LOUISIANA DEPARTMENT OF VETERANS AFFAIRS

LOUISIANA DEPARTMENT OF VETERANS AFFAIRS VETERANS HOME APPLICATION FOR ADMISSION

TO BE COMPLETED BY APPLICANT OR AUTHORIZED REPRESENTATIVE

APPLICANT INFORMATION:

Please select appropriate choice below:

☐ **VETERAN** ☐ **SPOUSE OF VETERAN** ☐ **GOLD STAR PARENT**

PREFERRED FACILITY	**APPLICATION DATE**	
FULL NAME OF APPLICANT	**DATES OF MILITARY SERVICE (Attach Copy of DD-214)**	
PERMANENT STREET ADDRESS	**HOME PHONE NUMBER**	**CELL PHONE NUMBER**
CITY, STATE, ZIP	**BRANCH OF SERVICE**	**SOCIAL SECURITY NUMBER**
PARISH OF RESIDENCE	**SERVICE-CONNECTION PERCENTAGE** (Please provide service-connected Award Letter)	**VA CLAIM # (If Applicable)**
DATE OF BIRTH	**PLACE OF BIRTH (CITY, STATE)**	**EMAIL ADDRESS (If Applicable)**

Does the applicant require an authorized representative?

☐ **Power of Attorney** ☐ **Interdicted** ☐ **Veteran Can Answer for Self**

AUTHORIZED REPRESENTATIVE(S) OR EMERGENCY CONTACT INFORMATION:

FULL NAME	**RELATIONSHIP**	**STREET ADDRESS**	**CELL PHONE**
CITY, STATE, ZIP		**EMAIL ADDRESS**	**HOME PHONE**

FULL NAME	**RELATIONSHIP**	**STREET ADDRESS**	**CELL PHONE**
CITY, STATE, ZIP		**EMAIL ADDRESS**	**HOME PHONE**

Applicant Name _____ Date _____

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STATEMENT OF HISTORY

CURRENT LIVING ARRANGEMENTS (Please select the correct box):

☐ Home ☐ Family ☐ Hospital ☐ Nursing Home

☐ Other (Please explain): _____

Marital Status: Married ☐ Single ☐ Divorced ☐ Widow(er) ☐

Number of Children: _____

Religion (Optional): _____ Highest Education Level: _____

Occupational History: _____

_____

_____

INSURANCE INFORMATION (Please check all that apply):

☐ VA Medical Benefits

☐ Medicare Part A

☐ Medicare Part B

☐ Medicare Part D (Pharmaceutical Benefits)

☐ HMO (Humana, People's Health/Choices 65, WellCare, Coventry, etc.)

☐ Commercial Insurance (List information below):

NAME _____ POLICY # _____ GROUP #_____

ADDRESS _____ CITY/STATE/ZIP _____PHONE _____

Applicant Name _____ Date _____

ORIGIN OF MEDICATION:

☐ VA Clinic ☐ VA MAIL PRIVATE INSURANCE ☐ OTHER

PLEASE ATTACH A COPY OF ALL INSURANCE CARDS FOR ALL POLICIES (INCLUDING MEDICARE CARDS)

NAME OF HOSPITAL _____

CITY/STATE/ZIP_____ PHONE _____

NAME OF PHYSICIAN _____

CITY/STATE/ZIP_____ PHONE _____

FUNERAL HOME PREFERENCE: _____

Please attach a copy of any life insurance or burial policy information

Applicant Name _____ Date _____

REQUEST FOR MEDICAL INFORMATION (TO BE COMPLETED BY DOCTOR OR NURSE)

APPLICANT'S NAME: _____

SS#_____ **MEDICARE #**_____

ALLERGIES: _____

PRIMARY DIAGNOSIS: _____ (ICD10 CODE) SECONDARY (ICD10 CODE)_____

OTHER _____

MEDICATIONS (Specify diagnosis, dosage, frequency and route. Please attach sheet with additional medications if necessary):

1._____ 4. _____7. _____

2._____ 5. _____ 8. _____

3._____ 6. _____ 9. _____

RECENT HOSPITALIZATIONS (Include psychiatric): _____

_____

PHYSICAL EXAMINATION:

HEIGHT _____ WEIGHT _____ PULSE _____RESP. _____TEMPERATURE _____BLOOD PRESSURE _____

LAB RESULTS: HCT _____ HGB _____ U/A _____ RADIOLOGY_____

GENERAL _____ HEADACHES _____

MOUTH AND EENT _____ CHEST _____

HEART AND CIRCULATION _____ ABDOMEN _____

GENITALIA _____ EXTREMITIES _____

SKIN _____ OTHER _____

MENTAL STATUS/BEHAVIOR (Mark correct response):

	NEVER	SELDOM	FREQUENT	ALWAYS		NEVER	SELDOM	FREQUENT	ALWAYS
ORIENTED	_____	_____	_____	_____	CONFUSED	_____	_____	_____	_____
FORGETFUL	_____	_____	_____	_____	HOSTILE	_____	_____	_____	_____
DEPRESSED	_____	_____	_____	_____	ELOPMENT RISK	_____	_____	_____	_____
COMBATIVE	_____	_____	_____	_____					

Applicant Name _____ Date _____

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PHYSICAL STATUS (Select appropriate choice): VERBAL _____ NON-VERBAL _____ COMATOSE _____

	SELF	ASSIST	TOTAL		
				_____IMPAIRED VISION	____IMPAIRED HEARING
EATING	____	____	_____	_____EYEGLASSES	_____HEARING AID
BATHING	____	____	_____	_____INCONTINENT BOWEL	_____DENTURES:
PERSONAL	____	____	_____	_____INCONTINENT BLADDEER	_____UPPER
ORAL CARE	____	____	_____	_____URINARY CATHETER	_____LOWER
AMBULATION	____	____	_____	_____OSTOMYCARE	_____PARTIAL

SPECIAL CARE/PROCEDURES (Select choice; when appropriate give type, frequency, size, stage and site):

GLUCOSE MONITORING _____ TUBE FEEDING _____

DIET _____ RESTRAINTS _____

MRSA/VRE _____ SEIZURES _____

REHAB _____ SUCTIONING _____

OTHER _____

IMMUNIZATIONS: LAST PPD_____ LAST FLU VACCINE_____ LAST PNEUMONIA VACCINE_____

MD/NURSE PRINTED NAME: _____ PHONE NUMBER _____

MD/NURSE SIGNNATURE: _____

Applicant Name _____ Date _____

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VETERAN BENEFITS DOCUMENTATION

The following documents (if applicable) are required for submission of claims
For Veterans Benefits to the U.S. Department of Veterans Affairs

DOCUMENT	**Attached**	**Not Available**
Military Discharge (DD-214 or Discharge Papers)	_____	_____
Monthly Income	_____	_____
Marriage License	_____	_____
Spouse Death Certificate	_____	_____
Divorce Decree	_____	_____
Birth Certificate (Dependents Age 0-17)	_____	_____
Post-High School Enrollment Verification (Dependents Age 18-23)	_____	_____
Medical Insurance Verification	_____	_____
(Copy of Insurance Cards)	_____	_____

Is the Veteran enrolled in a VA health care program at any VA medical center? Yes_____ No _____

If so, which? _____

List the social security numbers for the applicant's spouse (if applicable) and all minor children for whom the applicant is financially responsible:

Full Name of Spouse: _____

Date of Birth_____ SS# _____

Full Name of Dependent (Minor Children Only) _____

Date of Birth_____ SS# _____

Full Name of Dependent (Minor Children Only) _____

Date of Birth_____ SS# _____

Full Name of Dependent (Minor Children Only) _____

Date of Birth_____ SS# _____

Full Name of Dependent (Minor Children Only) _____

Date of Birth_____ SS# _____

Full Name of Dependent (Minor Children Only) _____

Date of Birth_____ SS# _____

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Applicant Name _____ Date _____

LEGAL PROCEDURE DISCLOSURES

A copy of appropriate legal documentation to verify any "yes" response

MUST BE ATTACHED to this application

1. Has applicant ever been interdicted (declared incompetent by a Court of law)?
   Yes _____ No _____
2. Has applicant authorized anyone to act as his/her agent or attorney (power of attorney)?
   Yes _____ No _____
3. Does applicant have a DO NOT RESUSCITATE (DNR) request?
   Yes _____ No _____
4. Does applicant have a living will?
   Yes _____ No _____
5. Does applicant have pending legal charges?
   Yes _____ No _____

If yes to any of the above, please give a brief description:

_____
_____
_____
_____
_____
_____
_____
_____
_____

I attest that the above information is true and correct to the best of my knowledge.

_____ Date _____
Signature of Applicant/Authorized Representative

Applicant Name _____ Date _____

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MONTHLY INCOME VERIFICATION

SOURCE	APPLICANT	SPOUSE	TOTAL
VA Service-Connected Compensation	$	$	$
VA Non-Service Connected Pension	$	$	$
Social Security	$	$	$
Retirement	$	$	$
Dividends and Interest	$	$	$
Real Estate	$	$	$
All Other Assets	$	$	$

PLEASE PROVIDE SUPPORTING DOCUMENTATION TO VERIFY THE INCOME NOTED ABOVE

Some examples are listed below:

VA Compensation	Award letter, copy of most recent check
VA Non-Service Compensation	Award letter, copy of most recent check
Social Security	Copy of most recent check, last statement showing monthly oncome or bank statement records showing most recent deposit
Retirement	Copy of most recent check, last statement showing monthly income or bank statement records showing most recent deposit
Dividends and Interest	Copy of most recent check, last statement showing monthly income or bank statement records showing most recent deposit
Real Estate	Copy of real estate agreement or copy of most recent canceled rent check
All Other Assets	Copy of most recent statement of the income

Every resident of the facility shall be responsible for payment of the full resident Care and Maintenance fee. The facility's administrator may consider waiver of payment of Care and Maintenance fees only for the amount of difference of total income of the Veteran and spouse, when applicable, and the total charge for Care and Maintenance.

The Care and Maintenance (C&M) fee for the Veteran is currently **$1,936.00** per month. The C&M fee for the spouse of a Veteran or a "Gold Star Parent" is **$4,500.00** per month. Please note that the C&M rate is not guaranteed and is based on total combined household financial resources. The rate is reviewed annually by Federal VA and tends to fluctuate. Every effort will be made by the facility to communicate any changes to the C&M fee at least 30 days in advance of any change. At the time of admission, per Federal VA guidelines, C&M fees will be assessed based on all family income sources. Fees are subject to change when there is a change in family income, retroactive to the change. Our facility Veteran Assistance Counselor will assist you in applying for a Federal VA pension and Aid and Attendance (A&A), which is a Federal VA program designed to help reduce any financial burden related to the cost of admission to our facility.

_____ Date _____

Signature of Applicant/Authorized Representative

_____ Date _____

Witness

Applicant Name _____ Date _____

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Name of Applicant	DOB	
Address	SSN	
City	State	Zip

PROVIDER AUTHORIZED TO RELEASE THE PHI	ENTITY RECEIVING THE PHI
	Name
	Address
	City LA Zip
	Attention:

Purpose of this Disclosure: ADMISSION TO VETERANS HOME

	PHI AND DATES OF PHI AUTHORIZED FOR USE OR DISCLOSURE		
☑	Description	Start Date	End Date
	Complete Health Record		
	Progress Notes		
	Laboratory Tests		
	X-Ray Tests/Reports/Images		
	History and Physical Examination		
	Discharge Summary		
	Consultation Reports		
	Itemized Billing Statement		
	Diagnosis and Treatment		
	Immunization Records		
	Other		

The following information will be released:

☑	Description
	AIDS or HIV test results
	Alcohol, drug or substance abuse treatment
	Psychiatric or mental care/treatment
	Other (specify)

I UNDERSTAND THAT:

1. I may refuse to sign this authorization, and it is strictly voluntary.
2. My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on my signing this authorization.
3. I may revoke the authorization at any time, in writing, to the provider authorized to release the protected health information, but, if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. I have the right to receive a copy of this form after I sign it.
5. A photocopy of this authorization will have the same effect as an original.
6. This authorization will automatically expire and be ineffective twelve months after date signed.

_____ Date _____
Signature of Patient

_____ Date _____
Signature of Representative (if necessary)

_____ Date _____
Personal Representative's Relationship to Patient

Applicant Name _____ Date _____

PRIVACY ACT STATEMENT – HEALTH CARE RECORDS

THIS FORM PROVIDES YOU THE ADVICE REQUIRED BY THE PRIVACY ACT OF 1974 (5USC 552a).
THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. **AUTHORITY FOR COLLECTION OF INFORMATION, INCLUDING SOCIAL SECURITY NUMBER AND WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY.** Authority for maintenance of the system is given under Sections 1102(a), 1819(b)(3)(A), 1819(f), 1919(b)(3)(A) and 1864 of the Social Security Act.

   The system contains information on all residents of long-term care (LTC) facilities that are Medicare certified or VA beds, including private pay individuals and not limited to Medicare enrollment and entitlement, and Medicare Secondary Payer data containing other party liability insurance information necessary for appropriate Medicare claim payment.

   Medicare and VA participating LTC facilities are required to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity and health status. To implement this requirement, the facility must obtain information from every resident. This information is also used by the Centers for Medicare & Medicaid Services, Federal VA to ensure that the facility meets quality standards and provides appropriate care to all residents. 42 CFR §483.20, requires LTC facilities to establish a database, the Minimum Data Set (MDS), of resident assessment information. The MDS data are required to be electronically transmitted to the CMS National Repository and Federal VA.

   Because the law requires disclosure of this information to Federal and State sources as discussed above, a resident does not have a right to refuse consent to these disclosures. These data are protected under the requirements of the Federal Privacy Act of 1974 and the MDS LTC System of Records.

2. **PRINCIPAL PURPOSES OF THE SYSTEM FOR WHICH INFORMATION IS INTENDED TO BE USED.** The primary purpose of the system is to aid in the administration of the survey and certification, and payment to Medicare LTC services which include skilled nursing facilities (SNFs), nursing facilities (NFs) and non-critical access hospitals with a swing bed agreement.

   Information in this system is also used to study and improve the effectiveness and quality of care given in these facilities. This system will only collect the minimum amount of personal data necessary to achieve the purposes of the MDS, reimbursement, policy and research functions.

3. **ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM.** The information collected will be entered into the LTC MDS System of Records, System No. 09-07-0528.

Applicant Name _____ Date _____

This system will only disclose the minimum amount of personal data necessary to accomplish the purposes of disclosure. Information from this system may be disclosed to the following entities under specific circumstances (routine uses), which include:

1) To support Agency contractors, consultants, or grantees who have been contracted by the Agency to assist in accomplishment of a CMS function relating to the purposes for this system and who need to have access to the records in order to assist CMS and Federal VA;
2) To assist another Federal or state agency, agency of a state government, an agency established by state law, or its fiscal agent for purposes of contributing to the accuracy requirement of a Federal statute or regulation that implements a health benefits program funded in whole or part with Federal funds for the purposes of determining, evaluating and/or assessing overall or aggregate cost, effectiveness, and/or quality of health care services provided in the State, and determine Medicare eligibility;
3) To assist Quality Improvement Organizations (QIOs) in connection with review of claims, or in connection with studies or other review activities, conducted pursuant to Title XI or Title XVIII of the Social Security Act in performing affirmative outreach activities to individuals for the purpose of establishing and maintaining their entitlement to Medicare benefits or health insurance plans;
4) To assist insurers and other entities or organizations that process individual insurance claims or oversees administration of health care services for coordination of benefits with the Medicare program and for evaluating and monitoring Medicare claims information of beneficiaries including proper reimbursement for services provided;
5) To support an individual or organization to facilitate research, evaluation, or epidemiological projects related to effectiveness, quality of care, prevention of disease or disability, the restoration or maintenance of health, or payment related projects;
6) To support litigation involving the agency, this information may be disclosed to the Department of Justice, courts of adjudicatory bodies;
7) To support a national accrediting organization whose accredited facilities, meet certain Medicare requirements for inpatient hospital (including swing beds) services;
8) To assist a CMS contractor (including but not limited to fiscal intermediaries and carriers) that assists in the administration of a CMS-administered health benefits program, or to a grantee of a CMS-administered grant program to combat fraud, waste and abuse in certain health benefit programs; and
9) To assist another Federal agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States (including any state or local governmental agency), that administers, or that has the authority to investigate potential fraud, waste and abuse in a health benefits program funded in whole or in part by Federal funds.

4. **EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION.** The information contained in the LTC MDS System of Records is generally necessary for the facility to provide appropriate and effective care to each resident.

Applicant Name _____ Date _____

If a resident fails to provide such information, e.g. thorough medical history, inappropriate and potentially harmful care may result. Moreover, payment for services by Medicare, and third parties, may not be available unless the facility has sufficient information to identify the individual and support a claim for payment.

NOTE: This notice will be included in the admission packet for all new nursing home admissions. Although signature of receipt is NOT required, providers may request to have the Resident or his or her Representative sign a copy of this notice as a means to document that notice was provided and merely acknowledges that they have been provided with this information.

Your signature is merely acknowledging that you have been advised of the foregoing. Residents or their Representative must be supplied with a copy of this notice.

Applicant Name _____ Date _____

LDVA VETERANS HOME VISITATION POLICY

The *Louisiana Veterans Homes* recognizes the right of the individual resident to live the lifestyle of his or her choosing. Families and friends are encouraged to visit regularly and maintain contact by letters, social media or telephone with the residents.

- Visitors will be welcomed at all reasonable times and may need to take into consideration when times are most suitable for the resident. This will ensure all visitors enjoy full and equal visitation privileges consistent with resident preferences.

- The facility requires that all visitors sign in the visitor's book in order to comply with fire safety regulations.

- There is no age limit for our visitors, although it is advisable to check with senior staff before bringing very young children into the home in case of infection. (During influenza season visitation may be limited due to confining the spread of the virus. Visitors who are symptomatic are encouraged to not visit the facility).

- When visiting late in the evening hours, we do ask that visitors telephone the facility ahead of the visit for reasons of security. Doors are securely locked by 8 p.m. evenings.

- During evening hours, visitors are asked to use the main gathering areas for visiting purposes; this allows the facility staff free access to rooms when preparing residents for the night. We also ask that visitors do not walk resident room corridors after 8 p.m. to ensure that those residents that want to keep their doors open can do so with privacy.

- Visitors are encouraged to use facility grounds and if arranged with facility staff, to accompany the resident on walks or shopping trips. Facility staff will ensure the resident is signed out on pass, is safe for the resident to leave the facility and agree to any special arrangements with the visitor including overnight stays providing any care related instructions and medications for the resident.

- During times of illness and end of life, when families and residents may wish to be together, the facility will do the utmost to accommodate a family member within the home.

- Unwanted Visitors- The residents of the Louisiana Veterans Homes have the right to refuse visitors, with or without explanation. The facility is their home and it is their right to see in their home whom they wish. Staff is to act according to the wishes of the residents and only admit to the home welcomed visitors.

Applicant Name _____ Date _____

- The Louisiana Veterans Homes will not tolerate any form of aggression, violence, harassment or discrimination from any visitor toward residents.

- Visitors are encouraged to direct any concerns, complaints, or suggestions to facility staff in order to safeguard and protect any residents from vulnerability.

- The Louisiana Veterans Homes do not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

Applicant Name _____ Date _____