STATE OF CONNECTICUT

DEPARTMENT OF VETERANS AFFAIRS
287 West Street
Rocky Hill, Connecticut 06067
Phone: 860-616-3733 Fax: 860-616-3548

Thomas J. Saadi
Commissioner

Respite Care Program Caregiver(s) Information Letter

Thank you for your interest in the Respite Care Program at the State of Connecticut Department of Veterans Affairs (DVA), Sgt. John L. Levitow Healthcare Center (HCC). The Respite Care Program offers the opportunity for caregivers of Veterans to have temporary relief from their duties for a scheduled period of time. This is a short-term program in which the Veteran is provided up to **twenty-eight (28)** days or less **(minimum of 5 days)** of respite admission per one-year period starting with the first day of the **Trial Respite Admission**.

Trial Respite Admission:

- Prior to and, separate from a Respite Care Admission a three (3) day trial period may be required to assess and ensure that the HCC is able to meet the needs of the Veteran. These are scheduled from Tuesday –Thursday.

If the HCC determines the Veteran cannot be cared for due to behavioral or other reasons not in the control of HCC, the Primary or Alternate Caregiver must take the Veteran into their care immediately. The HCC Admission Coordinator will discuss alternative respite options that you may pursue in the community and at the time of discharge will advise whether the HCC is potentially an appropriate facility for a future Respite Care Admission.

If the Trial Respite period is successful, a Respite Care Admission may then be scheduled by contacting the HCC Admission Coordinator who will determine the availability of a Respite Care bed. If a Respite Care bed is not available to meet the Veteran's needs, the HCC Admission Coordinator will discuss alternative respite options that you may pursue in the community.

To apply for Respite Care Admission, which includes the Trial Respite Admission, the following documents must be submitted and approved by the HCC Admission Committee before a Veteran may be accepted into the Respite Care Program:

- Acknowledgment of review of Caregiver(s) Information Letter to be completed by Primary Caregiver.
- Acknowledgment of Fiscal and Personal Responsibility for Veteran to be completed by Primary Caregiver.
- A complete Respite Care Program Application to be compiled by Primary Caregiver that includes:
  - **Annex A** - Caregiver/Veteran Questionnaire to be completed by Primary Caregiver (This is necessary for the caregivers at HCC to understand the Veteran's preferences and his/her daily routine).
  - **Annex B** - History and Physical to be completed by a primary care physician within ninety (90) days of submission of application.
  - **Annex C** - Current Medication List to include all prescriptions and over the counter (OTC) medications. (This is critical information as some medications may not be available through the VA requiring advanced healthcare planning with the Primary Caregiver.)
  - **10-10EZ** – Application for Health Benefits (VA)
  - **DD214** – Report of the Veteran's Discharge/Separation from the Armed Forces of the United States

These documents must be received and approved prior to the Trial Respite Admission date. It is the Primary Caregiver's responsibility to ensure that all information provided is accurate and all documents are submitted in a timely manner. Upon receipt of the above documents the Admission Committee will determine if the HCC is able to provide Respite Care to the Veteran. You may send the completed documents via US Mail or facsimile to the HCC Facility. If you need assistance or have questions, please call 860-616-3733.

The Primary Caregiver MUST accompany Veteran throughout the Trial and Respite Care Program admission process unless specific permission has been given by the HCC Admission Coordinator to waive this requirement. The Primary Caregiver must be present until the Veteran is admitted into the Trial and Respite Care Program at which time the nurse will inform the caregiver that he/she may leave.

With the Respite Care Application you must provide copies of the Veteran's insurance cards, 10-10 EZ, and DD214. If the Veteran has or is subject to a Power of Attorney, Conservatorship or Advance Directives, such as a Health Care Proxy and/or Living Will, copies of all such documents/orders must be provided to the HCC after approval of admission but at least five (5) days prior to the date of admission to be included in the Veteran's record.

The Veteran will be discharged from the Respite Care Program within the length of time specified by the Primary Caregiver which shall not exceed twenty-eight (28) days in any one year period. If the Primary Caregiver is unable or unwilling to resume the Primary Caregiver role for the Veteran a written plan of care for the Veteran must be presented at the time of admission. *Pursuant to State of Connecticut Department of Veterans Affairs (DVA) Regulations this plan should be "other than long-term admission to a departmental service, activity, or program."* It is imperative that the **Veteran is dropped off and picked up no later than 10:00 a.m. on the confirmed dates of admission and discharge**. Please follow this rule as it provides the staff time to prepare for the next admission. If an unanticipated situation prevents pick-up or drop-off by 10:00 a.m., please notify the HCC Admission Coordinator or nurse station immediately.

In the event the Veteran's stay in Respite Care Admissions exceeds the twenty-eight (28) day limit set by Connecticut Regulations of State Agencies Section 27-102l(d)-108(c)(3)(B) then charges will be assessed beginning on the 29th day of stay. You may contact the Billing Office at 860-616-3646 or 860-616-3644 for current daily rate charges. If the **unforeseen exceptional circumstance** should result in the Respite Care becoming a regular long-term placement then compliance with all applicable state statutes governing DVA with respect to Medicaid Title XIX **will be followed and enforced**.

By signing below I affirm that I have read this Caregiver(s) Informational Letter and understand and agree to follow the information, requests and requirements set forth herein in consideration of the Veteran in my care being considered for admission to the HCC Respite Care Program.

Primary Caregiver

Signature: ____________________________________ Date: ______/ _______/ _______

Printed Name: ________________________________

Relationship: _________________________________

Address: _____________________________________

Town _________________________ State ________

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Thomas J. Saadi
Commissioner

Respite Care Program
Acknowledgement of Fiscal and Personal Responsibility for Veteran

I have read and signed the Respite Care Program Caregiver(s) Information Letter. I understand that the Veteran in my care is being considered for approval to participate in the Respite Care Program of the State of Connecticut Department of Veterans Affairs (DVA) a period of not more than twenty-eight (28) days per one-year period beginning with the first day of the Trial Respite Admission. I understand that the Respite Care Program is a short-term program and that the admitted Veteran is to be discharged to my care or a designated alternative caregiver upon completion of the respite care period. I understand that there is no charge for this program, but that I must provide the requested financial information so that the DVA may be reimbursed Federal Per Diem costs.

I understand that in the event, the Veteran's medical condition changes while in the Respite Care Program and warrants an ambulance transport to an outside hospital/facility, any charges incurred for the ambulance and any outside healthcare provider are the responsibility of the Veteran or his/her estate.

I agree that in the event the Veteran’s stay in Respite Care Admissions exceeds the twenty-eight (28) day limit set by Regulations of State Agencies Section 27-102l(d)-108(c)(3)(B) then charges will be assessed beginning on the 29th day of stay. I understand that if the Veteran becomes a regular long-term placement then compliance with all applicable state statutes governing DVA with respect to Medicaid Title XIX will be followed and enforced.

I agree that in consideration for the Veteran's admission to the Respite Care Program if, during the Trial or Respite Care Admission period, the Veteran can no longer be cared for at the HCC for behavioral or other reasons not in the control of HCC that I, the Primary Caregiver, the designated Alternate Caregiver or a family member, whom I have notified of their responsibilities, must be available and agree to take custody of the Veteran upon notice by the DVA.

Primary Caregiver	Alternate Caregiver
Name:	Name:
Relationship:	Relationship:
Address:	Address:
POA? ☐ YES ☐ NO Health Care Rep? ☐ YES ☐ NO	POA? ☐ YES ☐ NO Health Care Rep? ☐ YES ☐ NO
Conservator of Person ☐ YES ☐ NO Estate? ☐ YES ☐ NO	Conservator of Person ☐ YES ☐ NO Estate? ☐ YES ☐ NO
Phone # (work):	Phone # (work):
Phone # (home):	Phone # (home):
Phone # (cell):	Phone # (cell):

Signature of Primary Caregiver ____________________ Date ____________

Signature of Veteran ____________________ Date ____________

Revised: March 19, 2021

STATE OF CONNECTICUT

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Respite Care Program Application

Veteran Name:	
Home address:	Date of birth:
	Marital status:
Phone #:	Religion:
Current living arrangements:	Community physician:
	Physician phone #:
Social security #:	Hospital preference:
Has placement at the HCC been discussed with the Veteran? ☐ YES ☐ NO	Funeral home preference:
	Prepaid funeral account: ☐ YES ☐ NO
Veteran has Advance Directives: ☐ YES ☐ NO	Funeral arrangements made: ☐ YES ☐ NO
Will prior living accommodations be available after HCC Respite Care stay? ☐ YES ☐ NO	

Emergency Contact	
Primary Caregiver	Alternate Caregiver
Name:	Name:
Relationship:	Relationship:
Address:	Address:
Power of Attorney: ☐ YES ☐ NO Health Care Rep: ☐ YES ☐ NO	Power of Attorney: ☐ YES ☐ NO Health Care Rep: ☐ YES ☐ NO
Conservator of person: ☐ YES ☐ NO Conservator of Estate: ☐ YES ☐ NO	Conservator of person: ☐ YES ☐ NO Conservator of Estate: ☐ YES ☐ NO
Phone # Work: Home: Mobile:	Phones: Work: Home: Mobile:
Alternate Contact 1	Alternate Contact 2
Name:	Name:
Relationship:	Relationship:
Power of Attorney: ☐ YES ☐ NO Health Care Rep: ☐ YES ☐ NO	Power of Attorney: ☐ YES ☐ NO Health Care Rep: ☐ YES ☐ NO
Conservator of person: ☐ YES ☐ NO Conservator of Estate: ☐ YES ☐ NO	Conservator of person: ☐ YES ☐ NO Conservator of Estate: ☐ YES ☐ NO
Address:	Address:
Phone Numbers: Work: Home: Mobile:	Phones: Work: Home: Mobile:

<table>
<tr><th colspan="2">Insurance Information</th></tr>
<tr><td>Medicare #:</td><td rowspan="3">Other medical insurance:</td></tr>
<tr><td>Medicaid # :</td></tr>
<tr><td>Pending as of:</td></tr>
<tr><td colspan="2">Primary Caregiver
Signature: ____________________________________ Date: ______/ _______/ ______</td></tr>
<tr><td colspan="2">Printed Name:</td></tr>
<tr><td colspan="2">Relationship:</td></tr>
<tr><td colspan="2">Address:</td></tr>
</table>

Respite Care Program Application Annex A
Caregiver / Veteran questionnaire

Ambulation	Continence	Feeding	Bathing
☐ Independent	☐ Continent	☐ Independent	☐ Independent
☐ With assist	☐ Incontinent	☐ With assist	☐ With assist
☐ Walker	☐ Bowel	☐ Total assist	☐ Total care
☐ Cane	☐ Bladder	☐ Feeding tube	
☐ Wheelchair	☐ Foley catheter	☐ NG	Dressing
☐ Bedbound	☐ Texas catheter	☐ Gastric	☐ Independent
☐ Transfers	☐ Ostomy (type)	☐ J-tube	☐ With assist
☐ Independent	__________________	☐ Rate	☐ Total care
☐ Assist of	☐ Commode utilized	☐ Solution	
☐ 1 ☐ 2		☐ Special diet	
Hoyer lift ☐ Sara ☐		☐ Food allergies:	

History of falls in the past 6 months:

Adaptive Equipment: (type)

Mental Status	Behavior	Miscellaneous
☐ Alert	☐ Cooperative	Weight ____________
☐ Understands	☐ Depressed	Height_____________
☐ Forgetful	☐ Withdrawn	☐ Hearing impaired
☐ Confused	☐ Belligerent	☐ Speech impaired
☐ Non responsive	☐ Noisy	☐ Vision impaired
☐ Oriented	☐ Needs restraints	☐ Oxygen ☐ CPAP
☐ Disoriented	☐ Wanders	☐ Allergies
	☐ Combative	☐ Skin:
Wears glasses ☐ YES ☐ NO		☐ Intact
Hearing aides: right ____ left ___	Dentures: upper ____ lower ____	☐ Reddened
What time do they usually get up in the morning?		☐ Open area
What time do they usually go to bed at night?		☐ Size
Are there any hobbies or special interests?		☐ Location
		Nap times:

Therapies Received: ☐ P.T. ☐ O.T. ☐ Speech
Treatments: ____

Do you have any other information for us to help make this Respite stay successful?

New medical issues since the date of last physical?

Revised: March 19, 2021

Respite Care Program Application Annex B
History and Physical for Respite Care Program

This form must be completed by the Veteran's primary care physician and returned to the Hospital Admission Coordinator before the respite stay can be scheduled. Contact the Hospital Admission Coordinator at 860-616-3733 with questions. (Note: Additional sheets may be added.)

Veteran Name:	
Code status:	Date of flu vaccination:
Date of PPD: Test results:	(Must have PPD placed within the last year)
Date of tetanus/diphtheria:	Date of pneumovac vaccination:
Medical and surgical history:	Date of COVID-19 vaccination:

1.	4.	7.
2.	5.	8.
3.	6.	9.

If Veteran has a diagnosis of Dementia, does he/she have a history of wandering/elopement? Yes/ No (if yes explain)

___

Does this Veteran have problems with behavioral disturbances or agitation? Yes/ No (if yes explain)

___

Does the Veteran have a history of psychiatric and/or substance abuse? Yes/ No (if yes explain)

___

Current medication(s):

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

Medication allergies: ___

Food allergies: ___

Physical exam:

Temp. ___ Pulse: ___ BP: ___ RR: ___

HEENT: ___

Neck: ___

Cardiac: ___

Pulmonary: ___

GI: ___

Extremities: ___

Neuro: ___

Skin/wound: ___

Other pertinent medical information: ___

___

Physician/PA/NP signature: ___ Date: ___

Office Address: ___

Phone #: ___ Fax #: ___

Revised: March 19, 2021

Respite Care Program Application Annex C
Current Medication List

Veteran Name: ____

Caregiver's Name: ____________________________ Phone #: __________________________

Medication name	Dose	Time give/special instructions

Other treatments and care that we should be aware of:
____
____
____
____
____

Are you receiving any services at home that we would need to notify of your discharge home, such as a visiting nurse association? If so, please provide the information on who we should be contacting and providing information:
____
____
____
____
____

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?

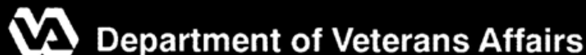
Mail the original application and supporting materials to the Health Eligibility Center, 2957 Clairmont Road, Suite 200 Atlanta, GA 30329.

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.

OMB Approved No. 2900-0091
Estimated Burden Avg. 30 min.



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	3B. SELF-IDENTIFIED GENDER IDENTITY	4. ARE YOU SPANISH, HISPANIC,OR LATINO?	5. WHAT IS YOUR RACE? *(You may check more than one. Information is required for statistical purposes only.)*	6. SOCIAL SECURITY NO.
☐ MALE ☐ FEMALE	☐ MALE ☐ FEMALE	☐ YES ☐ NO	☐ ASIAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ WHITE ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	

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)*	13. CURRENT MARTIAL STATUS
☐ ENROLLMENT/HEALTH SERVICES ☐ DENTAL	☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ 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	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?
☐ YES ☐ NO		☐ YES ☐ 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?	☐	☐	G. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	☐	☐
B. ARE YOU A FORMER PRISONER OF WAR?	☐	☐	IF "YES", WHAT IS YOUR RATED PERCENTAGE_________%		
C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?	☐	☐	H. DID YOU SERVE IN VIETNAM BETWEEN JANUARY 9, 1962 AND MAY 7, 1975?	☐	☐
D. WERE YOU DISCHARGED OR RETIRED FROM MILITARY FOR A DISABILITY INCURRED IN THE LINE OF DUTY?	☐	☐	I. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?	☐	☐
E. ARE YOU RECEIVING DISABILITY RETIREMENT PAY INSTEAD OF VA COMPENSATION?	☐	☐	J. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	☐	☐
F. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998?	☐	☐	K. DID YOU SERVE ON ACTIVE DUTY AT LEAST 30 DAYS AT CAMP LEJEUNE FROM AUGUST 1, 1953 THROUGH DECEMBER 31, 1987?	☐	☐

APPLICATION FOR HEALTH BENEFITS *Continued*

VETERAN'S NAME *(Last, First, Middle)*

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 *(include coverage through spouse or other person)*

2. NAME OF POLICY HOLDER

3. POLICY NUMBER

4. GROUP CODE

5. ARE YOU ELIGIBLE FOR MEDICAID? ☐ YES ☐ NO

6A. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A? ☐ YES ☐ NO

6B. EFFECTIVE DATE *(mm/dd/yyyy)*

SECTION IV - DEPENDENT INFORMATION *(Use a separate sheet for additional dependents)*

1. SPOUSE'S NAME *(Last, First, Middle Name)*

1A. SPOUSE'S SOCIAL SECURITY NUMBER

1B. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)*

1C. SPOUSE SELF-IDENTIFIED GENDER IDENTITY ☐ MALE ☐ FEMALE

1D. DATE OF MARRIAGE *(mm/dd/yyyy)*

1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP if different from Veteran's)*

3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT? ☐ YES ☐ NO

2. CHILD'S NAME *(Last, First, Middle Name)*

2A. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)*

2B. CHILD'S SOCIAL SECURITY NO.

2C. DATE CHILD BECAME YOUR DEPENDENT *(mm/dd/yyyy)*

2D. CHILD'S RELATIONSHIP TO YOU *(Check one)* ☐ SON ☐ DAUGHTER ☐ STEPSON ☐ STEPDAUGHTER

2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? ☐ YES ☐ NO

2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? ☐ YES ☐ NO

2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(e.g., tuition, books, materials)*

SECTION V - EMPLOYMENT INFORMATION

1A. VETERAN'S EMPLOYMENT STATUS *(Check one)*. ☐ FULL TIME ☐ PART TIME ☐ NOT EMPLOYED ☐ RETIRED

1B. DATE OF RETIREMENT

1C. COMPANY NAME. *(Complete if employed or retired)*

1D. COMPANY ADDRESS *(Complete if employed or retired -Street, City, State, ZIP)*

1E. COMPANY PHONE NUMBER *(Complete if employed or retired) (Include area code)*

SECTION VI - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN *(Use a separate sheet for additional dependents)*

	VETERAN	SPOUSE	CHILD 1
1. GROSS ANNUAL INCOME FROM EMPLOYMENT *(wages, bonuses, tips, etc.)* EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
3. LIST OTHER INCOME AMOUNTS *(e.g., Social Security, compensation, pension interest, dividends)* EXCLUDING WELFARE.	$	$	$

SECTION VII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE *(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home) VA will calculate a deductible and the net medical expenses you may claim.*	$
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES (INCLUDING PREPAID BURIAL EXPENSES) FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD *(Also enter spouse or child's information in Section VI.)*	$
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES *(e.g., tuition, books, fees, materials) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.*	$

APPLICATION FOR HEALTH BENEFITS *Continued*	VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

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** ______________________

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY 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 the last four of your Social Security Number (SSN) and Date of Birth (used to locate records for release) is not furnished completely and accurately, VA 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. VHA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10P2 "Patient Medical Record – VA" and in accordance with the VHA Notice of Privacy Practices. 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.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Address of VA Health Care Facility)*

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

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

Connecticut Department of Veterans Affairs, 287 West Street, Rocky Hill, CT 06067

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):

- [x] DRUG ABUSE
- [x] SICKLE CELL ANEMIA
- [x] ALCOHOLISM OR ALCOHOL ABUSE
- [x] HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

DESCRIPTION OF INFORMATION REQUESTED

Check applicable box(es) and state the extent or nature of information to be provided:

- [x] HEALTH SUMMARY *(Prior 2 Years)*
- [ ] INPATIENT DISCHARGE SUMMARY *(Dates)*:
- [ ] PROGRESS NOTES:
  - [ ] SPECIFIC CLINICS *(Name & Date Range)*:
  - [ ] SPECIFIC PROVIDERS *(Name & Date Range)*:
  - [ ] DATE RANGE:
- [ ] OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*:
- [ ] LAB RESULTS:
  - [ ] SPECIFIC TESTS *(Name & Date)*:
  - [ ] DATE RANGE:
- [ ] RADIOLOGY REPORTS *(Name & Date)*:
- [ ] LIST OF ACTIVE MEDICATIONS
- [ ] OTHER *(Describe)*:

PURPOSE(S) OR NEED

Information is to be used by the individual for:

- [x] TREATMENT
- [ ] BENEFITS
- [ ] LEGAL
- [ ] OTHER *(Specify below)*

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

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

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED		RELEASED BY:	