



## 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,

Jay Green  
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

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|   |              |   |
|---|--------------|---|
| Name: _____   |              | Gender: <input type="checkbox"/> M <input type="checkbox"/> F   |
| Current Address: _____  |              | Age: _____ DOB: _____   |
| City: _____   | State: _____ | Zip: _____  |
| Phone Number: _____   |              | Marital Status: _____   |
| Religious Preference: _____   |              | Place of Birth _____  |
| What was your Occupation: _____   |              | <input type="checkbox"/> I am a Veteran   |
| Father's Name: _____  |              | <input type="checkbox"/> I am the Spouse of a Veteran   |
| Mother's Maiden Name: _____   |              | <input type="checkbox"/> I am a Gold Star Parent  |
| Funeral Home Choice: _____  |              | Social Security # _____   |
| If you have a service connected disability, what percent? _____   |              | Medicare # _____  |
| Do you receive Aid and Attendance? <input type="checkbox"/> yes <input type="checkbox"/> no   |              | Other Insurance _____   |
| Do you have a Living Will? <input type="checkbox"/> yes <input type="checkbox"/> no P.O.A? <input type="checkbox"/> yes <input type="checkbox"/> no   |              | Do you have your DD-214? <input type="checkbox"/> yes <input type="checkbox"/> no   |
| Do you have a power of attorney for health care decisions? <input type="checkbox"/> yes <input type="checkbox"/> no   |              | Branch of Service: _____  |
| Who will we talk with about this admission?   |              | Dates of Service: _____   |
| Name: _____   |              | <b>*Attach a copy of the front &amp; back of all insurance cards along with the Veterans DD-214/Discharge Papers &amp; copy of marriage License if you are the Spouse of a Veteran.</b> |
| Address: _____  |              |   |
| Relation to Veteran _____ Phone _____   |              |   |
| Email address(optional): _____  |              |   |
| 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? <input type="checkbox"/> yes <input type="checkbox"/> no  |              |   |
| Dates: _____  |              |   |
| Where? _____ why? _____   |              |   |
| Answer the following by checking all the boxes that apply to you:   |              |   |
| <input type="checkbox"/> ostomy <input type="checkbox"/> trachostomy <input type="checkbox"/> catheter <input type="checkbox"/> cannot communicate needs <input type="checkbox"/> problem hearing                                   |              |   |
| <input type="checkbox"/> can bath self <input type="checkbox"/> can get in/out of bed by self <input type="checkbox"/> need total help <input type="checkbox"/> can walk alone <input type="checkbox"/> cannot walk                 |              |   |
| <input type="checkbox"/> toilet myself <input type="checkbox"/> need help going to toilet <input type="checkbox"/> incontinent <input type="checkbox"/> dress myself  |              |   |
| <input type="checkbox"/> someone has to dress me <input type="checkbox"/> limited vision <input type="checkbox"/> blind <input type="checkbox"/> confused <input type="checkbox"/> knows self <input type="checkbox"/> knows family |              |   |
| <input type="checkbox"/> knows date <input type="checkbox"/> knows time <input type="checkbox"/> knows where I am <input type="checkbox"/> agreeable <input type="checkbox"/> disruptive at times                                   |              |   |
| <input type="checkbox"/> wanderer <input type="checkbox"/> wound/skin problem <input type="checkbox"/> special diet <input type="checkbox"/> 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

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

Description of Asset: \_\_\_\_\_ Location: \_\_\_\_\_  
 Owner(s): \_\_\_\_\_ Present Value: \_\_\_\_\_

Description of Asset: \_\_\_\_\_ Location: \_\_\_\_\_  
 Owner(s): \_\_\_\_\_ Present Value: \_\_\_\_\_

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



## 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)<br><br><input style="width: 100%; height: 40px;" type="text"/> | PATIENT NAME (Last, First, Middle Initial)<br><br><input style="width: 100%; height: 20px;" type="text"/><br><br>SOCIAL SECURITY NUMBER<br><br><input style="width: 100%; height: 20px;" type="text"/> |
|--|--|

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

**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. Rediscovery 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) |
| <input style="width: 100%; height: 20px;" type="text"/> | <input style="width: 100%; height: 20px;" type="text"/>   |

**FOR VA USE ONLY**

|  |  |
|--|--|
| IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number) | TYPE AND EXTENT OF MATERIAL RELEASED<br><br><br><br>DATE RELEASED                      RELEASED BY |
|--|--|