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

Respite Care Program at the Sgt. John L. Levitow Healthcare Center

Caregiver(s) Information Letter

Thank you for your interest in the Connecticut Department of Veterans Affairs (DVA) Respite Care Program at the 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 that provides the Veteran up to 28 days or less (minimum of five days) of respite admission per one-year period starting with the first day of the Trial Respite Admission.

Prior to and separate from a Respite Care Admission, a three day Trial Respite Admission is required in order to conduct an assessment and ensure the HCC is able to meet the needs of the Veteran. This three day Trial Respite period is usually scheduled from Tuesday-Thursday. If the HCC determines during the Trial Respite period that the Veteran cannot be cared for due to behavioral or other reasons not in control of the HCC, the primary or alternate caregiver will be asked to and must take the Veteran into their care immediately. 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.

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

- ☐ Signed Caregiver(s) Information Letter *to be completed by Primary Caregiver*
- ☐ Signed Fiscal and Personal Responsibility for Veteran *to be completed by Primary Caregiver*
- ☐ Respite Care Program Application *to be completed by Primary Caregiver and includes:*
    - Application Annex A: Caregiver/Veteran Questionnaire
    - Application Annex B: History and Physical *to be completed by a primary care physician within 90 days of submission of application.*
    - Application Annex C: Current medication list
- ☐ 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).*
- ☐ Copy of the Veteran's DD241

*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.*

For questions concerning this application and admissions to the HCC 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

Sincerely,
The Connecticut Department of Veterans Affairs

Revised: 1/24/18

# 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 ☐ F ☐ | 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 Residential Facility (independent living domiciliary) ☐

Are you seeking admission to the Department's Health Care Center (long-term chronic care facility) ☐

If you are not currently residing in your home listed, where are you currently staying:

Shelter ☐ Substance Abuse facility ☐ Hospital ☐ Rest/Nursing Home ☐ With family/friends ☐ Other ☐

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.)

☐ American Indian or Alaska Native ☐ Black or African American
☐ Asian ☐ Native Hawaiian or other Pacific Islander
☐ Spanish, Latino, or Hispanic ☐ White ☐ Other

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

| BRANCH OF SERVICE ☐ Army ☐ Navy ☐ Airforce ☐ Marines ☐ Coast Guard | NAME SERVED UNDER (If different from your current name) |
|---|---|
| | |

DISCHARGE TYPE: ☐ Honorable ☐ Under Honorable Conditions ☐ Other (explain): _____

WARS/CONFLICT SERVED IN? ☐ WWII ☐ KOREA ☐ VIETNAM ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ No ☐ Not Sure

Do you have Medicare 'A' ☐ Yes Do you have Medicare 'B'? ☐ Yes Medicare # Date Issued

Do you have Medicaid? ☐ Yes ☐ No Medicaid Claim #

If not, have you applied for Medicaid? ☐ Yes ☐ 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? □ YES □ NO HEALTH CARE REPRESENTATIVE? □ YES □ NO

CONSERVATOR OF PERSON? □ YES □ NO CONSERVATOR OF ESTATE? □ YES □ 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? □ YES □ NO HEALTH CARE REPRESENTATIVE? □ YES □ NO

CONSERVATOR OF PERSON? □ YES □ NO CONSERVATOR OF ESTATE? ☐ YES ☐ 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? □ YES □ NO ALSO HEALTH CARE REPRESENTATIVE? □ YES □ 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? _____

3

## SECTION 8. MEDICAL INFORMATION (Check and complete all items that apply)

**Residential applicants complete Boxes A, B, C, D, J & K. Healthcare center applicants complete ALL BOXES**

### A. Ambulation

- □ Independent
- □ With assist
- □ Walker
- □ Cane
- □ Wheelchair manual
- □ Wheelchair electric
- □ Bedbound
- □ Transfers
  - □ Independent
  - □ Assist of
    - □ 1 □ 2

Hoyer lift □ Sara □

### B. Continence

- □ Continent
- □ Incontinent
  - □ Bowel
  - □ Bladder
- □ Foley catheter
- □ Texas catheter
  - □ Ostomy (type)

  _____
- □ Commode utilized

### C. Miscellaneous

Weight _____
Height_____

- □ Hearing impaired
- □ Speech impaired
- □ Vision impaired
- □ Oxygen □ CPAP
- □ Allergies
- □ Skin:
  - □ Reddened
  - □ Intact
  - □ Open area
    - □ Size
    - □ Location

### D. Devices & Incidents

Dentures □ upper □ lower
Glasses □ Yes □ No
Hearing aid □ Right □ Left

Falls in past 6 months:
_____
_____

Therapies:
□ PT □ OT □ Speech

Prosthetics: _____
_____

### E. Feeding

- □ Independent
- □ With assist
  - □ Total assist
  - □ Feeding tube
    - □ NG
    - ☐ Peg
    - □ Gastric
    - □ J-tube
      - □ Rate
      - □ Solution

□ Special diet:
_____

□ Food Allergies:
_____

### F. Behavioral

- □ Cooperative
- □ Depressed
- □ Withdrawn
- □ Belligerent
- □ Noisy
- □ Needs restraints
- □ Wanders
- □ Combative

### G. Mental Status

- □ Alert
- □ Understands
- □ Forgetful
- □ Confused
- □ Non responsive
- □ Oriented

### H. Bathing

- □ Independent
- □ With assist
- □ Total care

### I. Dressing

- □ Independent
- □ With assist
- □ Total care

### J. Additional information you feel important for us to know regarding medical care:

_____
_____
_____

### K. MEDICATIONS (list all medications and if necessary attach additional sheet of paper)

| Medication Name | Dose | frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## 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. These rules include, but are not limited to a prohibition on the DVA Campus of all firearms and other weapons, alcohol, illegal or unauthorized drugs to include marijuana (THC) in all forms as required by applicable federal law.

*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 medication, 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 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 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.

*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 or Transferees from Residential Program Facility:* I understand and agree that Veteran Patients in the Healthcare 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 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" 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. I understand and agree that if I have been convicted of a drug related crime or have participated in a drug detoxification or rehabilitative program in the previous two years I am subject to the DVA urine testing program.

*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 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[1]

| | |
|---|---|
| _____ | _____ |
| Signature of Veteran or Conservator | Signature of DVA Witness |
| _____ | _____ |
| Printed Name | Printed Name |
| Date: ___/ _____/ _____ | Date: ___/ _____/ _____ |

[1] Veterans conserved of person are not eligible for ad 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 _____
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 #: _____
_____

Department of Veterans Affairs

# 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.

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)

| 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<br>☐ FEMALE | ☐ MALE<br>☐ FEMALE | ☐ YES<br>☐ NO | ☐ ASIAN ☐ AMERICAN INDIAN OR ALASKA NATIVE<br>☐ BLACK OR AFRICAN AMERICAN ☐ WHITE<br>☐ 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<br>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)* | | 2. CHILD'S NAME *(Last, First, Middle Name)* | |
|---|---|---|---|
| 1A. SPOUSE'S SOCIAL SECURITY NUMBER | | 2A. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)* | 2B. CHILD'S SOCIAL SECURITY NO. |
| 1B. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)* | 1C. SPOUSE SELF-IDENTIFIED GENDER IDENTITY ☐ MALE ☐ FEMALE | 2C. DATE CHILD BECAME YOUR DEPENDENT *(mm/dd/yyyy)* | |
| 1D. DATE OF MARRIAGE *(mm/dd/yyyy)* | | 2D. CHILD'S RELATIONSHIP TO YOU *(Check one)* ☐ SON ☐ DAUGHTER ☐ STEPSON ☐ STEPDAUGHTER | |
| 1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP if different from Veteran's)* | | 2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? ☐ YES ☐ NO<br>2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? ☐ YES ☐ NO | |
| 3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT? ☐ 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** _____

# 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

## 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:

- [ ] 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 _____
- [X] OTHER *(Describe)*: ENTIRE RECORD

## PURPOSE(S) OR NEED

Information is to be used by the individual for:

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

CONTINUITY OF CARE

| 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: |
|---|---|
| | |