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. This package has been assembled to provide you with the information necessary to aid us in determining eligibility and to expedite the total process. Submit the completed application directly to the home in which you are applying for admittance or you may return it to your County Veterans Service Office. **Note**: If choosing mulitiple homes, only one package needs to be submitted. The receiving home will share the application with the other homes checked on page 1 of the application. The Homes are located at the following address:

1) Bill Nichols State Veterans Home
1784 Elkahatchee Road
Alexander City, Alabama 35010
(256) 329-3311

2) William F. Green State Veterans Home
300 Faulkner Drive
Bay Minette, Alabama 36507
(251) 937-8049

3) Floyd E. "Tut" Fann State Veterans Home
2701 Meridian Street
Huntsville, Alabama 35811
(256) 851-2807

4) Colonel Robert L. Howard State Veterans Home
7054 Veterans Parkway
Pell City, Alabama 35125
(205) 338-6487

If you have any questions, contact the State Home Director at the above number or you may contact me at:

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

Sincerely,

Kimberly B. Justice
Executive Director
Alabama State Veterans Homes

Eligibility Requirements:

Code of Alabama, Section 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 Section 641, 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 Active Duty service. Veterans who enlisted after September 7, 1980 and those commissioned after October 16, 1981 must have served a minimum of 24 continuous months or the full period for which the person was called and be honorably discharged. Active duty service means full-time service other than Active Duty for Training. A DD-214 or equivalent must be included in the application package. Veterans with war-time service are given perference for admission prior to peace time veterans.

- Must meet the qualifications as set forth by the U.S. Department of Veterans Affairs criteria for skilled nursing care or domiciliary/assisted living.

- Must have been a resident of the State of Alabama during the immediate past 12 months. (Proof of residency may be required).

- Must have had a medical examination by a physician that shows that veteran does not have:

    - medical or nursing care needs that the Home is not equipped or staffed to provide.

    - behavioral traits that 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 their medical condition.

- 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 a waiting list or placed before wartime veterans.

- Must meet the requirements of Alabama's immigration laws.

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:

- Quality food service with individual diet counseling by a certified dietician.

- Skilled nursing care and assisted living 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.

What the Facility Will Provide Continued:

- 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.
- In-house pharmacy and licensed pharmacist to dispense medications as dictated by physicians' orders.
- Basic supplies for personal care.
- 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), the Alabama Department of Public Health (ADPH) and Centers for Medicare and Medicaid Services (CMS).
- Appropriate support groups for families and responsible parties.

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
- Special adaptive appliances/devices (NOTE: we do assist in securing these items through the Federal Department of Veterans Affairs for those eligible.)
- Replacement for loss, damage or destruction of personal items
- Free ambulance service
- T.V. and cable may or may not be provided. Check with individual facility

Resident/Sponsor Responsibilities:

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

- Services not covered by insurance. (Third party provider charges that are billable include but are not limited to physician services, therapy services, labs, and x-rays).
- Charges/co-pays for pharmaceuticals.
- Barber/Beauty Shop
- Private telephone installation and services
- 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
- Non-covered transportation charges
- Bed Hold charges

Submission of this application is acceptance by all parties of the aforementioned 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 Col. Robert L. Howard State Veterans Home is a smoke free/tobacco free campus. There are limited smoking areas on the campus of Bill Nichols, Floyd E. "Tut" Fann, and William F. Green State Veterans Homes.

4. 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. Bedhold charges apply to all Residents residing in the home. Exception: Per diem will be paid for certain veterans based on service-connected disabilities. Veterans who qualify under Title 38, Part 51, Subpart C will not be billed for room and board or routine services if the resident meets one of the following criteria: (1) Is in need of nursing home care for a VA adjudicated service-connected disability, or (2) has a service connected rating of 70 percent or more based on one or more service-connected disabilities or a rating of total disability based on individual unemployability and is in need of nursing home care. Title 38 will only apply once USDVA has fully recognized the State Veterans Home. It is the authority of the Department of Veterans Affairs to give final approval for per diem and to determine the amount of payment. This process may take up to two weeks after admission. The veteran is responsible for the full daily rate to include federal/state per diem if the veteran is not approved. Discharge may result in some cases.

5. Transportation to local appointments and activities is provided. Other transportation is the responsibility of the veteran.

6. Residents shall furnish their own items of personal clothing. Resident furniture is provided.

7. Residents shall accept transfer and/or discharge to other medical facilities or home care if medical condition mandates, as determined by the State Veterans Homes Medical Staff/Director.

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., issued to them by the U. S. Department of Veterans Affairs.

11. Residents are allowed 10 days per occurrence for hospitalization and 12 days annually for therapeutic leave in which the USDVA will pay per diem and no bedhold charged to residents. The facility must be at 90% occupancy before this applies. The veteran is responsible for bedhold charges on any day occupancy rate is below 90%.

12. 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.

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

Application and Information Sheet and Checklist

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

	Description	To be completed by
☐	Personal Admission Information	Veteran or Sponsor
☐	Information on Legal Residency	Veteran or Sponsor
☐	VA Form 10-10EZ Application for Medical Benefits	Veteran or Sponsor
☐	VA Form 10-10SH Medical Certification	Medical Physician
☐	ADVA Assessment for Level of Care/Mental Illness	Medical Physician, RN, or Social Worker
☐	Medical Statement for Domiciliary Care	Medical Physician
☐	ADVA Declaration of Citizenship or Alien Status	Veteran or Sponsor
☐	Authorization for Release of Medical Information	Veteran or Sponsor

CHECKLIST FOR INFORMATION TO BE RETURNED WITH APPLICATION

- ☐ DD Form 214 or equivalent (mandatory)
- ☐ Copy of legal Power of Attorney (if available)
- ☐ Copy of Living Will / Advanced Directive (if available)
- ☐ Copy of insurance cards (front and back)
- ☐ Proof of Residence (completion of page 3) or voters records, employment records, State income tax records, etc. (if questionable)

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 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

Please check facility of choice: (May select more than one)

Bill Nichols State Veterans Home
☐ Skilled Care

Col. Robert L. Howard State Veterans Home
☐ Skilled Care ☐ Domiciliary/Assisted Living

Floyd E. "Tut" Fann State Veterans Home
☐ Skilled Care

William F. Green State Veterans Home
☐ Skilled Care

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: _____ CELL PHONE: _____ WORK PHONE: _____

7. PERSONAL PHYSICIAN: _____

ADDRESS: _____

PHONE NO. _____

8. HAS APPLICANT EVER BEEN CONVICTED OF A FELONY? ☐YES ☐ NO IF YES, PLEASE DESCRIBE BELOW:

TO BE COMPLETED BY: ***Veteran or Sponsor***

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

☐ 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) ☐ OEF/OIF

(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. DID A VETERANS SERVICE OFFICER ASSIST YOU? YES ☐ NO ☐ IF SO, WHAT COUNTY: _____

IS THE VETERAN CURRENTLY IN RECEIPT OF VA SERVICE CONNECTED DISABILITY COMPENSATION OR NON-SERVICE CONNECTED PENSION? YES ☐ NO ☐ IF SO, HOW MUCH? PENSION $ _____ COMPENSATION $ _____ SC DISABILITY PERCENTAGE: _____

HAS VETERAN APPLIED FOR NSC PENSION W/AID AND ATTENDANCE OR SERVICE CONNECTED DISABILITY COMPENSATION? YES ☐ NO ☐ IF SO, WHO ASSISTED WITH APPLICATION? _____

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: _____

Alabama State Veterans Home

TO BE COMPLETED BY: ***Veteran or Sponsor***

Information on Legal Residency

1. Have you been a resident of Alabama for the last twelve (12) preceeding months?

☐ Yes ☐ No

2. List the address(es) where you have resided during the past one (1) year.

Number	Street	County	City
Number	Street	County	City
Number	Street	County	City

Under penalty of Law, the undersigned swears or affirms that all answers to questions in this application are correct to the best of his/her knowledge, that all questions are fully understood, and that questions and answers have been read by the affiant or read and explained to him/her and that the affiant understands and accepts the terms and conditions required for admission.

_____
Signature of Veteran, His/Her Spouse or other Authorized Individual

SUSCRIBED AND SWORN before me this _____ day of _____, _____.

_____
(NOTARY PUBLIC)

SEAL

My commission expires: _____.

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

Department of Veterans Affairs

APPLICATION FOR HEALTH BENEFITS

SECTION I - GENERAL INFORMATION

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

1A. VETERAN'S NAME *(Last, First, Middle Name)*	1B. PREFERRED NAME	2. MOTHER'S MAIDEN NAME

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

7. VA CLAIM NUMBER	8A. DATE OF BIRTH *(mm/dd/yyyy)*	8B. PLACE OF BIRTH *(City and State)*	9. RELIGION

10A. PERMANENT ADDRESS *(Street)*	10B. CITY	10C. STATE	10D. ZIP CODE	10E.COUNTY

10F. HOME TELEPHONE NO. *(Include area code)*	10G. MOBILE TELEPHONE NO. *(Include area code)*	10H. E-MAIL ADDRESS

11A. RESIDENTIAL ADDRESS *(Street)*	11B. CITY	11C. STATE	11D. ZIP CODE	11E.COUNTY

12. TYPE OF BENEFIT(S) APPLYING FOR *(You may check more than one)*	13. CURRENT MARTIAL STATUS
☐ ENROLLMENT/HEALTH SERVICES ☐ DENTAL	☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED

14A. NEXT OF KIN NAME	14B. NEXT OF KIN ADDRESS	14C. NEXT OF KIN RELATIONSHIP

14D. NEXT OF KIN TELEPHONE NO. *(Include Area Code)*	14E. NEXT OF KIN WORK TELEPHONE NO. *(Include Area Code)*	15. DESIGNEE - INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH (*Note: This does not constitute a will or transfer of title*)

16. I AM ENROLLING TO OBTAIN MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT	17. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? *(for listing of facilities visit www.va.gov/directory)*	18. WOULD YOU LIKE FOR VA TO CONTACT YOU TO SCHEDULE YOUR FIRST APPOINTMENT?
☐ YES ☐ NO		☐ YES ☐ NO

SECTION II - MILITARY SERVICE INFORMATION

1A. LAST BRANCH OF SERVICE	1B. LAST ENTRY DATE	1C. FUTURE DISCHARGE DATE	1D. LAST DISCHARGE DATE

1E. DISCHARGE TYPE	1F. MILITARY SERVICE NUMBER

2. MILITARY HISTORY *(Check yes or no)*	YES	NO		YES	NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?	☐	☐	G. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	☐	☐
B. ARE YOU A FORMER PRISONER OF WAR?	☐	☐	IF "YES", WHAT IS YOUR RATED PERCENTAGE _____ %		
C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?	☐	☐	H. DID YOU SERVE IN VIETNAM BETWEEN JANUARY 9, 1962 AND MAY 7, 1975?	☐	☐
D. WERE YOU DISCHARGED OR RETIRED FROM MILITARY FOR A DISABILITY INCURRED IN THE LINE OF DUTY?	☐	☐	I. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?	☐	☐
E. ARE YOU RECEIVING DISABILITY RETIREMENT PAY INSTEAD OF VA COMPENSATION?	☐	☐	J. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	☐	☐
F. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998?	☐	☐	K. DID YOU SERVE ON ACTIVE DUTY AT LEAST 30 DAYS AT CAMP LEJEUNE FROM AUGUST 1, 1953 THROUGH DECEMBER 31, 1987?	☐	☐

APPLICATION FOR HEALTH BENEFITS
Continued

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

SOCIAL SECURITY NUMBER

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

1. ENTER YOUR HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER *(include coverage through spouse or other person)*

2. NAME OF POLICY HOLDER	3. POLICY NUMBER	4. GROUP CODE	5. ARE YOU ELIGIBLE FOR MEDICAID? ☐ YES ☐ NO	6A. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A? ☐ YES ☐ NO 6B. EFFECTIVE DATE *(mm/dd/yyyy)*

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

1. SPOUSE'S NAME *(Last, First, Middle Name)*		2. CHILD'S NAME *(Last, First, Middle Name)*	
1A. SPOUSE'S SOCIAL SECURITY NUMBER		2A. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)*	2B. CHILD'S SOCIAL SECURITY NO.
1B. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)*	1C. SPOUSE SELF-IDENTIFIED GENDER IDENTITY ☐ MALE ☐ FEMALE	2C. DATE CHILD BECAME YOUR DEPENDENT *(mm/dd/yyyy)*	
1D. DATE OF MARRIAGE *(mm/dd/yyyy)*		2D. CHILD'S RELATIONSHIP TO YOU *(Check one)* ☐ SON ☐ DAUGHTER ☐ STEPSON ☐ STEPDAUGHTER	
1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP if different from Veteran's)*		2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? ☐ YES ☐ NO 2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? ☐ YES ☐ NO	
3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT? ☐ YES ☐ NO		2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(e.g., tuition, books, materials)*	

SECTION V - EMPLOYMENT INFORMATION

1A. VETERAN'S EMPLOYMENT STATUS *(Check one)*. ☐ FULL TIME ☐ PART TIME ☐ NOT EMPLOYED ☐ RETIRED	1B. DATE OF RETIREMENT	
1C. COMPANY NAME. *(Complete if employed or retired)*	1D. COMPANY ADDRESS *(Complete if employed or retired -Street, City, State, ZIP)*	1E. COMPANY PHONE NUMBER *(Complete if employed or retired)*

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

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

SECTION VII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

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

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

SECTION VII - CONSENT TO COPAYS AND TO RECEIVE COMMUNICATIONS

By submitting this application you are agreeing to pay the applicable VA copays for treatment or services of your NSC conditions as required by law. You also agree to receive communications from VA to your supplied email or mobile number.

ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section 1729 and 42 U.S.C. 2651, the Department of Veterans Affairs (VA) is authorized to recover or collect from my health plan (HP) or any other legally responsible third party for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse. Furthermore, I hereby assign to the VA any claim I may have against any person or entity who is or may be legally responsible for the payment of the cost of medical services provided to me by the VA. I understand that this assignment shall not limit or prejudice my right to recover for my own benefit any amount in excess of the cost of medical services provided to me by the VA or any other amount to which I may be entitled. I hereby appoint the Attorney General of the United States and the Secretary of Veterans' Affairs and their designees as my Attorneys-in-fact to take all necessary and appropriate actions in order to recover and receive all or part of the amount herein assigned. I hereby authorize the VA to disclose, to my attorney and to any third party or administrative agency who may be responsible for payment of the cost of medical services provided to me, information from my medical records as necessary to verify my claim. Further, I hereby authorize any such third party or administrative agency to disclose to the VA any information regarding my claim.

ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS WHICH DEFINE WHO CAN SIGN ON BEHALF OF THE VETERAN.

SIGNATURE OF APPLICANT
(Sign in ink) _____ **DATE** _____

"Physicans Signature Required"

OMB Approval No. 2900-0160
Estimated Burden: Avg. 20 min.
EXP: Feb 28, 2019

Department of Veterans Affairs

VA FORM 10-10SH
HOME PROGRAM APPLICATION FOR VETERAN CARE MEDICAL CERTIFICATION

PART I - ADMINISTRATIVE

1. STATE HOME FACILITY	2. DATE ADMITTED

3. STATE HOME FACILITY ADDRESS (Street, City, State and Zip Code)

4. RESIDENT'S NAME (Last, First, Middle) (Mandatory field)

5. SOCIAL SECURITY NUMBER (Mandatory field)	6. GENDER ☐ M ☐ F	7. AGE	8. DATE OF BIRTH (MM/DD/YYYY)	9. ADVANCED MEDICAL DIRECTIVE ☐ NO ☐ YES

10. HAS THE VETERAN PROVIDED FINANCIAL DISCLOSURE FOR PURPOSES OF DETERMINING ELIGIBILITY FOR DOMICILIARY PER DIEM PAYMENTS?
☐ YES ☐ NO ☐ N/A **10-10EZ or 10-10EZR IS REQUIRED TO BE SUBMITTED EITHER IN PAPER FORM OR ELECTRONICALLY WITH THE 10-10SH**

PART II - HISTORY AND PHYSICAL (Use separate sheet if necessary)

11. HISTORY

12. HEIGHT	13. WEIGHT	14. TEMP	15. PULSE	16. BP	17. HEAD/EYES/EAR/NOSE AND THROAT

18. NECK	19. CARDIOPULMONARY
29. ABDOMEN	21. GENITOURINARY
22. RECTAL	23. EXTREMITIES
24. NEUROLOGICAL	25. ALLERGY/DRUG SENSITIVITY

26. X-RAY/ LAB							
	CHEST X-RAY	DATE (MM/DD/YYYY)	RESULT	CBC	DATE (MM/DD/YYYY)	RESULT	
	SEROLOGY						
	URINALYSIS	DATE (MM/DD/YYYY)	ALBUMIN	ACETONE	SUGAR		

CHECK ALL BOXES THAT APPLY OR CHECK N/A

27. IS DEMENTIA THE PRIMARY DIAGNOSIS	28. IS THERE A DIAGNOSIS OF MENTAL ILLNESS	29. HAS RESIDENT RECEIVED MENTAL HEALTH SERVICES WITHIN THE PAST 2 YEARS	30. IS CLIENT A DANGER TO SELF OR OTHERS
☐ YES ☐ NO ☐ N/A	☐ YES ☐ NO ☐ N/A	☐ YES ☐ NO ☐ N/A	☐ YES ☐ NO ☐ N/A

31. IS THERE ANY PRESSING EVIDENCE OF MENTAL ILLNESS SUCH AS:
☐ SCHIZOPHRENIA ☐ PARANOIA ☐ OTHER PSYCHOTIC OR MENTAL DISORDERS LEADING TO CHRONIC DISABILITY ☐ N/A
☐ MOOD SWINGS ☐ SOMATOFORM DISORDER ☐ PANIC OR SEVERE ANXIETY DISORDER ☐ PERSONALITY DISORDER

32. OXYGEN	33. FEEDING	34. WOUND	35. FOLEY CATHETER
☐ MASK ☐ PRN ☐ N/A	☐ TUBE FEEDING ☐ N/A	☐ DECUBITUS ULCERS ☐ N/A	☐ TEMPORARY ☐ N/A
☐ NASAL CANNULA ☐ CONTINUOUS	☐ OSTOMY ☐ TRACHEOSTOMY	☐ DRAINING WOUND ☐ WOUND CULTURED	☐ PERMANENT

36. REFERRING PHYSICIAN	37. PRIMARY DIAGNOSIS
38. SECONDARY DIAGNOSIS	39. TERTIARY DIAGNOSIS

40. ARE THE ADMITTING DIAGNOSIS RELATED TO A SERVICE CONNECTED CONDITION? ☐ YES ☐ NO ☐ UNKNOWN

41. TYPE OF CARE RECOMMENDED: ☐ SKILLED NURSING HOME CARE ☐ DOMICILIARY CARE ☐ ADULT DAY HEALTH CARE

42. MEDICATION AND TREATMENT ORDERS ON ADMISSION, CONTINUE ON SEPARATE SHEET IF NECESSARY

43. PRINTED OR TYPED NAME OF PRIMARY PHYSICIAN ASSIGNED	44. SIGNATURE OF PRIMARY PHYSICIAN ASSIGNED

OMB Approval No. 2900-0160
Estimated Burden: Avg. 20 min.
EXP: Feb 28, 2019

VA FORM 10-10SH
STATE HOME PROGRAM APPLICATION FOR VETERAN CARE MEDICAL CERTIFICATION

PART III - EVALUATION (Select an appropriate number in each category)

45. RESIDENT'S NAME *(Last, First, Middle) (This is a mandatory field)*	46. SOCIAL SECURITY NUMBER *(Mandatory field)*

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. Nearly or totally unable ☐ 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 activities ☐ 4. No tolerance	**MENTAL AND BEHAVIOR 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 transfer ☐ 3. Total assistance including personal hygiene, help with clothes ☐ A. Bathroom ☐ B. Bedside commode ☐ C. Bedpan	**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 wound ☐ 5. Decubitus Number _____ Stage _____	**WHEEL CHAIR USE**	☐ 1. Independence ☐ 2. Assistance in difficult maneuvering ☐ 3. Wheels a few feet ☐ 4. Unable to use ☐ N/A

47. SIGNATURE OF REGISTERED NURSE OR REFERRING PHYSICIAN	48. DATE

PHYSICAL THERAPY ***(To be completed by Physical Therapist or Referring Physician)*** 49. Check if ☐ NEW REFERRAL ☐ CONTINUATION OF THERAPY

50. SENSATION IMPAIRED	51. RESTRICT ACTIVITY	52. PRECAUTIONS	53. FREQUENCY OF TREATMENT
☐ YES ☐ NO	☐ YES ☐ NO	☐ CARDIAC ☐ OTHER (Type other, specify)	

54. TREATMENT GOALS:

☐ ACTIVE	☐ COORDINATING ACTIVITIES	☐ FULL WEIGHT BEARING	☐ WHEELCHAIR INDEPENDENT
☐ STRETCHING	☐ ACTIVE ASSISTIVE	☐ NON-WEIGHT BEARING	☐ PROGRESS BED TO WHEELCHAIR	☐ COMPLETE AMBULATION
☐ PASSIVE ROM	☐ PROGRESSIVE RESISTIVE	☐ PARTIAL WEIGHT BEARING	☐ RECOVERY TO FULL FUNCTION

55. ADDITIONAL THERAPIES	56. SIGNATURE OF AND TITLE OF THERAPIST OR PHYSICIAN	57. DATE
☐ O.T. ☐ SPEECH ☐ DIETARY		

PART IV - SOCIAL WORK ASSESSMENT *(To be completed by Social Worker)*

58. PRIOR LIVING ARRANGEMENTS	59. LONG RANGE PLAN		
60. ADJUSTMENT TO ILLNESS OR DISABILITY	61. PRINT NAME OF SOCIAL WORKER	62. SIGNATURE OF SOCIAL WORKER	63. DATE

64. REMARKS

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
____ Confused
____ Delusional
____ Hallucinates
____ Wanders
____ Depressed
____ Disoriented (Person, Place, Time, Situation)
____ Combative, Describe: _____
____ Agitated, Describe: _____
____ Self Abusive, Describe: _____
____ Seizures
____ None of the Above

3. SENSORY/COMMUNICATION

____ Hearing Impaired
____ Vision Impaired
___ Mute
____ Cannot Communicate, Describe: _____
____ Requires Assistance to Communicate, Describe: _____
_____

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.

____ 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.

Completed by: Medical Physician RN, or Social Worker

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):

___ Schizophrenia	___ Somatoform Disorder	___ Mood Disorder
___ Personality Disorder	___ Paranoid Disorder	___ Other Psychotic Disorder
___ Panic Disorder	___ Other Severe Anxiety Disorder	___ 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

Complete **ONLY** if Applying for Domiciliary Care at
Colonel Robert L. Howard State Veterans Home,
Pell City, Alabama

To Be Completed by Physician

Medical Statement for Domiciliary Care

_____
Veteran's Name

_____
Social Security Number

_____
Date of Birth

Veteran is found to be able to make rational and competent decisions as to his/her desire to remain or leave the facility.

Additionally, the Veteran is found to be unemployable due to a disability, disease, or defect of such a degree that incapacitates the Veteran from earning a living.

_____ _____
Physician Signature Date

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 Alabama Department of Veterans Affairs for the purpose of asessing medical needs related to potionial admision. I understand that this authorization may be revoked at any time at my request.

Please check the Veterans Home requesting information:

☐ Bill Nichols
1784 Elkahatchee Road
Alexander City, AL 35010

☐ William F. Green
300 Faulkner Drive
Bay Minette, AL 36507

☐ Floyd E. "Tut" Fann
2701 Meridian Street
Huntsville, AL 35811

☐ Col. Robert L. Howard
7054 Veterans Parkway
Pell City, AL 35125

_____ 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: _____

ALABAMA DEPARTMENT OF VETERANS AFFAIRS
DECLARATION OF CITIZENSHIP
OR ALIEN STATUS FOR ADMISSION TO THE
ALABAMA STATE VETERANS HOMES PROGRAM

Alabama Act No. 2011-535, as amended by Alabama Act No. 2012-491, requires government agencies to verify the lawful presence in the United States of all applicants for a state or local public benefit before issuing any benefits. Any applicant applying for admission to any Alabama veterans' home, a state public benefit codified in Ala. Code §§ 31- 5A-1 *et seq*., must complete this form before the Alabama Department of Veterans' Affairs can issue any benefits. If an applicant is unable to complete the form, his/her sponsor may complete and sign this form on behalf of the applicant.

Directions: This form must be completed by ALL applicants for admission to any Alabama state veterans' home. All applicants must complete Sections I, II, and IV of this form. Applicants who indicate that they are not United States citizens or nationals must also complete Section III. Submit this completed form with any required documentation with your application for admission to the Alabama state veterans' home.

SECTION I - APPLICANT INFORMATION

Name (Print or type):

_____ _____ _____
(Last) (First) (M.I.)

Current Address: _____

_____

County of Current Residence: _____ Date of Birth: _____ (MM/DD/YYYY)

SECTION II - CITIZENSHIP OR NATIONAL STATUS DECLARATION

Are you a citizen or national of the United States? (check one) ☐ Yes ☐ No

If you checked **YES**, complete Section IV (No additional documentation required.)

If you checked **NO**, complete Sections III and IV.

SECTION III - ALIEN STATUS

Are you an alien lawfully present in the United States? (check one) ☐ Yes ☐ No

If you checked **YES**, attach a legible copy of a document from the attached list or other document as evidence of your status. Name of document attached: _____
Complete Section IV.

If you checked **NO**, complete Section IV.

SECTION IV - DECLARATION

I declare under penalty of perjury under the laws of the State of Alabama that the answers and evidence I provided are true and correct to the best of my knowledge. I understand that this public benefit is granted pending verification of my lawful presence in the United States. I further understand that if at any time it is determined that I am not lawfully present in the United States, the ADVA will deny this benefit or will terminate this benefit, will remove me from the veterans' home, and will seek repayment of any benefit awarded on my behalf.

_____ _____

Applicant's Signature Date

_____ _____

Sponsor's Signature (only if applicant is unable to sign) Date

_____ _____

ADVA Employee Receiving Form (Print)* Date

(*) Tracking purposes only.

DOCUMENTS INDICATING QUALIFIED ALIEN STATUS

Evidence of "Qualified Alien" status includes the following:

Alien Lawfully Admitted for Permanent Residence

- Form I-551 (Alien Registration Receipt Card, commonly known as a "green card"); or
- Unexpired Temporary I-551 stamp in foreign passport or on * I Form-94

Asylee

- Form I-94 annotated with stamp showing grant of asylum under section 208 of the INA;
- Form I-688B (Employment Authorization Card) annotated "274a. 12(a) (50", or
- Form I-766 (Employment Authorization Document) annotated "A5";
- Grant letter from the Asylum Office of the U.S. Citizenship and Immigration Service; or
- Order of an immigration judge granting asylum.

Refugee

- Form I-94 annotated with stamp showing admission under §207 of the INA;
- Form I-688B (Employment Authorization Card) annotated "274a. 12(a) (3)"; or
- Form I-766 (Employment Authorization Document) annotated "A3"

Alien Paroled Into the U.S. for at Least One Year

- Form I-94 with stamp showing admission for at least one year under section 212 (d) (5) of the INA. (Applicant cannot aggregate periods of admission for less than one year to meet the one year requirement.)

Alien Whose Deportation or Removal Was Withheld

- Form I-688B (Employment Authorization Card) annotated "274a. 12(a) (10);
- Form I-766 (Employment Authorization Document) annotated "A10"; or
- Order from an immigration judge showing deportation withheld under §243(h) of the INA as in effect prior to April 1, 1997, or removal withheld under §241 (b) (3) of the INA.

Alien Granted Conditional Entry

- Form I-94 with stamp showing admission under §203(a)(7) of the INA;
- Form I-688B (Employment Authorization Card) annotated "274a. 12(a) (3)"; or
- Form I-766 Form I-766 (Employment Authorization Document) annotated "A3"

Cuban/Haitian Entrant

- Form I-551 (Alien Registration Receipt Card, commonly known as a "green card") with the code CU6, CU7, or CH6;
- Unexpired temporary I-551 stamp in foreign passport or on * Form I-94 with the code CU6 or CU7; or Form I-94 with stamp showing parole as "Cuba/Haitian Entrant "under Section 212(d) (5) of the INA.

Alien Who Has Been Declared a Battered Alien Subjected to Extreme Cruelty

- U.S. Citizenship and Immigration Service petition and supporting documentation