Department of Veterans Services
6880 S. McCarran Blvd, Bldg A –Ste 12
Reno, Nevada 89509
(775) 688-1653 • Fax (775) 688-1656

BRIAN SANDOVAL
Governor

ATD-817

Department of Veterans Services
6900 N. Pecos Road, Room 1C238
North Las Vegas, Nevada 89086
(702) 224-6025 • Fax (702) 224-6927

Northern Nevada
Veterans Memorial Cemetery
P.O. Box 1919
Fernley, Nevada 89408
(775) 575-4441 • Fax (775) 575-5713

STATE OF NEVADA
NEVADA STATE VETERANS HOME
100 Veterans Memorial Drive
Boulder City, Nevada 89005
(702) 332-6784 • Fax (702) 332-6762

Southern Nevada
Veterans Memorial Cemetery
1900 Veterans Memorial Drive
Boulder City, Nevada 89005
(702) 486-5920 • Fax (702) 486-5923

Dear Applicant, Family Member or Family Representative,

Please find attached an application for admission to our facility.

In order for us to process your application, it is important to return all the requested items as indicated on the enclosed checklist as quickly and completely as possible. This includes Power of Attorney documents, if applicable. The MD Certification and attached medication list requires the primary care provider to complete and sign.

***** Please note that we do not admit on a "first come-first served" basis. *****

There are multiple criteria for admission, including but not limited to: resident needs, bed availability, completed information as requested, medical and financial review and approval. We cannot hold or reserve a bed or room assignment.

Admission Eligibility:

- Veteran having 90 days active military service with discharge other than dishonorable
- Spouse of a qualifying veteran
- Gold-Star parents
- Currently deemed medically appropriate for a 24-hour skilled nursing facility or inpatient rehabilitation
- Qualified, verifiable pay source

Admission Prohibitions:

- Untreated psychiatric disease
- Active tuberculosis
- Requires IV narcotics*
  Requires the use of an external CADD Pump (continuous ambulatory delivery device for medication)*
- Requires the use of a ventilator/tracheotomy
- Requires dialysis

- Documented or stated combative or aggressive behaviors *
- Requirement of day to day care beyond that which is available at the facility (e.g., one-to-one (1:1) nursing care)
- Active infections requiring isolation
- Mental Disorder*
- Intellectual Disability*
- Total Parenteral Nutrition (TPN)
- Using marijuana in any form, including medically prescribed marijuana
- Other required care that the facility is unable to provide

*Administrator may make exceptions on a case-by-case basis

Nevada State Veterans Home will follow all application and admissions policies/regulations in place in order to provide the best care for our veterans and/or their spouses. The facility reserves the right to decline the admission of any applicant.

Please return the application with all the requested documentation via one of the following methods:

Mail: Nevada State Veterans Home-Boulder City
Attn: Admissions Department
100 Veterans Memorial Drive
Boulder City, NV 89005

Email: admissions@veterans.nv.gov

Fax: 702-332-6771

Please call 702-332-6730 with any questions.

Thank you for your interest in the Nevada State Veterans Home in Boulder City.

Nevada State Veterans Home
Pricing List for Residency

Resident Type:	Veteran	Spouse	Gold Star Parent
Per day - Semi Private Room:	$125.00	$187.00	$187.00
Per Day - Private Room:	$150.00	$212.00	$212.00
Per Month - Semi Private Room:	$3,875.00 *First Month's Rent due upon admission*	$5,797.00 *First Month's Rent due upon admission*	$5,797.00 *First Month's Rent due upon admission*
Per Month - Private Room:	$4,650.00 First Month's Rent due upon admission	$6,572.00 First Month's Rent due upon admission	$6,572.00 First Month's Rent due upon admission

Some residents may be eligible for VA benefits, Medicaid, Medicare, military retirement, and/or Social Security. Veterans with a service connected disability of 70% or higher may qualify for VA assistance with paying for their care. Assistance for low income applicants may be available through Medicaid and/or VA. To obtain an application and information regarding Medicaid, please call (800) 992-0900 or visit dwss.nv.gov. You may also contact our admission office at the number listed below. For VA benefits, please contact your local veterans Services Representative at (702) 791-9000.

NSVH Admissions Office

Tel: (702) 332-6730
Fax: (702) 332-6771

Monthly rate is based on a 31 day calendar month. Pricing does not include cost of medications, physician visits, supplies, and additional ancillary charges. A list of charges will be provided by the admissions office.

Above rates effective January 1, 2016 and subject to change

NEVADA STATE VETERANS HOME
Checklist for Applicants

Thank you for your interest in Nevada State Veterans Home (NSVH). Before an applicant can be considered for admission to our Home we must receive the following documentation:

General

- ☐ Completed Application for Admission (pages 1-4)
- ☐ Provider's Medical Certification for Skilled Nursing Facility Placement & Behavioral & Psychiatric History (pages 5-8) (Note: Must be completed by your medical provider)
- ☐ Proof of Income: Bank Statements,(for Previous 3 months) Tax Returns, etc. (For the previous three years)
- ☐ Guardianship Papers (if applicable)
- ☐ Durable Power of Attorney for Health and Finance (if applicable)
- ☐ Framed 8" x 10" Picture of Resident (if available)
- ☐ Physician's Order for Life Sustaining Treatment (POLST form)

Military

- ☐ Proof of Military Service: Record of Separation, DD-214
- ☐ VA Form 10-10EZ
- ☐ Service Connected Disability Rating Award Letter (if applicable)
- ☐ Aid & Attendance Award Letter (if applicable)

Identification and Insurance Information

- ☐ Health Insurance Cards: Medicare, Medicaid, Private Insurance
- ☐ Medicare Part D Information
- ☐ Identification Cards: Social Security, Driver's License, State ID, etc.

Medical Information

- ☐ Immunization history (Tuberculosis screening, Flu vaccine, Pneumonia vaccine)
- ☐ Chest X-ray showing negative for Tuberculosis (Note: Must have been done within 30 days prior to the planned admission to NSVH)
- ☐ Other: All medical records for the last two years.

Upon receipt of all items listed above, the applicant's file will be forwarded to the Admissions Review Committee, who will evaluate the application to determine if NSVH is able to provide the care required by the applicant. The Admissions Coordinator will contact the applicant to let them know of the Committee's decision, and, if appropriate, schedule a date and time for admission. This process can take as little as two, but no more than five business days.

Occasionally, the Admissions Review Committee will require additional information prior to rendering a decision. In these instances, the Admissions Coordinator will contact the applicant to let them know what information is needed. **If you have questions, please call the NSVH Admission Office at (702) 332-6730 or the main number, at (702) 332-6784.**

NEVADA STATE VETERANS HOME
Serving Nevada's Heroes

APPLICATION FOR ADMISSION

APPLICANT'S INFORMATION

Applicant is a: ☐ Veteran ☐ Spouse of Veteran ☐ Gold Star Parent

_____ _____ _____ _____
Last Name *First Name* *Middle Name* *Alias/Nickname*

_____ _____ ____/____/_____
Date of Birth *Place of Birth* *Social Security Number*

Gender: ☐ Male ☐ Female _____
Religious Preference

Home Address: _____

_____

Phone Numbers: (____)_____ (____)_____ (____)_____
Home *Cell* *Other*

Current Location: ☐ Home ☐ Assisted Living ☐ Nursing Home ☐ Hospital ☐ Other

Marital Status: ☐ Married ☐ Widowed ☐ Single ☐ Divorced ☐ Other

_____ _____
Spouse's Last Name *Spouse's First Name*

_____ ____/____/_____ _____
Spouse's Date of Birth *Spouse's Social Security #* *Date of Marriage*

APPLICANT'S OR SPOUSE'S MILITARY SERVICE INFORMATION

Branch of Service: _____ Service Number: _____

Entry Date: _____ Discharge Date: _____ Type of Discharge: _____

Were you a POW? ☐ Yes ☐ No Retired from Military? ☐ Yes ☐ No

Do you have a Service-Connected Disability? ☐ No ☐ Yes

If Yes: _____% and Reason(s) for disability

_____

_____

We must have copies of your rating decision and disability award letters.

Initial Date

EMERGENCY CONTACT INFORMATION

Primary Contact:

First & Last Name: _____

Relationship to Applicant: _____

Home Address: _____

Phone Number: (_____)_____ (_____)_____
Home *Cell/Other*

E-Mail Address: _____

Secondary Contact:

First & Last Name: _____

Relationship to Applicant: _____

Home Address: _____

Phone Number: (_____)_____ (_____)_____
Home *Cell/Other*

E-Mail Address: _____

ADDITIONAL INFORMATION

Do you/does the applicant have:

Medicare: ☐ No ☐ Yes, *Medicare #:* _____

Medicare Part D or Other Drug Plan ☐ No ☐ Yes, *Provider & #:* _____

Other Insurance: ☐ No ☐ Yes, *Provider & #:* _____

Prepaid Burial Plan: ☐ No ☐ Yes, *Name:* _____

Financial Power of Attorney: ☐ No ☐ Yes, *Name:* _____

Health Power of Attorney: ☐ No ☐ Yes, *Name:* _____

Advanced Directive/Living Will: ☐ No ☐ Yes

Court Ordered Guardian: ☐ No ☐ Yes, *Name:* _____

Revocable/Irrevocable Trust: ☐ No ☐ Yes

Initial Date

FINANCIAL INFORMATION

PLEASE PROVIDE SUPPORTING DOCUMENTATION FOR ALL INCOME AND ASSETS

MONTHLY INCOME:	*APPLICANT*	*SPOUSE*
Income from Farm/Ranch/Business:	$	$
Social Security Retirement/Disability:	$	$
Non Service-Connected VA Pension/A&A:	$	$
Service-Connected Disability Compensation:	$	$
Military Retirement Pay:	$	$
Retirement Income from Employer:	$	$
Civil Service Retirement Income:	$	$
U.S. Railroad Retirement Income:	$	$
Interest/Dividend (i.e. interest or standard dividend income from non tax deferred annuities):	$	$
Rental Income from Rental Property:	$	$
Real Estate Contract Held for Property Sold:	$	$
Other Income:	$	$
TOTAL MONTHLY INCOME:	$	$

TYPE OF ASSET:	*APPLICANT*	*SPOUSE*
Interest Bearing Checking/Savings Accounts:	$	$
Non-Interest Bearing Savings Account:	$	$
Life Insurance:	$	$
Interest in a Trust Fund:	$	$
Mutual Funds:	$	$
Stocks and Bonds:	$	$
Certificates of Deposits (CDs):	$	$
IRAs/Keoghs/401Ks:	$	$
Real Estate/Real Estate Contracts:	$	$
Other Assets:	$	$
TOTAL ASSETS:	$	$

Initial _____ Date _____

Has the applicant sold, transferred ownership, or gifted any property or financial assets in the last five (5) years? ☐ No ☐ Yes

Are you/is the applicant:

Capable of making informed decisions relative to their healthcare? ☐ No ☐ Yes

Capable of making informed decisions relative to their finances? ☐ No ☐ Yes

COMMENTS

_____

_____

_____

_____

_____

WITH MY SIGNATURE BELOW, I CERTIFY THE INFORMATION PROVIDED HEREIN IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF:

_____ _____

Signature Printed Name

_____ _____

Date Relationship to Applicant

Initial Date

NEVADA STATE VETERANS HOME
PROVIDER'S MEDICAL CERTIFICATION FOR SKILLED NURSING FACILITY PLACEMENT

THIS CERTIFICATION SHALL REMAIN VALID FOR THREE MONTHS.

APPLICANT NAME: _____

WHAT IS THE REASON THE APPLICANT REQUIRES 24-HOUR NURSING HOME CARE: _____

_____

_____

DATE OF BIRTH: _____/_____/_____ AGE: _____ MALE ☐ FEMALE ☐

ALLERGIES: _____ HEIGHT: _____ WEIGHT: _____

DIET: ☐ REGULAR ☐ NO ADDED SALT ☐ CONSISTENT CARBOHYDRATES

☐ LOW FAT/LOW CHOLESTEROL ☐ LOW POTASSIUM

TEXTURE: ☐ REGULAR ☐ MECHANICAL SOFT ☐ PUREE

☐ THICKENED LIQUIDS ☐ TUBE FEEDING – TYPE_____

OXYGEN: ☐ NO ☐ YES – LITERS PER MINUTE: _____ FREQUENCY: _____

TREATMENTS: ☐ PT ☐ OT ☐ ST ☐ WOUND CARE/DECUBS: _____

FOLSTEIN MINI MENTAL STATE EXAMINATION SCORE: _____ DATE: _____/_____/_____

MEMORY IMPAIRMENT: ☐ NONE ☐ MILD ☐ MODERATE ☐ SEVERE

COMMUNICATION ABILITY:

CAN SPEAK: ☐ NO ☐ YES UNDERSTAND SPEECH: ☐ NO ☐ YES
CAN HEAR: ☐ NO ☐ YES USES HEARING AIDE: ☐ NO ☐ YES

VISION: ☐ ADEQUATE ☐ MODERATELY IMPAIRED ☐ GLASSES ☐ SEVERELY IMPAIRED

HISTORY OF ALCOHOL USE: ☐ NO ☐ YES HISTORY OF DRUG USE: ☐ NO ☐ YES

HISTORY OF PSYCHIATRIC ILLNESS: ☐ NO ☐ YES, DIAGNOSIS: _____

CURRENT SMOKER: ☐ YES ☐ NO HISTORY OF SMOKING: ☐ YES ☐ NO

Initial Date

NEVADA STATE VETERANS HOME
PROVIDER'S MEDICAL CERTIFICATION FOR SKILLED NURSING FACILITY PLACEMENT

HISTORY OF FALLS: ☐ NO ☐ YES, DATE OF LAST FALL: ____/____/_____

IS APPLICANT AWARE OF HIS/HER MEDICAL CONDITION? ☐ NO ☐ YES

DOES APPLICANT REQUIRE A SECURED CARE AREA DUE TO WANDERING? ☐ NO ☐ YES

IS APPLICANT ABLE TO HANDLE HIS/HER OWN FINANCIAL/MEDICAL AFFAIRS? ☐ NO ☐ YES

LAST 2-STEP PPD/TB SKIN TEST DATE: ____/____/_____ RESULTS: _____

LAST FLU VACCINE DATE: ____/____/_____ LAST PNEUMOVAX DATE: ____/____/_____

CAN APPLICANT PARTICIPATE IN SUPERVISED OUTINGS? ☐ NO ☐ YES

EVALUATION OF CARE NEEDS:

BATHING:
☐ INDEPENDENT
☐ LIMITED ASSIST/CUEING
☐ TOTAL ASSIST

DRESSING:
☐ INDEPENDENT
☐ LIMITED ASSIST/CUEING
☐ TOTAL ASSIST

GROOMING:
☐ INDEPENDENT
☐ LIMITED ASSIST/CUEING
☐ TOTAL ASSIST

EATING:
☐ INDEPENDENT
☐ LIMITED ASSIST
☐ FULL ASSISTANCE
☐ SWALLOWING DISORDER

TRANSFER:
☐ INDEPENDENT
☐ DEPENDENT
☐ #____ PERSON ASSIST

TOILETING:
☐ CONTINENT
☐ INCONTINENT
☐ FOLEY CATHETER

AMBULATION:
☐ CAN WALK _____ FEET WITHOUT ASSISTANCE
☐ USES CANE / WALKER / #_____PERSON ASSIST
☐ USES WHEELCHAIR
☐ PROTHESIS

PLEASE ATTACH A LIST OF ALL CURRENT MEDICATIONS

I CERTIFY THIS APPLICANT REQUIRES 24-HOUR NURSING CARE: ☐ NO ☐ YES

PHYSICIAN'S PRINTED NAME: _____ LICENSE #: _____

PHYSICIAN'S SIGNATURE: _____ DATE: ____/____/_____

PHYSCIAN'S PHONE #: (_____) _____ FAX #: (_____) _____

Initial Date

NEVADA STATE VETERANS HOME
BEHAVIORAL AND PSYCHIATRIC HISTORY

Please be as accurate as possible. This is instrumental in placing residents correctly and assists us in assuring that the roommate relationship is as successful as possible.

Note: "Yes" answers DO NOT disqualify a resident from admission.

	BEHAVIORS	Yes	No	WHEN WAS THE LAST EPISODE (DAILY, WEEKLY, OCCASIONALLY, ONCE, NEVER)
1.	Wandering/Getting lost			
2.	Hiding things (money, keys, jewelry, etc.)			
3.	Resisting necessary care			
4.	Hoarding things			
5.	Rummaging through others belongings			
6.	Being suspicious or accusative			
7.	Verbally abusive to others			
8.	Seeing or speaking to things that are not there			
9.	Physically aggressive toward self (banging head, hitting, cuts self)			
10.	Throws self on floor			
13.	Physically aggressive toward others (hit, kick, choking)			
14.	Attempts to damage furniture, glass, decorations			
15.	Attempting to break furniture or glass			
16.	Indiscriminate touching genitals, breasts or undressing others			
17.	Attempts sexual intercourse with others			
18.	Exposing self to others in inappropriate setting			
19.	Expressing thoughts/plan of suicide			
20.	Attempting to eat non-edible items (PICA)			
21.	Voiding or defecating in inappropriate places			
22.	Other noted behaviors			

Signature of Person Completing

Relationship to Applicant

Initial Date

NEVADA STATE VETERANS HOME
CURRENT MEDICATIONS

Please note any anticipated changes.

	MEDICATION	DOSE	FREQUENCY
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

Physician Printed Name: _____

Physician's Signature: _____ Date: _____

License #: _____ Phone #: _____ Fax: _____

Continue above medications: Yes ☐ No ☐

NEVADA STATE VETERANS HOME
AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

I authorize _____ to release the protected health information of:

Name: _____ Date of Birth: _____

Social Security No: _____

Information to be disclosed:	Purpose for Use and/or Disclosure: *(check all that may apply)*
☐ Last 2 years- Medical Records *(Please include immunization history)* ☐ Restrict to the following dates/conditions: _____	☐ At the request of the individual ☐ Physician Follow Up ☐ Application for Admission to Nevada State Veterans Home

_____ (initial) I agree to the release of the following information should it be contained in my medical record: behavioral or mental health services. If I do not specifically agree, this information will not be disclosed.

Unless otherwise revoked, this authorization will expire on the following date or event: _____. If a date or event is not specified, this authorization will expire one year from the date of my signature below.

I understand I have the right to revoke this authorization at any time. My revocation must be in writing, addressed to HIPAA Privacy Officer, Nevada State Veterans Home. I am aware that my revocation is not effective to the extent that the persons I have authorized to use/disclose my protected health information have acted in reliance upon this authorization.

I understand that the health information released under this authorization may be re-disclosed by the recipient and may no longer be protected under federal privacy regulations.

I understand I have the right to inspect and copy my own protected health information to be used or disclosed in accordance with the requirements of federal privacy regulations.

I understand that I have a right to receive a copy of this authorization upon my request.

_____ _____
Signature of Resident or Personal Representative Date

_____ _____
Relationship to Applicant Date

Initial Date

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** _____

NEVADA STATE VETERANS HOME
RESIDENT PHOTO

At the Nevada State Veterans Home, we recognize the importance of knowing our residents. We also understand the importance of getting to know the "whole" person, who they were twenty, forty, sixty years ago, and the role they play in our ability to provide the very best care possible.

Consequently, as part of the admissions process, we need an 8"x10" military photo if available of each resident on the day of their admission. This picture will be hung outside the resident's room and assist us in our efforts to help them identify their room.

These pictures will also assist our Team Members in their efforts t get to know each resident, not only as they are today, but as they were in years past. This project will also enhance our efforts to create a more home-like environment and is one more way the Nevada State Veterans Home can honor our Nevada heroes.

In addition to a framed 8"x10" picture of each resident we ask that you provide a brief biography about your loved one to help us learn more about them and their life story and accomplishments.

Thank you in advance for providing this framed photo. If you have questions or concerns, please contact the Neighborhood Social Worker at (702) 332-6784.

NDVS NEVADA STATE VETERANS HOME
Serving Nevada's Heroes

We Need Your Help in Fall Prevention

Our staff has been trained to reduce the risk of falling for your family member. We need information to identify fall risks because falls in the elderly can be very serious. We want to do everything possible to prevent your loved one from falling. Knowledge is power when it comes to fall prevention.

Does your loved one (check all that apply):

- ☐ Have history of falls within the last 12 months?
- ☐ Have any long-term habits we should be aware of, such as feeding the dog at home, eating in the early morning hours?
- ☐ Have any problems with balance or walking in the past?
- ☐ Have trouble getting from a chair to bed, bed to chair or getting on/off the toilet?
- ☐ Have weak muscles or bones, or complain about stiffness when rising?
- ☐ Have any new medications in the last 30 days?
- ☐ Have vision/hearing loss? Do they wear glasses or hearing aids?
- ☐ Have memory loss or confusion?
- ☐ Think they can perform activities beyond their capability?
- ☐ Use a cane, wheelchair, walker, crutch or restraint?
- ☐ Rock back and forth or sit too quickly?
- ☐ Experience dizziness?
- ☐ Experience pain?

Other Questions

Does your loved one snack at a certain time of the day?_____

Do they like to walk at a certain time of the day?_____

What else do you know about your loved one that is important for us to know? Please list anything that we can discuss when we meet/talk.

_____

_____

_____

_____

_____

_____

_____

Please list anything you have done in the past to decrease the risk of falls, such as installing handrails or using a shower chair.

_____

_____

_____

_____

_____

If you have questions or concerns, please tell our staff. Our goal is to provide a safe and healthy environment for all residents.