



STATE OF ALABAMA
DEPARTMENT OF VETERANS AFFAIRS
P.O. BOX 1509
MONTGOMERY, ALABAMA 36102-1509



R/ADM W. Clyde Marsh, USN, (Ret.)
Commissioner

Dear Alabama Veteran:

Thank you for your interest in the Alabama State Veterans Home Program. Our Homes provide a dignified environment to Veterans who have honorably served our country, and are now in need for nursing home services. We would like to extend an invitation to you and your family to visit any of our State Veterans Homes to see the state of the art facilities that are available.

The State Board of Veterans Affairs is comprised of fifteen wartime veterans from various service organizations across the state. Our interest is in serving fellow veterans and to assure the highest quality care is provided for those in need.

Our goal is to continue to serve America's Finest.

Sincerely,

Wayne Dial
Vice-Chairman
State Board of Veterans Affairs

Alabama State Veterans Home



Dear Veteran:

Thank you for your interest in the Alabama State Veterans Homes. Please review the enclosed information relative to terms of admission and discharge prior to completion of the application.

You have an option of selecting one of the three Homes which best serves the needs of you and your family. This package has been assembled to provide you with the information necessary to aid our Department and the Veterans Administration in determining eligibility and to expedite the total process. The Homes are located at the following address:

- 1) Bill Nichols State Veterans Home
1784 Elkahatchee Road
Alexander City, Alabama 35010
- 2) William F. Green State Veterans Home
300 Faulkner Drive
Bay Minette, Alabama 36507
- 3) Floyd E. "Tut" Fann State Veterans Home
2701 Meridian Street
Huntsville, Alabama 35811

Contact your local County Veterans Service Officer or:

Alabama State Department of Veterans Affairs
P.O. Box 1509
Montgomery, Alabama 36102-1509
(334) 242-5077

Sincerely,

Kimberly B. Justice
State Veterans Home Coordinator

Alabama State Veterans Home



Eligibility Requirements:

Alabama Act 88-776 states that the Alabama State Department of Veterans Affairs shall establish and set conditions and standards for admission and discharge of all persons to and from the State Homes. Alabama's Statute under 31-5A-8 states, "Admission to and discharges from any Alabama state veterans' home shall be in accordance with the policies and procedures as established by the State Board of Veterans Affairs at the time application for admission or for discharge is presented; provided, however, that the State Board of Veterans Affairs may admit and discharge veterans to any Alabama veterans' home who qualify for care and treatment under Title 38, U.S.C., Section 101 (19), and may adopt appropriate rules consistent with accepted medical considerations to carry out this function." To be eligible for care from any Alabama State Veterans Home the veteran must meet the following eligibility requirements:

- Must be honorably discharged from military service with a minimum of 90 days of service, of which one day was during a wartime period. DD-214 or equivalent must be part of the application package. (no exceptions)
- Must meet the qualifications as set forth by the U.S. Department of Veterans Affairs criteria for skilled nursing care.
- Must have been a resident of the State of Alabama during the immediate past 12 months. (No exceptions) (Proof of residency may be required).
- Must have had a medical examination by a physician within 90 days of admission request and exam will show that veteran does not have:
 - medical or nursing care needs for which Home is not equipped or staffed to provide.
 - behavioral traits which may prove to be dangerous to the well-being of the resident, other residents, staff or visitors.
 - a diagnosis or confirmed history of mental illness or mental retardation that outweighs medical condition.
- Other veterans who do not have war-time service may be admitted to the Home on a space available basis. These veterans will not be placed on waiting list or placed before wartime veterans.

Note: Applicants for the State Veterans Home will be checked against the Sex Offender Registry and a background check for active felony status. Anyone found to be on the Sex Offender Registry or in a felony fugitive status shall not be considered for admission.

What the Facility Will Provide:

- Semi-private room.
- Quality food service with individual diet counseling by qualified dietetic services supervisor.
- Skilled nursing care by licensed professionals with around the clock supervision by Registered Nurses.
- Medical supervision by a Veterans Home Medical Director, a licensed physician knowledgeable in long term care.
- Initial dental examination and an annual exam thereafter.
- Social Services programs tailored to meet the individual needs of the resident.
- Activity program designed to appeal to the interests of the individual resident.
- Appropriate resident education programs.
- Prescribed pharmaceuticals provided to those veterans meeting Federal VA eligibility requirements. (co-payment may be required).
- Basic supplies for personal care, such as toothbrushes, razors, skin creams, mouth care items.
- Transportation to local activities and routine medical appointments, including transportation to VA Medical Centers during normal business hours.
- Laundry and linen services to include personal laundry.
- Around the clock security staff.
- Maintain licensure and certification standards established by the U.S. Department of Veterans Affairs (USDVA), Healthcare Financing Administration (HCFA) and the Department of Public Health Division of Healthcare Facilities.
- Appropriate support groups for families and responsible parties.
- Medicare Part B Services (Medical Supplies, Therapies - Physical, Speech, Occupational, Prosthetics, Ostomy Supplies)

Alabama State Veterans Home



What the Facility Will Not Provide:

- Free nursing home care
- Acute or sub-acute care
- One-on-one care
- Dispense medications not prescribed by a physician
- Restraints requested by family members, responsible parties, or friends
- Free haircuts or permanents
- Free tobacco products
- Special adaptive appliances/devices (NOTE: we do assist in securing these items through the Federal Department of Veterans Affairs for those eligible.)
- We do not provide private TV's, telephones, radios, or TV stands
- Replacement for loss, damage or destruction of personal items
- Free cable TV
- Free ambulance service

Resident/Sponsor Responsibilities:

The below listed items are examples of non-covered charges and are the responsibility of the Resident/Sponsor. These items are not all inclusive:

- All prescribed pharmaceuticals which are not provided by federal VA pharmacy.
- Co-pays for pharmaceuticals provided by VA Pharmacy.
- Barber/Beauty Shop
- Cable TV charges
- Private telephone installation and services
- Long distance telephone and Internet access charges made on facility telephones
- Physician specialist consultation fees
- Durable Medical Equipment (including oxygen), not furnished by the Veterans Administration
- Private duty nurses and sitters
- Definitive dental treatment and repairs
- Maintenance and repair of personal property including television sets
- Non covered transportation charges
- Bed Hold charges
- Co-insurance amounts for Part B services when not covered under private insurance.

Submission of this application is acceptance by all parties of the afore mentioned Services and applicable charges.

Alabama State Veterans Home



General Information

1. The term Resident is used synonymously with the term sponsor/guardian when the resident is deemed incapable of making rational decisions. Such sponsor/guardian shall be legally appointed and documentation of proof provided to the Homes at the time of application.
2. The Resident shall consent to abide by all rules and/or regulations governing the Homes and to follow the course of treatment prescribed by the Home's medical staff or outside medical consultant(s) before admission to the Home.
3. The Homes shall charge the residents for comprehensive care. Every resident shall be responsible for the full payment of the comprehensive care rate payable one month in advance, and not later than the 10th of each month thereafter.
4. Residents shall pay costs of transportation to and from the Homes for whatever reasons, unless provided by the U.S. Department of Veterans Affairs.
5. Residents shall furnish their own items of personal clothing.
6. Residents shall accept transfer to other medical facilities, including those operated by the U.S. Department of Veterans Affairs and/or State Department of Veterans Affairs, if medical condition mandates, as determined by the State Veterans Homes Medical Staff/Director.
7. Residents shall accept discharge from the Homes when medical and/or administrative review determines such action to be appropriate or warranted.
8. Residents shall recognize that the Home will be operated in full compliance with the Civil Rights Act without discrimination as to race, color, creed, religion or gender.
9. Residents may apply for all U. S. Department of Veterans Affairs benefits for which he/she may be entitled. He/she may be counseled about benefit entitlements by a representative of the Department of Veterans Affairs, (normally this will be our Veterans Service Officer in your county).
10. Residents shall also bring with them any orthopedic appliances, braces, wheelchairs, walkers, etc., which may have been issued to them by the U. S. Department of Veterans Affairs.
11. Residents may be authorized a leave of absence, not to exceed 96 hours. Comprehensive care rate shall be charged for all periods of leave from the Home after 96 hours retroactive to the first day of leave.
12. Residents shall be charged full comprehensive care rate when out of the facility, including hospitalization in excess of 96 hours. The comprehensive care rate will be retroactive to the first day of absence from the facility. Any resident admitted to a VA Medical Center and receiving federal VA per diem for the hospital stay shall not receive federal VA per diem for nursing home care concurrently. The comprehensive care rate shall be charged for the days admitted to a VA Medical Center.
13. Failure to pay for comprehensive care will result in discharge from the Homes. The Contractor is authorized to use all applicable laws to recoup monies due the Homes for comprehensive care.
14. The Resident shall designate a beneficiary to receive all personal belongings.

Submission of this application is acceptance by all parties of the afore mentioned rules and regulations.

Application and Information Sheet and Checklist

You are encouraged to contact your local Veterans Service Officer for assistance.

<u>Description</u>	<u>Page #</u>	<u>To be completed by</u>
___ Personal Admission Information	1 & 2	Veteran or Sponsor
___ Information on Legal Residency	3	Veteran or Sponsor
___ VA Form 10-10EZ Application for Medical Benefits	4 & 4A,	Veteran or Sponsor
___ VA Form 10-10EZ Instruction Sheet	4B & 4C	Veteran or Sponsor
___ VA Form 10-10SH Medical Certification	5, 5A, & 5B	Medical Physician
___ ADVA Assessment for Level of Care/Mental Illness	6 and 6A	Medical Physician
___ Authorization for Release of Medical Information	7	Veteran or Sponsor

CHECKLIST FOR INFORMATION TO BE RETURNED WITH APPLICATION

- ___ Copy of legal Power of Attorney (if appropriate)
- ___ DD Form 214 or equivalent (mandatory)
- ___ Proof of Residence (completion of page 3) or voters records, employment records, State income tax records, etc. (if questionable)
- ___ If filing claim for pension with A&A send proof of income, marital documents, need of medical evidence showing disability is permanent and total, DD-214 or equivalent. For original claim, file VA 21-526. For reopened claim, file VA 21-527. For either claim file VA 21-22 (POA).

If applicant is in a long term care facility, please include the following items when returning admission packet:

- History & Physical
- Nurse's Notes (last 3 months)
- Physician Notes (last 3 months)
- Social Services Notes
- MDS & Care Plan

If applicant is in the hospital during the application process, please include the following when returning the admission packet:

- History & Physical
- Interim Summary or Discharge Summary

Notice to Applicant: The following forms: VA Form 10-10SH, 10-10EZ, ADVA Assessment for Level of Care/Mental Illness, are very detailed and require concise and accurate information to ensure your application is processed in the most efficient manner. Failure to provide the requested information could adversely affect your prospects for entering an Alabama State Veterans Home. Each form serves a specific purpose, whether it be for the Admissions Committee to determine your medical eligibility for admission or the category of skilled care you will require or for the expediting of the processing for payment of the VA Per Diem to the Home. In any case, these documents are of the utmost importance and merit your closest attention. Acceptance for admission or placement on the waiting list **will not occur until all information is received.**

Alabama State Veterans Home

STAFF OF VETERANS HOMES

The staff of all Alabama State Veterans Homes welcomes your comments and questions. For further information, please contact the following personnel at the Home indicated:

Bill Nichols Home

Kathryn Fuller ADVA Representative
Ph: (256) 329-3311 Fax: (256) 329-3350

Administrator
Ph: (256) 329-0868 Fax: (256) 329-1101

Floyd E. "Tut" Fann Home

Charlotte V. Eason ADVA Representative
Ph: (256) 851-2807 Fax: (256) 851-2967

Administrator
Ph: (256) 852-5170 Fax: (256) 859-4115

William F. Green Home

Kathleen Voll ADVA Representative
Ph: (334) 937-8049 Fax: (251) 937-2472

Administrator
Ph: (334) 937-9881 Fax: (251) 937-9804



Alabama State Veterans Home

TO BE COMPLETED BY: Veteran or Sponsor

APPLICATION IS HEREBY MADE FOR ADMISSION TO:

_____ (NAME OF HOME SELECTED)

Personal Information

1. APPLICANT NAME: _____ (Nickname/Alias) _____

2. VA CLAIM #: _____ SSN: _____

3. HOME ADDRESS: _____
Street Apt #

City

State

Zip

Phone No.

4. LEGAL ADDRESS (IF DIFFERENT FROM HOME ADDRESS)

5. PRESENT LOCATION OF APPLICANT:

HOME HOSPITAL NURSING HOME OTHER FACILITY

IF OTHER THAN HOME, PROVIDE NAME, ADDRESS & PHONE NO. OF FACILITY.

6. NAME OF SPOUSE/RESPONSIBLE PARTY: _____

IF OTHER THAN SPOUSE, RELATION TO VETERAN: _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____

7. PERSONAL PHYSICIAN: _____

ADDRESS: _____

PHONE NO. _____

8. HAVE YOU EVER BEEN CONVICTED OF A FELONY? YES NO IF YES, PLEASE DESCRIBE BELOW:

9. NAME OF MEDICAL/DENTAL INSURANCE COMPANY

CARRIER: _____

ADDRESS: _____ PHONE: _____

POLICY NUMBER(S): _____ EFFECTIVE DATE: _____

10. HIGHEST LEVEL OF EDUCATION ACHIEVED: _____

11. USUAL OCCUPATION BEFORE RETIREMENT: _____ DATE LAST EMPLOYED: _____

12. DATE OF BIRTH: _____ COUNTY OF BIRTH: _____

STATE/COUNTRY OF BIRTH: _____ CURRENT AGE: _____

13. DATE ENTERED SERVICE: _____ DATE RELEASED FROM SERVICE: _____

BRANCH OF SERVICE: _____ PERIOD OF SERVICE: WAR PEACE

WWI (4/6/17-11/11/18)* WWII(12/7/41-12/31/46) KOREAN (6/27/50-1/31/55)

VIETNAM (8/5/64-5/7/75)* GULF WAR (8/20/90-Date to be set)

(WWI-Russian service extends date to 4/1/20 or 7/1/21 if served (1) day during 4/6/17-11/11/18)

(VIETNAM-Start date of 2/28/61 for service "in country" before 8/5/64)

14. DESIGNEE TO RECEIVE PERSONAL EFFECTS UPON DISPOSITION IN THE EVENT OF DEATH OR
INCAPACITATION AT THE TIME OF DISCHARGE.

NAME: _____

ADDRESS: _____

PHONE NUMBER(S): _____

15. VSO: _____ COUNTY: _____

VSO PHONE #: _____ VETERAN IS IN RECEIPT OF NSC

PENSION \$ _____ COMPENSATION \$ _____ NONE _____

DATE VETERAN APPLIED FOR NSC PENSION W/AID AND ATTENDANCE? _____

DOES THE ALABAMA STATE DEPARTMENT OF VETERANS AFFAIRS HAVE POWER OF ATTORNEY

(VA-FORM 21-22) WITH THIS VETERAN/GUARDIAN? _____

I HAVE READ AND UNDERSTAND THE TERMS AND CONDITIONS OF ADMISSIONS/DISCHARGE TO THE STATE VETERANS HOMES. I CONSENT TO ABIDE BY ALL THE RULES AND/OR REGULATIONS GOVERNING THE HOMES.

SIGNATURE OF RESIDENT/SPONSOR: _____

DATE COMPLETED: _____



APPLICATION FOR HEALTH BENEFITS

SECTION I - GENERAL INFORMATION

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

1. VETERAN'S NAME (Last, First, Middle Name)		2. OTHER NAMES USED	3. MOTHER'S MAIDEN NAME	4. GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
5. ARE YOU SPANISH, HISPANIC, OR LATINO? <input type="checkbox"/> YES <input type="checkbox"/> NO	6. WHAT IS YOUR RACE? (You may check more than one.) (Information is required for statistical purposes only.) <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> ASIAN <input type="checkbox"/> WHITE <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER			
7. SOCIAL SECURITY NUMBER	9. DATE OF BIRTH (mm/dd/yyyy)		10. RELIGION	
8. CLAIM NUMBER	9A. PLACE OF BIRTH (City and State)			
11. PERMANENT ADDRESS (Street)		11A. CITY	11B. STATE	11C. ZIP CODE (9 digits)
11D. COUNTY	11E. HOME TELEPHONE NUMBER (Include area code)		11F. E-MAIL ADDRESS	
11G. CELLULAR TELEPHONE NUMBER (Include area code)		11H. PAGER NUMBER (Include area code)		
12. TYPE OF BENEFIT(S) APPLIED FOR (You may check more than one) <input type="checkbox"/> HEALTH SERVICES <input type="checkbox"/> NURSING HOME <input type="checkbox"/> DOMICILIARY <input type="checkbox"/> DENTAL				
13. IF APPLYING FOR HEALTH SERVICES OR ENROLLMENT, WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER?				
14. DO YOU WANT AN APPOINTMENT WITH A VA DOCTOR OR PROVIDER AS SOON AS ONE BECOMES AVAILABLE? <input type="checkbox"/> YES <input type="checkbox"/> NO I am only enrolling in case I need care in the future.		15. HAVE YOU BEEN SEEN AT A VA HEALTH CARE FACILITY? <input type="checkbox"/> YES, LOCATION: <input type="checkbox"/> NO		
16. CURRENT MARITAL STATUS (Check one) <input type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> UNKNOWN				
17. NAME, ADDRESS AND RELATIONSHIP OF NEXT OF KIN		17A. NEXT OF KIN'S HOME TELEPHONE NUMBER (Include area code)		
		17B. NEXT OF KIN'S WORK TELEPHONE NUMBER (Include area code)		
18. NAME, ADDRESS AND RELATIONSHIP OF EMERGENCY CONTACT		18A. EMERGENCY CONTACT'S HOME TELEPHONE NUMBER (Include area code)		
		18B. EMERGENCY CONTACT'S WORK TELEPHONE NUMBER (Include area code)		
19. 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 (Check one) <input type="checkbox"/> EMERGENCY CONTACT <input type="checkbox"/> NEXT OF KIN				

APPLICATION FOR HEALTH BENEFITS, Continued	VETERAN'S NAME (<i>Last, First, Middle</i>)	SOCIAL SECURITY NUMBER
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SECTION II - INSURANCE INFORMATION (Use a separate sheet for additional information)

1. ARE YOU COVERED BY HEALTH INSURANCE? (<i>Including coverage through a spouse or another person</i>) <input type="checkbox"/> YES <input type="checkbox"/> NO	2. HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER				
3. NAME OF POLICY HOLDER					
4. POLICY NUMBER	5. GROUP CODE				
		YES	NO		
6. ARE YOU ELIGIBLE FOR MEDICAID?	<input type="checkbox"/>	<input type="checkbox"/>			
7. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A?	<input type="checkbox"/>	<input type="checkbox"/>	7A. EFFECTIVE DATE (<i>mm/dd/yyyy</i>)		
8. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART B?	<input type="checkbox"/>	<input type="checkbox"/>	8A. EFFECTIVE DATE (<i>mm/dd/yyyy</i>)		
9. NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD			10. MEDICARE CLAIM NUMBER		
11. IS NEED FOR CARE DUE TO ON THE JOB INJURY? (<i>Check one</i>) <input type="checkbox"/> YES <input type="checkbox"/> NO			12. IS NEED FOR CARE DUE TO ACCIDENT? (<i>Check One</i>) <input type="checkbox"/> YES <input type="checkbox"/> NO		

SECTION III - EMPLOYMENT INFORMATION

1. VETERAN'S EMPLOYMENT STATUS (<i>Check one</i>) <i>If employed or retired, complete item 1A</i> <input type="checkbox"/> FULL TIME <input type="checkbox"/> NOT EMPLOYED <input type="checkbox"/> PART TIME <input type="checkbox"/> RETIRED <i>Date of retirement (mm/dd/yyyy)</i>	1A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER
2. SPOUSE'S EMPLOYMENT STATUS (<i>Check one</i>) <i>If employed or retired, complete item 2A</i> <input type="checkbox"/> FULL TIME <input type="checkbox"/> NOT EMPLOYED <input type="checkbox"/> PART TIME <input type="checkbox"/> RETIRED <i>Date of retirement (mm/dd/yyyy)</i>	2A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER


SECTION IV - MILITARY SERVICE INFORMATION

1. LAST BRANCH OF SERVICE	1A. LAST ENTRY DATE	1B. LAST DISCHARGE DATE	1C. DISCHARGE TYPE	1D. MILITARY SERVICE NUMBER
2. CHECK YES OR NO	YES	NO		YES NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?	<input type="checkbox"/>	<input type="checkbox"/>	E1. ARE YOU RECEIVING DISABILITY RETIREMENT PAY INSTEAD OF VA COMPENSATION?	<input type="checkbox"/> <input type="checkbox"/>
B. ARE YOU A FORMER PRISONER OF WAR?	<input type="checkbox"/>	<input type="checkbox"/>	F. DO YOU NEED CARE OF CONDITIONS POTENTIALLY RELATED TO SERVICE IN SW ASIA DURING THE GULF WAR?	<input type="checkbox"/> <input type="checkbox"/>
C. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	<input type="checkbox"/>	<input type="checkbox"/>	G. WERE YOU EXPOSED TO AGENT ORANGE WHILE SERVING IN VIETNAM?	<input type="checkbox"/> <input type="checkbox"/>
C1. IF YES, WHAT IS YOUR RATED PERCENTAGE? %			H. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?	<input type="checkbox"/> <input type="checkbox"/>
D. DID YOU SERVE IN COMBAT AFTER 11/11/1998?	<input type="checkbox"/>	<input type="checkbox"/>	I. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	<input type="checkbox"/> <input type="checkbox"/>
E. WAS YOUR DISCHARGE FROM MILITARY FOR A DISABILITY INCURRED OR AGGRAVATED IN THE LINE OF DUTY?	<input type="checkbox"/>	<input type="checkbox"/>	J. DO YOU HAVE A SPINAL CORD INJURY?	<input type="checkbox"/> <input type="checkbox"/>

SECTION V - 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 45 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 through a computer-matching program. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices and in accordance with the VHA Notice of Privacy Practices. Providing the requested information is voluntary, but if any or all of the requested information is not provided, it may delay or result in denial of your request for health care benefits. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

 Department of Veterans Affairs		STATE HOME PROGRAM APPLICATION FOR VETERAN CARE MEDICAL CERTIFICATION					
PART I - ADMINISTRATIVE							
STATE HOME FACILITY			DATE ADMITTED	GENDER <input type="checkbox"/> M <input type="checkbox"/> F			
RESIDENT'S NAME (Last, First, Middle)			SOCIAL SECURITY NUMBER				
RESIDENT'S STREET ADDRESS			AGE	DATE OF BIRTH			
CITY, STATE AND ZIP CODE			ADVANCED MEDICAL DIRECTIVE <input type="checkbox"/> NO <input type="checkbox"/> YES				
PART II - HISTORY AND PHYSICAL (Use separate sheet if necessary)							
HISTORY							
HEIGHT	WEIGHT	TEMP	PULSE	BP	HEAD/EYES/EAR/NOSE AND THROAT		
NECK			CARDIOPULMONARY				
ABDOMEN			GENITOURINARY				
RECTAL			EXTREMITIES				
NEUROLOGICAL			ALLERY/DRUG SENSITIVITY				
X-RAY/ LAB	CHEST X-RAY	DATE:	RESULTS	CBC	DATE:	RESULTS	
	SEROLOGY						
	URINALYSIS	DATE:	ALBUMEN	SUGAR	ACETONE		
CHECK ALL BOXES THAT APPLY OR CIRCLE NA							
IS DEMENTIA THE PRIMARY DIAGNOSIS <input type="checkbox"/> YES <input type="checkbox"/> NO		IS THERE A DIAGNOSIS OF MENTAL ILLNESS <input type="checkbox"/> YES <input type="checkbox"/> NO		HAS RESIDENT RECEIVED MENTAL SERVICES WITHIN THE PAST 2 YEARS <input type="checkbox"/> YES <input type="checkbox"/> NO		IS CLIENT A DANGER TO SELF OR OTHERS <input type="checkbox"/> YES <input type="checkbox"/> NO	
IS THERE ANY PRESSING EVIDENCE OF MENTAL ILLNESS SUCH AS:							
<input type="checkbox"/> SCHIZOPHRENIA		<input type="checkbox"/> PARANOIA		<input type="checkbox"/> OTHER PSYCHOTIC OR MENTAL DISORDERS LEADING TO CHRONIC DISABILITY		<input type="checkbox"/> PERSONALITY DISORDER	
<input type="checkbox"/> MOOD SWINGS		<input type="checkbox"/> SOMATOFORM DISORDER		<input type="checkbox"/> PANIC OR SEVERE ANXIETY DISORDER		<input type="checkbox"/> PERSONALITY DISORDER	
OXYGEN		TUBE FEEDING		DECUBITUS ULCERS		FOLEY CATHETER	
<input type="checkbox"/> MASK <input type="checkbox"/> PRN		<input type="checkbox"/> OSTOMY		<input type="checkbox"/> DRAINING WOUND		<input type="checkbox"/> TEMPORARY	
<input type="checkbox"/> NASAL CANNULAR <input type="checkbox"/> CONTINUOUS		<input type="checkbox"/> TRACHOSTOMY		<input type="checkbox"/> WOUND COLULTERED		<input type="checkbox"/> PERMANENT	
REFERRING PHYSICIAN				PRIMARY DIAGNOSIS			
SECONDARY DIAGNOSIS				TERTIARY DIAGNOSIS			
TYPE OF CARE RECOMMENDED: <input type="checkbox"/> SKILLED NURSING HOME CARE <input type="checkbox"/> DOMICILIARY CARE <input type="checkbox"/> ADULT DAY HEALTH CARE <input type="checkbox"/> HOSPITAL							
MEDICATION AND TREATMENT ORDERS ON ADMISSION, CONTINUE ON SEPARATE SHEET IF NECESSARY							
PRINTED OR TYPED NAME OF PRIMARY PHYSICIAN ASSIGNED				SIGNATURE OF PRIMARY PHYSICIAN ASSIGNED			

STATE HOME PROGRAM APPLICATION FOR VETERAN CARE - MEDICAL CERTIFICATION CONTINUED			
RESIDENT'S NAME (Last, First, Middle)		SOCIAL SECURITY NUMBER	
EVALUATION (Circle appropriate number in each category)			
COMMUNICATION	1. Transmits messages/receives information. 2. Limited ability. 3. Nearly or totally unable.	SPEECH	1. Speaks clearly with others of same language 2. Limited ability 3. Unable to speak clearly or not at all
HEARING	1. Good 2. Hearing slightly impaired 3. Limited hearing (e.g. must speak loudly) 4. Virtually/completely deaf	SIGHT	1. Good 2. Vision adequate - Unable to read/see details 3. Vision limited - Gross object differentiation 4. Blind
TRANSFER	1. No assistance 2. Equipment only 3. Supervision only 4. Requires human transfer w/wo equipment 5. Bedfast	AMBULATION	1. Independence w/wo assistive device 2. Walks with supervision 3. Walks with continuous human support 4. Bed to chair (total help) 5. Bedfast
ENDURANCE	1. Tolerates distances (250 feet sustained activity) 2. Needs intermittent rest 3. Rarely tolerates short distances 4. No tolerance	MENTAL AND BEHAVIORAL STATUS	1. Alert 2. Confused 3. Disoriented 4. Comatose 5. Agreeable 6. Disruptive 7. Apathetic 8. Well motivated
TOILETING	1. No assistance 2. Assistance to and from and transfer 3. Total assistance including personal hygiene help with clothes	BATHING	1. No assistance 2. Supervision only 3. Assistance 4. Is bathed A. Tub B. Shower C. Sponge bath
DRESSING	1. Dresses Self 2. Minor assistance 3. Needs help to complete dressing 4. has to be dressed	FEEDING	1. No assistance 2. Minor assistance, needs tray set up only 3. Help feeding/encouraging 4. Is fed
BLADDER CONTROL	1. Continent 2. Rarely incontinent 3. Occasional - once/week or less 4. Frequent - up to once a day 5. Total incontinence 6. Catheter, indwelling	BOWEL CONTROL	1. Continent 2. Rarely incontinent 3. Occasional - once/week or less 4. Frequent - up to once a day 5. Total incontinence 6. Ostomy
SKIN CONDITION	1. Intact 2. Dry/Fragile 3. Irritations (Rash) 4. Open Wounds 5. Decubitus	WHEEL CHAIR USE	1. Independence 2. Assistance in difficult maneuvering 3. Wheels a few feet 4. Unable to use NA
SIGNATURE OF REGISTERED NURSE OR REFERRING PHYSICIAN			DATE
PHYSICAL THERAPY (To be completed by Physical Therapist or Referring Physician)			
		NEW REFERRAL	CONTINUATION OF THERAPY
SENSATION IMPAIRED <input type="checkbox"/> YES <input type="checkbox"/> NO	RESTRICT ACTIVITY <input type="checkbox"/> YES <input type="checkbox"/> NO	PRECAUTIONS <input type="checkbox"/> CARDIAC <input type="checkbox"/> OTHER (Specify)	FREQUENCY OF TREATMENT
TREATMENT GOALS:			
<input type="checkbox"/> ACTIVE	<input type="checkbox"/> COORDINATING ACTIVITIES	<input type="checkbox"/> FULL WEIGHT BEARING	<input type="checkbox"/> WHEELCHAIR INDEPENDENT
<input type="checkbox"/> STRETCHING	<input type="checkbox"/> ACTIVE ASSISTIVE	<input type="checkbox"/> NON-WEIGHT BEARING	<input type="checkbox"/> COMPLETE AMBULATION
<input type="checkbox"/> PASSIVE ROM	<input type="checkbox"/> PROGRESSIVE RESISTIVE	<input type="checkbox"/> PARTIAL WEIGHT BEARING	<input type="checkbox"/> RECOVERY TO FULL FUNCTION
ADDITIONAL THERAPIES <input type="checkbox"/> O.T. <input type="checkbox"/> SPEECH <input type="checkbox"/> DIETARY	SIGNATURE OF AND TITLE OF THERAPIST		DATE
SOCIAL WORK ASSESSMENT (To be completed by Social Worker)			
PRIOR LIVING ARRANGEMENTS		LONG RANGE PLAN	
ADJUSTMENT TO ILLNESS OR DISABILITY		SIGNATURE OF SOCIAL WORKER	DATE
VA AUTHORIZATION FOR PAYMENT			
DATE RECEIVED BY VA	ELIGIBILITY FOR PER DIEM PAYMENT <input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED	LEVEL OF CARE RECOMMENDED <input type="checkbox"/> NHC <input type="checkbox"/> DOMICILIARY <input type="checkbox"/> HOSPITAL <input type="checkbox"/> ADHC	
REASON FOR DISAPPROVAL		<input type="checkbox"/> APPROVED	REASON FOR DISAPPROVAL
		<input type="checkbox"/> DISAPPROVED	
SIGNATURE OF VA OFFICIAL	DATE	SIGNATURE OF VA PHYSICIAN	DATE

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICE

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 The information requested on this form is solicited under the authority of Title 38, U.S.C., Sections 1741, 1742, and 1743. It is being collected to enable us to determine your eligibility for medical benefits in the State Home Program and will be used for that purpose. The income and eligibility you supply may be verified through a computer matching program at any time and information may be disclosed outside the VA as permitted by law; possible disclosures include those described in the "routine uses" identified in the VA system of records 24VA136, Patient Medical Record-VA, published in the Federal Register in accordance with the Privacy Act of 1974. Disclosure is voluntary; however, the information is required in order for us to determine your eligibility for the medical benefit for which you have applied. Failure to furnish the information will have no adverse affect on any other benefits to which you may be entitled. Disclosure of Social Security number(s) of those for whom benefits are claimed is requested under the authority of Title 38, U.S.C., and is voluntary. Social Security numbers will be used in the administration of veterans benefits, in the identification of veterans or persons claiming or receiving VA benefits and their records and may be used for other purposes where authorized by Title 38, U.S.C., and the Privacy Act of 1974 (5 U.S.C. 552a) or where required by other statute.

VA FORM
JUL 1998

10-10SH

ADVA ASSESSMENT FOR LEVEL OF CARE/MENTAL ILLNESS

Please Print in Ink

Completed by: RN, Social Worker or Physician

NAME: _____ SS#: _____ DOB: _____

CURRENT LOCATION: _____
Street City State Zip Code

LEGAL GUARDIAN (If applicable):

Name: _____ Address: _____
ATTENDING PHYSICIAN:
(Name & Address) _____

DISCHARGING HOSPITAL: _____
(Name and Address of Hospital)

ADMITTING RETAINING NURSING FACILITY NAME: Admit Date, if applicable: _____
(Name & Address) _____

1. ADMITTING DIAGNOSIS: _____ SIGNIFICANT MEDICAL PROBLEMS: _____
Primary: _____
Secondary: _____

2. BEHAVIOR ADJUSTMENT (Check all those that apply):
 Anxious Disoriented (Person, Place, Time, Situation)
 Confused Combative, Describe: _____
 Delusional Agitated, Describe: _____
 Hallucinates Self Abusive, Describe: _____
 Wanders Seizures
 Depressed None of the Above

3. SENSORY/COMMUNICATION
 Hearing Impaired Cannot Communicate, Describe: _____
 Vision Impaired Requires Assistance to Communicate, Describe: _____
 Mute _____

4. PSYCHOTROPIC, ANTI-DEPRESSANT & ANTI-ANXIETY MEDICATIONS (Identify medication name and the corresponding diagnosis for the medication):

5. NEED FOR NURSING FACILITY LEVEL OF CARE, (Check the specific services that this individual requires on a regular basis. It is imperative that a resident must meet two (2) criteria):
 Administration of a potent and dangerous injectable medication and intravenous medication and solutions on a daily basis or administration of routine oral medications, eye drops, or ointment
 Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of residents who are determined to have restorative potential and can benefit from the training on a daily basis per physician's orders.
 Nasopharyngeal aspiration required for the maintenance of a clear airway.
 Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy, and other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created.
 Administration of tube feedings by naso-gastric tube.
 Care of extensive decubitus ulcers or other widespread skin disorders.
 Other specified and individual justified services, including observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse. Specify: _____

 Use of oxygen on a regular or continuous basis.
 Application of dressing involving prescription medications and aseptic techniques and/or changing of dressing in noninfected, postoperative, or chronic conditions per physician's orders.
 Comatose resident receiving routine medical treatment.

VETERAN NAME: _____ SSN: _____

6. Is the individual applying to nursing home care due to one of the following conditions? Yes No

If "Yes" please check the condition.

- Need for Convalescent Care of 120 days or less as prescribed by physician.
- Terminal illness with life expectancy of six months or less
- Comatose
- Ventilator Dependent
- Functioning only at Brain Stem Level
- Cerebellar Degeneration
- Advanced Amolytrophic Lateral Sclerosis
- Huntington's Disease

7. Does the individual have a diagnosis of Alzheimer's Disease or Dementia in the absence of Mental Retardation or a primary diagnosis of Mental Illness? Yes No

8. SUSPECTED MENTAL ILLNESS (Please check all diagnosis that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Somatoform Disorder | <input type="checkbox"/> Mood Disorder |
| <input type="checkbox"/> Personality Disorder | <input type="checkbox"/> Paranoid Disorder | <input type="checkbox"/> Other Psychotic Disorder |
| <input type="checkbox"/> Panic Disorder | <input type="checkbox"/> Other Severe Anxiety Disorder | <input type="checkbox"/> Unspecified Mental Disorder that may lead to chronic disability |

A. LEVEL OF IMPAIRMENT DUE TO THE ABOVE SUSPECTED MENTAL ILLNESS

Does the above noted disorder result in functional limitations in major life activities within the past 3-6 months with:

1. Difficulty in interpersonal functioning? Yes No
2. Serious difficulty in concentration, persistence and pace? Yes No
3. Serious adaptation to change? Yes No

B. DURATION OF ABOVE NOTED ILLNESS:

Has the individual had:

1. Psychiatric treatment more intensive than outpatient care more than once in the last 5 years? Yes No If Yes, Give name of facility: _____
2. Within the last 5 years, due to the mental disorder, experienced an episode of significant disruption to the normal living situation? Yes No (If Yes, please describe): _____

9. SUSPECTED MENTAL RETARDATION/RELATED CONDITION (Please check all diagnosis that apply. If none, proceed to Number 10):

- Mental Retardation Cerebral Palsy or Epilepsy
- Any other condition, other than MI or Dementia, found to be closely related to MR because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with MR (including autism).
 - a. Was the above condition manifested before (check one):
 Age 18 Age 22 Age of Onset Unknown OR After 22nd birthdate
 - b. Is the condition likely to continue indefinitely? Yes No
 - c. The condition results in substantial functional limitations in the following areas of major life activity (check all that apply):
 Self Care Learning Understanding and Use of Language
 Mobility Direction Capacity for Independent Living

10. DANGEROUSNESS

Is the individual combative? Yes No If Yes, describe: _____

Is the individual suicidal? Yes No If Yes, describe: _____

11. CERTIFICATION

I certify that the above information is correct to the best of my knowledge.

Physician, RN or Social Worker's Signature _____ Date

12. Referral Source: _____ Phone: _____

Alabama State Veterans Home

TO BE COMPLETED BY: Veteran or Sponsor

Authorization for Release of Medical Information

(Applicant/Sponsor complete Part A only)

A. I hereby authorize the _____

to release medical records or other information regarding my treatment, hospitalization, and/or outpatient care to Health Management Resources (HMR). I understand that this authorization may be revoked at any time and that it will automatically expire within twelve (12) months from the date of signing.

Please check the Veterans Home requesting information:

- | | | |
|--|--|--|
| <input type="checkbox"/> Bill Nichols
1784 Elkahatchee Road
Alexander City, AL 35010 | <input type="checkbox"/> William F. Green
300 Faulkner Drive
Bay Minette, AL 36507 | <input type="checkbox"/> Floyd E. "Tut" Fann
2701 Meridian Street
Huntsville, AL 35811 |
|--|--|--|

Witness Signature

Patient/Sponsor Signature

Date

Date

B. FOR FACILITY USE ONLY

RE:

Patient's Name

Date of Birth

Social Security Number

VA Claim Number

Dear Correspondence Secretary:

The above named patient is currently being treated or has made application for admission to one of the Alabama State Veterans Home and gives a history of having been a patient at your facility. In order to provide optimal care, the patient or applicant authorizes that his/her medical records be released to our office. Please forward a copy of:

Complete Medical Records: _____ Medical X-Rays: _____

Discharge Summary: _____ Dates: _____