



STATE OF CONNECTICUT
DEPARTMENT OF VETERANS AFFAIRS
Admissions Office
287 West Street
Rocky Hill, CT 06067



Dear Veteran:

Thank you for your interest in the Connecticut Department of Veterans Affairs (DVA) Residential and Health Care Center Programs and Services. To be eligible for consideration for Admission to the DVA Residential Program or Health Care Center a Veteran must:

1. Have received an honorable discharge or general discharge under honorable conditions from the Armed Forces of the United States on their most recent DD214.
2. Have been a resident of Connecticut for two years prior to submission of application or was a resident of Connecticut at time of induction or enlistment into the Armed Forces.
3. Have served at least ninety (90) days of active duty in the Armed Forces not including active duty for initial entry training.

Applicants to the DVA Residential Facility must be able to perform regular activities of daily living without assistance such as bathing, eating, dressing and cleaning. Applicants to the Health Care Center must require twenty-four hour long-term nursing care.

For an application to be considered for review the following must be provided:

- Completed and signed Application for Admission with most recent DD 214.
- DVA Release of Information (*Application Attachment A*).
- Acknowledgement of DVA Rules and Veteran Responsibilities (*Application Attachment B*).
- Medical Certificate completed by Primary Care Provider at VA CT Healthcare System or other Physician (*Application Attachment C*)
- U.S. Dept. of Veterans Affairs Health Benefits Application (10-10EZ) (*Application Attachment D*).
- U.S. Dept. of Veterans Affairs Medical Information Release (10-5345) (*Application Attachment E*).

Copies of the following must be provided as applicable:

- Veterans who are conserved must provide Probate Court Order of Conservatorship.
- Living Will, Health Care Representative/Proxy and any Power of Attorney document(s).
- Court orders with terms and conditions of Probation or Parole.
- Medical/Health Insurance cards (VA CT Health System Card, Medicare, Medicaid and Private).
- Marriage certificate, if currently married.

For questions concerning this application and admissions to the Healthcare Center call: 860-616-3734.

Health Care Center applications may be submitted via facsimile to: 860-616-3548 or via US Mail:

Healthcare Center Admissions Coordinator
Department Of Veterans Affairs
287 West Street
Rocky Hill, CT 06067

For questions regarding this application and admission to the Residential Facility call: 860-616-3802.

Residential Facility applications may be submitted via facsimile to: 860-616-3556 or via US Mail:

Residential Admission Coordinator.
Department Of Veterans Affairs
287 West Street
Rocky Hill, CT 06067

Applicants denied admission may appeal in writing to the Commissioner within ten days of notification of a denial.

Sincerely,
The Connecticut Department of Veterans Affairs

Revised: 1/30/18

Connecticut Department of Veterans Affairs Application for Residential or Health Care Center Admission

SECTION 1. PERSONAL INFORMATION (Must be completed by all applicants and proof of Connecticut residency provided such as copies of driver's license or other photo identification)

FIRST NAME	MIDDLE NAME	LAST NAME	SOCIAL SECURITY NUMBER	
OTHER NAME/S USED	MAIDEN NAME (if applicable)			
GENDER M <input type="checkbox"/> F <input type="checkbox"/>	DATE OF BIRTH ____/____/____	PLACE OF BIRTH	RELIGION	MARITAL STATUS
HOME ADDRESS	APT.#	CITY	STATE	ZIP CODE
HOME PHONE ()	CELL PHONE ()	WORK PHONE ()	EMAIL ADDRESS	
Resident of Connecticut: _____ From _____ to _____				
Current or most recent occupation: _____				
Select one option:				
Are you seeking admission to the Department's <u>Residential Facility</u> (independent living domiciliary) <input type="checkbox"/>				
Are you seeking admission to the Department's <u>Health Care Center</u> (long-term chronic care facility) <input type="checkbox"/>				
If you are not currently residing in your home listed, where are you currently staying:				
Shelter <input type="checkbox"/> Substance Abuse facility <input type="checkbox"/> Hospital <input type="checkbox"/> Rest/Nursing Home <input type="checkbox"/> With family/friends <input type="checkbox"/> Other <input type="checkbox"/>				
If other, explain _____				
Name of Facility _____ Time at Facility: _____				
Contact person: _____ Title: _____ Phone: _____				
Address: _____				
What is your race? (Optional information is for statistical purposes only. You may indicate more than one.)				
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Spanish, Latino, or Hispanic <input type="checkbox"/> White <input type="checkbox"/> Other				

SECTION 2. MILITARY SERVICE (All applicants must submit a copy of most recent DD 214)

BRANCH OF SERVICE <input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Airforce <input type="checkbox"/> Marines <input type="checkbox"/> Coast Guard	NAME SERVED UNDER (If different from your current name)
DISCHARGE TYPE: <input type="checkbox"/> Honorable <input type="checkbox"/> Under Honorable Conditions <input type="checkbox"/> Other (explain): _____	
WARS/CONFLICT SERVED IN? <input type="checkbox"/> WWII <input type="checkbox"/> KOREA <input type="checkbox"/> VIETNAM <input type="checkbox"/> GULF OTHER: _____	
If you have a service connected disability rating state percentage: _____%	
For what condition(s): _____	

FAILURE TO SUBMIT DD-214 WILL RESULT IN TECHNICAL DENIAL OF APPLICATION

SECTION 3. HEALTH INSURANCE INFORMATION (Must be completed by all applicants)

Are you covered by private Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If you responded yes above provide name of Policy Holder		Policy #	Group Code
Health Insurance Company's Name, Address (Street, City, State, Zip) and Telephone # _____			
Are you enrolled in VA CT Healthcare System? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure			
Do you have Medicare 'A' <input type="checkbox"/> Yes		Do you have Medicare 'B'? <input type="checkbox"/> Yes	Medicare # Date Issued
Do you have Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicaid Claim #	
If not, have you applied for Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date Applied	
Medicaid Case Worker's Name _____ Case Worker's Phone Number: _____			

SECTION 4. EMERGENCY CONTACTS (Must be completed by all applicants)**A. Primary Emergency Contact**

FIRST	MIDDLE	LAST	RELATIONSHIP	
HOME ADDRESS		CITY/STATE	ZIP	COUNTY
HOME PHONE # ()		CELL PHONE # ()	WORK PHONE # ()	
POWER OF ATTORNEY? <input type="checkbox"/> YES <input type="checkbox"/> NO		HEALTH CARE REPRESENTATIVE? <input type="checkbox"/> YES <input type="checkbox"/> NO		
CONSERVATOR OF PERSON? <input type="checkbox"/> YES <input type="checkbox"/> NO		CONSERVATOR OF ESTATE? <input type="checkbox"/> YES <input type="checkbox"/> NO		

B. Secondary Emergency Contact (If any)

FIRST	MIDDLE	LAST	RELATIONSHIP	
HOME ADDRESS		CITY/STATE	ZIP	COUNTY
HOME PHONE # ()		CELL PHONE # ()	WORK PHONE # ()	
POWER OF ATTORNEY? <input type="checkbox"/> YES <input type="checkbox"/> NO		HEALTH CARE REPRESENTATIVE? <input type="checkbox"/> YES <input type="checkbox"/> NO		
CONSERVATOR OF PERSON? <input type="checkbox"/> YES <input type="checkbox"/> NO		CONSERVATOR OF ESTATE? <input type="checkbox"/> YES <input type="checkbox"/> NO		

SECTION 5. CONSERVATOR CONTACT (Complete if different from emergency contact)**A. CONSERVATOR OF PERSON? YES NO**

FIRST	MIDDLE	LAST	RELATIONSHIP	
HOME ADDRESS		CITY/STATE	ZIP	COUNTY
HOME PHONE # ()		CELL PHONE # ()	WORK PHONE # ()	

B. CONSERVATOR OF ESTATE? YES NO

FIRST	MIDDLE	LAST	RELATIONSHIP	
HOME ADDRESS		CITY/STATE	ZIP	COUNTY
HOME PHONE # ()		CELL PHONE # ()	WORK PHONE # ()	
ALSO POWER OF ATTORNEY? <input type="checkbox"/> YES <input type="checkbox"/> NO		ALSO HEALTH CARE REPRESENTATIVE? <input type="checkbox"/> YES <input type="checkbox"/> NO		

SECTION 6. CRIMINAL HISTORY (Must be completed by all applicants)

Have you been convicted of a violent crime or felony? Yes No If yes, dates _____
 Type of conviction(s): _____
 State of conviction(s): _____

Are you currently on probation or on parole? Yes For what charges? _____
 Probation/parole officer name: _____ Phone number: (____) _____ - _____

YOU MUST PROVIDE A COPY OF YOUR CURRENT TERMS/CONDITIONS OF PROBATION/PAROLE

Do you have any outstanding criminal proceedings against you? Yes No

If yes, please explain: _____

Are you registered as a sex offender? Yes No

SECTION 7. SUBSTANCE ABUSE & RECOVERY INFORMATION (Must be completed by all applicants)

Have you ever attended a program for drug and alcohol abuse? YES NO

If yes, state when and where?

Are you currently attending a substance abuse program now? When did you start? _____

When will you complete it? _____ Where is it located? _____

SECTION 9. INCOME & ASSET INFORMATION

(Health Care Center applicants with a seventy percent (70%) or greater service connected disability rating do not complete this section. All other applicants must complete this form as instructed below.)

A. Income statement (must be completed by all Residential and Health Care Center applicants except those with a seventy percent service connected disability rating.)

Type of Income	Veteran Amount	Spouse Amount	Frequency
Social Security			
VA Pension Comp			
Retirement/Pension (first)			
Retirement/Pension (second)			
Dividends/Interest			
Rental Property Income			
Employment Income			
Other (annuity, alimony, etc)			

B. Asset statement (must be completed by all Health Care Center applicants except those with a seventy percent service connected disability rating.)

Type of Asset (ID # if applicable)	Veteran Amount	Spouse Amount
Savings Acct #:		
Checking Acct #:		
Cert of Deposit Acct #:		
Stock Cert Acct #:		
Bonds Cert Acct #:		
Funeral Contract #:		
Life Insurance Policy #:		
Motor Vehicle Vin #:		
Real Estate Address:		
Other Asset Acct #:		

APPLICATION SIGNATURE AND CERTIFICATION

Relationship to Veteran of person signing below: Self Power of Attorney Conservator of Person or Estate.

If Conservator of Person or Estate signing below provide name of issuing Probate Court: _____

Date of Court order: _____

I certify that all personal, medical and financial information provided in this application for Admission and attachments hereto is complete and accurate to the best of my knowledge and belief and understand that knowingly making a false statement intended to mislead a state official in the processing of this application is a Class A misdemeanor pursuant to Conn. Gen. Stat. §53a-157b and is punishable by up to one year imprisonment.

Veteran Applicant or Conservator of Person or of Estate:

Signature: _____ Date _____

Printed name: _____ Phone: _____

APPLICATION ATTACHMENT A
DVA RELEASE OF INFORMATION

Veteran's Name _____ Date of Birth ____/____/____

Social Security Number _____ - _____ - _____ VA Claim Number _____

**I HEREBY AUTHORIZE THE STATE OF CONNECTICUT, DEPARTMENT OF VETERANS AFFAIRS,
TO OBTAIN INFORMATION FROM:**

1. US VA Medical Centers
2. Other Treatment Facilities: List _____
3. CT Department of Public Safety, Division of State Police (criminal background check)

This release applies to relevant information for the admissions process regarding the Veteran's military service and medical treatment which may include information relating to medical, psychiatric, alcohol, and drug abuse, HIV/AIDS, and Sickle Cell to/from such facilities as necessary for the admissions process.

The Department of Veterans Affairs, its employees, officers and attending physicians are required to comply with all privacy laws and rules including but not limited to the protection of medical and health related information pursuant to HIPPA. The Department of Veterans Affairs, its employees, officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. This release will automatically expire ninety (90) days from the date below.

Veteran or Conservator of Person

Signature: _____

Date _____

Printed name: _____

APPLICATION ATTACHMENT B

ACKNOWLEDGEMENT OF DVA RULES AND VETERAN RESIDENT AND PATIENT RESPONSIBILITIES

READ CAREFULLY BEFORE SIGNING

All Applicants: I understand and agree that upon admission Veteran Residents and Patients must follow all rules and regulations of the Connecticut Department of Veterans Affairs (DVA). A copy will be provided upon admission.

Healthcare Center applicants or Transferees from Residential Program Facility: I understand and agree that Veteran Patients in the Health Care Center are required to pay for care provided by the DVA and if unable to pay healthcare costs the Veteran Patient must have a completed and filed "pending" Medicaid (Title XIX) application. I understand Veteran Patients in the Health Care Center are required to apply for Title XIX Medicaid benefits upon request by the DVA, and take all steps reasonably necessary to obtain Medicaid eligibility including cooperating with DVA staff for the purpose of obtaining Title XIX. While a Title XIX application is pending, I understand that Veteran Patients are responsible for paying their portion of the cost of care as assessed by the DVA pursuant to C.G.S. §27-108 until such time as Title XIX is granted. If Medicaid eligibility is determined by the Department of Social Services, I understand that Veterans are responsible for contributing their "applied income" towards the cost of care, as computed by the Department of Social Services.

For Residential Program applicants: I understand and agree that Veterans seeking admission to the Residential Program Facility are required to provide verification that they have the ability to physically perform and manage all Activities of Daily Living (ADL) without assistance. Self reporting, medical records documentation and scheduled interviews with DVA clinicians are utilized to assess admission eligibility. Any Veteran requiring the use of adaptive equipment such as a cane, walker or motorized scooter will be required to complete a self-evacuation assessment conducted by DVA staff. Veterans are required to self-manage their medical and psychiatric care and appointments. Veterans appointed a Conservator of Person by a Court are not eligible for admission to the Residential Program Facility.

All Applicants: I understand and agree that Veteran Patients in the Health Care Center are not permitted to maintain or operate a vehicle on the DVA Campus and that any Veteran Resident in the Residential Program with an authorized vehicle on the DVA Campus who are transferred to the Health Care Center will not be allowed to maintain or operate a vehicle on the DVA Campus.

For Residential Program applicants: I understand and agree that Veteran Residents in the DVA Residential Program Facility are required to pay a monthly Program Fee, the amount of which is set by the DVA and its Board of Trustees.

For Residential Program applicants: I understand and agree that Veteran Residents that have demonstrated a current abuse of alcohol or prescription medication or the use of illegal drugs will be referred to a treatment program. I understand and agree that Veteran Residents that have been convicted of a drug related crime or who have participated in a drug detoxification or rehabilitative program in the previous two years are subject to the DVA drug abuse testing program.

All Applicants: I understand and agree that Veteran Residents and Patients are required to register to receive medical care through the VA Connecticut Healthcare system if eligible and that Veteran Residents and Patients are to be active participants in managing their medical care to the fullest extent possible including following all Physician, primary care and Interdisciplinary provider treatment plans and complete an annual physical and PPD test.

All Applicants: I understand and agree that Veteran Residents and Patients will be provided with an assigned room or living space along with state issued furniture that is not to be removed at any time from the DVA Campus.

All Applicants: I understand and agree that Veteran Residents and Patients are responsible for the safe keeping of their personal property and valuables including money, clothing, and jewelry retained by them while a resident of this facility unless such items are in the possession of the DVA pursuant to DVA policy.

All Applicants: I understand and agree that Veteran Residents who are discharged from the Residential Program Facility are required to have all personal property removed within 30 days and that Veteran Patients discharged from the Health Care Center are required to have all personal property removed within 60 days and that after that time the DVA has the authority to dispose of said property.

All Applicants: I understand and agree that in the event of the death of a Veteran Resident or Patient, the Commissioner may make a claim against the Veteran's estate for the cost of care provided to the Veteran.

I HAVE READ THIS FORM AND UNDERSTAND THE DUTIES AND RESPONSIBILITIES THEREIN.

Veteran or **Conservator of Person**

Signature: _____

Date _____

Printed name: _____

Print Name of Witness

Date: _____

Signature of Witness

Date: _____

APPLICATION ATTACHMENT C

MEDICAL CERTIFICATE

*To be completed by Primary Care Provider at VA CT Healthcare System or by personal physician
for Applicants to the Health Care Center & Residential Program Facility*

Veteran Name: _____ Date of birth: _____
 Code status: _____ Date of flu Vaccination: _____
 Immunization dates: 1.) Influenza _____ 2.) TD/Tdap _____ 3.) Pneumonia _____
 4.) Zoster _____
 Colonoscopy date: _____
 Date of PPD: _____ Test results: _____ Must have PPD placed within the last year: _____
 Dates of tetanus/diphtheria: _____ Date of pneumovac vaccination: _____
 Allergies: _____
 Organ/tissue donor? Yes No

Medical and Surgical History

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

Review of Systems

Cough _____ Abdominal Pain _____ Extremities _____ Mental Status _____
 Dyspnea _____ Vomiting _____ Skin _____ Vision _____
 Chest Pain _____ UTI/frequency _____ Dentures _____ Hearing _____
 Substance Abuse _____ Other _____

Physical Exam: P _____ **R** _____ **B/P** _____ / _____ **T** _____ **Wgt** _____ **Ht** _____

Check	Normal	Abnormal	Positive Findings
General			
Head - Eyes/Ears/Mouth			
Chest/ Breast			
Lungs			
Heart/ Vascular			
Abdomen/ Rectum			
Genitalia/ Pelvic			
Extremities/ Back			
Neurologic			
Mental Status			
Skin/ Other			

Laboratory Studies:

X-Ray _____ EKG: _____
 Blood Tests: WBC _____ HBG _____ HCT _____ PLT _____ FBS _____ K _____
 Cr _____ BUN _____ Other: _____ (i.e. PSA, TSH, Electrolytes etc.)

Name of PCP _____ Signature of PCP: _____ Date: _____

Address: _____ Telephone #: _____

**INSTRUCTIONS FOR COMPLETING ENROLLMENT APPLICATION FOR HEALTH BENEFITS****Please Read Before You Start . . . What is VA Form 10-10EZ used for?**

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

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

You may use ANY of the following to request assistance:

- Ask VA to help you fill out the form by calling us at 1-877-222-VETS (8387).
- Access VA's website at <http://www.va.gov> and select "Contact the VA."
- Contact the Enrollment Coordinator at your local VA health care facility.
- Contact a National or State Veterans Service Organization.

Definitions of terms used on this form:

SERVICE-CONNECTED (SC): A VA determination that an illness or injury was incurred or aggravated in the line of duty, in the active military, naval or air service.

COMPENSABLE: A VA determination that a service-connected disability is severe enough to warrant monetary compensation.

NONCOMPENSABLE: A VA determination that a service-connected disability is not severe enough to warrant monetary compensation.

NONSERVICE-CONNECTED (NSC): A Veteran who does not have a VA determined service-related condition.

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

Section I - General Information: Answer all questions.

Section II - Military Service Information: If you are not currently receiving benefits from VA, you may attach a copy of your discharge or separation papers from the military (such as DD-214 or, for WWII Veterans, a "WD" Form), with your signed application to expedite processing of your application. If you are currently receiving benefits from VA, we will cross-reference your information with VA data.

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

Directions for Sections IV-VI:

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

Financial Disclosure Requirements Do Not Apply To:

- a former Prisoner of War; or
- those in receipt of a Purple Heart; or
- a recently discharged Combat Veteran; or
- those discharged for a disability incurred or aggravated in the line of duty; or
- those receiving VA SC disability compensation; or
- those receiving VA pension; or
- those in receipt of Medicaid benefits; or
- those who served in Vietnam between January 9, 1962 and May 7, 1975; or
- those who served in SW Asia during the Gulf War between August 2, 1990 and November 11, 1998; or
- those who served at least 30 days at Camp Lejeune between August 1, 1953 and December 31, 1987.

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

Continued ...

Section IV - Dependent Information: Include the following:

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

Section V - Previous Calendar Year Gross Annual Income of Veteran, Spouse and Dependent Children.

Report:

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

Do Not Report:

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

Section VI - Previous Calendar Year Deductible Expenses.

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

Section VII - Submitting your application.

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

Where do I send my application?

Mail the original application and supporting materials to the Health Eligibility Center, 2957 Clairmont Road, Suite 200 Atlanta, GA 30329.

PAPERWORK REDUCTION ACT AND PRIVACY 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 Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 30 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

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



APPLICATION FOR HEALTH BENEFITS

SECTION I - GENERAL INFORMATION

Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)

1A. VETERAN'S NAME (Last, First, Middle Name)		1B. PREFERRED NAME		2. MOTHER'S MAIDEN NAME	
3A. BIRTH SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	3B. SELF-IDENTIFIED GENDER IDENTITY <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	4. ARE YOU SPANISH, HISPANIC, OR LATINO? <input type="checkbox"/> YES <input type="checkbox"/> NO	5. WHAT IS YOUR RACE? (You may check more than one. Information is required for statistical purposes only.) <input type="checkbox"/> ASIAN <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> WHITE <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER		6. SOCIAL SECURITY NO.
7. VA CLAIM NUMBER	8A. DATE OF BIRTH (mm/dd/yyyy)	8B. PLACE OF BIRTH (City and State)		9. RELIGION	
10A. PERMANENT ADDRESS (Street)		10B. CITY	10C. STATE	10D. ZIP CODE	10E. COUNTY
10F. HOME TELEPHONE NO. (Include area code)		10G. MOBILE TELEPHONE NO. (Include area code)		10H. E-MAIL ADDRESS	
11A. RESIDENTIAL ADDRESS (Street)		11B. CITY	11C. STATE	11D. ZIP CODE	11E. COUNTY
12. TYPE OF BENEFIT(S) APPLYING FOR (You may check more than one) <input type="checkbox"/> ENROLLMENT/HEALTH SERVICES <input type="checkbox"/> DENTAL		13. CURRENT MARTIAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			
14A. NEXT OF KIN NAME		14B. NEXT OF KIN ADDRESS		14C. NEXT OF KIN RELATIONSHIP	
14D. NEXT OF KIN TELEPHONE NO. (Include Area Code)	14E. NEXT OF KIN WORK TELEPHONE NO. (Include Area Code)	15. DESIGNEE - INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH (Note: This does not constitute a will or transfer of title)			
16. I AM ENROLLING TO OBTAIN MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT <input type="checkbox"/> YES <input type="checkbox"/> NO		17. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? (for listing of facilities visit www.va.gov/directory)		18. WOULD YOU LIKE FOR VA TO CONTACT YOU TO SCHEDULE YOUR FIRST APPOINTMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	

SECTION II - MILITARY SERVICE INFORMATION

1A. LAST BRANCH OF SERVICE		1B. LAST ENTRY DATE		1C. FUTURE DISCHARGE DATE		1D. LAST DISCHARGE DATE	
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?	<input type="checkbox"/>	<input type="checkbox"/>	G. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	<input type="checkbox"/>	<input type="checkbox"/>		
B. ARE YOU A FORMER PRISONER OF WAR?	<input type="checkbox"/>	<input type="checkbox"/>	IF "YES", WHAT IS YOUR RATED PERCENTAGE _____%				
C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?	<input type="checkbox"/>	<input type="checkbox"/>	H. DID YOU SERVE IN VIETNAM BETWEEN JANUARY 9, 1962 AND MAY 7, 1975?	<input type="checkbox"/>	<input type="checkbox"/>		
D. WERE YOU DISCHARGED OR RETIRED FROM MILITARY FOR A DISABILITY INCURRED IN THE LINE OF DUTY?	<input type="checkbox"/>	<input type="checkbox"/>	I. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?	<input type="checkbox"/>	<input type="checkbox"/>		
E. ARE YOU RECEIVING DISABILITY RETIREMENT PAY INSTEAD OF VA COMPENSATION?	<input type="checkbox"/>	<input type="checkbox"/>	J. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	<input type="checkbox"/>	<input type="checkbox"/>		
F. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998?	<input type="checkbox"/>	<input type="checkbox"/>	K. DID YOU SERVE ON ACTIVE DUTY AT LEAST 30 DAYS AT CAMP LEJEUNE FROM AUGUST 1, 1953 THROUGH DECEMBER 31, 1987?	<input type="checkbox"/>	<input type="checkbox"/>		

APPLICATION FOR HEALTH BENEFITS <i>Continued</i>		VETERAN'S NAME <i>(Last, First, Middle)</i>		SOCIAL SECURITY NUMBER	
SECTION III - INSURANCE INFORMATION (Use a separate sheet for additional information)					
1. ENTER YOUR HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER <i>(include coverage through spouse or other person)</i>					
2. NAME OF POLICY HOLDER		3. POLICY NUMBER	4. GROUP CODE	5. ARE YOU ELIGIBLE FOR MEDICAID? <input type="checkbox"/> YES <input type="checkbox"/> NO	6A. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A? <input type="checkbox"/> YES <input type="checkbox"/> NO
					6B. EFFECTIVE DATE <i>(mm/dd/yyyy)</i>
SECTION IV - DEPENDENT INFORMATION (Use a separate sheet for additional dependents)					
1. SPOUSE'S NAME <i>(Last, First, Middle Name)</i>			2. CHILD'S NAME <i>(Last, First, Middle Name)</i>		
1A. SPOUSE'S SOCIAL SECURITY NUMBER			2A. CHILD'S DATE OF BIRTH <i>(mm/dd/yyyy)</i>	2B. CHILD'S SOCIAL SECURITY NO.	
1B. SPOUSE'S DATE OF BIRTH <i>(mm/dd/yyyy)</i>	1C. SPOUSE SELF-IDENTIFIED GENDER IDENTITY <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		2C. DATE CHILD BECAME YOUR DEPENDENT <i>(mm/dd/yyyy)</i>		
1D. DATE OF MARRIAGE <i>(mm/dd/yyyy)</i>			2D. CHILD'S RELATIONSHIP TO YOU <i>(Check one)</i> <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> STEPSON <input type="checkbox"/> STEPDAUGHTER		
1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER <i>(Street, City, State, ZIP if different from Veteran's)</i>			2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? <input type="checkbox"/> YES <input type="checkbox"/> NO		
			2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? <input type="checkbox"/> YES <input type="checkbox"/> NO		
3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT? <input type="checkbox"/> YES <input type="checkbox"/> NO			2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING <i>(e.g., tuition, books, materials)</i>		
SECTION V - EMPLOYMENT INFORMATION					
1A. VETERAN'S EMPLOYMENT STATUS <i>(Check one)</i> . <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> NOT EMPLOYED <input type="checkbox"/> RETIRED				1B. DATE OF RETIREMENT	
1C. COMPANY NAME. <i>(Complete if employed or retired)</i>		1D. COMPANY ADDRESS <i>(Complete if employed or retired -Street, City, State, ZIP)</i>		1E. COMPANY PHONE NUMBER <i>(Complete if employed or retired) (Include area code)</i>	
SECTION VI - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN (Use a separate sheet for additional dependents)					
1. GROSS ANNUAL INCOME FROM EMPLOYMENT <i>(wages, bonuses, tips, etc.)</i> EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	\$	VETERAN	\$	SPOUSE	\$
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	\$	VETERAN	\$	SPOUSE	\$
3. LIST OTHER INCOME AMOUNTS <i>(e.g., Social Security, compensation, pension interest, dividends)</i> EXCLUDING WELFARE.	\$	VETERAN	\$	SPOUSE	\$
SECTION VII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES					
1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE <i>(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home)</i> 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 <i>(Also enter spouse or child's information in Section VI.)</i>					\$
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES <i>(e.g., tuition, books, fees, materials)</i> DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.					\$

APPLICATION FOR HEALTH BENEFITSVETERAN'S NAME *(Last, First, Middle)*

SOCIAL SECURITY NUMBER

*Continued***SECTION VII - CONSENT TO COPAYS AND TO RECEIVE COMMUNICATIONS**

By submitting this application you are agreeing to pay the applicable VA copays for treatment or services of your NSC conditions as required by law. You also agree to receive communications from VA to your supplied email or mobile number.

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**

LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH
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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.

- UPON SATISFACTION OF THE NEED FOR DISCLOSURE
- ON _____ (enter a future date other than date signed by patient)
- UNDER THE FOLLOWING CONDITION(S): _____

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

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED	RELEASED BY:
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