STATE OF FLORIDA
DEPARTMENT OF VETERANS' AFFAIRS

ROBERT H. JENKINS JR. VETERANS DOMICILIARY HOME OF FLORIDA APPLICATION PACKET

An Assisted Living Facility for Veterans
Florida ALF License # 7975

751 SE Sycamore Terrace
Lake City, Florida 32025
Phone: (386) 758-0600
Fax (386) 758-0549

Any questions regarding this packet should be forwarded to the Admissions Coordinator for assistance: (386)758-0600 ext. 1005

APPLICATION PACKET CONTENTS

BASIC ADMISSION CRITERIA

Basic criteria for admission into the FDVA Domiciliary:

- Be a veteran as determined under Chapter 1.01 (14), Florida Statutes.
- Not be in need nursing home level of care.
- Have a need for assistance or supervision with at least one Activity of Daily Living (bathing, dressing, grooming, toileting, eating, ambulation, or have need of assistance with medication management.
- If dependent on a wheelchair for ambulation, applicant must be able to transfer in/out of chair independently.
- Power scooters are **not allowed** inside the facility, they may be used outside the building and in the community. A sheltered area is provided outside the building for residents to store and charge scooters. We do allow power wheelchairs in the building. If your power wheelchair was not issued by VA you will need an order from your physician stating that you have need of a power wheelchair.
- At the time of admission, applicant must have photo identification, in the form of a driver's license, state ID card, VA card, or bank debit card with photo.
- Applicant must have proof of service to be eligible for admission.
- The Domiciliary is unable to admit residents that are on kidney dialysis.
- The Domiciliary is unable to admit residents that have aspiration precautions or have need of thickened liquids.
- Due to county and city ordinances anyone who is on the sex offender registry cannot reside in this facility.
- Personal pets are not allowed in this facility.

APPLICATION PROCESS

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

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

- When an application is submitted it is reviewed for all needed documents.
- If any additional paperwork is required the admission coordinator will request the information from applicant or person that submitted application.
- When all needed documents are obtained, application is routed to the admissions committee for review.
- The review committee consist of the following:
    - **Director of Nursing** is reviewing the medical information to assess level of care needs and appropriateness for ALF placement.
    - **Licensed Clinical Social Worker** reviewing for any psychiatric, substance abuse, or behavior issues.
    - **Business Manager** verifying that proof of income was provided.
- When the admission committee has completed their review, the file is forwarded to the administrator for final approval.
- When the administrator approves the application, a letter is sent to the applicant asking them to call and make an appointment to come in for a face-to-face visit with the admissions committee.
- If an application is denied by the administrator a letter will be sent to the applicant with reason for denial and information about the appeal process.

WHAT WE PROVIDE FOR YOUR COST OF CARE

Included in the cost of care is the following:

- Housing;
- Utilities;
- Transportation within the community and to local medical appointments, shopping, activities, and banking;
- Three hot meals and evening snack each day;
- A nurse on duty everyday around the clock;
- Housekeeping services provided weekly;
- Furnished room;
- Towels and linens provided;
- TV and satellite;
- Laundry facilities on site at no charge;
- Numerous activities in and out of the home;
- Assistance with activities of daily living as needed: bathing, dressing, grooming, medication management;
- *EXCELLENT ASSISTED LIVING CARE FOR OUR VETERANS!!*

WHAT DOES IT COST MONTHLY TO LIVE IN THE HOME?

(Effective January 1, 2022)

To calculate your cost of living in our Home, you will need to use your **NET MONTHLY INCOME:**

- IF YOUR NET MONTHLY INCOME IS **$1713.63 or more**, your monthly cost of care is $1557.63.
- IF YOUR NET MONTHLY INCOME IS **less than $1713.63** use the following formula:
    - ***FORMULA =*** *NET MONTHLY INCOME minus $156.00= monthly cost of care for double occupancy (semi-private) room.*
- The Veteran gets to keep $156.00 each month as a personal use/needs allowance.
- A veteran who receives an income from any source of more than $156.00 per month shall contribute to his/her monthly cost to live in the facility.
- Any veteran who receives back pay from any source will be responsible for a monthly co-payment from his/her LATEST ADMISSION DATE TO THE CURRENT DATE.
- A limited number of private rooms are available the rate is $1626.90 per month.
- This facility has an EXTENDED CONGREGATE CARE (ECC) license, and the unit monthly cost for this type of care is higher. If your income is less than the full cost of care, these services will still be provided regardless of ability to pay.

Please read and understand: ***"Cost of care for living in our Home is subject to change with a 30-day written notice."***

APPLICATION DOCUMENTS CHECKLIST

These are the documents needed for the application

Please read this entire document as it contains important information concerning the application process and what to provide with the application packet.

Forms to fill out by applicant:

☐ Completed and signed application (to be signed by applicant, power of attorney, or legal guardian). If guardian or POA is signing application please include this information with application. **6 pages**

☐ VA form 10-5345 (Medical Release Form for VA) (To be signed and dated by applicant) (attached) **2 pages**

Documents to provide:

☐ Copy of DD214 (MILITARY DISCHARGE) If you need information on applying for a DD214 please contact the admissions coordinator for assistance (386) 758-0600 ext.1005.

☐ If you have a power of attorney (for financial, health care, or both) health care surrogate, a legal guardian, advance directives (living will) please provide copies of these documents.

☐ If you are on probation or parole, please send a copy of the conditions/terms of your probation/parole.

Medical information/documents:

☐ AHCA Form 1823 - resident health assessment for assisted living facilities (to be completed by Physician, DO, PA, or ARNP) (attached) **3 pages**

☐ Copy of current medication list.

☐ Current medical diagnosis/problem list.

☐ Medical progress notes from your last two visits with Primary Care Physician, if you are followed by psychiatry or psychology progress notes from last two visits.

☐ Discharge summary from your last hospital admission if you have been hospitalized in the last three months (you may have the physician's office or hospital fax the notes to our facility, attention admissions coordinator, fax number (386)758-0549.

☐ PPD results less than 30 days old (this is a test for tuberculosis) or chest x-ray results less than one-year-old.

☐ Copy of most recent lab results.

Financial information to provide:

☐ Copy of a current bank statement that shows the direct deposit of your benefits. If your benefits are not direct deposited to your bank please provide documentation of your income/benefit. Considered income sources are retirement, Social Security, SSI, OSS, VA pension or compensation (service connected and non-service connected), interest income from stocks, bonds, cd's, etc.

☐ If you have any deductions from your income for child support, alimony, IRS, or arrears payment please provide this documentation.

☐ If you receive disability pay due to a service-connected injury, please provide your award letter from the US Department of Veteran Affairs.

Please note that your application cannot be processed without valid proof of income.

APPLICATION FOR CERTIFICATE OF ELIGIBILITY (COE)

SECTION A: PERSONAL INFORMATION

VETERAN'S LAST NAME, FIRST NAME, MIDDLE NAME, SUFFIX

VETERAN'S SOCIAL SECURITY #

NAME YOU PREFER TO BE CALLED

VETERAN'S DATE OF BIRTH VETERAN'S BIRTHPLACE VETERAN'S SEX
☐ Male ☐ Female

PHONE NUMBER CELL PHONE NUMBER

ADDRESS: Number, Street, City

ADDRESS: State, Zip Code COUNTY

EMAIL ADDRESS

MARITAL STATUS
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Significant Other
Date of Marriage: _ Date of Divorce:

RACE (please check appropriate box below):
☐ American Indian/Alaskan Native ☐ Asian/Pacific Islander ☐ Hispanic
☐ Black, Not of Hispanic Origin Hispanic ☐ White, Not of Hispanic Origin

Have you previously resided in our Home? ☐ NO ☐ YES
If YES: a) What date did you leave?
b) Please give the reason for leaving?

HOW DID YOU HEAR ABOUT OUR FACILITY?

PLACE OF RESIDENCE: ☐ Independent ☐ With a Family Member ☐ Homeless ☐ Nursing Home
☐ Assisted Living ☐ Hotel ☐ Shelter ☐ Other, explain:

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

BRANCH OF SERVICE	SERVICE NUMBER	DATE ENTERED	DATE DISCHARGED

TYPE OF DISCHARGE: ☐ Honorable ☐ Under Honorable Conditions ☐ General ☐ Medical ☐ Retired

WARS/CONFLICTS (check those that apply): ☐ World War Il ☐ Korean War ☐ Vietnam ☐ Vietnam Era
☐ Grenada ☐ Panama ☐ Persian Gulf War ☐ Somalia ☐ Bosnia ☐ Haiti

☐ Kosovo-Yugoslav ☐ War on Terrorism ☐ Operation Enduring Freedom ☐ Operation Iraqi Freedom
☐ Other ☐ Other

WERE YOU EVER A POW? ☐ NO ☐ YES
If YES, Where?

ARE YOU A PURPLE HEART RECIPIENT? ☐ NO ☐ YES

ARE YOU A PEARL HARBOR SURVIVOR? ☐ NO ☐ YES

THEATER OF OPERATION(S) (I.E. EUROPE, KOREA CHINA. VIETNAM. PACIFIC, ATLANTIC)

MILITARY HONORS (awards/medals) (i.e. Good Conduct Medal: Medal of Honor, Purple Heart)

VETERAN SERVICE ORGANIZATION S IN WHICH YOU HAVE CURRENT MEMBERSHIP (i.e. American Legion, Veterans of Foreign Wars (VFW), AMVETS, Disabled American Veterans (DAV)

SECTION C: FINANCIAL

APPLICANT'S MONTHLY NET INCOME	
Retirement	
SSI: Was the benefit granted due to a mental health diagnosis?	
SSDI: Was the benefit granted due to a mental health diagnosis?	
Optional State Supplementation (OSS)	
Pension (including VA NSC Pension)	
Compensation (including VS Service connected pay)	
Interest/Dividends	
All other income	

Do you have a service connected disability rating? ☐ NO ☐ YES
If YES, percentage _____ %
If YES, what is you service connected disability?

Which of the following ways do you receive your benefits or income?
☐ Direct Deposit to Bank Account ☐ Debit Card ☐ via Mail ☐ Representative Payee ☐ Other

Who handles your finances?
☐ Fiduciary ☐ Guardian ☐ Family Member/Friend ☐ Veteran handles own finances

Do you have any of the following?
☐ Financial Power of Attorney ☐ Legal Guardian ☐ Health Care Power of Attorney
☐ Health Care Surrogate ☐ Living will ☐ DNR

If you **do not** currently have any type of income have you applied for benefits? ☐ NO ☐ YES
If YES, what type of benefit?
☐ Social Security — what date did you apply?
☐ VA Service Connected Pension — what date did you apply?

☐ VA Non-Service Connected Pension — what date did you apply?

SECTION D: INSURANCE INFORMATION

Medicaid Number
Medicare Number ☐ Part A ☐ Part B ☐ Part D
Medical Insurance Policy Number
Medicare Supplement Policy Number
Dental Insurance Policy Number
Long-term Care Insurance Policy Number
Tri-Care

SECTION E: EMERGENCY CONTACT/NEXT OF KIN

Contact #1 Name _____
Relationship _____
Address _____
City _____ State _____ Zip Code _____
Email Address _____
Phone Number _____
May we contact this person concerning your health care issues? ☐ NO ☐ YES

Contact #2 Name _____
Relationship _____
Address _____
City _____ State _____ Zip Code _____
Email Address _____
Phone Number _____
May we contact this person concerning your health care issues? ☐ NO ☐ YES

Contact #3 Name _____
Relationship _____
Address _____
City _____ State _____ Zip Code _____
Email Address _____
Phone Number _____
May we contact this person concerning your health care issues? ☐ NO ☐ YES

SECTION F: MEDICAL INFORMATION

Have you been treated by a VA or Private Physician, or been hospitalized in the past year? ☐ NO ☐ YES
If YES, please complete information below:

Name of Physician	Reason for Visit	Date	Location	VA or Private

At what VA Medical Centers or VA Out-Patient Clinics have you received services in the past 5 years?

Do you consume alcoholic beverages? ☐ NO ☐ YES
If YES, How often?

Are you currently being treated for alcohol or other substance abuse/dependence? ☐ NO ☐ YES
If YES, where are you receiving treatment:

In the past, have you ever been treated for substance abuse/dependence? ☐ NO ☐ YES
If YES, yes, when and where were you treated:

Have you ever been referred to a substance abuse treatment program that you declined to attend or did not complete? ☐ NO ☐ YES ☐ Declined to attend ☐ Failed to complete
If treatment was declined or failed to complete, when and where and why was treatment declined or not completed?

Are you presently being seen by a mental health professional? ☐ NO ☐ YES ☐ Psychiatrist ☐ Psychologist ☐ Social Worker ☐ Other:
For what are you being treated?

Do you use tobacco products? ☐ NO ☐ YES
If YES: ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chewing Tobacco ☐ Snuff

Do you have your own teeth? ☐ NO ☐ YES
If YES, are your teeth in good condition? ☐ NO ☐ YES
If NO, what type of issues are you having?

Do you have dentures? ☐ NO ☐ YES
If YES: ☐ Upper Denture ☐ Lower Denture ☐ Partial
If YES, do you wear your dentures? ☐ NO ☐ YES Do they fit well? ☐ NO ☐ YES

Do you have any problems chewing? ☐ NO ☐ YES
If YES, please describe the issue

Do you have any problems swallowing? ☐ NO ☐ YES
If YES, please describe the issue:

Have you had a swallow study completed related to your swallowing issue? ☐ NO ☐ YES
If yes, when and where completed?

Has your doctor advised of a specific diet? ☐ NO ☐ YES
If YES, what type of diet?
If YES, do you follow the recommended diet? ☐ NO ☐ YES
If YES, do you follow the diet ☐ all the time ☐ most of the time ☐ sometimes

What is your usual weight?
Have you lost or gained weight I the last 6 months? ☐ NO ☐ YES
If you lost weight, was it a planned weight loss? ☐ NO ☐ YES How much did you lose?
If this was not a planned weight loss, have you discussed with your doctor? ☐ NO ☐ YES

What time do you usually go to bed?
What time do you usually awaken?
Do you prefer your sleeping environment to be: ☐ cool ☐ very cool ☐ warm ☐ very warm
Do you have difficulty sleeping? ☐ NO ☐ YES

Do you have/use any of the following equipment/devices?

☐ Walker ☐ Hearing Aids ☐ Glasses ☐ Shower Chair ☐ Rollator Walker
☐ Manual Wheelchair ☐ Power Chair ☐ Scooter ☐ Trapeze Bar
☐ C-Pap Machine ☐ Cane ☐ Oxygen ☐ Oxygen Concentrator ☐ Raised Toilet Seat
☐ Prosthetic Limb(s), please describe:

SECTION G: SOCIAL HISTORY

Religious Preference?
Do you attend religious services?

Where were you born? City _____ State ____ Country _____

Former occupation(s)?

Jobs you held in the military?
What was your highest rank?

Schooling in years: ____ years. Degree earned? ☐ NO ☐ YES
If YES, field(s) of study:

Father's Name: ☐ Living ☐ Deceased
Mother's Name: ☐ Living ☐ Deceased
Mother's Maiden Name:

Names of children:
Are you in contact with your children? ☐ NO ☐ YES

Names of any brothers:
Names of any sisters:
Are you in contact with your siblings? ☐ NO ☐ YES

Hobbies:

☐ Antiques ☐ Fishing ☐ Pottery ☐ Games ☐ Reading ☐ Card Games ☐ Gardening
☐ Sports ☐ Computers ☐ Golf ☐ Swimming ☐ Volunteering ☐ Continued Education
☐ Knitting/Crocheting ☐ Tennis ☐ Jig Saw Puzzles ☐ Cooking Movies ☐ Theater
☐ Word Puzzles ☐ Crafts Music ☐ Travel ☐ Creative Writing ☐ Needlework
☐ Woodworking ☐ Painting ☐ Exercise ☐ Photography
☐ Other:

Do you own a vehicle? ☐ NO ☐ YES
If YES, do you plan to bring your vehicle with you to the facility? ☐ NO ☐ YES
Please note that to keep a vehicle on premises you must have a valid driver's license, insurance and current tag.

SECTION H: LEGAL INFORMATION

Are you currently on Probation or Parole? ☐ NO ☐ YES
Do you have any pending legal issues? ☐ NO ☐ YES
If YES to either question above, please explain:
Named of any Probation or Parole Officer(s)
Their phone number:

Have you ever been convicted of a felony? ☐ NO ☐ YES

Pled guilty, or no contest to a felony? ☐ NO ☐ YES

If you have had a felony charge when was the charge (month, day, year)?

What was the charge(s)?

Where did this charge(s) occur? City: County: State:

SECTION A-H ATTESTATION

STATEMENT

The statements made in this application are true and correct to the best of my knowledge. I understand that if I have given false statements or information on this application, at the discretion of the Administrator, I may be discharged from the Robert H. Jenkins, Jr. Veterans' Domiciliary Home of Florida.

_____ _____

Applicant's Signature, or person authorized to sign for applicant Date signed

SECTION I: IMPORTANT INFORMATION ABOUT WHAT THINGS MAY OR MAY NOT BRING INTO THE FACILITY

ITEMS THAT ARE PROVIDED IN EACH ROOM

-- Bed
-- Bed side table
-- Medicine cabinet
-- Wardrobe cabinet with drawers (drawers and cabinets lock)
-- Chair (upon request)
-- Television (satellite service is provided)
-- Bed linens/towels/pillows

WHAT <u>ITEMS YOU MAY BRING</u> INTO THE FACILITY

-- Clothing
-- Personal hygiene items
-- Alarm clock
-- Computer (laptop only)
-- Pictures (maintenance staff will hang/install)
-- Radio/ cd player
-- Bed linens/towels/pillows (the home provides these items but you may bring your own if you wish.)
-- DVD player or VCR (upon request maintenance will install holder/rack for this equipment)

WHAT <u>ITEMS NOT TO BRING</u> WITH YOU TO THE FACILITY

-- Recliners, chairs, chairs with rollers, beds, desk, dressers or other furniture
-- Exercise equipment
-- Tools
-- Candles
-- Heating pads
-- Electric blankets
-- Space heaters
-- Appliances (coffee pots, electric skillets, microwaves, etc.)
-- Throw rugs or any other type of carpeting
-- No extension cords (you may use a power strip)

Contraband is PROHIBITED in this facility at any time, and they include (but not limited to):

-- Weapons, guns, knives, etc., alcoholic beverages of any type and illegal drugs are not allowed in the home or on the grounds. Possession of these items could lead to discharge from the home.

STORAGE

-- A limited amount of storage is available for each resident. As needed each resident will be provided with 4 boxes for storage the box size is 22" x 22" x 18". Four boxes are strictly the limit.

SECTION I: ATTESTATION

STATEMENT

I am verifying by my signature below that I have read and understood what items are and are not allowed to be brought into the facility in Section H of this application.

_____

Printed name of applicant _____

Signature of applicant _____

Date _____

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPERWORK REDUCTION ACT INFORMATION: 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 the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out this form. The execution of this form does not authorize the release of information other than that specifically described below.

The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if information needed to locate records for release is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. 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 system of records notices identified as 24VA10A7 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Location of the VA Health Care Facility)*

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

PATIENT'S MAILING ADDRESS (*including City, State and Zip Code*)

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

☐ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ EMPLOYMENT ☐ OTHER *(Please specify below):*

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

☐ HEALTH SUMMARY *(Prior 2 Years)*

☐ PATIENT MEDICAL RECORDS *(Dates)*:

☐ INPATIENT DISCHARGE SUMMARY *(Dates)*:

☐ PROGRESS NOTES:

- ☐ SPECIFIC CLINICS *(Name & Date Range)*:
- ☐ SPECIFIC PROVIDERS *(Name & Date Range)*:
- ☐ DATE RANGE:

☐ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*:

☐ LAB RESULTS:

- ☐ SPECIFIC TESTS *(Name & Date)*:
- ☐ DATE RANGE:

☐ RADIOLOGY REPORTS *(Name & Date)*:

☐ LIST OF ACTIVE MEDICATIONS:

☐ VACCINATION *(Dose, Lot Number, Date & Location)*:

☐ ADMINISTRATIVE RECORDS:

☐ OTHER *(Describe)*:

VA FORM JUL 2021 **10-5345**

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

EXPIRATION: Without my express revocation, the authorization will automatically expire *(select one of the following)*:

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed by patient)*

☐ UNDER THE FOLLOWING CONDITION(S): _____

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
LEGAL REPRESENTATIVE SIGNATURE *(if applicable) (Sign in ink)*	**DATE** *(mm/dd/yyyy)*
PRINT NAME OF LEGAL REPRESENTATIVE	**RELATIONSHIP TO PATIENT**

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED *(mm/dd/yyyy)*	RELEASED BY:

ICAL RECORDS AND HEALTH INFORMATION RELEASE

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

MEDICAL RECORDS AND HEALTH INFORMATION RELEASE

(to be completed by applicant or representative)

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

I authorize the use or disclosure of the above individual's health information as described below. The following individual or organization is authorized to make the disclosure: Robert H. Jenkins, Jr Veterans Domiciliary Home of Florida

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:

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

INITIAL BELOW FOR RELEASE OF INFORMATION

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

Nursing notes, Care plans, Medication list
Dietary notes, Activity notes, Social Services assessment
Consultations-specify: _____
Other-specify: _____

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

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

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

I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire if my application is denied, or if accepted, upon my permanent transfer or discharge from the facility.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to obtain treatment. I understand the potential for the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by the Federal privacy laws.

_____ _____

Signature of Resident or Legal Representative Date

_____

Relationship of Legal Representative to Resident

_____ _____

Signature of Witness Date

Resident Health Assessment for Assisted Living Facilities

To Be Completed By Facility:

Resident Information	
Resident Name:	DOB:
Authorized Representative (if applicable):	

Facility Information		
Facility Name:	Telephone Number:	
Street Address:	Fax Number:	
City:	County:	Zip:
Contact Person:		

INSTRUCTIONS TO LICENSED HEALTH CARE PROVIDERS:
After completion of all items in Sections 1 and 2 (pages 1 - 3), return this form to the facility at the address indicated above.

Section 1. Health Assessment

NOTE: This section must be completed by a licensed health care provider and must include a face-to-face examination.

Known Allergies:	**Height:**	**Weight:**
Medical History and Diagnoses:		
Physical or Sensory Limitations:		
Cognitive or Behavioral Status:		
Nursing/Treatment/Therapy Service Requirements:		
Special Precautions:	**Elopement Risk:** Yes: ☐ No: ☐	

To Be Completed By Facility:

Resident Information	
Resident Name:	DOB:
Authorized Representative (if applicable):	

Section 1. Health Assessment (continued)

NOTE: This section must be completed by a licensed health care provider and must include a face-to-face examination.

A. To what extent does the individual need supervision or assistance with the following?

Key	I = Independent	S = Needs Supervision	A = Needs Assistance	T = Total Care
	Staff does not assist at all	Staff provide cueing or prompting, but resident completes the action	Staff provide physical assistance with the resident's participation	Staff completes the action for the resident

Indicate by a checkmark (✓) in the appropriate column below.

ACTIVITIES OF DAILY LIVING:	I	S	A	T
Ambulation	☐	☐	☐	☐
Bathing	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Eating	☐	☐	☐	☐
Self-Care (grooming)	☐	☐	☐	☐
Toileting	☐	☐	☐	☐
Transferring	☐	☐	☐	☐

B. Special Diet Instructions:

Regular ☐ Calorie Controlled ☐ No Added Salt ☐ Low Fat/Low Cholesterol ☐

Other (specify, including consistency changes such as puree): _____

C. Does the individual have any of the following conditions/requirements?

STATUS	YES	NO
A communicable disease, which could be transmitted to other residents or staff?	☐	☐
Bedridden?	☐	☐
Any stage 2, 3, or 4 pressure sores?	☐	☐
Pose a danger to self or others? (Consider any significant history of physically or sexually aggressive behavior.)	☐	☐
Require 24-hour nursing or psychiatric care?	☐	☐

D. In your professional opinion, can this individual's needs be met in an assisted living facility, which is not a medical, nursing, or psychiatric facility? Yes ☐ No ☐

To Be Completed By Facility:

Resident Information	
Resident Name:	DOB:
Authorized Representative (if applicable):	

Section 2. Self-Care and General Oversight Assessment - Medications

A. Attach a listing of all currently prescribed medications, including dosage, directions for use, and route.

B. Does the individual need help with taking his or her medications (meds)? Yes ☐ No ☐
If YES, place a checkmark (✓) in front of the appropriate box below:

☐ **Needs Assistance With Self-Administration**
- This allows unlicensed staff to assist with nasal, ophthalmic, oral, otic, and topical medications.

☐ **Needs Medication Administration**
- Not all assisted living facilities have licensed staff to perform this service.

☐ **Able To Self-Administer Medications**
- Resident does not need staff assistance

C. Additional Comments/Observations (use additional pages, if necessary):

NOTE: MEDICAL CERTIFICATION IS INCOMPLETE WITHOUT THE FOLLOWING INFORMATION.

Name of Examiner (please print):	
Medical License Number:	
Title of Examiner (check one): ☐ MD ☐ DO ☐ APRN ☐ PA	
Telephone Number:	
Address of Examiner:	
Signature of Examiner:	**Date of Examination:**