

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	MOBILE PHONE NUMBER
--------------------------	-------------------	---------------------

CITY, STATE, ZIP	BRANCH OF SERVICE	SOCIAL SEC. NUMBER
------------------	-------------------	--------------------

PARISH OF RESIDENCE	SERVICE-CONNECTION PERCENTAGE	VA CLAIM # (If applicable)
---------------------	-------------------------------	----------------------------

DATE OF BIRTH	PLACE OF BIRTH (CITY, STATE)	EMAIL ADDRESS (IF APPLICABLE)
---------------	------------------------------	-------------------------------

DOES THE APPLICANT REQUIRE AN AUTHORIZED REPRESENTATIVE?

YES

NO

AUTHORIZED REPRESENTATIVE(S) OR EMERGENCY CONTACT INFORMATION:

PLEASE LIST AUTHORIZED REPRESENTATIVE(S) FIRST (IF APPLICABLE)

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

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

STATEMENT OF HISTORY

CURRENT LIVING ARRANGEMENTS: (PLEASE SELECT THE CORRECT BOX)

<input type="checkbox"/>	HOME	<input type="checkbox"/>	FAMILY	<input type="checkbox"/>	HOSPITAL	<input type="checkbox"/>	NURSING HOME
<input type="checkbox"/>	OTHER (PLEASE EXPLAIN IN NEXT BOX)			<input type="text"/>			

MARITAL STATUS:

<input type="checkbox"/>	MARRIED	<input type="checkbox"/>	SINGLE	<input type="checkbox"/>	DIVORCED	<input type="checkbox"/>	WIDOW(ER)
--------------------------	---------	--------------------------	--------	--------------------------	----------	--------------------------	-----------

RELIGION: (OPTIONAL)

NUMBER OF CHILDREN:

HIGHEST EDUCATION LEVEL:

OCCUPATIONAL HISTORY:

INSURANCE INFORMATION: (PLEASE CHECK ALL THAT APPLY)

<input type="checkbox"/>	VA MEDICAL BENEFITS
<input type="checkbox"/>	MEDICARE PART A
<input type="checkbox"/>	MEDICARE PART B
<input type="checkbox"/>	MEDICARE PART D (PHARMACEUTICAL BENEFITS)
<input type="checkbox"/>	HMO (HUMANA, ETC.)
<input type="checkbox"/>	COMMERCIAL INSURANCE (LIST INFORMATION IN NEXT BOX)

NAME	POLICY #	GROUP #
<input type="text"/>	<input type="text"/>	<input type="text"/>
ADDRESS	CITY,STATE,ZIP	PHONE #
<input type="text"/>	<input type="text"/>	<input type="text"/>

ORIGIN OF MEDICATION:

<input type="checkbox"/>	VA CLINIC	<input type="checkbox"/>	VA MAIL	<input type="checkbox"/>	PRIVATE INSURANCE	<input type="checkbox"/>	OTHER
--------------------------	-----------	--------------------------	---------	--------------------------	-------------------	--------------------------	-------

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

NAME OF HOSPITAL	CITY, STATE	PHONE #
<input type="text"/>	<input type="text"/>	<input type="text"/>
NAME OF PHYSICIAN	CITY, STATE	PHONE #
<input type="text"/>	<input type="text"/>	<input type="text"/>

FUNERAL HOME PREFERENCE:

PLEASE ATTACH A COPY OF ANY LIFE INSURANCE OR BURIAL POLICY INFORMATION

REQUEST FOR MEDICAL INFORMATION

TO BE COMPLETED BY DOCTOR OR NURSE

APPLICANT'S NAME: _____ SS #: _____ MEDICARE #: _____

ALLERGIES _____

PRIMARY DIAGNOSIS: (ICD9 CODE) _____ SECONDARY (ICD9 CODE) _____

OTHER _____

MEDICATIONS: (SPECIFY DIAGNOSIS, DOSAGE, FREQUENCY AND ROUTE. PLEASE ATTACH SHEET WITH ADDITIONAL MEDICATIONS IF NECESSARY)

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 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	_____	_____	_____	_____	WANDER-RISK	_____	_____	_____	_____
COMBATIVE	_____	_____	_____	_____					

PHYSICAL STATUS: (SELECT APPROPRIATE CHOICE)

_____ VERBAL _____ NON-VERBAL _____ COMATOSE

	SELF	ASSIST	TOTAL		IMPAIRED VISION	IMPAIRED HEARING
EATING	_____	_____	_____	_____	EYEGASSES	HEARING AID
BATHING	_____	_____	_____	_____	INCONTINENT BOWEL	DENTURES:
PERSONAL	_____	_____	_____	_____	INCONTINENT BLADDER	_____ 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 _____
RESTRAINTS _____ DIET _____
MRSA/VRE _____ SEIZURES _____
REHAB _____ SUCTIONING _____
DECUBITUS _____ DIALYSIS _____
OTHER _____

IMMUNIZATIONS: LAST PPD _____ LAST FLU VACCINE _____ LAST PNEUMONIA VACCINE _____

MD/NURSE PRINTED NAME _____ PHONE NUMBER _____

ADDRESS _____ DATE _____

MD/NURSE SIGNATURE _____

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

<u>DOCUMENT</u>	<u>ATTACHED</u>	<u>N/A</u>
MILITARY DISCHARGE (DD-214 OR DISCHARGE PAPERS)	_____	_____
MONTHLY INCOME	_____	_____
MARRIAGE LICENSE	_____	_____
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?

NO _____ YES _____ 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	DATE OF DEATH (IF APPLICABLE)	SOCIAL SECURITY #
---------------------	---------------	-------------------------------	-------------------

FULL NAME OF DEPENDENT (MINOR CHILDREN ONLY)	DATE OF BIRTH	SOCIAL SECURITY #
--	---------------	-------------------

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 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, PLEASE GIVE A BRIEF DESCRIPTION: _____

I ATTEST THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE

DATE

MONTHLY INCOME VERIFICATION

SOURCE

VA SERVICE-CONNECTED COMPENSATION
 VA NON-SERVICE CONNECTED PENSION
 SOCIAL SECURITY
 RETIREMENT
 DIVIDENDS AND INTEREST
 REAL ESTATE
 ALL OTHER ASSETS

APPLICANT	SPOUSE	TOTAL
\$	\$	\$
\$	\$	\$
\$	\$	\$
\$	\$	\$
\$	\$	\$
\$	\$	\$
\$	\$	\$

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 Connected Pension	award letter, copy of most recent check
Social Security	copy of most recent check, last statement showing monthly income 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 FEE FOR THE VETERAN IS CURRENTLY \$1,794 PER MONTH. THE CARE AND MAINTENANCE FEE FOR THE SPOUSE OF A VETERAN OR A “GOLD STAR PARENT” IS \$4,500 PER MONTH. PLEASE NOTE THAT THE CARE AND MAINTENANCE FEE RATE IS NOT GUARANTEED AND IT IS BASED ON QUALIFICATIONS. AT THE TIME OF ADMISSION, CARE AND MAINTENANCE FEES WILL BE ASSESSED ON ALL FAMILY INCOME SOURCES. FEES WILL BE ADJUSTED WHEN THERE IS A CHANGE IN FAMILY INCOME, RETROACTIVE TO THE CHANGE.

SIGNATURE OF APPLICANT/AUTHORIZED REPRESENTATIVE

DATE

WITNESS

DATE

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	
			LA
		ATTN:	
Purpose of this Disclosure: ADMISSION TO VETERANS HOME			
PHI AND DATES OF PHI AUTHORIZED FOR USE OR DISCLOSURE			
Description		Start Date	End Date
<input type="checkbox"/> Complete Health Record			
<input type="checkbox"/> Progress Notes			
<input type="checkbox"/> Laboratory Tests			
<input type="checkbox"/> X-Ray Tests / Reports/ Images			
<input type="checkbox"/> History and Physical Examination			
<input type="checkbox"/> Discharge Summary			
<input type="checkbox"/> Consultation Reports			
<input type="checkbox"/> Itemized Billing Statement			
<input type="checkbox"/> Diagnosis and Treatment Codes			
<input type="checkbox"/> Immunization Records			
<input type="checkbox"/> Other:			
The following information will be released:			
<input type="checkbox"/> AIDS or HIV test results		<input type="checkbox"/> Psychiatric or mental care / treatment	
<input type="checkbox"/> Alcohol, drug or substance abuse treatment		<input type="checkbox"/> Other (specify)	
I UNDERSTAND THAT:			
1. I MAY REFUSE TO SIGN THIS AUTHORIZATION, AND IT IS STRICTLY VOLUNTARY.			
2. 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 AFFECT ON ANY ACTIONS TAKEN PRIOR TO RECEIVING THE REVOCATION.			
3. I HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM AFTER I SIGN IT.			
4. A PHOTOCOPY OF THIS AUTHORIZATION WILL HAVE THE SAME EFFECT AS AN ORIGINAL.			
5. THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE AND BE INEFFECTIVE TWELVE MONTHS AFTER DATE SIGNED.			
Signature of Patient:		Date:	
Signature of Representative (if necessary):		Date:	
Personal Representative's Relationship to Patient:			