

APPLICATION FOR ADMISSION TO LOUISIANA WAR VETERANS' HOME

(TO BE COMPLETED BY APPLICANT OR AUTHORIZED REPRESENTATIVE)

(DATE)

Name of Applicant	Dates of Military Service (Attach copy of Discharge/DD214)		
Permanent Address	Branch of Service	Serial #	
Home Telephone Number	Type of Discharge	VA Claim #	
Age	Date of Birth	Social Security #	Home Parish

NEXT OF KIN OR AUTHORIZED REPRESENTATIVE

	NAME	RELATIONSHIP	ADDRESS	TELEPHONE
1.				
2.				
3.				

Signature of Applicant/Authorized
Representative

A DECISION REGARDING ADMISSION TO A STATE WAR VETERANS' HOME IS MADE WITHOUT REGARD TO RACE, COLOR, NATIONAL ORIGIN, AGE, SEX, OR HANDICAP.

STATEMENT OF SOCIAL HISTORY

Applicant's Name _____

Last

First

MI

Present Living Arrangements: Home _____ Family _____ Hospital _____ Nursing Home _____ Other _____

Marital Status: Married _____ Single _____ Divorced _____ Separated _____ Widow(er) _____

Religion: Protestant _____ Catholic _____ Baptist _____ Other _____ Number of Children _____

Date of Birth _____ Place of Birth _____

City

Parish (County)

State

Education/Occupational History _____

Legal Problems (If Applicable) _____

INSURANCE INFORMATION

Medicare Part A: Yes _____ No _____ Part B: Yes _____ No _____ VA Medical Benefits: Yes _____ No _____

Private Insurance: Yes _____ No _____ Policy Number: _____

Name of Company _____

Address _____ Telephone _____

Medicines / supplies paid by: VA _____ Medicaid _____ Private Insurance _____ Other _____

Please attach a copy of card(s) for all insurance policies. Include Medicare card, also.

HOSPITAL PREFERENCE

Please complete information requested below. If no preference is listed, the Department of Veterans' Affairs Medical Center or a state health care facility in the immediate area will be utilized.

NAME OF HOSPITAL _____

NAME OF PHYSICIAN _____ TELEPHONE _____

POST MORTEM INFORMATION

PLEASE ATTACH A COPY OF THE LIFE INSURANCE INFORMATION AND BURIAL INSURANCE POLICY

FUNERAL HOME PREFERENCE _____

VETERAN BENEFITS DOCUMENTATION

THE FOLLOWING DOCUMENTS (IF APPLICABLE) ARE REQUIRED FOR SUBMISSION OF CLAIMS FOR VETERANS BENEFITS TO THE VETERANS ADMINISTRATION

<u>DOCUMENT</u>	<u>ATTACHED</u>	
	<u>YES</u>	<u>NO</u>
MILITARY DISCHARGE (DD-214)	_____	_____
MONTHLY INCOME	_____	_____
MARRIAGE LICENSE	_____	_____
DIVORCE DECREE	_____	_____
BIRTH CERTIFICATE (MINOR DEPENDENTS)	_____	_____
POST HIGH SCHOOL ENROLLMENT VERIFICATION (DEPENDENTS AGED 18 TO 23)	_____	_____
MEDICAL INSURANCE VERIFICATION (e.g. MEDICARE SUPP. ETC)	_____	_____
IS VETERAN ENROLLED IN A VA HEALTH CARE PROGRAM AT ANY VA MEDICAL CENTER	_____	_____

LIST THE SOCIAL SECURITY NUMBERS FOR YOUR SPOUSE AND ALL MINOR CHILDREN THAT YOU ARE FINANCIALLY RESPONSIBLE FOR:

SPOUSE'S NAME _____

SPOUSE'S SOCIAL SECURITY NUMBER _____

CHILDREN'S NAMES	DATE OF BIRTH	SOCIAL SECURITY #

LEGAL PROCEDURE DISCLOSURES

1. Has applicant been interdicted?

*YES _____ NO _____

2. Has applicant authorized anyone to act as his/her attorney or agent?

*YES _____ NO _____

3. Does applicant have a DO NOT RESUSCITATE (DNR) request?

*YES _____ NO _____

4. Does applicant have a Living Will?

*YES _____ NO _____

5. Does applicant have current legal charges pending?

*YES _____ NO _____

* **PLEASE NOTE:** A copy of the appropriate legal document to verify any **YES** response must be attached to this application.

I ATTEST THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature of Applicant or Authorized Representative

Date

MONTHLY INCOME VERIFICATION

SOURCE	APPLICANT	SPOUSE	TOTAL
VA Service-Connected Compensation	_____	_____	_____
VA Non-Service-Connected Pension	_____	_____	_____
Social Security	_____	_____	_____
Retirement	_____	_____	_____
Dividends and Interest	_____	_____	_____
Real Estate	_____	_____	_____
All Other Assets	_____	_____	_____

- PLEASE PROVIDE SUPPORTING DOCUMENTATION TO VERIFY THE INCOME NOTED ABOVE.
- PROVIDE A COPY OF ANY AWARD LETTER FOR VA COMPENSATION, SOCIAL SECURITY, RETIREMENT OR OTHER BENEFITS
 - FOR EXAMPLE: PROVIDE ONE OF THE FOLLOWING FOR VA COMPENSATION, SOCIAL SECURITY, RETIREMENT, DIVIDENDS OR INTEREST:
 - MOST RECENT CHECK STUB, COPY OF MOST RECENT CHECK, LAST STATEMENT SHOWING MONTHLY INCOME OR BANK STATEMENT RECORDS SHOWING MOST RECENT DEPOSIT
- REAL ESTATE – PLEASE PROVIDE COPIES OF CANCELLED CHECKS OR COPY OF REAL ESTATE AGREEMENT
- ALL OTHER ASSETS – PLEASE PROVIDE COPIES OF THE MOST RECENT STATEMENT FOR INCOME FROM OTHER ASSETS

EVERY RESIDENT OF THE FACILITY SHALL BE RESPONSIBLE FOR THE FULL RESIDENT CARE AND MAINTENANCE FEE. THE FACILITY’S ADMINISTRATOR MAY CONSIDER WAIVER OF PAYMENT OF CARE AND MAINTENANCE FEES ONLY FOR THE AMOUNT OF DIFFERENCE OF TOTAL INCOME OF THE VETERAN AND SPOUSE, WHEN APPLICABLE, AND THE TOTAL CHARGE FOR CARE AND MAINTENANCE.

THE CARE AND MAINTENANCE FEE IS CURRENTLY *\$1644.00* PER MONTH. AT THE TIME OF ADMISSION, CARE AND MAINTENANCE FEES WILL BE ASSESSED ON ALL FAMILY INCOME SOURCES. FEES WILL BE ADJUSTED WHEN THERE IS A CHANGE IN FAMILY INCOME, RETROACTIVE TO THE CHANGE.

Signature of Applicant/Authorized Representative

Date

Witness

Date

REQUEST FOR MEDICAL INFORMATION

Applicant's Name: _____ SS #: _____ Medicare #: _____

ALLERGIES _____

A. Primary Diagnosis: (ICD 9 code) _____ Secondary (ICD 9 code) _____

Other _____

B. Medications:(Specify dosage, frequency, and route)

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

C. Recent Hospitalizations: (include psychiatric) _____

D. Mental Status/Behavior: Circle appropriate response and indicate frequency 1-seldom 2-frequent 3-always, if applicable

Oriented ___Yes (1, 2, 3)___No Forgetful ___Yes (1, 2, 3) ___No Depressed ___Yes (1, 2, 3) ___No Confused ___Yes (1, 2, 3) ___No

Wanders ___Yes (1, 2, 3)___No Hostile ___Yes (1, 2, 3) ___No Combative ___Yes (1, 2, 3) ___No

E. Activities of Daily Living: (Select appropriate choice) ___Verbal ___Non-Verbal ___Comatose

	SELF	ASSIST	TOTAL			
Eating	_____	_____	_____	Impaired vision	___Glasses	Impaired Hearing ___Hearing Aid
Bathing	_____	_____	_____	Incontinent Bowel	_____	Incontinence Bladder _____
Personal	_____	_____	_____	Urinary Catheter	_____	
Oral Hygiene	_____	_____	_____	Ostomy care	_____	
Ambulation	_____	_____	_____	Dentures	___Upper___ Lower ___Partial	
DME	_____	_____	_____			

F. SPECIAL CARE/PROCEDURES: (check appropriate choice - when appropriate give type, frequency, size, stage and site)

Glucose Monitoring _____	Diet/Tube Feeding _____
Restraints _____	Dialysis _____
MRSA/VRE- _____	Seizures _____ Suctioning _____
Rehab _____	MRSA/VRE- _____
Decubitus _____	
Other _____	

G. PHYSICAL EXAMINATION: Height _____ Weight _____ Pulse _____ Resp _____ Temp _____ B/P _____

Lab Results: HCT _____ HGB _____ U/A _____	Radiology _____
General _____	Head and CNS _____
Mouth and EENT _____	Chest _____
Heart and Circulation _____	Abdomen _____
Genitalia _____	Extremities _____
Skin _____	Other _____

H. Immunizations: Last PPD _____ Last Flu Vaccine _____ Last Pneumonia Vaccine _____

MD/Licensed Nurse Signature _____ Date _____

RELEASE OF INFORMATION AUTHORIZATION

Resident's Name (Printed): _____ Date of Birth: _____
Address: _____
Social Security#: _____ Telephone: _____

Authority to Release Protected Health Information

I hereby authorize _____ to release the information identified in this authorization form from the medical records of _____ and provide such information to:

Information to be Released -- Covering the Periods of Health Care

From (date) _____ to (date) _____

Please check type of information to be released

<input type="checkbox"/> Complete health record	<input type="checkbox"/> Diagnosis & treatment codes	<input type="checkbox"/> Discharge summary
<input type="checkbox"/> Progress notes	<input type="checkbox"/> History and physical exam	<input type="checkbox"/> Consultation reports
<input type="checkbox"/> Itemized Bill	<input type="checkbox"/> X-Ray films/images	<input type="checkbox"/> Laboratory test results
<input type="checkbox"/> Photographs, videotapes	<input type="checkbox"/> X-Ray reports	<input type="checkbox"/> Immunization Records
<input type="checkbox"/> Other, (specify) _____		

Purpose of the Requested Disclosure of Protected Health Information

I am authorizing the release of my Protected Health Information for the following purposes (e.g. a purpose may be at the request of the individual):

Drug and/or Alcohol Abuse and/or Psychiatric and/or HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, and/or other sensitive information, I agree to release. Check One: Yes No

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release. Check One: Yes No

(over)

Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, the authorization may be revoked at any time by submitting a written notice to the LWVH, Medical Records Department. Unless revoked, this authorization will expire on the following date, or after the following time period or event (date): _____

Re-disclosure

I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

Acknowledgement of Authorization

I understand that I do not have to sign this authorization. My treatment or payment for services will not be denied if I do not sign this form. However, if health care services are being provided to me for the purpose of providing information to a third-party, I understand that services may be denied if I do not authorize the release of information related to such health care services to the third party. I can inspect or copy the Protected Health Information to be used or disclosed. I hereby release and discharge the LWVH of any liability and the undersigned will hold LWVH harmless for complying with the LWVH authorization.

Printed Name of Resident

Resident/Authorized Representative's Signature

Date

Relationship

Witness

Date

THE FOLLOWING DOCUMENTS ARE NEEDED
TO PROCESS YOUR ADMISSIONS REQUEST.
FAILURE TO PROVIDE THIS INFORMATION
COULD DELAY YOUR APPLICATION:

1. Most recent IRS form;
2. Most recent, complete bank statement;
3. Confirmation of:
 - Social Security Check
 - VA Pension Check
 - Retirement Check
 - Any other income
4. Copies of (never give out your originals):
 - A. Medicare card
 - B. Any other insurance card
 - D. Power of Attorney (if possess one)
 - E. Living Will (if possess one)

Thank you. April Fontenot, MSW, LCSW
Admissions Coordinator

NOTE

The first section of this packet (Forms 202-206) should be completed and mailed to me ASAP to ensure placement on our waiting list. Please ensure that every question and blank is completed. Failure to complete each question or to provide the documents needed (such as bank statements, DD 214, copies of Medicare and medical insurance cards, etc.) could slow the admission process for you.

As soon as possible, we will be calling you to complete the following two documents.

1. THE 224 MEDICAL FORM THAT MUST BE COMPLETED BY A MEDICAL DOCTOR OR LICENSED NURSE 30 DAYS PRIOR TO ADMISSIONS;
2. THE 607 RELEASE OF INFORMATION FORM THAT ALSO MUST BE COMPLETED WITHIN 30 DAYS OF ADMISSION.

The Form 224 (medical form) will need an updated (within 30 days) x-ray. I need only the written results of the x-ray and not the actual film(s).

When you have completed Forms 224 and 607, please mail or fax to me at (985) 479-4090.

If you have any questions, please feel free to call, April Fontenot, MSW, LCSW, Director of Social Services/Admissions at: 985-479-4080.