Arkansas State Veterans Home at Fayetteville

1179 N. College Avenue, Fayetteville, AR 72703
Phone: (479) 444-7001 | Fax: (479) 695-0184

Asa Hutchinson
Governor

Matt Snead
Director

Dear Applicant or Family Member:

We appreciate your interest in placing yourself or a family member in the Arkansas Veterans Home at Fayetteville. General information to assist in making the difficult decision of nursing home placement is listed below.

Cost of Services:

1. If you have a Service Connected Disability (SCD) at 60%, and rated unemployable, or 70% or more, it is possible that the Veterans Administration (VA) would pay for your stay at the Arkansas Veterans Home.
2. The cost per day for a semi-private room is: $130.00 and a private room is: $145.00.
3. If you are not SCD and do not have the financial resources to pay privately, we will help you apply for long term care under the Arkansas Medicaid program.
4. Long Term Care insurance policies are also accepted.
5. If qualified, Medicare Part A could pay for a short term rehabilitation stay.

Medication: Your medication will be billed separately to you, or your responsible party, or your prescription drug insurance carrier from a pharmacy with whom the facility is contracted. Only Veterans already on VA Aid and Attendance compensation can continue to obtain their medication through the VA system. The State Medicaid program pays for medications for all residents receiving nursing home Medicaid.

The use of tobacco products are not allowed inside the facility. However, we do allow smoking in the designated area (outside) on the ground floor. There are designated times when staff will assist you. Family members may take residents to smoke at any time during their visit(s). Smoking products and lighters are kept in a secure area. They are not allowed in residents rooms.

If you have any questions or need assistance, please call us at (479) 444-7001. We invite you to come by for a tour at your convenience.

Sincerely,

Martin C. (Kriss) Schaffer, RN
Administrator

Application Instructions:

The following documents are required for admission to the Arkansas Veterans Home at Fayetteville.

1. A Government Issued DD-214, or separation records showing an Honorable Discharge with entry and separation dates.

2. Social Security, Medicare, Medicaid, Veterans Administration, and any current insurance card (front and back of all cards).

3. A completed, dated, and signed application for admission. If there is something you do not know, leave blank and submit what you do know.

4. A Release of Information (ROI) form(s). There are two (2) of them. The facility ROI form needs to be signed and dated at the bottom only. If you have medical records at the VA, sign and date the bottom of the VA form. You may have a VA and private physician, so both would be needed. If the Veteran does not or is unable to sign the ROI forms, we must have the Healthcare Power of Attorney sign them and return a copy of the Healthcare Power of Attorney to be submitted with the Release of Information (ROI) forms.

5. For spouses of Veterans – send a copy of your Marriage license along with all other items listed in 1 –4.

6. If you have a Service Connected Disability (SCD) rating, please send written verification from the VA showing the percentage of the disability rating.

Application for Admission to Arkansas Veterans Home at Fayetteville

Name:_____

Current Address:_____

City:_____State:_____Zip:_____

Phone Number:_____

Religious Preference:_____

What was your Occupation:_____

Father's Name:_____

Mother's Maiden Name:_____

Funeral Home Choice:_____

If you have a service connected disability, what percent?_____

Do you receive Aid and Attendance? ___yes ___no

Do you have a Living Will? ___yes ___no P.O.A? ___yes ___no

Do you have a power of attorney for health care decisions? ___yes ___no

Who will we talk with about this admission?

Name:_____

Address:_____

_____

Relation to Veteran_____Phone _____

Email address(optional):_____

Gender: ___M ___F

Age:____DOB:_____

Marital Status:_____

_____
Place of Birth

___I am a Veteran
___I am the Spouse of a Veteran
___I am a Gold Star Parent

_____
Social Security #

_____
Medicare #

_____
Other Insurance

Do you have your DD-214?
___yes ___no

Branch of Service:
_____

Dates of Service:
_____

Attach a copy of the front & back of all insurance cards along with the Veterans DD-214/Discharge Papers & copy of marriage License if you are the Spouse of a Veteran.

Last eye exam was _____by_____
Last dental visit was _____by_____
Last hearing test was _____by_____

Have you been admitted to a hospital in the last year or currently in the hospital? ___yes ___no
Dates:_____
Where?_____ why?_____

Answer the following by checking all the boxes that apply to you:
___ostomy ___trachostomy ___catheter ___cannot communicate needs ___problem hearing
___can bath self ___can get in/out of bed by self ___need total help ___can walk alone ___cannot walk
___toilet myself ___need help going to toilet ___incontinent ___dress myself
___someone has to dress me ___limited vision ___blind ___confused ___knows self ___knows family
___knows date ___knows time ___knows where I am ___agreeable ___disruptive at times
___wanderer ___wound/skin problem ___special diet ___use oxygen
Other information you want to share (use wheelchair, cane, walker, trapeze bar, wound care explain , special diet explain, etc.): _____
_____

Current Height:_____ **Current Weight**:_____

We will need to send for Medical Records. Please supply the following info for that purpose:
Your primary doctor is: VA team #:_____**OR** Other Physician:_____

Application for Admission to Arkansas Veterans Home at Fayetteville

Current living situation: ___at home with no help ___at home with help
___in the hospital at _____
___in assisted living at _____
___in a nursing home at _____
If you are in a nursing home do you pay: ___as a private pay resident
___as a medicaid resident
___as a Medicare resident under Part A
___other, explain:_____

In this calendar year, have you lived in any other nursing facility? If so, provide name:
Name of Facility:_____
Name of Facility: _____

FINANCIAL INFORMATION SECTION:

_____I know I will be private pay/VA per diem. If so, you do not need to give any financial information.
(check if applicable and skip this section)

Please list the gross monthly income.

	VA Benefits	Social Security	Military Ret Pay	Civil Service	Interest	Dividends	Wages	Railroad Ret	Other Income
Veteran									
Spouse									

Please list all assets (home, automobiles, bonds, CDs, saving /checking accounts), **in order to determine eligibility for VA benefits and assessment of charges.**

Description of Asset: _____Location:_____
Owner(s):_____Present Value:_____

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Description of Asset: _____Location:_____

Return the required forms and requested copies to: **Arkansas Veterans Home at Fayetteville**
1179 N. College Ave
Fayetteville AR 72703 or bring to the facility

CHECK ONE: ____I am **ready to move** to the nursing home now **OR** ____I am just placing my name for the future

I certify that I have read and understand the information provided on this form and that the above answers are true and correct to the best of my knowledge and belief.

Applicant:_____**Date:**_____

RELEASE OF INFORMATION FOR ARKANSAS VETERANS HOME AT FAYETTEVILLE

This section to be completed by nursing home only:

To:_____Phone: _____

(Name of hospital, physician, facility or other)

_____

(Address of hospital, physician, facility, or other)

****

Medical Information to be used in considering applicant for placement

This section to be completed by applicant/power of attorney

Name:_____SSN:_____-_____-_____

DOB_____ Sex: _____M _____F

I request authorize the release of medical information to include:

☐ Medication and therapies

☐ Advance directive, durable power of attorney, DNR, Living Will

☐ Last hospital discharge summary (if within the last six months)

☐ Outpatient treatment notes

☐ Drug screens/substance abuse

☐ Alcoholism or alcohol abuse

☐ T.B. skin test

☐ Medical history and diagnosis from last six months

☐ Nursing assessments for last six months

☐ Infection with human immunodeficiency virus (HIV/AIDS)

☐ Current pharmacy profile

☐ MDS/careplans

☐ Other:_____

Send the requested information to: Arkansas Veterans Home at Fayetteville, 1179 N. College, Fayetteville AR 72703

Phone: 479-444-7001 Fax: 479-695-0184

Authorization: I certify that this request has been made freely, voluntarily, and without coercion. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken. Disclosure of my medical record by those receiving the above authorized information may not be accomplished without my further written consent.

_____ _____

Resident or Responsible Party Date

****

For releasing agent use only

Content of material released

Date released: _____ Released by:_____

NOTE: This Form is only valid for a 90 day period from date of signature

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA10P2 "Patient Medical Record - VA" and in accordance with the Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect 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. 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 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

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

Arkansas Veterans Home at Fayetteville
1179 N. College Ave. Fayetteville, AR 72703

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☐ OTHER (Specify)

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

DATE (mm/dd/yyyy)

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED

RELEASED BY