment is not used to determine your priority for enrollment you may choose not to disclose your information. However, if a financial assessment is used to determine your eligibility for cost-free medication, travel assistance or waiver of the travel deductible, and you do not disclose your financial information, you will not be eligible for these benefits.

**Section VII - Previous Calendar Year Gross Annual Income of Veteran, Spouse and Dependent Children**

**Report:**

- Gross annual income from employment, except for income from your farm, ranch, property or business. Include your wages, bonuses, tips, severance pay and other accrued benefits and your child's income information if it could have been used to pay your household expenses.
- Net income from your farm, ranch, property, or business.
- Other income amounts, including retirement and pension income, Social Security Retirement and Social Security Disability income, compensation benefits such as VA disability, unemployment, Workers and black lung, cash gifts, interest and dividends, including tax exempt earnings and distributions from Individual Retirement Accounts (IRAs) or annuities.

**Do Not Report:**

Donations from public or private relief, welfare or charitable organizations; Supplemental Security Income (SSI) and need-based payments from a government agency; profit from the occasional sale of property; income tax refunds, reinvested interest on Individual Retirement Accounts (IRAs); scholarships and grants for school attendance; disaster relief payments; reimbursement for casualty loss; loans; Radiation Compensation Exposure Act payments; Agent Orange settlement payments; Alaska Native Claims Settlement Acts Income, payments to foster parent; amounts in joint accounts in banks and similar institutions acquired by reason of death of the other joint owner; Japanese ancestry restitution under Public Law 100-383; cash surrender value of life insurance; lump-sum proceeds of life insurance policy on a Veteran; and payments received under the Medicare transitional assistance program.

**Section VIII - Previous Calendar Year Deductible Expenses**

Report non-reimbursed medical expenses paid by you or your spouse. Include expenses for medical and dental care, drugs, eyeglasses, Medicare, medical insurance premiums and other health care expenses paid by you for dependents and persons for whom you have a legal or moral obligation to support. Do not list expenses if you expect to receive reimbursement from insurance or other sources. Report last illness and burial expenses, e.g., prepaid burial, paid by the Veteran for spouse or dependent(s).

**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.

## Submitting Your Application

1. You or an individual to whom you have delegated your Power of Attorney must sign and date the form. If you sign with an "X", 2 people you know must witness you as you sign. They must sign the form and print their names. If the form is not signed and dated appropriately, VA will return it for you to complete.
2. Attach any continuation sheets, a copy of supporting materials and your Power of Attorney documents to your application.

**Where do I send my application?**

Mail the original application and supporting materials to the Health Eligibility Center, PO Box 5207, Janesville, WI 53547-5207.

## PAPERWORK REDUCTION ACT AND PRIVACY ACT INFORMATION

**VA Burden Statement:** An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-0091, and it expires 07/31/2027. Public reporting burden for this collection of information is estimated to average 35 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing this burden, to VA Reports Clearance Officer at VACOPaperworkReduAct@va.gov. Please refer to OMB Control No. 2900-0091 in any correspondence. Do not send your completed VA Form 10-10EZ to this email address.

**Privacy Act Information:** VA is asking you to provide the information on this form under 38 U.S.C. Sections 1705,1710, 1712, and 1722 in order for VA to determine your eligibility for medical benefits. Information you supply may be verified from initial submission forward through a computer-matching program. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices and in accordance with the VHA Notice of Privacy Practices. Providing the requested information is voluntary, but if any or all of the requested information is not provided, it may delay or result in denial of your request for health care benefits. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify Veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

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. FDVAmay disclose the information you put on this formas 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

OMB Control No. 2900-0091
Estimated Burden Avg. 35 min.
Expiration Date: 07/31/2027

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<br>☐ FEMALE | ☐ MAN ☐ WOMAN ☐ TRANSGENDER MAN ☐ TRANSGENDER WOMAN<br>☐ NON-BINARY ☐ PREFER NOT TO ANSWER ☐ A GENDER NOT LISTED HERE | ☐ YES<br>☐ 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<br>☐ 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 |
|---|---|
| | |

## 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? | ☐ | ☐ | D. WERE YOU DISCHARGED OR RETIRED FROM MILITARY FOR A DISABILITY INCURRED IN THE LINE OF DUTY? | ☐ | ☐ |
| B. ARE YOU A FORMER PRISONER OF WAR? | ☐ | ☐ | E. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998? | ☐ | ☐ |
| C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998? | ☐ | ☐ | F. DO YOU HAVE A VA SERVICE-CONNECTED RATING? | ☐ | ☐ |

# APPLICATION FOR HEALTH BENEFITS
***Continued***

VETERAN'S NAME *(Last, First, Middle)*

SOCIAL SECURITY NUMBER

## SECTION II - MILITARY SERVICE INFORMATION *(Continued)*

| 3. MILITARY EXPOSURE INFORMATION *(Check yes or no)* | YES | NO |
|---|---|---|
| A. DID YOU SERVE IN AN IONIZING RADIATION LOCATION AND PARTICIPATE IN ANY NUCLEAR TESTING, TREATMENTS, OR CLEAN UP? (*Hiroshima and Nagasaki cleanup or Enewetak Atoll, cleanup of Air Force B-52 bomber carrying nuclear weapons off the coast of Palomares, Spain, response to the fire onboard an Air Force B-52 bomber carrying nuclear weapons near Thule Air Force Base in Greenland.)* | ☐ | ☐ |
| B. DID YOU SERVE IN ANY OF THE FOLLOWING GULF WAR HAZARD LOCATIONS? *(Iraq, Kuwait, Saudi Arabia, the neutral zone between Iraq and Saudi Arabia, Bahrain, Qatar, the United Arab Emirates, Oman, Yemen, Lebanon, Somalia, Afghanistan, Israel, Egypt, Turkey, Syria, Jordan, Djibouti, Uzbekistan, the Gulf of Aden, the Gulf of Oman, the Persian Gulf, the Arabian Sea, and the Red Sea.)*<br>WHEN DID YOU SERVE IN THESE LOCATIONS?<br>***NOTE:*** *Please provide an approximate time-frame (mm/yyyy)*<br>FROM: _____ TO: _____ | ☐ | ☐ |
| C. WERE YOU DEPLOYED IN SUPPORT OF ANY OF THE FOLLOWING OPERATIONS? *(Enduring Freedom, Freedom's Sentinel, Iraqi Freedom, New Dawn, Inherent Resolve, and Resolute Support Mission)* | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| D. DID YOU SERVE IN ANY OF THE FOLLOWING HERBICIDE *(e.g. Agent Orange)* LOCATIONS? *(Republic of Vietnam to include 12 nautical mile territorial waters; Thailand at any United States or Royal Thai base; Laos; Cambodia at Mimot or Krek; Kampong Cham Province; Guam or American Samoa; or in the territorial waters thereof; Johnston Atoll or a ship that called at Johnston Atoll; Korean demilitarized zone; aboard (to include repeated operations and maintenance with) a c-123 aircraft known to have been used to spray an herbicide agent (during service in the Air Force and Air Force Reserves.)*<br>WHEN DID YOU SERVE IN THESE LOCATIONS?<br>***NOTE:*** *Please provide an approximate time-frame (mm/yyyy)*<br>FROM: TO: | ☐ | ☐ |

E. HAVE YOU BEEN EXPOSED TO ANY OF THE FOLLOWING? *(Check all that apply)*
Veterans can locate additional military exposure categories on VA's Public Health website at: https://www.publichealth.va.gov/exposures/

- ☐ AIR POLLUTANTS *(burn pits, sand, oil well/sulfur fires)*
- ☐ CHEMICALS *(pesticides, herbicides, contaminated water)*
- ☐ CONTAMINATED WATER AT CAMP LEJEUNE
- ☐ RADIATION ☐ SHAD *(Shipboard Hazard and Defense)*
- ☐ OCCUPATIONAL HAZARDS *(jet fuel, industrial solvents, lead, firefighting foams)*
- ☐ ASBESTOS ☐ MUSTARD GAS
- ☐ WARFARE AGENTS *(nerve agents, chemical and biological weapons)*
- ☐ OTHER *(Specify)*:

WHEN WERE YOU EXPOSED?
***NOTE:*** *Please provide an approximate time-frame (mm/yyyy)*
FROM: TO:

## 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)*

1A. SPOUSE'S SOCIAL SECURITY NUMBER

1B. SPOUSE'S DATE OF BIRTH *(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

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

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

3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT?
☐ YES ☐ NO

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

2A. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)*

2B. CHILD'S SOCIAL SECURITY NO.

2C. DATE CHILD BECAME YOUR DEPENDENT *(mm/dd/yyyy)*

2D. CHILD'S RELATIONSHIP TO YOU *(Check one)*
☐ SON ☐ DAUGHTER ☐ STEPSON ☐ STEPDAUGHTER

2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18?
☐ YES ☐ NO

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 WITH REPORTABLE INCOME FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(e.g., tuition, books, materials)*

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

## SECTION V - EMPLOYMENT INFORMATION

1A. VETERAN'S EMPLOYMENT STATUS *(Check one)*.

☐ FULL TIME ☐ PART TIME ☐ NOT EMPLOYED ☐ RETIRED

1B. DATE OF RETIREMENT *(mm/dd/yyyy)*

| 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)* |
|---|---|---|
| | | |

## 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)* _____

OMB Control No. 2900-0321
Respondent Burden: 5 minutes
Expiration Date:7/31/2026

Department of Veterans Affairs

**VA DATE STAMP**
(DO NOT WRITE IN THIS SPACE)

# APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

**INSTRUCTIONS:** Before completing the form, read the Privacy Act and Respondent Burden on Page 3. The VA Office of General Counsel maintains a list of all attorneys, claims agents, and Veterans Service Organization (VSO) representatives accredited by VA to assist in preparing, presenting, and prosecuting claims for VA benefits at: https://www.va.gov/ogc/apps/accreditation/index.asp. You can search this list by name, state, or zip code. We recommend you use the list to confirm and validate VA accreditation before signing any contract or appointing someone to represent you on your VA benefits claim. If you prefer to have an individual assist you with your claim instead of a VSO, complete VA Form 21-22a, *Appointment of Individual as Claimant's Representative*. For more information, you can contact us through Ask VA: https://ask.va.gov/, or call us toll-free at 1-800-827-1000 (TTY:711). VA forms are available at www.va.gov/vaforms. After completing the form, use the mailing addresses provided on Page 4.

## 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. SOCIAL SECURITY NUMBER *(SSN)*

3. VA FILE NUMBER *(If applicable)*

4. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)*
Month – Day – Year

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

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

7. 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. TELEPHONE NUMBER *(Include Area Code)*

9. EMAIL ADDRESS *(Optional)*

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

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

11A. CLAIMANT'S DATE OF BIRTH
Month – Day – Year

11B. RELATIONSHIP TO VETERAN

12. 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

13.TELEPHONE NUMBER *(Include Area Code)*

14. EMAIL ADDRESS *(Optional)*

## 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

**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 **(Required)** | 22B. DATE SIGNED *(MM/DD/YYYY)* |
|---|---|
| 23A. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 16A **(Required)** | 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: ☐ VR&E FILE ☐ EDU FILE ☐ LG FILE ☐ INSURANCE FILE | DATE SENT *(MM/DD/YYYY)* | ACKNOWLEDGED *(Date) (MM/DD/YYYY)* | REVOKED *(Reason and date (MM/DD/YYYY))* |
|---|---|---|---|---|

**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.

## RECOGNIZED SERVICE ORGANIZATIONS

Membership in an organization is not a prerequisite to appointment of the organization as claimant's representative.

The following is a listing of national, regional, or local organizations recognized by the Secretary of Veterans Affairs in the preparation, presentation, and prosecution of claims under laws administered by the Department of Veterans Affairs.

African American PTSD Association
American Legion
American Red Cross
American Veterans (AMVETS)
Armed Forces Services Corporation
Army and Navy Union, USA
Blinded Veterans Association
Catholic War Veterans of the U.S.A.
Dale K. Graham Veterans Foundation
Disabled American Veterans
Fleet Reserve Association
Gold Star Wives of America, Inc.
Green Beret Foundation
Italian American War Veterans of the United States, Inc.
Jewish War Veterans of the United States
Legion of Valor of the United States of America, Inc.
Marine Corps League
Military Officers Association of America (MOAA)
National Association for Black Veterans, Inc.
National Association of County Veterans Service Officers, Inc,
National Law School Veterans Clinic Consortium
National Montford Point Marine Association, Inc.
National Veterans Legal Services Program
National Veterans Organization of America
Navajo Nation Veterans Administration
Navy Mutual Aid Association
Paralyzed Veterans of America, Inc.
Polish Legion of American Veterans, U.S.A.
Swords to Plowshares, Veterans Rights Organization, Inc.
The Retired Enlisted Association
United Spanish War Veterans of the United States
United Spinal Association, Inc.
Veterans of Foreign Wars
Veterans of the Vietnam War, Inc. & The Veterans Coalition
Veterans of World War I of the U.S.A., Inc.
Veterans' Voice of America
Vietnam Veterans of America
Wounded Warrior Project

Although agency titles vary, the following States and possessions maintain veterans service agencies which are recognized to present claims:

| | | | | |
|---|---|---|---|---|
| Alabama | Hawaii | Minnesota | North Dakota | Tennessee |
| American Samoa | Idaho | Mississippi | Northern Mariana Islands | Texas |
| Arizona | Illinois | Missouri | Ohio | Utah |
| Arkansas | Iowa | Montana | Oklahoma | Vermont |
| California | Kansas | Nebraska | Oregon | Virginia |
| Colorado | Kentucky | Nevada | Pennsylvania | Virgin Islands |
| Connecticut | Louisiana | New Hampshire | Puerto Rico | Washington |
| Delaware | Maine | New Jersey | Rhode Island | West Virginia |
| Florida | Maryland | New Mexico | South Carolina | Wisconsin |
| Georgia | Massachusetts | New York | South Dakota | Wyoming |
| Guam | Michigan | North Carolina | | |

**PRIVACY ACT NOTICE:** VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Veteran Readiness and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. However, the requested information is considered relevant and necessary to recognize a service organization as your representative and/or identify disclosable records. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

**RESPONDENT BURDEN:** We need this information to recognize the service organization you name to act on your behalf in the preparation, presentation, and prosecution of claims for VA benefits (38 U.S.C. 5902). We will also use the information to identify any VA records that we may disclose to the service organization (38 U.S.C. 5701(b)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

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. FDVAmay disclose the information you put on this formas 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

## WHERE TO SEND YOUR WRITTEN CORRESPONDENCE

Documents may be submitted by mail, in person at a VA regional office or electronically. However, VA recommends submitting correspondence electronically as this is the fastest method of receipt.

VA provides several tools to assist in electronic submission. To learn more about how to submit documents and claims electronically, visit www.va.gov/disability/upload-supporting-evidence. You can also go directly to access.va.gov to digitally upload any correspondence using Direct Upload.

By visiting www.va.gov you can also check your claims status and learn about other VA benefits.

If you need assistance, you can find a local, accredited representative at https://www.benefits.va.gov/vso/.

If you prefer to mail your correspondence, please use the related mailing address below.

| COMPENSATION CLAIMS | PENSION & SURVIVORS BENEFIT CLAIMS |
|---|---|
| **Department of Veterans Affairs**<br>**Evidence Intake Center**<br>**PO Box 4444**<br>**Janesville, WI 53547-4444** | **Department of Veterans Affairs**<br>**Pension Intake Center**<br>**PO Box 5365**<br>**Janesville, WI 53547-5365** |
| **FIDUCIARY** | **BOARD OF VETERANS' APPEALS** |
| **Department of Veterans Affairs**<br>**Fiduciary Intake**<br>**PO Box 95211**<br>**Lakeland, FL 33804-5211** | **Department of Veterans Affairs**<br>**Board of Veterans' Appeals**<br>**PO Box 27063**<br>**Washington, DC 20038** |

These addresses serve **all United States** and **foreign locations**.

OMB Control No. 2900-0883
Estimated Burden: 30 minutes
Expiration Date: 11/30/2023

Department of Veterans Affairs

# Request for Prescription Drugs from an Eligible Veteran in a State Home

| | VA Facility | | Name and Address of State Home |
|---|---|---|---|
| **To:** | | **From:** | |

**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)* |
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| **Name of Prescribing Physician:** | | **Telephone Number:** |

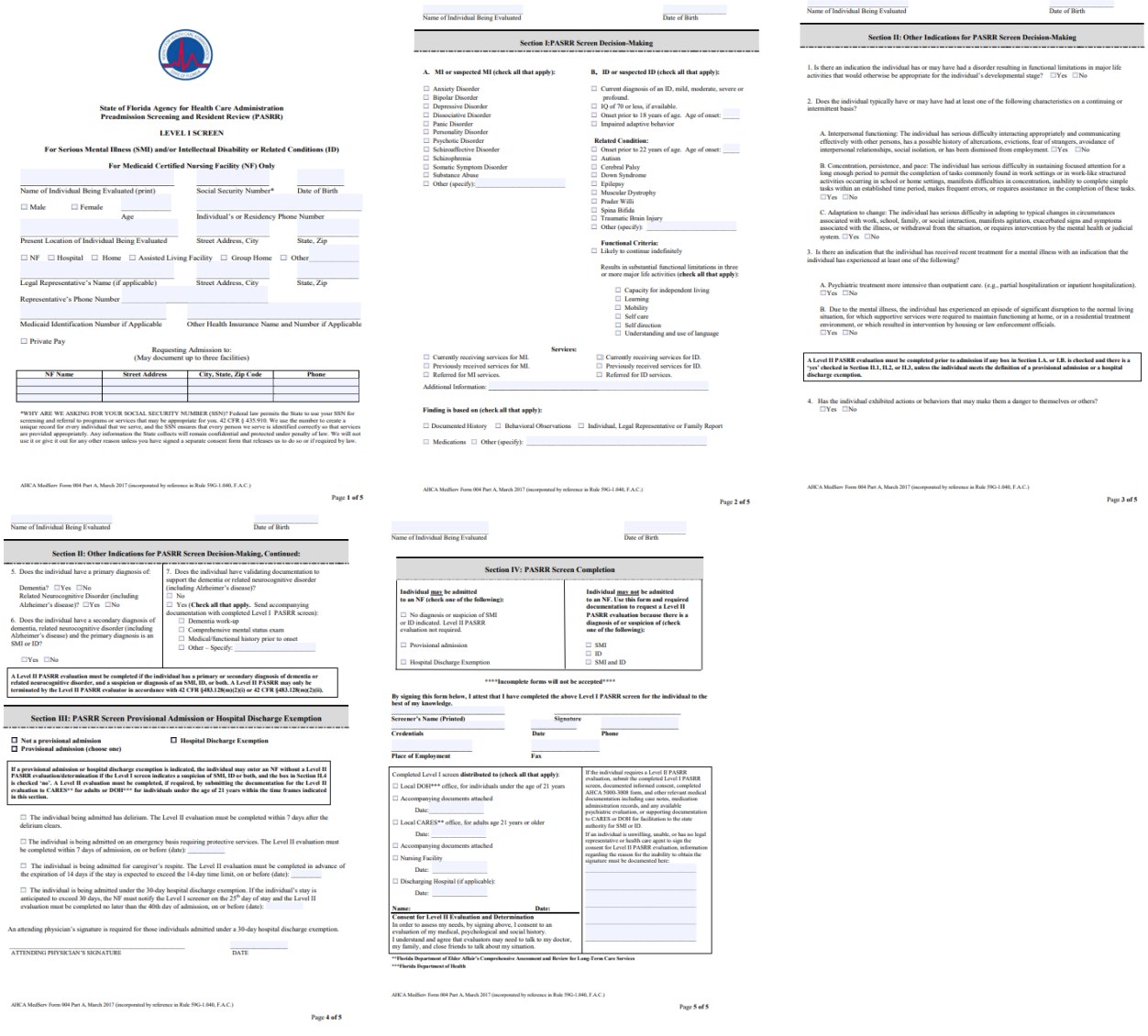
I certify that the following medications are prescribed for _____ .
Veteran's Name

_____
Signature of State Home Representative

**The Paperwork Reduction Act of 1995** requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of this Act. We may not conduct or sponsor, and the respondent is not required to respond to, a collection unless it displays a valid OMB Control Number. The public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, gather the necessary facts and fill out the form. This information is collected under the authority of Title 38 CFR Parts 51 and 58. It is being collected under the medical benefits in the State Homes Program and will be used for that purpose.

**Privacy Act Information:** It is being collected to enable us to determine your eligibility for medical benefits and will be used for that purpose. The income and eligibility you supply may be verified through a computer matching program at any time and information may be disclosed outside the VA as permitted by law; possible disclosures include those described in the "routine uses" identified in the VA system of records 24VA136, Patient Medical Record-VA, published in the Federal Register in accordance with the Privacy Act of 1974. Disclosure is voluntary; however, the information is required in order for us to determine your eligibility for the medical benefit for which you have applied. Failure to furnish the information will have no adverse affect on any other benefits to which you may be entitled. Disclosure of Social Security number(s) of those for whom benefits are claimed is requested under the authority of Title 38, U.S.C., and is mandatory. Social Security numbers will be used in the administration of veterans benefits, in the identification of veterans or persons claiming or receiving VA benefits and their records and may be used for other purposes where authorized by Title 38, U.S.C., and the Privacy Act of 1974 (5 U.S.C. 552a) or where required by other statute

# Sample PASRR



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.)

Page 1 of 5

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.)

Page 2 of 5

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.)

Page 3 of 5

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.)

Page 4 of 5

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):**

☐ No diagnosis or suspicion of SMI or ID indicated. Level II PASRR evaluation not required.
☐ Provisional admission
☐ Hospital Discharge Exemption

**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):**

☐ SMI
☐ ID
☐ 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.)

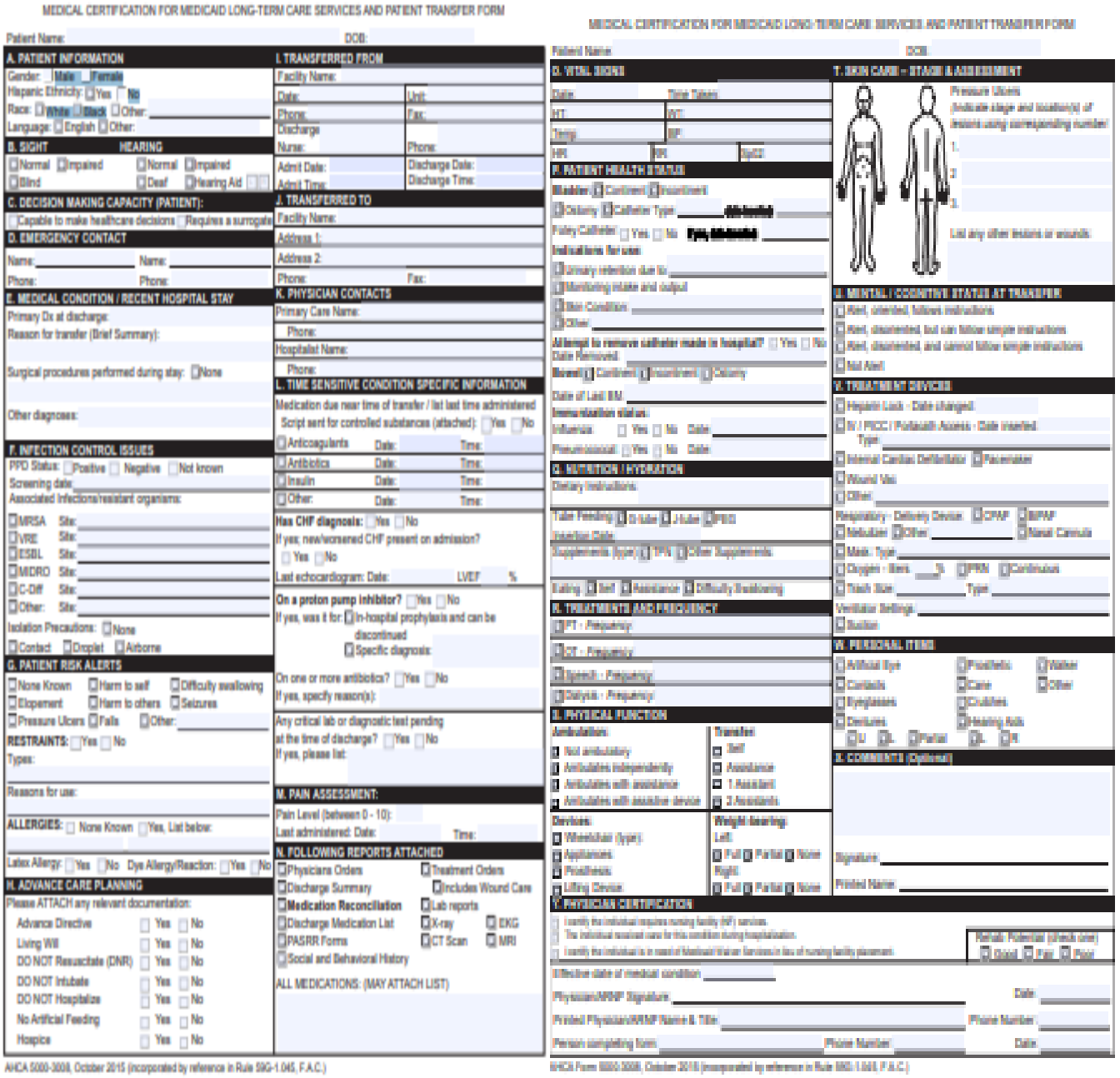
Page 5 of 5

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**

***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 / last 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 SERVICES
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: 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/ARNP Signature: Date:
Printed Physician/ARNP 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.)