STATE OF FLORIDA
DEPARTMENT OF VETERANS' AFFAIRS
DIVISION OF LONG-TERM CARE SERVICES

FLORIDA DEPARTMENT OF VETERANS' AFFAIRS

STATE VETERANS' HOME NURSING HOME VETERAN APPLICATION PACKET

☐ **Ardie R. Copas SVNH** 13000 SW Tradition Parkway, Port St. Lucie, FL 34987 Phone: 772-241-6132 Fax: 772-241-6150	☐ **Baldomero Lopez SVNH** 6919 Parkway Boulevard Land O' Lakes, FL 34639 Phone: 813-558-5000 Fax: 813-558-5021
☐ **Emory L. Bennett SVNH** 1920 Mason Avenue Daytona Beach, FL 32117 Phone: 386-274-3460 Fax: 386-274-3487	☐ **Clifford Chester Sims SVNH** 4419 Tram Road Panama City, FL 32404 Phone: 850-747-5401 Fax: 850-747-5301
☐ **Alwyn C. Cashe SVNH** 5255 Raymond Street Orlando, FL 32814 Phone: 407-741-4614 Fax: 407-741-4631	☐ **Douglas T. Jacobson SVNH** 21281 Grayton Terrace Port Charlotte, FL 33954 Phone: 941-613-0919 Fax: 941-613-0935
☐ **Alexander Nininger SVNH** 8401 West Cypress Drive Pembroke Pines, FL 33025 Phone: 954-985-4824 Fax: 954-985-4866	☐ **Clyde E. Lassen SVNH** 4650 State Road 16 St. Augustine, FL 32092 Phone: 904-940-2193 Fax: 904-940-9913

By submitting this application, the Veteran or representative understands the purpose in its completion is to support admission and the provision of medical care into a Florida State Veterans' Nursing Home (SVNH). Information provided may be disclosed to and shared with another Florida State Veterans' Home for the purpose of placement and/or continuity of care - at the time of submission and/or a later date.

Failure to submit a complete and accurate application may result in a delayed or denied application.

INTRODUCTION - GENERAL INFORMATION

Thank you for applying to the Florida Department of Veterans' Affairs State Veteran Home. We offer skilled nursing care, including physical, occupational, and speech therapy, as well as restorative, hospice, and respite services, all provided by licensed professionals.

Overview of Application Process:

1. Submit all required VA, financial, and medical documents.
2. Our admissions team will review your completed application.
3. You'll be notified by phone or mail of the decision. **

Admission Criteria for Veteran:

Veterans must meet the following requirements:

- Be a Veteran as defined in Florida Statute 1.01(14).
- Have an honorable discharge from the most recent active-duty service.
- Be a Florida resident at the time of application.
- Require skilled nursing care for a medical condition.
- Have no outstanding debts to the FDVA from prior nursing home or domiciliary stays.
- Submit a complete application and any additional information requested.
- If admitted, pay any required share of cost *prior* to admission.

APPLICATION PROCESS

(*Incomplete applications may cause delays or denial.*)

To process your application, the following must be completed:

- Submit a fully completed application via fax, mail, email, or in person.
- Provide all required financial information. (Veterans with a 70%–100% service-connected disability are exempt from submitting financial documentation, but must include proof of 70%–100% service connection.)
- Ensure all required medical forms are completed by a licensed healthcare provider.
- Submit any additional information requested (e.g., medical, financial, service/disability documentation).
- The Admissions Coordinator will evaluate eligibility for skilled nursing placement.
- The Interdisciplinary Team will review the application before admission is scheduled.
- If approved but placed on the waiting list, a reassessment will be conducted prior to admission to confirm medical eligibility.
- You will be notified by phone or mail regarding approval, denial, or placement on the waiting list.

**** Please be advised that not all applications submitted to a Florida State Veterans' Home is approved. ****

SMOKING POLICY

In compliance with the Florida Clean Air Act, the facility is 100% tobacco-free. Smoking and tobacco use are prohibited anywhere on property, including in vehicles, on porches, or lawns. Smoking is strictly banned near oxygen storage or use areas.

Prohibited products include:

- All tobacco (cigarettes, cigars, pipes, chew, dip, snuff, etc.)
- Electronic cigarettes, vaporizers, and any vapor-producing or smokeless devices
- Smoking is not allowed off-campus or during facility-sponsored events.

Note: Veterans admitted to the Emory L. Bennett State Veterans' Nursing Home before 07/01/2019 may continue smoking under prior privileges. Those admitted on or after 07/01/2019 are not allowed to smoke.

VETERAN DEFINITION

13 CFR § 125.11 provides: Veteran has the meaning given the term in 38 U.S.C. 101(2). A Reservist or member of the National Guard called to Federal active duty or disabled from a disease or injury incurred or aggravated in line of duty or while in training status also qualify as a Veteran. 38 U.S.C. § 101(2) provides: The term "Veteran" means a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.

MONTHLY COST OF CARE AND WHAT IS AND IS NOT INCLUDED

Veterans rated 70%–100% service-connected are exempt from room and board charges, pharmacy charges, and other specific costs as outlined in 38 C.F.R. § 51.41 – Contracts and State Home Care Agreements for Certain Veterans with Service-Connected Disabilities. This exemption covers all standard daily services, including meals, nursing care, social services, activities, rehabilitative therapies, housekeeping, maintenance, and medically necessary equipment and supplies. It also includes physician-prescribed medications, medical supplies, oxygen, laboratory services, and other physician-ordered treatments. Medically necessary services from outside providers—such as dental, podiatry, optometry, audiology, or mental health—are also included when arranged by the facility as part of the Veteran's treatment plan. However, if such services are available through facility-arranged providers and the resident chooses to use their own provider instead, the resident may be responsible for the associated costs. Transportation services, whether emergency or routine, are not covered under this exemption and may be billed directly to the Veteran by the transportation provider.

Other Veterans—those who are non-service connected or have a service-connected disability rating of 0% to 69%—may have a required monthly share of cost, calculated as Net Monthly Income – $160 personal needs allowance = Monthly Cost of Care. Veterans keep $160 per month for personal needs, must provide income documentation, and are required to apply for any financial aid for which they qualify (e.g., Medicaid). Additional charges may apply if income exceeds the daily care rate, including the full cost of all medications. The facility's daily rate for Other Veterans includes room and board, nursing care, social services, activities, rehabilitative services, housekeeping, maintenance, physician-ordered medications, personal care items, and special equipment such as oxygen, IV fluids, braces, and splints. Additional facility charges may apply for licensed therapy services (physical, occupational, and speech) and beauty or barber services. Certain services are billed directly by outside providers, including physician fees, specialist consultations (dental, podiatry, optometry, audiology, and mental health), sitters or private nurses (must meet facility and AHCA requirements), bedside telephone service, dry cleaning, personal shopping, clothing repair or purchase, and all transportation services, whether emergency or routine.

The Florida Department of Veterans' Affairs (FDVA) will provide a system to ensure that appropriate current and accurate financial information is obtained from Veterans upon admission, and then annually thereafter. The facility Business Office will request bank statements for a financial review, and may request the following documents to determine the cost of care:

- Copies of award letters
- Social Security notices
- Tax returns
- VA notices
- Pension statements
- Proof of investment income
- Notice of Case Action from Medicaid
- Proof of supplemental insurances payments
- Other information needed to make a current and accurate calculation for cost-of-care

FINANCIAL INFORMATION IS NOT REQUIRED BY VETERANS WHO HAVE A 70% - 100% SERVICE-CONNECTED DISABILITY RATING, (*VA Disability letter required as proof of rating*).

APPLICATION CHECKLIST

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

A signed and complete application packet must be returned for review process to begin.

Forms to be completed/submitted by Veteran or representative.

☐ Form 54 – Application for Admission
☐ Medical Information Release From
☐ Medical Provider Contact Information
☐ Activities of Daily Living (ADLs) Questionnaire
☐ Family Questionnaire
☐ VA 21-22
☐ VA 10-0460
☐ Form 10-10 EZ
☐ Document of proof of Veteran status determined under Chapter 1.01(14), FL (i.e. DD-214)
☐ All medical insurance cards for health insurance verification (copies of front and back)
☐ A government issued identification care (ID) for Veteran applicant
☐ If applicable, documents showing proof of service-connected disability from the VA

Forms to be completed by a health care provider.

☐ Current medication list
☐ Statement of Health (indicating free from a communicable disease)
☐ Verification of Capacity
☐ 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
☐ Proof of vaccinations, and included in the medical documentation

If applicable, any of these documents must be submitted with application.

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

Financial Information completed/submitted by Veteran and/or representative.

REQUIRED for all Veterans who do not have a service-connected disability, or those with a service-connected disability rating of 69% or below.

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

FINANCIAL INFORMATION IS NOT REQUIRED BY VETERANS WHO HAVE A 70% - 100% SERVICE-CONNECTED DISABILITY RATING, (*VA Disability letter required as proof of rating*).

To be completed by facility - date application received by facility representative: _____

FDVA FLORIDA DEPARTMENT OF VETERANS' AFFAIRS	**STATE OF FLORIDA** **DEPARTMENT OF VETERANS' AFFAIRS** **DIVISION OF LONG-TERM CARE SERVICES**

APPLICATION FOR ADMISSION (FORM 54)

(to be completed by Veteran 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 Last Name	**Veteran First Name**	**Veteran Middle Name**	*** Veteran Social Security #**	**Veteran VA Claim #**
Veteran Date of Birth	**Veteran Birthplace**	**Veteran Sex (Male or Female)**	**Veteran Medicare #**	**Veteran Medicaid #**
Name of Other Insurance		**Other Insurance Member #**		

Place of Residence: ☐ Own Home ☐ Hospital ☐ Nursing Home ☐ Retirement Home
☐ Boarding Home ☐ Other, explain: _____

Residence Address (Street, City, State Zip Code)

Mailing Address (Street, City, State Zip Code) – if different from residence address

Home Phone #	**Cell Phone #**	**Work Phone #**	**Other Phone #**

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Date of Marriage: _____ Date of Divorce: _____

Spouse Name	**Spouse SSN**	**Spouse DOB**

Has Veteran been a patient/resident in a hospital or nursing home in the past year? ☐YES ☐NO
Name of Facility: _____
Address of Facility: _____

Has the Veteran ever applied to another State of Florida Veteran Home or Domiciliary previous to this application? ☐YES ☐NO
If yes, which facility? _____ When was it submitted (MM/YY): ____

Has Veteran ever been convicted of a felony?
☐ YES ☐ NO If yes, in what state? _____ Date of conviction? _____

Has Veteran ever registered as a sex offender?
☐ YES ☐ NO If yes, in what state? _____ Year of Offense? _____

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 AAPLICANTS WITH PROOF OF 70%-100% SERVICE-CONNECTED DISABILITY (*VA Disability letter required as proof of rating*).

MONTHLY INCOME	VETERAN	SPOUSE
VA Pension/VA Compensation	Gross: _____ Net: _____	Gross: _____ Net: _____
Social Security	Gross: _____ Net: _____	Gross: _____ Net: _____
U.S. Civil Service	Gross: _____ Net: _____	Gross: _____ Net: _____
U.S. Railroad Retirement	Gross: _____ Net: _____	Gross: _____ Net: _____
Military Retirement	Gross: _____ Net: _____	Gross: _____ Net: _____
Employment	Gross: _____ Net: _____	Gross: _____ Net: _____
Other Retirement, or Income Source: Attach additional page is 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 Veteran 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. Appli Veteran cant agrees to follow the rules of conduct and policies and procedures of the Department of Veteran s' 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.

Veteran's signature (or authorized representative): _____ 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**

FDVA FLORIDA DEPARTMENT OF VETERANS' AFFAIRS	**STATE OF FLORIDA** **DEPARTMENT OF VETERANS' AFFAIRS** **DIVISION OF LONG-TERM CARE SERVICES**

MEDICAL RECORDS AND HEALTH INFORMATION RELEASE (pg. 1 of 2)

(to be completed by Veteran 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:

Leave Blank

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 FACILITY	
☐ **Ardie R. Copas SVNH** 13000 SW Tradition Parkway, Port St. Lucie, FL 34987 Phone: 772-241-6132 Fax: 772-241-6150	☐ **Baldomero Lopez SVNH** 6919 Parkway Boulevard Land O' Lakes, FL 34639 Phone: 813-558-5000 Fax: 813-558-5021
☐ **Emory L. Bennett SVNH** 1920 Mason Avenue Daytona Beach, FL 32117 Phone: 386-274-3460 Fax: 386-274-3487	☐ **Clifford Chester Sims SVNH** 4419 Tram Road Panama City, FL 32404 Phone: 850-747-5401 Fax: 850-747-5301
☐ **Alwyn C. Cashe SVNH** 5255 Raymond Street Orlando, FL 32814 Phone: 407-741-4614 Fax: 407-741-4631	☐ **Douglas T. Jacobson SVNH** 21281 Grayton Terrace Port Charlotte, FL 33954 Phone: 941-613-0919 Fax: 941-613-0935
☐ **Alexander Nininger SVNH** 8401 West Cypress Drive Pembroke Pines, FL 33025 Phone: 954-985-4824 Fax: 954-985-4866	☐ **Clyde E. Lassen SVNH** 4650 State Road 16 St. Augustine, FL 32092 Phone: 904-940-2193 Fax: 904-940-9913

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.

MEDICAL RECORDS AND HEALTH INFORMATION RELEASE (pg. 2 of 2)

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

_____
If signed by Legal Representative, Relationship of Legal Representative to Resident

_____ _____
Signature of Witness Date

ACTIVITIES OF DAILY LIVING (ADLS) AND BEHAVIORAL QUESTIONNAIRE

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

VETERAN NAME: _____ **DATE OF BIRTH:** _____

AMBULATION (walking) ☐ Ambulates safely w/no physical help ☐ Needs assistance, set-up help, or supervision ☐ Needs 1 person or 2-person physical assist ☐ Does not ambulate	EATING ☐ Can safely eat meals or snacks with no assistance ☐ Needs assistance, set-up help, or supervision ☐ Needs 1 person or 2-person physical assist ☐ Does not eat (other modes of nutrition)
WHEELCHAIR ☐ Can safely propel self in wheelchair ☐ Needs assistance, set-up help, or supervision ☐ Needs 1 or 2 people to physical assist	TOILETING ☐ Can safely toilet with no assistance or supervision ☐ Needs assistance, set-up help, or supervision ☐ Needs 1 person or 2-person physical assist
BOWEL FUNCTION ☐ Continent ☐ Occasional incontinence – once or twice a week ☐ Frequent incontinence – at least once a day ☐ Total incontinence ☐ Ostomy	BLADDER FUNCTION ☐ Continent ☐ Occasional incontinence – once or twice a week ☐ Frequent incontinence – at least once a day ☐ Total incontinence ☐ Catheter
BED MOBILITY ☐ Can safely position and move in the bed alone ☐ Needs assistance, set-up help, or supervision ☐ Needs 1 person or 2-person physical assist	TRANSFERS ☐ Can safely sit to stand or stand to sit with no help ☐ Needs assistance, set-up help, or supervision ☐ Needs 1 person or 2-person physical assist
BATHING ☐ Can safely bathe with no assistance or supervision ☐ Needs assistance, set-up help, or supervision ☐ Needs 1 person or 2-person physical assist	DRESSING ☐ Can safely dress with no assistance or supervision ☐ Needs assistance, set-up help, or supervision ☐ Needs 1 person or 2-person physical assist
PERSONAL HYGIENE / GROOMING ☐ Can safely complete hygiene/ personal grooming with no assistance or supervision ☐ Needs assistance, set-up help, or supervision ☐ Needs 1 person or 2-person physical assist	ALCOHOL USE ☐ Never occurs ☐ Occurs less than daily ☐ Occurs daily or more frequently
TOBACCO USE (CIGARETTES, CIGARS, PIPE) ☐ Never occurs ☐ Occurs less than daily ☐ Occurs daily or more frequently	DRUG USE ☐ Never occurs ☐ Occurs less than daily ☐ Occurs daily or more frequently
BEHAVIORS (circle all that apply) ☐ Has current diagnosis of dementia or Alzheimer's ☐ "Sundowns" ☐ Exit seeking or eloping ☐ Verbally abusive ☐ Physically abusive ☐ Resistant to care ☐ Inappropriate toileting habits ☐ Inappropriate sexual behavior ☐ Hallucinations, Delusions, or Paranoia ☐ Resistant to care (stiffening, rigidity, refusal) ☐ Wandering ☐ Pacing	BEHAVIORS (circle all that apply) ☐ Hallucinations (hears or sees things not there) ☐ Delusions (tells stories that are not fact based) ☐ Current smoker ☐ Former smoker ☐ Can understand others ☐ Can be understood by others ☐ Verbal ☐ Non-verbal ☐ Wandering ☐ Comments about death of self or others ☐ Verbally abusive (curses, screams, threatens) ☐ Physically abusive (strikes out, grabs)

MEDICAL PROVIDER CONTACT INFORMATION

(to be completed by Veteran or representative)

VETERAN NAME: _____ DATE OF BIRTH: _____

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		
Other		
Other		

Hospitalizations & Admission History

List all Hospitalizations, Skilled Nursing Facility or Assisted Living Facility admissions **IN THE LAST YEAR.**

Name of Hospital, SNF, ALF	Date of Admission	Reason for Admission	Reason for Discharge

FAMILY QUESTIONNAIRE

(To be completed by Veteran or representative)

VETERAN NAME: _____ **DATE OF BIRTH:** _____

1. Veteran's marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
    - If married, spouse's name / nickname: _____
    - Is spouse in a nursing/assisted living facility? ☐ Yes ☐ No
2. Veteran's highest education level: _____
3. Veteran's former occupation(s): _____
4. Veteran's DPOA or guardian name & relationship: _____
5. Veteran is being admitted from (Facility/Location): _____
6. Does the Veteran have memory problems: ☐ Yes ☐ No
    - Duration: ☐ <1 yr ☐ 1–3 yrs ☐ 3–5 yrs ☐ >5 yrs
    - Onset: ☐ Sudden ☐ Gradual
7. Has the Veteran had recent mood/behavior changes in the last 6 mos.: ☐ Yes ☐ No
    - If yes, describe: _____
8. Does the Veteran have any psychiatric History (depression, hospitalizations, etc.): ☐ Yes ☐ No
    - If yes, explain: _____
9. Does the Veteran have a history of substance use below?
    - Tobacco ☐ Yes ☐ No If yes, last use _____
    - Alcohol ☐ Yes ☐ No If yes, last use _____
    - Drugs ☐ Yes ☐ No If yes, last use _____
10. Has the Veteran had any traumatic events in the last 10 years: ☐ Yes ☐ No
    - If yes, please describe_____
11. What activities has the Veteran enjoyed in the last 6 months? _____

    _____
12. Does the Veteran have any pain or physical discomforts affecting activities? (e.g., joint pain)?

    _____
13. Is there anything else to share about the Veteran that the staff should be aware of? _____

    _____

    _____

FEDERAL VA FORMS

TO BE COMPLETED BY VETERAN

OR

REPRESENTATIVE

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.

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**

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

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

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

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

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

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

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

Signature of Veteran Applying for Benefit _____ **Date of Application** _____

Applicant Information

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

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

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

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

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

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

_____
Signature of State Home Representative

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

Department of Veterans Affairs

APPLICATION FOR HEALTH BENEFITS

VA DATE STAMP
(For VHA Use Only)

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

3. SEX	4. WHAT IS YOUR RACE/ ETHNICITY? *(Check all that apply. Information is required for statistical purposes only.)*	5. SOCIAL SECURITY NO. *(999-99-9999)*
☐ MALE ☐ FEMALE	☐ ASIAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ WHITE ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ HISPANIC or LATINO ☐ MIDDLE EASTERN or NORTH AFRICAN ☐ CHOOSE NOT TO ANSWER	

6A. DATE OF BIRTH *(MM/DD/YYYY)*	6B. PLACE OF BIRTH *(City and State)*	7. PREFERRED LANGUAGE	8. RELIGION

9A. MAILING ADDRESS *(Street)*	9B. CITY	9C. STATE	9D. ZIP CODE	9E.COUNTY

9F. HOME TELEPHONE NO. *(optional) ((999) 999-9999)*	9G. MOBILE TELEPHONE NO. *(optional) ((999) 999-9999)*	9H. E-MAIL ADDRESS *(optional)*

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

11. CURRENT MARITAL STATUS

☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED

12A. NEXT OF KIN NAME	12B. NEXT OF KIN ADDRESS	12C. NEXT OF KIN RELATIONSHIP

12D. NEXT OF KIN TELEPHONE NO. *(Include Area Code) ((999) 999-9999)*	13A. EMERGENCY CONTACT NAME	13B. EMERGENCY CONTACT TELEPHONE NO. *(Include Area Code) ((999) 999-9999)*

14. 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*)

15. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? *(for listing of facilities visit www.va.gov/find-locations)*	16. 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 NO. *(999-99-9999)*

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.)* WHEN DID YOU SERVE IN THESE LOCATIONS? ***NOTE:*** *Please provide an approximate time-frame (MM/YYYY)* 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.)* WHEN DID YOU SERVE IN THESE LOCATIONS? ***NOTE:*** *Please provide an approximate time-frame (MM/YYYY)* 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 SEX
☐ MALE ☐ FEMALE

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. *(999-99-9999)*

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 NO. *(999-99-9999)*

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) ((999) 999-9999)*

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)* _____

MEDICAL DOCUMENTATION

TO BE COMPLETED BY A MEDICAL OR HEALTH CARE PROVIDER

FDVA FLORIDA DEPARTMENT OF VETERANS' AFFAIRS	**STATE OF FLORIDA** **DEPARTMENT OF VETERANS' AFFAIRS** **DIVISION OF LONG-TERM CARE SERVICES**

VERIFICATION OF CAPACITY

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

(to be completed by a physician)

Patient/Resident Name: _____ DOB: _____

I, DR. _____ (physician's name), a physician for _____ (Veteran's name), who is a potential or current resident at a Florida State Veterans' Nursing Home (SVNH), have evaluated my patient on _____ (date) and determined that the Veteran

_____ HAS CAPACITY or _____ LACKS CAPACITY (check one)

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

Stamp, if available

FDVA FLORIDA DEPARTMENT OF VETERANS' AFFAIRS	**STATE OF FLORIDA** **DEPARTMENT OF VETERANS' AFFAIRS** **DIVISION OF LONG-TERM CARE SERVICES**

STATEMENT OF HEALTH

(to be completed by a physician or healthcare provider 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.

DATE OF EXAM: _____

PROVIDER NAME (PRINTED): _____ DATE: _____
PHYSICIAN SIGNATURE: _____ DATE: _____
OFFICE PHONE NUMBER: _____

Stamp, if available

CURRENT MEDICATION LIST

(medications can either be written and be signed Health Care Provider, or medications can be attached as part of the medical/clinical records submitted)

VETERAN NAME: _____ DATE OF BIRTH: _____

Medication Name	Dose	Instructions for Use	Route

PHYSICIAN OR PROVIDER NAME (PRINTED): _____
SIGNATURE: _____
OFFICE PHONE NUMBER: _____
DATE OF EXAM: _____

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

*Patient Name: *Last 4 SSN: *DOB:

***A. PATIENT INFORMATION**

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

***B. SIGHT HEARING**

☐ Normal ☐ Impaired ☐ Deaf ☐ Normal ☐ Impaired
☐ Blind ☐ Hearing Aid L ☐ R ☐

C. DECISION MAKING CAPACITY (PATIENT)

☐ Capable to make healthcare decisions ☐ Requires a surrogate

***D. EMERGENCY CONTACT**

Name: _____ Name: _____
Phone: Phone:

***E. MEDICAL CONDITION**

*Primary diagnosis:
*Other diagnoses:

If Hospitalized:
Primary diagnosis at discharge:
Reason for transfer:
Surgical procedures performed:

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: AM ☐ PM ☐ Discharge Time: AM ☐ PM ☐

J. TRANSFERRED TO

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

K. PHYSICIAN CONTACTS

Primary Care Name:
Phone:
Hospitalist Name:
Phone:

L. TIME SENSITIVE CONDITION SPECIFIC INFORMATION

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

☐ Anticoagulants	Date:	Time:	AM ☐ PM ☐
☐ Antibiotics	Date:	Time:	AM ☐ PM ☐
☐ Insulin	Date:	Time:	AM ☐ PM ☐
☐ Other:	Date:	Time:	AM ☐ PM ☐

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: AM ☐ PM ☐

***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 ☐ History & Physical

*ALL MEDICATIONS: (MUST ATTACH LIST)

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

*Patient Name: *Last 4 SSN: *DOB:

O. VITAL SIGNS

Date: Time Taken: AM ☐ PM ☐

HT: FEET INCHES WT:

Temp: BP: /

HR: RR: Sp02:

*P. PATIENT HEALTH STATUS

***Bladder:** ☐ Continent ☐ Incontinent

☐ Ostomy ☐ Catheter Type:_____ **date inserted:** _____

Foley Catheter: ☐ Yes ☐ No **If yes, date inserted:** _____

Indications for use:

☐ Urinary retention due to:_____

☐ Monitoring intake and output

☐ Skin Condition:_____

☐ Other:_____

Attempt to remove catheter made in hospital? ☐ Yes ☐ No

Date Removed: _____

***Bowel:** ☐ Continent ☐ Incontinent ☐ Ostomy

Date of Last BM:_____

Immunization status:

Influenza: ☐ Yes ☐ No Date:_____

Pneumococcal: ☐ Yes ☐ No Date:

*Q. NUTRITION / HYDRATION

***Dietary** Instructions:

Tube Feeding: ☐ G-tube ☐ J-tube ☐ PEG

Insertion Date:

Supplements (type): ☐ TPN ☐ Other Supplements:

Eating: ☐ Self ☐ Assistance ☐ Difficulty Swallowing

R. TREATMENTS AND FREQUENCY

☐ PT - *Frequency:*

☐ OT - *Frequency:*

☐ Speech - *Frequency:*

☐ Dialysis - *Frequency:*

*S. PHYSICAL FUNCTION

***Ambulation:**

☐ Not ambulatory

☐ Ambulates independently

☐ Ambulates with assistance

☐ Ambulates with assistive device

***Transfer:**

☐ Self

☐ Assistance

☐ 1 Assistant

☐ 2 Assistants

Devices:

☐ Wheelchair (type):

☐ Appliances:

☐ Prosthesis:

☐ Lifting Device:

Weight-bearing:

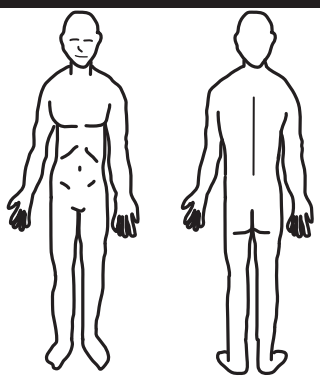
Left:

☐ Full ☐ Partial ☐ None

Right:

☐ Full ☐ Partial ☐ None

T. SKIN CARE – STAGE & ASSESSMENT



Pressure Ulcers

(Indicate stage and location(s) of lesions using corresponding number:

1.

2

3.

List any other lesions or wounds:

*U. MENTAL / COGNITIVE STATUS AT TRANSFER

☐ Alert, oriented, follows instructions

☐ Alert, disoriented, but can follow simple instructions

☐ Alert, disoriented, and cannot follow simple instructions

☐ Not Alert

V. TREATMENT DEVICES

☐ Heparin Lock - Date changed:

☐ IV / PICC / Portacath Access - Date inserted:

Type:_____

☐ Internal Cardiac Defibrillator ☐ Pacemaker

☐ Wound Vac

☐ Other:_____

Respiratory - Delivery Device: ☐ CPAP ☐ BiPAP

☐ Nebulizer ☐ Other:_____ ☐ Nasal Cannula

☐ Mask: Type_____

☐ Oxygen - liters: ____% ☐ 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/PA License #: _____

*Physician/ARNP/PA Signature: _____ *Date: _____

*Printed Physician/ARNP/PA Name & Title:_____ *Phone Number: _____

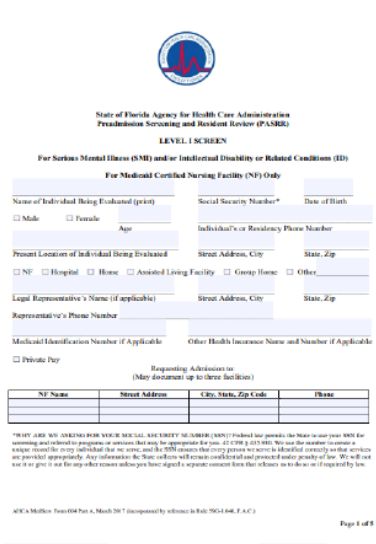
Z. PERSON COMPLETING FORM

Name: _____ Phone Number: _____ Date: _____

Your health care provider may access this form electronically and is responsible for its completion.

It can be found at https://floridapasrr.acentra.com/

Sample PASRR



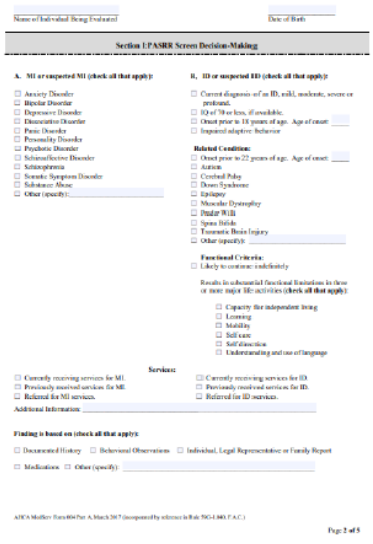
State of Florida Agency for Health Care Administration
Preadmission Screening and Resident Review (PASRR)

LEVEL I SCREEN

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

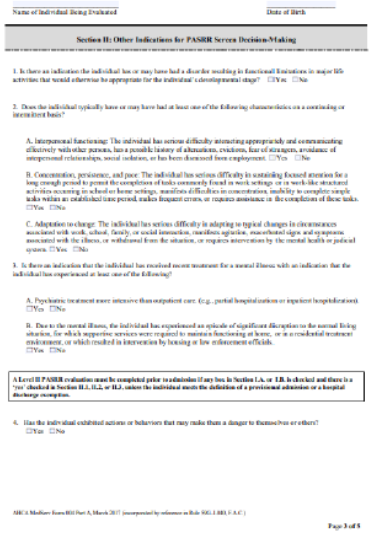
For Medicaid Certified Nursing Facility (NF) Only

Page 1 of 5



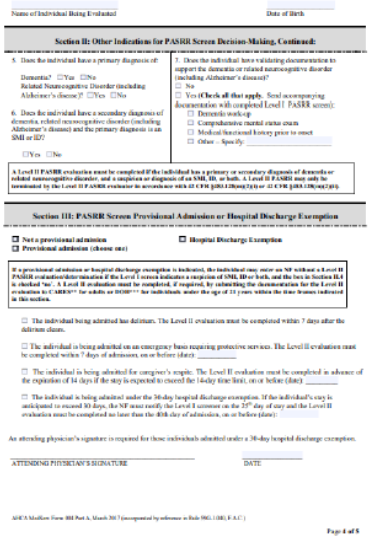
Section I: PASRR Screen Decision-Making

Page 2 of 5



Section II: Other Indications for PASRR Screen Decision-Making

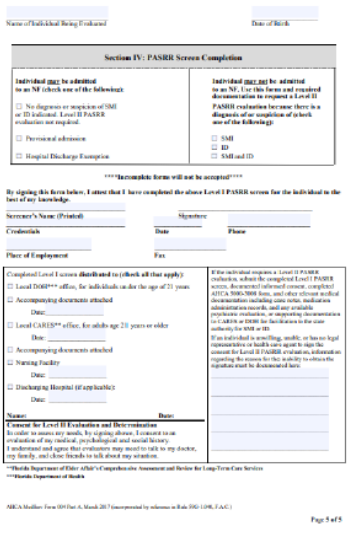
Page 3 of 5



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

Section III: PASRR Screen Provisional Admission or Hospital Discharge Exemption

Page 4 of 5



Section IV: PASRR Screen Completion

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**