Arkansas State Veterans Home at Fayetteville
1179 N. College Avenue, Fayetteville, AR 72703
Phone: (479) 444-7001 I Fax: (479)695-0184

ASA HUTCHINSON
Governor

ADVAcates for Arkansas Veterans
NATHANIEL (NATE) TODD
Secretary

Dear Applicant or Family Member:

We appreciate your interest in placing yourself or loved one in the Arkansas Veterans Home at Fayetteville. Below is some general information.

Who can apply:

- Veteran with an Honorable or general discharge from the military
- Spouse of veteran
- Gold Star parents

Cost of Services:

1. If you have a Service Connected Disability rated through the VA at 60% and unemployable OR rated at 70% or higher, it is possible that the Veterans Administration will pay for your stay here. Please provide that rating letter to us when you send in the completed application packet.
2. The cost per day for a semi-private room is 85% of the current Medicaid rate. Private rooms incur a $15 addition and for deluxe private rooms a $25 addition.
   Please contact for exact pricing.
3. If you are not a service connected disabled veteran nor have the financial resources to pay, we can help you apply for long term care support under the Arkansas Medicaid Program.
4. We do accept long term care insurance policies. Please provide that with your application packet, if applicable.
5. Medicare Part A could also pay for short term rehabilitation, if you qualify

Medication:

Your medication will be billed separately to you.

Smoking:

The use of tobacco products are not allowed inside the facility. However, we do allow smoking in designated area outside on the ground floor.

Call for more information on these criteria.

If you have any questions or need assistance, please call (479) 444-7001. You are welcome to come by for a tour during regular business hours, Monday - Friday, no appointment needed.

NATHANIEL (NATE) TODD
Secretary

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1179 N. College Avenue, Fayetteville, AR 72703
Phone: (479) 444-7001 I Fax: (479)695-0184
FVH@arkansas.gov

ADVAcates for Arkansas Veterans
BUSTER MCCALL
Administrator

Application Instructions:

Please provide the following documentation along with completed application. These are required for consideration for admission to the Veterans Home. Application packet is considered incomplete if items are missing or not signed.

- ☐ Complete, **date**, and sign ALL forms within the application.
- ☐ A documented visit with your primary care doctor within 30 days of admission may be required to ensure our nursing team can meet all medical needs unless coming directly from a hospital or long term care facility
- ☐ Submit a government issued DD-214 or separation records showing a **Honorable Discharge** with entry and separation dates. *If unable to locate, please contact us and we may be able to assist.*
- ☐ Submit Social Security card, Medicare, Medicaid, Veterans Administration and any other current insurance cards (copy of the front and back of all cards)
- ☐ Signed copy for release of information (ROI) forms. There are **TWO** of them in the admission packet. One is the facility ROI, please sign and date it. The other is an ROI VA form. Please sign if you have medical records from the VA. *If applicant is unable to sign, the Healthcare Power of Attorney must sign the form.*
- ☐ Power of attorney documents or Guardianship documents. (*if applicable*)
- ☐ For spouses of veteran - please include a copy of your marriage license
- ☐ If you have a service connected disability rated through the VA, include written verification.
- ☐ **Mail** or *fax* signed copy of VA release form 10-5245 to: 1179 N. College Avenue, Fayetteville, AR 72703 , (479) 695-0184

Application for Admission to the Arkansas Veterans Home at Fayetteville

1179 N. College Avenue, Fayetteville, AR 72703 | (479) 444-7001 | FVH@arkansas.gov

Name:_____ **DOB**:_____ **Age**:_____

☐I am a veteran ☐I am the spouse of a veteran ☐I am a Gold Star Parent of a veteran

Seeking: ◯ **Long Term Care** or ◯ **Short - Term Rehabilitation**

Phone Number:_____ **Gender**:_MALE_____ **Marital Status**:_____

_____

Permanent Address **City** **State** **Zip**

*Current Residence: ☐In Hospital ☐Nursing Home ☐Assisted Living Facility ☐Permanent Address

Name of facility/hospital: _____

Place of Birth:_____ Primary Language:_____ Ethnicity: _____

***Social Security Number**: _____ _____ _____

Medicare#:_____ Other insurance: _____

Branch of Service:_____ Dates of service:_____

Do you have your DD214: ☐**Yes** ☐**No** Do you receive Aid & Attendance? ☐**Yes** ☐**No**

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

Do you have a Power of Attorney? ☐YES ☐NO Do you have a guardian? ☐YES ☐NO

Do you wish to be contacted by a veteran services officer regarding services connected disability or VA pension to help pay for long term care? ☐YES ☐NO

Who should we talk to about this admission (*if applicant is unable*)? Name:_____

Relation:_____ Phone number:_____

Email: _____

Who is your current primary care doctor?_____ Location:_____

Have you been seen by a primary care doctor in the last 30 days? ☐YES ☐NO

Have you been admitted to the hospital in the past 6 months or currently in the hospital? ☐YES ☐NO

Dates:_____ Hospital name:_____ Location:_____

Reason:_____

***Funeral Home Choice**: _____ Phone Number: _____

_____

Address City State Zip

How did you hear about us?

☐ Referred by:_____ ☐ Facebook ☐ veterans.arkansas.gov ☐ Other: _____

Financial Information for Admission to the Arkansas Veterans Home at Fayetteville

1179 N. College Avenue, Fayetteville, AR 72703 | (479) 444-7001 | FVH@arkansas.gov

_____ I know that I will be private pay/VA per diem. If so, you do not need to give financial information below

Please list the gross monthly income:

	VA Benefits	Social Security	Military Retired Pay	Civil Service	Interest	Dividends	Wages	R R Ret	Other: _____
Veteran	$	$	$	$	$	$	$	$	$
Spouse	$	$	$	$	$	$	$	$	$

Please list all assets (home, auto, bonds, CDs, savings/checking accounts, life insurance policies etc.) to determine eligibility for VA benefits and assessment of charges:

1. Description of Asset: _____ Location: _____
   Owner: _____ Present Value: _____
2. Description of Asset: _____ Location: _____
   Owner: _____ Present Value: _____
3. Description of Asset: _____ Location: _____
   Owner: _____ Present Value: _____
4. Description of Asset: _____ Location: _____
   Owner: _____ Present Value: _____

Other: _____

Return signed application, DD214, copy of ID, Medicare and insurance cards and releases of information to:

Arkansas Veterans Home at Fayetteville
1179 North College Ave
Fayetteville AR 72703

Or email to: FVH@arkansas.gov

Or fax to: **479-695-0184**

Please check one: ☐ I am ready to move now OR ☐ I want to move in: _____

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

Signature: _____ Date: _____

Check one of the following: ☐ I am the applicant ☐ I am a representative for the applicant

Criteria for Admission to the Arkansas Veterans Home at Fayetteville

1179 N. College Avenue, Fayetteville, AR 72703 | (479) 444-7001 | FVH@arkansas.gov

SKILLED NURSING HOME LEVEL OF CARE

Besides being an honorably discharged veteran, spouse, or Gold Star Parent, to be eligible for admission to the Arkansas Veterans Home at Fayetteville, you MUST meet the skilled care requirements of Medicaid/Medicare in **AT LEAST TWO** of the Katz Index listed below. You must answer **YES** to at least **TWO** of the following:

Katz Index of Independence in Activities of Daily Living

Activity of Daily Living	Response	Dependence WITH supervision, direction, personal assistance or total care.
Bathing	☐ YES ☐NO	Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing
Dressing	☐ YES ☐NO	Needs help with dressing self or needs to be completely dressed.
Toileting	☐ YES ☐NO	Needs help transferring to the toilet, cleaning self or uses bed an or commode.
Transferring	☐ YES ☐NO	Needs help in moving from bed to chair or requires a complete transfer.
Continence	☐ YES ☐NO	Is partially or totally incontinent of bowel or bladder
Feeding	☐ YES ☐NO	Needs partial or total help with feeding or requires parenteral feeding
Eating	☐ YES ☐NO	Have trouble chewing or swallowing solid food or thin liquid

Services provided by our skilled nursing facility include:

- services that are needed temporarily due to an injury or illness
- post-operative wound care, dispensing and monitoring intravenous medications
- physical therapy to help correct strength and balance issues
- speech therapy to assist residents in reclaiming their ability to communicate following a stroke
- occupational therapy to help residents to become independent again, particularly when it comes to dressing, personal hygiene and eating
- pharmaceutical, laboratory and radiology services
- social and educational activities

Release of Information to the Arkansas Veterans Home at Fayetteville

1179 N. College Avenue, Fayetteville, AR 72703 | (479) 444-7001 | FVH@arkansas.gov

This section to be completed by ASVH-Fayetteville only:

To:_____ Phone:_____

Name of hospital, facility or other Physician

_____

Address City State Zip

This section to be completed by applicant/power of attorney

Medical Information to be used in considering applicant for placement:

Name_____ SSN:_____

DOB: _____ Gender: MALE

I 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 screen/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/Care Plans
- ☐ 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: _____

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPER WORK REDUCTION 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 Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is 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 the instructions, gather the necessary facts and fill out this form. 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 the last four of your Social Security Number (SSN) and Date of Birth (used to locate records for release) is not furnished completely and accurately, VA 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 system of records notices identified as 24VA10P2 "Patient Medical Record – VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Address of VA Health Care Facility)*

LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

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

Arkansas State Veterans Home Fayetteville

1179 N. College Ave. Fayetteville, AR 72703

PURPOSE(S) OR NEED: Information is to be used by the individual for:

☐ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ EMPLOYMENT ☐ OTHER *(Please specify)* _____

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

☐ HEALTH SUMMARY *(Prior 2 Years)*

☐ INPATIENT DISCHARGE SUMMARY *(Dates)*: _____

☐ PROGRESS NOTES:

- ☐ SPECIFIC CLINICS *(Name & Date Range)*: _____
- ☐ SPECIFIC PROVIDERS *(Name & Date Range)*: _____
- ☐ DATE RANGE: _____

☐ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: _____

☐ LAB RESULTS:

- ☐ SPECIFIC TESTS *(Name & Date)*: _____
- ☐ DATE RANGE: _____

☐ RADIOLOGY REPORTS *(Name & Date)*: _____

☐ LIST OF ACTIVE MEDICATIONS: _____

☐ FLU VACCINATION *(Dose, Lot Number, Date & Location)*: _____

_____

☐ OTHER *(Describe)*: _____

LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

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 records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider'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.

EXPIRATION: Without my express revocation, the authorization will automatically expire.

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON _____ *(enter a future date other than date signed by patient)*

☐ UNDER THE FOLLOWING CONDITION(S): _____

_____

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
LEGAL REPRESENTATIVE SIGNATURE *(if applicable)* *(Sign in ink)*	DATE *(mm/dd/yyyy)*

PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED	RELEASED BY:

Department of Veterans Affairs

INSTRUCTIONS FOR COMPLETING ENROLLMENT APPLICATION FOR HEALTH BENEFITS

Please Read Before You Start . . . What is VA Form 10-10EZ used for?

For Veterans to apply for enrollment in the VA health care system. The information provided on this form will be used by VA to determine your eligibility for medical benefits and on average will take 30 minutes to complete. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Where can I get help filling out the form and if I have questions?

You may use ANY of the following to request assistance:

- Ask VA to help you fill out the form by calling us at 1-877-222-VETS (8387).
- Access VA's website at http://www.va.gov and select "Contact the VA."
- Contact the Enrollment Coordinator at your local VA health care facility.
- Contact a National or State Veterans Service Organization.

Definitions of terms used on this form:

SERVICE-CONNECTED (SC): A VA determination that an illness or injury was incurred or aggravated in the line of duty, in the active military, naval or air service.

COMPENSABLE: A VA determination that a service-connected disability is severe enough to warrant monetary compensation.

NONCOMPENSABLE: A VA determination that a service-connected disability is not severe enough to warrant monetary compensation.

NONSERVICE-CONNECTED (NSC): A Veteran who does not have a VA determined service-related condition.

Getting Started: ALL VETERANS MUST COMPLETE SECTIONS I - III.

Directions for Sections I - III:

Section I - General Information: Answer all questions.

Section II - Military Service Information: If you are not currently receiving benefits from VA, you may attach a copy of your discharge or separation papers from the military (such as DD-214 or, for WWII Veterans, a "WD" Form), with your signed application to expedite processing of your application. If you are currently receiving benefits from VA, we will cross-reference your information with VA data.

Section III - Insurance Information: Include information for all health insurance companies that cover you, this includes coverage provided through a spouse or significant other. Bring your insurance cards, Medicare and/or Medicaid card with you to each health care appointment.

Directions for Sections IV-VI:

Financial Disclosure: ONLY NSC AND 0% NONCOMPENSABLE SC VETERANS MUST COMPLETE THIS SECTION TO DETERMINE ELIGIBILITY AND COPAY RESPONSIBILITY FOR VA HEALTH CARE ENROLLMENT AND/OR CARE OR SERVICES.

Financial Disclosure Requirements Do Not Apply To:

- a former Prisoner of War; or
- those in receipt of a Purple Heart; or
- a recently discharged Combat Veteran; or
- those discharged for a disability incurred or aggravated in the line of duty; or
- those receiving VA SC disability compensation; or
- those receiving VA pension; or
- those in receipt of Medicaid benefits; or
- those who served in Vietnam between January 9, 1962 and May 7, 1975; or
- those who served in SW Asia during the Gulf War between August 2, 1990 and November 11, 1998; or
- those who served at least 30 days at Camp Lejeune between August 1, 1953 and December 31, 1987.

You are not required to disclose your financial information; however, VA is not currently enrolling new applicants who decline to provide their financial information unless they have other qualifying eligibility factors. If a financial assessment is not used to determine your priority for enrollment you may choose not to disclose your information. However, if a financial assessment is used to determine your eligibility for cost-free medication, travel assistance or waiver of the travel deductible, and you do not disclose your financial information, you will not be eligible for these benefits.

Continued ...

Section IV - Dependent Information: Include the following:

- Your spouse even if you did not live together, as long as you contributed support last calendar year.
- Your biological children, adopted children, and stepchildren who are unmarried and under the age of 18, or at least 18 but under 23 and attending high school, college or vocational school (full or part-time), or became permanently unable to support themselves before age 18.
- Child support contributions. Contributions can include tuition or clothing payments or payments of medical bills.

Section V - Previous Calendar Year Gross Annual Income of Veteran, Spouse and Dependent Children.

Report:

- Gross annual income from employment, except for income from your farm, ranch, property or business. Include your wages, bonuses, tips, severance pay and other accrued benefits and your child's income information if it could have been used to pay your household expenses.
- Net income from your farm, ranch, property, or business.
- Other income amounts, including retirement and pension income, Social Security Retirement and Social Security Disability income, compensation benefits such as VA disability, unemployment, Workers and black lung, cash gifts, interest and dividends, including tax exempt earnings and distributions from Individual Retirement Accounts (IRAs) or annuities.

Do Not Report:

Donations from public or private relief, welfare or charitable organizations; Supplemental Security Income (SSI)and need-based payments from a government agency; profit from the occasional sale of property; income tax refunds, reinvested interest on Individual Retirement Accounts (IRAs); scholarships and grants for school attendance; disaster relief payments; reimbursement for casualty loss; loans; Radiation Compensation Exposure Act payments; Agent Orange settlement payments; Alaska Native Claims Settlement Acts Income, payments to foster parent; amounts in joint accounts in banks and similar institutions acquired by reason of death of the other joint owner; Japanese ancestry restitution under Public Law 100-383; cash surrender value of life insurance; lump-sum proceeds of life insurance policy on a Veteran; and payments received under the Medicare transitional assistance program.

Section VI - Previous Calendar Year Deductible Expenses.

Report non-reimbursed medical expenses paid by you or your spouse. Include expenses for medical and dental care, drugs, eyeglasses, Medicare, medical insurance premiums and other health care expenses paid by you for dependents and persons for whom you have a legal or moral obligation to support. Do not list expenses if you expect to receive reimbursement from insurance or other sources. Report last illness and burial expenses, e.g., prepaid burial, paid by the Veteran for spouse or dependent(s).

Section VII - Submitting your application.

1. You or an individual to whom you have delegated your Power of Attorney must sign and date the form. If you sign with an "X", 2 people you know must witness you as you sign. They must sign the form and print their names. If the form is not signed and dated appropriately, VA will return it for you to complete.
2. Attach any continuation sheets, a copy of supporting materials and your Power of Attorney documents to your application.

Where do I send my application?

Mail the original application and supporting materials to the Health Eligibility Center, 2957 Clairmont Road, Suite 200 Atlanta, GA 30329.

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 30 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 from initial submission forward 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.

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) (Include area code)*

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** _____