



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



Thomas J. Saadi  
Commissioner

Dear Veteran:

Thank you for your interest in the Connecticut Department of Veterans Affairs (DVA) Residential and Healthcare Center Programs and Services. To be eligible for consideration for Admission to the DVA Residential Program or Healthcare 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 DD 214.
2. Be a resident of Connecticut at time 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 (e.g. basic 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 Healthcare Center must require twenty-four hour long-term skilled 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 admissions to the Healthcare Center call: 860-616-3708. Healthcare Center applications may be submitted via facsimile: 860-616-3548, email: Linda.Norman@ct.gov, or via US Mail:

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

For questions regarding admission to the Residential Program call: 860-616-3802. Residential Facility applications may be submitted via facsimile: 860-616-3548, email: Carol.Greatorex@ct.gov or via US Mail:

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

Admission denials may be appealed in writing to the Commissioner within ten days of notification of a denial.

Sincerely,  
The Connecticut Department of Veterans Affairs

# 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: Male <input type="checkbox"/> Female <input type="checkbox"/> Nonbinary <input type="checkbox"/>	DATE OF BIRTH ____/____/____	PLACE OF BIRTH	RELIGION
HOME ADDRESS	APT.#	CITY	STATE
HOME PHONE ( )	CELL PHONE ( )	WORK PHONE ( )	EMAIL ADDRESS
Resident of Connecticut: _____ From _____ to _____			
Current or most recent occupation: _____			
<b>Select one option:</b>			
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**  
**READ CAREFULLY BEFORE SIGNING**

ACKNOWLEDGEMENT OF DEPARTMENT OF VETERANS AFFAIRS ADMISSION  
REQUIREMENTS AND VETERAN RESIDENT AND PATIENT RESPONSIBILITIES

*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) copies of which will be provided upon admission. Copies are available prior to admission upon request.

*All Applicants:* I understand and agree that Veteran Patients in the Healthcare 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 Healthcare Center will not be allowed to maintain or operate a vehicle on the DVA Campus.

*All Applicants:* I understand and agree that Veteran Residents and Veteran 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 or patient of this facility unless such items are in the possession of the DVA pursuant to DVA policy. In the Residential Program Veterans are responsible for safe keeping of their medications unless such items are in the possession of the DVA pursuant to DVA policy.

*All Applicants:* I understand and agree that Veteran Residents and Patients who are discharged from the Residential Program Facility or the Healthcare Center are required to have all personal property removed within 60 days in the Residential Program and within 30 days in the Healthcare Center. 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.

*All Applicants:* I understand and agree as part of my plan of care to apply for all state and federal medical, insurance and other benefits that I am eligible to receive.

*Healthcare Center Applicants:* I understand and agree that Veteran Patients in the Healthcare Center are required to have a payor source 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 Healthcare 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" (aka Patient Liability Amount or "PLA") towards the cost of care, as computed by the Department of Social Services.

*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.

*Residential Program Applicants:* I understand and agree that Veteran Residents who have demonstrated a current abuse of alcohol or prescription medication or the use of illegal drugs will be referred to a treatment program. Urine testing is done on an individual basis when working with Recovery Support Team.

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

*Residential Program Applicants:* I understand and agree as part of my plan of care to meet with an assigned DVA Social Worker and/or Case Manager at least on a monthly basis, if not more frequently to establish and work on identified goals and objectives.

*Residential Program Applicants:* I understand and agree that Veteran Residents admitted to the Residential Facility will be responsible for the upkeep and cleaning of their assigned living spaces.

*Residential Program Applicants:* I understand and agree that Veteran Residents are to participate in some type of work activity either non-compensated or compensated. Non-compensated work activity may include assignments that support the daily upkeep and maintenance of the facility. Those Veteran Residents approved for participation in the Veteran Vocation Therapeutic Program (VVTP) will receive compensation for the hours of participation in the VVTP Program and compensation will be based on the established minimum wage.

I understand and agree that this work activity plan will be jointly developed between the Veteran Resident and Staff within 30 days of admission and will be reviewed every 90 days and documented in the medical record. Any updates or changes that need to be made to the plan will be made jointly and also documented in the medical record. The work activity plan will be part of the ITP process and will be reviewed and assessed on an ongoing basis. I hereby consent to the work activity and the work activity plan described herein and further understand and agree that I must approve and consent to the work activity plan as part of the admissions process.

*Residential Program Applicants:* I understand that I am subject to arrest for any crime committed on the DVA Campus, which may also result in my involuntary discharge from the Residential Facility.



**I have read, understand, and agree to comply with all requirements and responsibilities set forth above as a condition of my admission to and continued residency at the Residential Facility at the Connecticut Department of Veterans Affairs. I understand that should I violate any of these requirements and responsibilities or any regulations, rules or policies of the DVA, I may be subject to disciplinary action up to and including discharge from the DVA Residential Facility.**

Check Applicable box:     Veteran     Conservator of Person<sup>1</sup>

\_\_\_\_\_  
Signature of Veteran or Conservator

\_\_\_\_\_  
Signature of DVA Witness

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Printed Name

Date: \_\_\_/ \_\_\_/ \_\_\_\_\_

Date: \_\_\_/ \_\_\_/ \_\_\_\_\_

Revised: March 19, 2021

\_\_\_\_\_  
<sup>1</sup> Veterans conserved of person are not eligible for admission to the Residential Program.

**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 \_\_\_\_\_ 5.) COVID-19 \_\_\_\_\_  
 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**

<b>1.</b>	<b>5.</b>	<b>9.</b>
<b>2.</b>	<b>6.</b>	<b>10.</b>
<b>3.</b>	<b>7.</b>	<b>11.</b>
<b>4.</b>	<b>8.</b>	<b>12.</b>

**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.



Department of Veterans Affairs

# 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)**

1. VETERAN'S NAME (Last, First, Middle Name)		2. MOTHER'S MAIDEN NAME	3. GENDER <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"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> ASIAN <input type="checkbox"/> WHITE <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER			
6. SOCIAL SECURITY NUMBER	7. DATE OF BIRTH (mm/dd/yyyy)	7A. PLACE OF BIRTH (City and State)		
8. PERMANENT ADDRESS (Street)		8A. CITY	8B. STATE	8C. ZIP CODE
8D. COUNTY	8E. HOME TELEPHONE NUMBER (Include area code)	8F. MOBILE TELEPHONE NUMBER (Include area code)		
8G. E-MAIL ADDRESS		9. CURRENT MARTIAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		
10. I AM ENROLLING TO OBTAIN MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT <input type="checkbox"/> YES <input type="checkbox"/> NO		11. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? (for listing of facilities visit <a href="http://www.va.gov/directory">www.va.gov/directory</a> )		12. 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

1. LAST BRANCH OF SERVICE	1A. LAST ENTRY DATE	1B. LAST DISCHARGE DATE	1C. DISCHARGE TYPE	
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"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. ARE YOU A FORMER PRISONER OF WAR?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>
		E. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998?	<input type="checkbox"/>	<input type="checkbox"/>
		F. DID YOU SERVE IN VIETNAM BETWEEN JANUARY 9, 1962 AND MAY 7, 1975?	<input type="checkbox"/>	<input type="checkbox"/>
		G. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?	<input type="checkbox"/>	<input type="checkbox"/>
		H. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	<input type="checkbox"/>	<input type="checkbox"/>
		I. 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"/>

## 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	6. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A? <input type="checkbox"/> YES <input type="checkbox"/> NO	
				6A. EFFECTIVE DATE (mm/dd/yyyy)	

<b>APPLICATION FOR HEALTH BENEFITS, Continued</b>	VETERAN'S NAME <i>(Last, First, Middle)</i>	SOCIAL SECURITY NUMBER	
<b>SECTION IV - DEPENDENT INFORMATION <i>(Use a separate sheet for additional dependents)</i></b>			
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 NUMBER	
1B. SPOUSE'S DATE OF BIRTH <i>(mm/dd/yyyy)</i>	2C. DATE CHILD BECAME YOUR DEPENDENT <i>(mm/dd/yyyy)</i>		
1C. 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		
1D. 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>		
<b>SECTION V - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN <i>(Use a separate sheet for additional dependents)</i></b>			
	<b>VETERAN</b>	<b>SPOUSE</b>	<b>CHILD 1</b>
1. GROSS ANNUAL INCOME FROM EMPLOYMENT <i>(wages, bonuses, tips, etc.)</i> EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	\$ _____	\$ _____	\$ _____
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	\$ _____	\$ _____	\$ _____
3. LIST OTHER INCOME AMOUNTS <i>(e.g., Social Security, compensation, pension interest, dividends)</i> EXCLUDING WELFARE.	\$ _____	\$ _____	\$ _____
<b>SECTION VI - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES</b>			
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.	\$ _____		
<b>SECTION VII - CONSENT TO COPAYS AND TO RECEIVE COMMUNICATIONS</b>			
<b>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.</b>			
<b>ASSIGNMENT OF BENEFITS</b>			
<p>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.</p>			
<b>ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS WHICH DEFINE WHO CAN SIGN ON BEHALF OF THE VETERAN</b>			
SIGNATURE OF APPLICANT _____		DATE _____	



Department of Veterans Affairs

**REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION**

**Privacy Act and Paperwork Reduction Act Information:** The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. 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 identified as 24VA10P2 "Patient Medical Record - VA" and in accordance with the Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect 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. 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 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

**ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.**

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)	PATIENT NAME (Last, First, Middle Initial)
	SOCIAL SECURITY NUMBER

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

**VETERAN'S REQUEST:** I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):  
 DRUG ABUSE ALCOHOLISM OR ALCOHOL ABUSE TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) SICKLE CELL ANEMIA

**INFORMATION REQUESTED** (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)  
 COPY OF HOSPITAL SUMMARY COPY OF OUTPATIENT TREATMENT NOTE(S) OTHER (Specify)

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

**NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM**

**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 the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on (date supplied by patient); (3) under the following condition(s):

**I understand that the VA health care practitioner'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.**

DATE (mm/dd/yyyy)	SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA) (Sign in ink)
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**FOR VA USE ONLY**

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)	TYPE AND EXTENT OF MATERIAL RELEASED	
	DATE RELEASED	RELEASED BY