



**STATE OF CONNECTICUT**  
**DEPARTMENT OF VETERANS AFFAIRS**  
**ADMISSIONS OFFICE**  
287 West Street  
Rocky Hill, Connecticut 06067



*Ronald P. Welch*  
*Commissioner*  
*Brigadier General U.S. Army (Ret)*

Dear Veteran:

Thank you for your interest in the **Connecticut Department of Veterans Affairs (DVA) Residential Programs and Services**. To be eligible for consideration for admission to the DVA Residential Program, Veteran must:

1. Have received an honorable discharge or general discharge under honorable conditions from the Armed Forces of the United States on Veteran's 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.**

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

- Completed and signed Application for Admission with most recent DD 214.
- Proof of Connecticut residency
- Current Federal VA Benefit Verification Letter
- All Disability Federal VA Rating Decision Letters
- 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.
- (Veterans conserved of person are not eligible for admission to the Residential Program)
- Living Will, Healthcare 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 regarding admission to the Residential Program call: 860-616-3802. Residential Facility applications may be submitted via facsimile: 860-616-3556, email: [Residential.DVA@ct.gov](mailto:Residential.DVA@ct.gov), or via US mail to:

Residential Admissions 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  
Residential Programs and Services

Rev. June 29, 2023

## Connecticut Department of Veterans Affairs

### Application for Residential or Healthcare Center Admission

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

FIRST NAME	MIDDLE NAME	LAST NAME	SOCIAL SECURITY #
OTHER NAME/S USED	MAIDEN NAME (if applicable)	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Nonbinary	DATE OF BIRTH
PLACE OF BIRTH		RELIGION	MARITAL STATUS
HOME ADDRESS		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 Healthcare Center (skilled nursing facility)?

If you are not currently residing in your home listed, indicate 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: \_\_\_\_\_

**RACE, ETHNICITY AND LANGUAGE:** Race and ethnicity information is optional for statistical purposes only. You may indicate more than one or decline.  Decline to provide.

*Race:*

American Indian or Alaska Native                       Asian                       Black or African American  
 Native Hawaiian or Other Pacific Islander                       White                       Other \_\_\_\_\_

*Ethnicity:*

Hispanic, Latino, Spanish Origin  
 Not of Hispanic, Latino, Spanish Origin

*Primary Language:*

English                       Spanish  
 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"/> Marine Corps <input type="checkbox"/> Navy <input type="checkbox"/> Air Force <input type="checkbox"/> Space Force <input type="checkbox"/> Coast Guard	NAME SERVED UNDER (If different from your current name)
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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): \_\_\_\_\_  
 You must provide a copy of all current Federal VA Benefit Verification Letters and all Disability Federal VA Rating Decision Letters.

**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 to above, provide:

Name of Policy Holder	Policy #	Group Code
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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     No    Medicare 'B'?     Yes     No  
 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 and/or Email:
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**SECTION 4. EMERGENCY CONTACTS (Must be completed by all applicants)****A. Primary Emergency Contact**

FIRST	MIDDLE	LAST	RELATIONSHIP	
HOME ADDRESS		CITY/STATE	ZIP	COUNTY
CONTACT PHONE NUMBERS				
CELL PHONE		HOME PHONE	WORK PHONE	
EMAIL ADDRESS				
POWER OF ATTORNEY? <input type="checkbox"/> YES <input type="checkbox"/> NO		HEALTHCARE REPRESENTATIVE? <input type="checkbox"/> YES <input type="checkbox"/> NO		
CONSERVATOR OF PERSON? <input type="checkbox"/> YES <input type="checkbox"/> NO		CONSERVATOR OF ESTATE? YES NO		

**B. Secondary Emergency Contact (If any)**

FIRST	MIDDLE	LAST	RELATIONSHIP	
HOME ADDRESS		CITY/STATE	ZIP	COUNTY
CONTACT PHONE NUMBERS				
CELL PHONE		HOME PHONE	WORK PHONE	
EMAIL ADDRESS				
POWER OF ATTORNEY? <input type="checkbox"/> YES <input type="checkbox"/> NO		HEALTHCARE 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	
ADDRESS		CITY/STATE	ZIP	COUNTY
CONTACT PHONE NUMBERS				
CELL PHONE		HOME PHONE	WORK PHONE	
EMAIL ADDRESS				

**B. Conservator of Estate?  YES  NO**

FIRST	MIDDLE	LAST	RELATIONSHIP	
ADDRESS		CITY/STATE	ZIP	COUNTY
CONTACT PHONE NUMBERS				
CELL PHONE		HOME PHONE	WORK PHONE	
EMAIL ADDRESS				

ALSO POWER OF ATTORNEY?  YES  NO ALSO HEALTHCARE 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, date(s): \_\_\_\_\_

Type of conviction(s): \_\_\_\_\_

State of conviction(s): \_\_\_\_\_

Are you registered as a sex offender?  Yes  No

Are you currently on probation or on parole?  Yes  No

Probation:  Yes  No      Parole:  Yes  No

If yes, for what charges? \_\_\_\_\_

Probation/Parole officer name: \_\_\_\_\_

Phone number and/or Email: \_\_\_\_\_

**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: \_\_\_\_\_

**SECTION 7. SUBSTANCE USE DISORDER & RECOVERY INFORMATION (Must be completed by all applicants)**

Have you ever attended a program for drug and/or alcohol use disorder?  Yes  No

If yes, state when and where:

Are you currently attending a program for Substance Use Disorder now?  Yes  No

When did you start? \_\_\_\_\_

When will you complete it? \_\_\_\_\_

Where is it located? \_\_\_\_\_

**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**

<p><b>A. <u>Ambulation</u></b></p> <p><input type="checkbox"/> Independent</p> <p><input type="checkbox"/> With assist</p> <p><input type="checkbox"/> Walker</p> <p><input type="checkbox"/> Cane</p> <p><input type="checkbox"/> Wheelchair manual</p> <p><input type="checkbox"/> Wheelchair electric</p> <p><input type="checkbox"/> Bedbound</p> <p><input type="checkbox"/> Transfers</p> <p>    <input type="checkbox"/> Independent</p> <p>    <input type="checkbox"/> Assist of</p> <p>        <input type="checkbox"/> 1   <input type="checkbox"/> 2</p> <p><input type="checkbox"/> Hoyer lift   <input type="checkbox"/> Sara</p>	<p><b>B. <u>Continence</u></b></p> <p><input type="checkbox"/> Continent</p> <p><input type="checkbox"/> Incontinent</p> <p>    <input type="checkbox"/> Bowel</p> <p>    <input type="checkbox"/> Bladder</p> <p><input type="checkbox"/> Foley catheter</p> <p><input type="checkbox"/> Texas catheter</p> <p>    <input type="checkbox"/> Ostomy (type)</p> <p>        _____</p> <p><input type="checkbox"/> Commode utilized</p>	<p><b>C. <u>Miscellaneous</u></b></p> <p>Weight _____</p> <p>Height _____</p> <p><input type="checkbox"/> Hearing impaired</p> <p><input type="checkbox"/> Speech impaired</p> <p><input type="checkbox"/> Vision impaired</p> <p><input type="checkbox"/> Oxygen   <input type="checkbox"/> CPAP</p> <p><input type="checkbox"/> Allergies _____</p> <p><input type="checkbox"/> Skin:</p> <p>    <input type="checkbox"/> Reddened</p> <p>    <input type="checkbox"/> Intact</p> <p>    <input type="checkbox"/> Open area</p> <p>    Size</p> <p>        _____</p> <p>    Location</p> <p>        _____</p>	<p><b>D. <u>Devices &amp; Incidents</u></b></p> <p>Dentures:</p> <p>    <input type="checkbox"/> Upper   <input type="checkbox"/> Lower</p> <p>Glasses: <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>Hearing Aid:</p> <p>    <input type="checkbox"/> Right   <input type="checkbox"/> Left</p> <p>Falls in past 6 months:</p> <p>    _____</p> <p>    _____</p> <p>    _____</p> <p>Therapies:</p> <p><input type="checkbox"/> PT   <input type="checkbox"/> OT   <input type="checkbox"/> Speech</p> <p>Prosthetics:</p> <p>    _____</p> <p>    _____</p>
<p><b>E. <u>Feeding</u></b></p> <p><input type="checkbox"/> Independent</p> <p><input type="checkbox"/> With assist</p> <p>    <input type="checkbox"/> Total assist</p> <p><input type="checkbox"/> Feeding tube</p> <p>    <input type="checkbox"/> NG</p> <p>    <input type="checkbox"/> Peg</p> <p>    <input type="checkbox"/> Gastric</p> <p>    <input type="checkbox"/> J-tube</p> <p>        <input type="checkbox"/> Rate</p> <p>        <input type="checkbox"/> Solution</p> <p><input type="checkbox"/> Special Diet:</p> <p><input type="checkbox"/> Food Allergies:</p>	<p><b>F. <u>Behavioral</u></b></p> <p><input type="checkbox"/> Cooperative</p> <p><input type="checkbox"/> Depressed</p> <p><input type="checkbox"/> Withdrawn</p> <p><input type="checkbox"/> Belligerent</p> <p><input type="checkbox"/> Noisy</p> <p><input type="checkbox"/> Needs restraints</p> <p><input type="checkbox"/> Wanders</p> <p><input type="checkbox"/> Combative</p> <p><input type="checkbox"/> Other</p> <p>    (Please explain)</p>	<p><b>G. <u>Mental Status</u></b></p> <p><input type="checkbox"/> Alert</p> <p><input type="checkbox"/> Understands</p> <p><input type="checkbox"/> Forgetful</p> <p><input type="checkbox"/> Confused</p> <p><input type="checkbox"/> Non responsive</p> <p><input type="checkbox"/> Oriented</p>	<p><b>H. <u>Bathing</u></b></p> <p><input type="checkbox"/> Independent</p> <p><input type="checkbox"/> With assist</p> <p><input type="checkbox"/> Total care</p> <p><b>I. <u>Dressing</u></b></p> <p><input type="checkbox"/> Independent</p> <p><input type="checkbox"/> With assist</p> <p><input type="checkbox"/> Total care</p>

**SECTION 8 CONTINUED. MEDICAL INFORMATION CONTINUED**

**J. MEDICATIONS (list all medications, and if necessary attach additional sheet of paper)**

Name of Medication	Dose	Frequency

**K. Additional information you feel important for us to know regarding your medical care:**

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**SECTION 9. INCOME & ASSET INFORMATION (Healthcare 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 Healthcare 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.)			

**SECTION 9 CONTINUED. INCOME & ASSET INFORMATION CONTINUED**

**B. Asset Statement** (must be completed by all Healthcare 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 (copy must be provided): \_\_\_\_\_

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 Number

**NOTICE OF PRIVACY RIGHTS**

A summary of your HIPAA rights is included in this application as the last two pages, Attachment F. Please make a selection and sign below.

Acknowledge Receipt of the Notice  Refuse to Sign Acknowledgement of Receipt of the Notice

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

*\*Veterans Conserved of Person are not eligible for Residential Program*



**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<sup>1</sup>**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

<sup>1</sup> Veterans Conserved of Person are not eligible for admission to the Residential Program.

**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 policies, 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 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.

*All Applicants:* I understand and agree that all firearms, ammunition, and other weapons (including but not limited to knives that present a danger to Staff or other Veterans) are prohibited on campus at all times.

*All Applicants:* I understand and agree that all alcoholic beverages, alcoholic beverage containers, pornographic materials, marijuana in any form (including medical marijuana), illegal drugs, (including unauthorized prescription medication) and drug paraphernalia are prohibited on campus at all times.

*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 (DSS), I understand that Veterans are responsible for contributing their "applied income" towards the cost of care, as computed by the Department of Social Services. Once eligibility is determined, the Veteran Patient agrees to cooperate and take necessary steps to renew and continue eligibility as required by DSS.

*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 acknowledge the requirements and responsibilities set forth above and agree to comply with all requirements and responsibilities as a condition of my admission. *Residential Program Applicants:* I further understand and acknowledge that for continued participation in the Residential Program, I must comply with all requirements and responsibilities set forth above and should I violate any of these requirements and responsibilities or any DVA rules, regulations, or policies, 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

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

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

\_\_\_\_\_  
<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 Sgt. John L. Levitow Healthcare 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).
- Go to [www.va.gov/health-care](http://www.va.gov/health-care) for information about VA health benefits.
- 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.
- **TOXIC EXPOSURE RISK ACTIVITY (TERA):** Veterans who were exposed to one or more of the following hazards or conditions during active duty, active duty for training, or inactive duty training (this is not an all-inclusive list): air pollutants, chemicals, occupational hazards, radiation, and warfare agents. For more information visit <https://www.publichealth.va.gov/exposures/>.
- **NONSERVICE-CONNECTED (NSC):** A Veteran who does not have a VA determined service-related condition.
- **REPORTABLE INCOME:** The minimum amount of gross income required to file a Federal income tax return according to the Internal Revenue Code of 1954 Section 6012(a).

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

### Directions for Sections I - III:

**Section I - General Information:** Answer all questions.

#### Type of Benefit Applying For:

- **Enrollment** - Veterans applying for enrollment for the Full Medical Benefits Package provide in 38 C.F.R. 17.38 must meet the eligibility requirements of 38 C.F.R. 17.36.
- **Registration** - For Registrations, only complete Sections I, II, and III. Enrollment not required - Veterans requesting an eligibility assessment, clinical evaluation, care or treatment pursuant to a special treatment authority provided in 38 C.F.R. 17.37:
  - Care for a Veteran with a VA service connected disability rating of 50% or greater
  - Care for a VA rated service connected disability
  - Care for psychosis or other mental illness
  - Care for Military Sexual Trauma treatment (MST)
  - Catastrophically Disabled Examination
  - A veteran who was discharged or released from active military service for a disability incurred or aggravated in the line of duty can receive VA care for the 12-month period following discharge or release
  - Care for a Veteran participating in VA's vocational rehabilitation program under 38 U.S.C. 31

**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 claiming a Military Exposure, you may provide us a written statement, or statements from people who witnessed your claimed exposure(s). 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-IX:

### 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 - Employment Information:

- Veterans Employment Status
- Date of Retirement
- Company Name
- Company Address
- Company Phone Number

### Section VI - Financial Disclosure: ONLY NSC AND 0% NONCOMPENSABLE SC VETERANS MUST COMPLETE THIS SECTION TO DETERMINE ELIGIBILITY 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 who served in a toxic exposure risk activity (TERA); 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 an Agent Orange exposure location; 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.

### Section VII - 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 VIII - 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 IX - Consent to Copays and to Receive Communications

By submitting this application, you are agreeing to pay the applicable VA copayments for care or services (including urgent care) as required by law. You also agree to receive communications from VA to your supplied email, home phone number, or mobile number. However, providing your email, home phone number, or mobile number is voluntary.

### 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, PO Box 5207, Janesville, WI 53547-5207.

### PAPERWORK REDUCTION ACT AND PRIVACY ACT INFORMATION

**Public Burden Statement:** An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-0091, and it expires 6/30/2024. Public reporting burden for this collection of information is estimated to average 35 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing this burden, to VA Reports Clearance Officer at [VACOPaperworkReduAct@va.gov](mailto:VACOPaperworkReduAct@va.gov). Please refer to OMB Control No. 2900-0091 in any correspondence. Do not send your completed VA Form 10-10EZ to this email address.

**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.



<b>Department of Veterans Affairs</b>	<b>VA DATE STAMP</b> <i>(For VHA Use Only)</i>
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## 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)

TYPE OF BENEFIT(S) APPLYING FOR:

- ENROLLMENT** - VA Medical Benefits Package (Veteran meets and agrees to the enrollment eligibility criteria specified at 38 CFR 17.36)
- REGISTRATION (Complete Sections I, II, and III)** - VA Health Services (Veterans meets the "Enrollment not required" eligibility criteria specified at 38 CFR 17.37)

1A. VETERAN'S NAME <i>(Last, First, Middle Name)</i>	1B. PREFERRED NAME	2. MOTHER'S MAIDEN NAME
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3A. BIRTH SEX	3B. SELF-IDENTIFIED GENDER IDENTITY	4. ARE YOU HISPANIC OR LATINO?
<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> MAN <input type="checkbox"/> WOMAN <input type="checkbox"/> TRANSGENDER MAN <input type="checkbox"/> TRANSGENDER WOMAN <input type="checkbox"/> NON-BINARY <input type="checkbox"/> PREFER NOT TO ANSWER <input type="checkbox"/> A GENDER NOT LISTED HERE	<input type="checkbox"/> YES <input type="checkbox"/> NO

5. WHAT IS YOUR RACE? <i>(You may check more than one. Information is required for statistical purposes only.)</i>	6. SOCIAL SECURITY NO.
<input type="checkbox"/> ASIAN <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> WHITE <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER <input type="checkbox"/> CHOOSE NOT TO ANSWER	

7A. DATE OF BIRTH <i>(mm/dd/yyyy)</i>	7B. PLACE OF BIRTH <i>(City and State)</i>	8. PREFERRED LANGUAGE	9. RELIGION
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10A. MAILING ADDRESS <i>(Street)</i>	10B. CITY	10C. STATE	10D. ZIP CODE	10E. COUNTY
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10F. HOME TELEPHONE NO. <i>(optional)</i> <i>(Include Area Code)</i>	10G. MOBILE TELEPHONE NO. <i>(optional)</i> <i>(Include Area Code)</i>	10H. E-MAIL ADDRESS <i>(optional)</i>
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11A. HOME ADDRESS <i>(Street)</i>	11B. CITY	11C. STATE	11D. ZIP CODE	11E. COUNTY
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12. CURRENT MARITAL STATUS

MARRIED     NEVER MARRIED     SEPARATED     WIDOWED     DIVORCED

13A. NEXT OF KIN NAME	13B. NEXT OF KIN ADDRESS	13C. NEXT OF KIN RELATIONSHIP
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13D. NEXT OF KIN TELEPHONE NO. <i>(Include Area Code)</i>	14A. EMERGENCY CONTACT NAME	14B. EMERGENCY CONTACT TELEPHONE NO. <i>(Include Area Code)</i>
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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. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? <i>(for listing of facilities visit <a href="http://www.va.gov/find-locations">www.va.gov/find-locations</a>)</i>	17. WOULD YOU LIKE FOR VA TO CONTACT YOU TO SCHEDULE YOUR FIRST APPOINTMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
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### SECTION II - MILITARY SERVICE INFORMATION

1A. LAST BRANCH OF SERVICE	1B. LAST ENTRY DATE <i>(mm/dd/yyyy)</i>	1C. FUTURE DISCHARGE DATE <i>(mm/dd/yyyy)</i>	1D. LAST DISCHARGE DATE <i>(mm/dd/yyyy)</i>
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1E. DISCHARGE TYPE	1F. MILITARY SERVICE NUMBER
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2. MILITARY HISTORY <i>(Check yes or no)</i>	YES	NO		YES	NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?	<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"/>
B. ARE YOU A FORMER PRISONER OF WAR?	<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"/>
C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?	<input type="checkbox"/>	<input type="checkbox"/>	F. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	<input type="checkbox"/>	<input type="checkbox"/>

<b>APPLICATION FOR HEALTH BENEFITS</b> <i>Continued</i>	VETERAN'S NAME <i>(Last, First, Middle)</i>	SOCIAL SECURITY NUMBER
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**SECTION II - MILITARY SERVICE INFORMATION (Continued)**

3. MILITARY EXPOSURE INFORMATION <i>(Check yes or no)</i>	YES	NO		YES	NO
<b>A. DID YOU SERVE IN AN IONIZING RADIATION LOCATION AND PARTICIPATE IN ANY NUCLEAR TESTING, TREATMENTS, OR CLEAN UP?</b> <i>(Hiroshima and Nagasaki cleanup or Enewetak Atoll, cleanup of Air Force B-52 bomber carrying nuclear weapons off the coast of Palomares, Spain, response to the fire onboard an Air Force B-52 bomber carrying nuclear weapons near Thule Air Force Base in Greenland.)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<b>D. DID YOU SERVE IN ANY OF THE FOLLOWING HERBICIDE</b> <i>(e.g. Agent Orange) LOCATIONS?</i> <i>(Republic of Vietnam to include 12 nautical mile territorial waters; Thailand at any United States or Royal Thai base; Laos; Cambodia at Mimot or Krek; Kampong Cham Province; Guam or American Samoa; or in the territorial waters thereof; Johnston Atoll or a ship that called at Johnston Atoll; Korean demilitarized zone; aboard (to include repeated operations and maintenance with) a c-123 aircraft known to have been used to spray an herbicide agent (during service in the Air Force and Air Force Reserves.)</i>	<input type="checkbox"/>	<input type="checkbox"/>
<b>B. DID YOU SERVE IN ANY OF THE FOLLOWING GULF WAR HAZARD LOCATIONS?</b> <i>(Iraq, Kuwait, Saudi Arabia, the neutral zone between Iraq and Saudi Arabia, Bahrain, Qatar, the United Arab Emirates, Oman, Yemen, Lebanon, Somalia, Afghanistan, Israel, Egypt, Turkey, Syria, Jordan, Djibouti, Uzbekistan, the Gulf of Aden, the Gulf of Oman, the Persian Gulf, the Arabian Sea, and the Red Sea.)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<b>WHEN DID YOU SERVE IN THESE LOCATIONS?</b> <b>NOTE:</b> <i>Please provide an approximate time-frame (mm/yyyy)</i> FROM: _____ TO: _____		
<b>C. WERE YOU DEPLOYED IN SUPPORT OF ANY OF THE FOLLOWING OPERATIONS?</b> <i>(Enduring Freedom, Freedom's Sentinel, Iraqi Freedom, New Dawn, Inherent Resolve, and Resolute Support Mission)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<b>E. HAVE YOU BEEN EXPOSED TO ANY OF THE FOLLOWING?</b> <i>(Check all that apply)</i> Veterans can locate additional military exposure categories on VA's Public Health website at: <a href="https://www.publichealth.va.gov/exposures/">https://www.publichealth.va.gov/exposures/</a>		
			<input type="checkbox"/> AIR POLLUTANTS <i>(burn pits, sand, oil well/sulfur fires)</i> <input type="checkbox"/> CHEMICALS <i>(pesticides, herbicides, contaminated water)</i> <input type="checkbox"/> CONTAMINATED WATER AT CAMP LEJEUNE <input type="checkbox"/> RADIATION <input type="checkbox"/> SHAD <i>(Shipboard Hazard and Defense)</i> <input type="checkbox"/> OCCUPATIONAL HAZARDS <i>(jet fuel, industrial solvents, lead, firefighting foams)</i> <input type="checkbox"/> ASBESTOS <input type="checkbox"/> MUSTARD GAS <input type="checkbox"/> WARFARE AGENTS <i>(nerve agents, chemical and biological weapons)</i> <input type="checkbox"/> OTHER <i>(Specify):</i> <b>WHEN WERE YOU EXPOSED?</b> <b>NOTE:</b> <i>Please provide an approximate time-frame (mm/yyyy)</i> FROM: _____ TO: _____		

**SECTION III - INSURANCE INFORMATION (Use a separate sheet for additional information)**

1. ENTER YOUR HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER <i>(include coverage through spouse or other person)</i>					
2. NAME OF POLICY HOLDER		3. POLICY NUMBER		4. GROUP CODE	
5. ARE YOU ELIGIBLE FOR MEDICAID? <i>(Federal health insurance for low income adults)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO		6A. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A? <input type="checkbox"/> YES <input type="checkbox"/> NO		6B. EFFECTIVE DATE <i>(mm/dd/yyyy)</i>	
6C. MEDICARE NUMBER:					

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

1. SPOUSE'S NAME <i>(Last, First, Middle Name)</i>		2. CHILD'S NAME <i>(Last, First, Middle Name)</i>	
1A. SPOUSE'S SOCIAL SECURITY NUMBER		2A. CHILD'S DATE OF BIRTH <i>(mm/dd/yyyy)</i>	2B. CHILD'S SOCIAL SECURITY NO.
1B. SPOUSE'S DATE OF BIRTH <i>(mm/dd/yyyy)</i>		2C. DATE CHILD BECAME YOUR DEPENDENT <i>(mm/dd/yyyy)</i>	
1C. SPOUSE'S SELF-IDENTIFIED GENDER IDENTITY <input type="checkbox"/> MAN <input type="checkbox"/> WOMAN <input type="checkbox"/> TRANSGENDER MAN <input type="checkbox"/> TRANSGENDER WOMAN <input type="checkbox"/> NON-BINARY <input type="checkbox"/> PREFER NOT TO ANSWER <input type="checkbox"/> A GENDER NOT LISTED HERE		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. DATE OF MARRIAGE <i>(mm/dd/yyyy)</i>		2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? <input type="checkbox"/> YES <input type="checkbox"/> NO	
1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER <i>(Street, City, State, ZIP if different from Veteran's)</i>		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 WITH REPORTABLE INCOME FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING <i>(e.g., tuition, books, materials)</i>	

<b>APPLICATION FOR HEALTH BENEFITS</b> <i>Continued</i>	VETERAN'S NAME <i>(Last, First, Middle)</i>	SOCIAL SECURITY NUMBER
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**SECTION V - EMPLOYMENT INFORMATION**

1A. VETERAN'S EMPLOYMENT STATUS <i>(Check one)</i> . <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> NOT EMPLOYED <input type="checkbox"/> RETIRED	1B. DATE OF RETIREMENT <i>(mm/dd/yyyy)</i>	
1C. COMPANY NAME. <i>(Complete if employed or retired)</i>	1D. COMPANY ADDRESS <i>(Complete if employed or retired - Street, City, State, ZIP)</i>	1E. COMPANY PHONE NUMBER <i>(Complete if employed or retired)</i> <i>(Include area code)</i>

**SECTION VI - FINANCIAL DISCLOSURE**

Disclosure allows VA to accurately determine whether certain Veterans will be charged copays for care and medications, their eligibility for other services and enrollment priority. Veterans are not required to disclose their financial information. Veterans who choose not to disclose financial information may not be eligible for enrollment or may be responsible for any applicable VA copayments, if they are enrolled. **Recent Combat Veterans (e.g., OEF/OIF/OND)** may answer YES in Section VI and complete Sections VII and VIII to have their priority for enrollment and financial eligibility for travel assistance, cost-free medications and/or medical care for services unrelated to military experience.

**No, I do not wish to provide financial information in Sections VII through VIII.** If I am enrolled, I agree to pay applicable VA copayments. Sign and date the form in the Assignment of Benefits section.

**Yes, I will provide my household financial information for last calendar year.** Complete applicable Sections VII and VIII. Sign and date the form in the Assignment of Benefits section.

**SECTION VII - 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 <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.	\$ _____	\$ _____	\$ _____

**SECTION VIII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES**

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

**SECTION IX - CONSENT TO COPAYS AND TO RECEIVE COMMUNICATIONS**

**By submitting this application, you are agreeing to pay the applicable VA copayments for care or services (including urgent care) as required by law. You also agree to receive communications from VA to your supplied email, home phone number, or mobile number. However, providing your email, home phone number, or mobile number is voluntary.**

**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.**

<b>SIGNATURE OF APPLICANT</b> <i>(Sign in ink)</i> _____	<b>DATE</b> <i>(mm/dd/yyyy)</i> _____
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APPLICATION ATTACHMENT E



Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT STATEMENT:

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 information needed 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 the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. 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 system of records notices identified as 24VA10A7 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS (Name and Location of the VA Health Care Facility)

LAST NAME- FIRST NAME- MIDDLE NAME

DATE OF BIRTH (mm/dd/yyyy)

PATIENT'S MAILING ADDRESS (including City, State and Zip Code)

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

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

- TREATMENT BENEFITS LEGAL EMPLOYMENT OTHER (Please specify below):

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

- HEALTH SUMMARY (Prior 2 Years)
PATIENT MEDICAL RECORDS (Dates):
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:
VACCINATION (Dose, Lot Number, Date & Location):
ADMINISTRATIVE RECORDS:
OTHER (Describe):

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH (mm/dd/yyyy)
<b>SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.</b>	
<p>I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.</p> <p> <input type="checkbox"/> DRUG ABUSE      <input type="checkbox"/> ALCOHOLISM OR ALCOHOL ABUSE      <input type="checkbox"/> SICKLE CELL ANEMIA  <input type="checkbox"/> HUMAN IMMUNODEFICIENCY VIRUS (HIV) </p> <p>I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked <u>unless</u> I indicate by checking the box below that I do not want this information released for this specific disclosure.</p> <p><input type="checkbox"/> <b>I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.</b></p>	
<p><b>AUTHORIZATION:</b> 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.</p> <p>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.</p>	
<p><b>EXPIRATION:</b> Without my express revocation, the authorization will automatically expire (select one of the following):</p> <p> <input type="checkbox"/> AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED  <input type="checkbox"/> ON (mm/dd/yyyy) _____ (enter a future date other than date signed by patient)  <input type="checkbox"/> UNDER THE FOLLOWING CONDITION(S): _____  _____ </p>	
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
<b>FOR VA USE ONLY</b>	
TYPE AND EXTENT OF MATERIAL RELEASED	
DATE RELEASED (mm/dd/yyyy)	RELEASED BY:



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



**CONNECTICUT DEPARTMENT OF VETERANS AFFAIRS ("DVA")**  
**SUMMARY OF YOUR HIPAA PRIVACY RIGHTS**  
(Health Insurance Portability Accountability Act)

***THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.***

**DVA'S DUTIES:**

The Connecticut Department of Veterans Affairs (DVA) is required by law to keep your protected health information private, to provide you with notice of our legal duties and privacy practices concerning your protected health information and to notify you following a breach of unsecured protected health information. The DVA must also follow all of the rules listed in this notice and send or give you a new notice if we make important changes to our privacy rules and practices. The DVA reserves the right to change its privacy practices. If the privacy practices change, the DVA will send you a new notice. The new privacy practices will apply to the information the DVA already has about you.

**YOUR RIGHTS:**

While the records we maintain about you belong to the agency, under federal privacy law, you have a variety of rights with respect to the information in those records. For example:

- You have the right to **inspect and request a copy of your health records**. Apply to Medical Records in writing. There will be a charge for providing you with copies.
- You may request that we **amend your medical record** if you believe your record is incorrect or incomplete. Apply to Medical Records in writing.
- You may request a list of **whom we sent information about you to** up to the last six years. Apply to Medical Records in writing.
- **You may request restrictions or limitations on your health information** we disclose (see below). Again, apply to Medical Records in writing.
- You may request we **communicate with you about medical matters in a certain way** or at a certain location. Apply to Medical Records in writing.
- **You may authorize (in writing) other releases** of your health information not described above.
- Except for legal disclosures described below, **your authorization is necessary** before your health records are shared for any other reason.
- You have **the right to file a complaint** (see below) if you believe your rights have been violated. **You will not be penalized if you file a complaint.**

## **LEGAL DISCLOSURES THAT WE MAY MAKE WITHOUT YOUR PERMISSION:**

We may use and disclose your protected health information to carry out **Treatment, Payment, or Healthcare Operations** without your permission. Below are examples of when we may disclose your information:

- To exchange information with other state agencies as required by law.
- To avert a serious threat to your health or safety or the health and safety of the public.
- To treat you in an emergency or something is preventing us from communicating with you.
- To health insurance companies we may bill
- For organ and tissue donation.
- To communicate with law enforcement if you are the victim of a crime, involved in a crime, or threatening to commit a crime.
- If it is believed that you have been a victim of abuse or domestic violence.
- To the Food and Drug Administration to report adverse events, product defects, and so on.
- To coroners, medical examiners, and funeral directors so they may do their job.
- To healthcare oversight agencies such as the State Health Department for audits, investigations, inspections, or licensing purposes.
- For lawsuits and disputes when ordered to do so by a court or administrative order.
- As required by state, federal, or local law.

## **FOR FURTHER INFORMATION OR QUESTIONS:**

As this document nor the Full Notice of Privacy Practices covers every possible use or disclosure, for further information, please contact your DVA Social Worker or HIMS (DVA Medical Records Department) at (860) 616-3763.

## **IF YOU THINK THE DVA SHARED YOUR INFORMATION INCORRECTLY:**

You may complain in writing to the DVA HIPAA Officer at 287 West Street, Rocky Hill, CT 06067 or to the Connecticut Attorney General's Office at 165 Capitol Avenue, Hartford, CT 06106.

You may also file complaint with the federal Office for Civil Rights, U.S. Department of Health and Human Services by mail, fax, email or via the online [OCR Complaint Portal](#) (encouraged method). Mailing address is: Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201. Email address is [OCRComplaint@hhs.gov](mailto:OCRComplaint@hhs.gov). Complaint is to be filed within 180 days of when the problem occurred. Your benefits will not be affected if you make a complaint.