Department of Veterans Services
6630 S. McCarran Blvd Suite C204
Reno, Nevada 89509
(775) 688-1653 • Fax (775) 688-1656

STEVE SISOLAK
Governor

ATD-827

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
SOUTHERN 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 Representative,

As the Administrator of the Nevada State Veterans Home, I welcome you to our home, on behalf of our residents, team members, and volunteers.

We hope to convey to you how special our Veterans Home is, primarily because of our team's dedication to our mission. As a team, we all share the responsibility of "Caring for Nevada's Heroes" and we take that responsibility very seriously. We are committed to providing quality nursing care to Nevada's heroes - our veterans, and we are proud to do just that!

A few of the things that are in the packet include:

- Valuable information for applicants
- Admission criteria
- Contact information
- Links to numerous resources for veterans and their families

If you have any questions, please contact us at (702) 332-6784 or admissions@veterans.nv.gov.

Warm Regards,

Linda Gelinger
Administrator

SOUTHERN NEVADA STATE VETERANS HOME
"Serving Nevada's Heroes"

Resident Contact List

Resident Name: _____ Admit Date: _____

Your Room Number: _____ Your Phone Number: _____

Neighborhood Unit: _____

Nurse's Station Phone Number: _____

	Neighborhood Unit		
	Mariner	**Falconer**	**Sidewinder**
Nurse Manager: (Contact for any clinical issues)	Kathy Steffen, RN (702) 332-6737	Shirley Pfannebecker, RN (702) 332-6740	Madeline Rice, RN (702) 332-6745
Social Services: (Contact for Non-Clinical Issues)	Sharon Gillie, LSW (702) 332-6735	Nancy Edwards, LSW (702) 332-6742	Rebecca Felch, LSW (702) 332-6746
Veterans Services: (Contact for Veterans' Benefits)	Clinton Johnson, Veteran Service Officer (VSO) (702) 791-9000 x14472 - VAMC (702) 332-6716 - BC Veterans Home		

Director of Nursing Services:	Poppy Helgren, RN, MSN (702) 332-6719
Financial Questions:	Phone: (775) 825-9760 Email: finance@veterans.nv.gov
Maintenance Services:	Bob Robinson (702) 332-6751
Housekeeping/Laundry:	Beatrice Marr (702) 332-6753
Administrator:	Linda Gelinger (702) 332-6711

SOUTHERN NEVADA STATE VETERANS HOME
ADMISSION GUIDELINES

All individuals requesting admission to this facility, regardless of pay source, will be prescreened by Nevada Medicaid.

Residents are accepted only as permitted by licensure law that applies to this class facility. All residents are admitted upon the recommendation of a qualified licensed physician without regard to race, color, national origin, sex, religion, political affiliation, sexual orientation, age and/or handicap/disability (including AIDS and AIDS-related conditions.) Residents will not be accepted if, in the judgment, of the Administrator and/or Director of Nursing Services, the facility itself or in co-operation with community resources or contracted providers of service cannot for any reason provide adequate care.

The facility will accept, for care, those residents referred by the Nevada State Health Division with a diagnosis of non contagious tuberculosis after acute treatment has been rendered in one of the area general hospitals. All residents will receive two steps Mantoux tuberculosis testing upon admission and every twelve months thereafter unless proof of positive PPD or treatment of TB disease is provided.

The decision to admit a resident diagnosed with HIV or known to have AIDS will be made on an individual case by case basis after extensive planning to assure that the facility can meet the needs of the individual. Any decision not to admit an HIV or AIDS resident would be based on a complete pre-admission screen and the facility's inability to provide adequate care and not solely because the resident has HIV or AIDS.

All physically disabled persons will be assisted by facility personnel during the admission process and their subsequent stay as the individual disability warrants. Mentally retarded or specially disabled resident who exhibit moderate to severe behavioral problems should be transferred to appropriate facilities as soon as possible.

The facility will not admit residents who require care that the facility is unable to provide.

Each resident must be under the supervision of a physician who has been credentialed as an active member of the SNSVH medical staff and who accepts responsibility for the resident's medical care. Each resident may choose his own physician, whose name, address and phone number and that of his alternative physician will be recorded. Similar information will be recorded when applicable for the resident's dentist, pharmacy, optometrist and others as necessary to care for the resident's needs.

Southern Nevada State Veterans Home
100 Veterans Memorial Drive
Boulder City, NV 89005

SOUTHERN NEVADA STATE VETERANS HOME
RESIDENT PHOTO REQUEST

At the Southern 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.

Therefore, 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 to 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 Southern 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

SOUTHERN NEVADA STATE VETERANS HOME

"Serving Nevada's Heroes"

SOUTHERN NEVADA STATE VETERANS HOME

"Serving Nevada's Heroes"

SATELLITE TV CHANNEL GUIDE

Channel	Station
3	NBC
5	FOX
8	CBS
9	PBS
13	ABC
17	SYFI
18	MILITARY
19	TVLAND
22	TBS
23	USA
24	TNT
25	WGN
26	TMC – TURNER CLASSIC MOVIES
27	AMC – AMERICAN MOVIE CLASSICS
28	FOX NEWS
29	CNN NEWS
30	HNN – HEADLINE NEWS NETWORK
31	ESPN – SPORTS
32	ESPN2 – SPORTS
33	NFL – WATCH FOOTBALL HERE
34	TDC – THE DISCOVERY CHANNEL
35	GEO – NATIONAL GEOGRAPHIC
36	HIST – HISTORY CHANNEL
37	A&E – ARTS AND ENTERTAINMENT
38	ANIMAL PLANET
39	TRAVEL CHANNEL
40	CMT – COUNTRY MUSIC TELEVISION

Southern Nevada State Veterans Home
Admission Authorization / Consent Form

Name Med Rec # Admission Date

The following authorization/consent statements are necessary to provide quality care to yourself or your loved one. Please read each statement and check the appropriate box to indicate that you have selected to authorize or not authorize the procedures explained therein.

GENERAL CONSENT FOR TREATMENT
I understand that consent is given in advance of any specific diagnosis, treatmentor other services and is given to provide authority to the physician, or under his/her orders, for treatment of any condition the physician may deem advisable in the exercise of his/her judgment of my needs. ☐Yes ☐No
I understand that physicians are independent contractors, not agents of the facility and agree that each of the professional groups or individual practitioners which render professional services to the resident will bill and collect for these professional services, separate and apart from SNSVH billing and collections. ☐Yes ☐No
RESIDENT'S RIGHTS AND RECEIPT OF HANDBOOK
I have been given a full explanation and I understand the rights as a resident under Federal and State Laws and Regulations as well as SNSVH policies and procedures governing resident rights. ☐Yes ☐No
I have received a copy of the SNSVH Resident's Rights Handbook ☐Yes ☐No
AUTHORIZATION TO TAKE PHOTOGRAPHS/PUBLISH
Photograph may be taken of the resident while under the care of the SNSVH for the purpose of resident identification and medical record documentation. ☐Yes ☐No
Photographs may also be taken for use in SNSVH publications and for public relations purposes, to be used in video tapes, published or broadcast by SNSVH or by public media. ☐Yes ☐No
RESIDENT LAUNDRY
I prefer to have my personal clothing laundered by SNSVH ☐Yes ☐No
I prefer that my personal clothing be laundered by family member or friends. I understand that soiled laundry must be picked up on a weekly basis or more often. Heavily soiled items not picked up weekly may be laundered by SNSVH for sanitary and infection control purposes. ☐Yes ☐No

Southern Nevada State Veterans Home
Admission Authorization / Consent Form

RESIDENT MAIL
Please choose one of the options below: ☐**I request that all mail be delivered to me unopened.** If I have difficulty in opening, reading or understanding its content, I will request assistance from the Activities Department. ☐**I request that all mail be delivered to me opened.** If I have difficulty in reading or understanding its content, I will request assistance from the Activities Department.
I authorize mail that pertains to Veteran Affairs, Social Security, Medicare, Medicaid, pension disbursements, or any other similar type of mail to be opened immediately and distributed to the proper entity for timely response. ☐Yes ☐No
GENERIC MEDICATION NOTIFICATION
Nevada State Board of Pharmacy allows substitution of a "generic" medication for a "brand Name" if the resident or resident representative and the physician grant authorization. The SNSVH provider pharmacy will substitute only those generic medications for which there exists scientific data indicating that the generic form is equivalent to the brand name. If you choose not to allow generic substitution, you may be responsible for a portion of or the entire cost of the brand name medication. ☐Yes ☐No

Authorizations or denial of authorization given above are based on a full understanding of the explanations provided and accordingly are knowingly and voluntarily given.

_____
Dated

_____ _____
Resident/Resident Representative Signature Printed Name of Resident/Resident Representative

_____ _____
Signature of Witness Printed Name of Witness

SOUTHERN NEVADA STATE VETERANS HOME
ADMISSION CONTRACT

RESIDENT NAME	RESIDENT MEDICAL RECORD NUMBER
BIRTHDATE	DATE OF ADMISSION

I. PRELIMINARY STATEMENTS:

This document is a binding legal Contract. Please read it carefully before signing to make sure you fully understand its terms and the obligations you are assuming. If you are signing as a party to the Contract, be sure you understand the obligations you are assuming. This admission agreement complies with Nevada Revised Statutes and the Code of Federal Regulations.

This Admission Contract ("Contract") is executed as of_____by and among the **Southern Nevada State Veterans Home**, located at 100 Veterans Memorial Drive, Boulder City, Nevada, and _____ , (Resident), and/or _____, ("Fiduciary Party"), if any.

II. NONDISCRIMINATION:

The Facility encourages applications from all qualified Veterans, Veteran's Spouses, and Gold Star parents in need of its services without regard to age, to race, color, national origin, sex, religion, political affiliation, sexual orientation, age and/or handicap/disability (including AIDS and AIDS-related conditions)

IN CONSIDERATION OF THE MUTUAL PROMISES CONTAINED IN THIS CONTRACT, THE PARTIES AGREE AS FOLLOWS:

I. GENERAL PROVISIONS

A. Term. Resident agrees to reside in the Southern Nevada State Veterans Home (SNSVH). This Contract shall remain in effect until terminated by the Resident in accordance with applicable law or terminated by the SNSVH as provided in Article VIII below.

B. Fiduciary Parties. Resident's representative, if any, (Fiduciary Party) shall act on behalf of Resident for all purposes permitted under applicable law.

_____ _____
INITIAL DATE

Fiduciary Party shall pay fees and charges incurred hereunder by or on behalf of Resident from Resident's assets or estate. Fiduciary Party may act in more than one capacity and shall be bound by the applicable terms and conditions of this Contract.

II. FEES, PAYMENTS and SERVICES

A. CHARGES AND FEES

1. Per Diem Costs / Daily Rates

The Resident shall be charged a room and board co-pay to be applied toward the facility's current daily bed rate based on a pricing schedule adopted annually by the Home's Governing Board.

Charges are payable in advance or as otherwise arranged with the business office.

2. Itemized Ancillary Charges

The parties acknowledge that a copy of an itemized list of charges for all Ancillary services and products will be provided to the Resident within 45 days following the month in which the services were provided.

3. Late Payment Fee

The SNSVH may charge Resident and/or Resident's Representative and/or Agent, if any, a late payment fee or interest at a rate equal to the lesser of: (a) twelve percent (12%) per annum or, if less, the highest percentage allowed by law, on all charges (exclusive of interest) for which Resident is liable that are outstanding for more than 30 days from the date on which the Resident was billed for said charges; or (b) the amount set forth in any Contract Addendum.

4. Fees for Collecting Outstanding Bills

The SNSVH shall be entitled to all costs of collection, including court costs and reasonable attorney's fees incurred to collect fees and charges not paid when due, to the fullest extent permitted by applicable law. To the extent permitted by applicable law, in disputes arising from this Contract, the prevailing party shall be entitled to attorney's fees and costs.

5. Additional Charge for One-to-One Monitoring

INITIAL _____ DATE _____

On occasion, it may become necessary to provide One-to-One monitoring for the protection of a Resident or others. When One-to-One monitoring is provided, the SNSVH may assess an additional charge to the Resident and/or Resident's Representative to offset the cost of providing such services.

6. **Refunds**

On termination of this Contract or upon the death of a Resident with a personal fund deposited with the facility, the facility will convey within 30 days the Resident's funds, less any balance of charges, and a final accounting of those funds, to the individual or probate jurisdiction administering the Resident's estate. In cases where third-party coverage is involved, (Medicare, etc.) refunds may be delayed until formal determination and documentation of patient's eligibility is received by the SNSVH from the appropriate agency. If any fees or charges have been prepaid, any excess less any other balance of charges shall be refunded to the Resident or Resident's representative in accordance with applicable law. All fees due shall be prorated to the date of termination.

7. **Changes in Charges and Fees**

Charges and fees for services and products provided by the SNSVH may be changed from time to time. Services and products may also be curtailed or eliminated completely, as permitted by applicable law. The SNSVH shall notify Resident and any other party liable for charges and fees, at least 30 days prior to the effective date of change.

B. **PAYMENT**

1. It is the responsibility of the Resident and/or the Resident's representative, if any, to pay for the Resident portion of his or her care at the SNSVH. Resident's responsibility for payment may change if the third party payer responsible for the payment of Resident's charges changes. Resident and/or Resident's representative, if any, shall execute a new Contract Addendum describing his or her new responsibilities for payment whenever his or her third party payer changes.

2. Lack of payment will result in the SNSVH pursuing all remedies available under State or Federal law.

C. **MEDICARE / MEDICAID CERTIFICATION**

The Southern Nevada State Veterans Home is certified by the Medicare and Medicaid Program to accept Medicare/Medicaid Residents.

INITIAL _____ DATE _____

III. RESIDENT'S RESPONSIBILITY AND AUTHORIZATIONS

A. RESIDENT'S RESPONSIBILITIES

1. **Policies and Rules**

Resident agrees to abide by the policies and rules of the SNSVH and its regulating agencies. Resident and/or Resident's representative, if any, shall agree to provide all items for his or her personal use, including, but not limited to, daytime clothing, personal items, and other items as listed in the SNSVH policies and rules. Resident shall be permitted to use personal possessions to the extent possible without interference upon the rights, health or safety of others. The SNSVH will not be liable for Resident's clothing or personal items, except to the extent required by applicable law.

a. To ensure the safety of Residents and staff the following items are forbidden:

- Personal Vehicles
- Electrical Appliances - Refrigerators, microwaves, space heaters, heating pads, electric blankets, toasters, coffee pots, irons, and other heat producing devices are not allowed in Resident rooms. The use of Residential rated extension cords or multiple outlets are strictly prohibited.
- Weapons - Firearms, swords, bayonets, crossbows, tasers, knives with blades over 2 ½ inches long or materials that could be utilized in the manufacture of explosive devices
- Combustibles / Flammables, cleaning supplies requiring Safety Data Sheets (SDS), and lighter fluid, propane, butane, petroleum spirits or other highly flammable liquids.
- Alcoholic beverages are not permitted unless prescribed by the Resident's physician, and then must be stored in the nutrition kitchen labeled and dated.

b. Residents wishing to leave the facility grounds must have properly executed doctor's orders and be accompanied by a qualified individual capable of providing assistance. **Residents are not permitted to venture off facility grounds on their own**. Residents may travel courtyard and parking lot sidewalks and garden paths without supervision unless determined to be unsafe by the interdisciplinary treatment team. **Residents may not travel on roadways, sidewalks adjacent to roadways or within the parking lot unless supervised by a Responsible party.**

INITIAL _____ DATE _____

2. **Living Quarters**

The SNSVH shall initially place the Resident in accommodations that, in the opinion of the SNSVH, will result in a compatible Resident relationship and/or appropriate and efficient care by the SNSVH. However, the SNSVH reserves the right to transfer Resident to other living quarters as required or for efficient management (to the extent permitted by applicable law and the SNSVH policies) and will notify Resident, in accordance with applicable Law.

3. **Request for Admission and Treatment**

By executing this Contract, the Resident and/or Resident's representative represents that the Resident requires the care and treatment service provided by the SNSVH and is requesting admission to the SNSVH for the purposes of receiving the care and treatment services normally provided by the SNSVH for his or her level of care, including, but not limited to:

a. Nursing services;

b. Dietary services;

c. Activities program services;

d. Room/bed maintenance and housekeeping services;

e. Routine personal hygiene services;

f. Personal laundry services are available upon request. (The Facility does not provide dry cleaning and shall not be responsible for lost or damaged clothing.)

g. Medically related social services;

h. Medical care services recommended by Resident's physician;

i. Transportation for facility-sponsored activities;

j. Resident trust account and cashier services;

k. Transportation for medical /dental services when Resident's representative is unable to make arrangements for the provision of such services and staff and vehicles are available. (There is charge for these services.)

INITIAL DATE

4. **Administration**

By executing this Contract, Resident authorizes the SNSVH and the Resident's Physician and/or the Physician's designee to administer care and treatment services. In this Contract, Resident acknowledges that no warranty or guarantee has been made by the SNSVH concerning Resident's condition or any changes related thereto.

5. **Choice of Physicians**

The Resident and/or Resident's representative is free to choose one of the Facility's primary care physicians. If the Resident and/or Resident's representative, if any, do not select one of the facilities Attending Physicians, the Resident and/or Resident's representative, if any, may request that an Attending Physician be appointed by the facility.

B. MEDICAL SERVICES AND EQUIPMENT

1. Resident and/or Resident's representative, if any, shall be financially responsible for all medical and other services, equipment and supplies necessary for Resident's personal use that is not within the parameters of insurance reimbursements or routinely provided by the SNSVH. Resident and/or Resident's representative, if any, hereby authorizes the SNSVH to Bill Medicare, or any other applicable third party payer, for qualified equipment, supplies and services furnished directly by the SNSVH or by others to Resident.

2. A full range of medical specialty consultants are available by appointment and are billable to the Resident or the Resident's primary payer when ordered by the attending physician. When other arrangements cannot be made, the Facility will provide transportation to off-site physician offices as required based on availability of SNSVH staff and vehicles. Treatment by licensed Therapists, such as Physical Therapists, Speech Therapists, Occupational Therapists and Respiratory Therapists are Available on-site. Portable oxygen, IV fluids, prostheses, walkers, crutches, canes, wheelchairs, (electric and manual) braces, splints, etc. are considered ancillary charges. All services, if approved by the treating Physician or other authorized healthcare practitioner, will be billed to the applicable payer, Resident, or his/her representative.

3. **Pharmaceuticals**

Each Resident must complete an agreement for pharmaceutical services. All medications prescribed by a physician or other authorized healthcare Practitioner, are filled through the SNSVH Contracted pharmacy and

_____ _____
INITIAL DATE

billed to the appropriate payer by the Contracted Pharmacy. It is the responsibility of the Resident and/or Resident's representative to pay the pharmacy bill.

4. **Emergency Medical Treatment**

The SNSVH is hereby authorized to provide or arrange for any emergency medical treatment deemed necessary for the Resident or to arrange for the Resident's transfer to a hospital or other facility for such purposes within the restrictions stipulated to the Resident's Advanced Directives.

C. NON-COVERED SERVICES

All Resident care services must be ordered by a physician or other authorized healthcare practitioner. Any services provided to a Resident upon the Resident's request without prior authorization from or in consult with the Resident's attending Physician becomes the responsibility of the Resident.

IV. CONSENT TO SERVICES

A. Nursing Services

1. The Resident and/or Resident's representative, if any, acknowledges that the Resident is under the medical treatment and care of an Attending Physician and that the Facility renders services to the Resident under the general and specific instructions of said Physician.

2. The Resident and/or Resident's representative, if any, hereby consents to the Facility providing skilled nursing care as directed by said Attending Physician.

B. Transportation

The Resident and/or Resident's representative, if any, hereby grants Permission to the Facility, its employees, or agents to provide transportation to Off-site medical appointments (charge for service) and any activity to which the Resident's Physician has given permission to attend.

C. Personal Property

The Facility shall make reasonable efforts to safeguard the Resident's property and valuables that are in the possession of the Resident. The Resident and/or Resident's representative, if any, agrees to store all valuable

INITIAL _____ DATE _____

personal property in the Facility's safe or other secured storage area as the Facility may provide, with the exception of hearing aids, dentures and other items required for daily living. The Facility will not be liable for either damage to or loss of personal property of the Resident.

D. Resident Mail

The Resident or Family member is responsible for completing a change of address card(s) and returning it to Sender(s).

It is the policy of the Southern Nevada State Veterans Home not to accept mail addressed to a Resident who has been discharged from SNSVH. **Due to potential liability, mail received by the Southern Nevada State Veterans Home addressed to a discharged Resident will be returned to the U.S. Postal Service.**

V. RESIDENT'S RIGHTS UNDER FEDERAL AND STATE LAW

A. Resident's Rights

The Facility agrees to abide by Federal and State mandates and the policies contained in the Resident's Handbook and notice of health information practices. By signature to this Contract, Resident and/or Resident's representative, if any, acknowledges that he or she has received a copy of the Resident's Handbook and notice of health information practices.

B. Healthcare Provider

1. The Resident and/or Resident's representative, if any, recognizes that, while he or she has the right to privacy in medical treatment and personal care, the Facility may from time to time become involved in healthcare provider education programs through which future health care professionals gain experience. The Facility will ensure that medical treatment is rendered only at the direction of competent licensed professionals and instruct such students as may be involved that all such treatment is confidential and private. Healthcare providers may include Medical, Nursing, Social Services, Pharmacy, Lab, and Health Information Technology Personnel.

2. The Resident and/or Resident's representative, if any, hereby consents to such involvement unless he or she, by specific writing, denies permission to student health care professionals to become involved in the Resident's treatment.

_____ _____
INITIAL DATE

VI. RESPONSIBLE PARTY AND / OR AGENT

If it is required that a Resident's representative act as Agent and Sponsor for the Resident, the Resident and the Resident's representative shall pay fees and charges incurred hereunder by or on behalf of Resident from Resident's assets or estate.

VII. ENFORCEMENT

A. Sole Agreement

This Agreement, except as specific reference is made to other documents which are attached herein or incorporated herein by reference, is the entirety of the Agreement between the Facility and the Resident and/or Resident's representative, if any. Should changes in Federal or State law render any part of the Agreement invalid, the remainder of the Contract shall stand as a valid Agreement. _____ ***(initial)***

B. Acknowledgement

By signing below, the Resident and/or Resident's representative, if any, indicate that they have read the Agreement, clarified any doubts as to its meaning or the meaning of any terms therein, and freely consent to be legally bound by all of its terms and their subsequent implementation by the Rules and Regulations permitted under this Agreement.

C. Guarantee of Truthfulness

The Resident and/or Resident's representative, if any, hereby certify and warrant that all information that they have submitted in connection with the Resident's admission, including all information provided in the Application for Residency and all information submitted under Title XVIII of the Social Security Act (Medicare) is true and correct.

VIII. TERMINATION OR MODIFICATION OF CONTRACT

A. Change in Resident's Health

If the physical or mental condition of a Resident changes such that the Resident requires a higher level of care and the SNSVH determines that it cannot provide appropriate care, the Resident will be transferred, in accordance with applicable law, to another facility for appropriate care and this Contract shall terminate unless accommodations are reserved as provided in the SNSVH Bed Hold policy. If the Resident dies, this Contract

_____ _____
INITIAL DATE

shall terminate after the satisfaction of outstanding Resident obligations agreed to in this contract.

B. Transfer or Discharge

The SNSVH reserves the right to transfer or discharge Resident, in accordance with applicable law, following written notice of transfer or discharge planning. Except in an emergency or other circumstance permitted by law, a Resident will be provided with a least a thirty (30) day advance written notice of discharge or transfer.

C. Termination of Contract

The Resident may terminate this Contract at anytime with a written notice of 30 days. The Facility may terminate the Contract with a 30-day written notice provided to the Resident and/or Resident's representative.

IX. REPRESENTATIONS, INTERPRETATIONS AND COMPLETENESS

A. Resident Representation

Admission of the Resident is based on the representations contained in the admission documents.

The Resident and Resident's representative represent that the statements made in all admissions documents are true, correct and complete without omissions of any material facts. Furthermore, the Resident and/or Resident's representative shall promptly inform the SNSVH in writing of any changes in the statements included in all admission documents.

B. Acknowledgment of Resident's Financial Responsibility

While the SNSVH may assist in the procurement of third-payer coverage, including Medicaid, Medicare, and other insurance coverage, for the cost of residency and treatments, the Resident and Resident's representative acknowledge that SNSVH does not guarantee coverage or the amount of payment by any payer source. The Resident acknowledges that assistance by the SNSVH does not alter his or her responsibility to satisfy debts incurred for services rendered.

C. Southern Nevada State Veterans Home Representations

Because the provision of health care services is personalized, the SNSVH will attempt to provide goods and services to Resident in accordance with applicable law. The Resident and Resident's representative acknowledge

_____ _____
INITIAL DATE

that provision of services or goods to one Resident creates no inherent entitlement to similar goods or services. All goods/services decisions will be determined on individual best outcome basis.

D. Interpretation of Provisions

Wherever possible, each provision of this Contract shall be interpreted in such manner to be effective under applicable law. If at any time any provision of this Contract shall be prohibited, or held invalid under applicable law, such provision shall be severed from the Contract and the remaining provisions of this Contract shall be unaffected.

X. ARBITRATION

Pursuant to the Federal Arbitration Act, any action, dispute, claim, or controversy of any kind (e.g. whether in Contract or in tort, statutory or common law, legal, equitable, or otherwise) now existing or hereafter arising between the parties in any way arising out of, pertaining to or in connection with the provision of health care services, any agreement between the parties, the provision of any other goods or services by the SNSVH or other transactions, Contracts or agreements of any kind whatsoever, any past, present or future incidents, omissions, acts, errors, practices, or occurrence causing injury to either party whereby the other party or its agents, employees, or resident's representative may be liable, in whole or in part, or any other aspect of the past, present, or future relationships between shall be resolved by binding arbitration administered by the National Health Lawyers Association ("NULA"). This section shall not apply to actions brought by SNSVH against the Resident and/or the Resident's representative of the Resident to obtain amounts charged in connection with the provision of goods or services provided to the Resident by SNSVH.

This Admission Agreement is signed in duplicate; the Resident and/or Resident's representative will be provided a copy.

If this agreement is not signed in the presence of the Facility Administrator or the Facility Administrator's designee, the signature of the Resident and/or Resident's representative, if any, must be notarized.

If the Resident is unable to sign because of his or her medical condition, the admitting physician shall document the reason in the Resident's medical record.

_____ _____
INITIAL DATE

THE UNDERSIGNED ACKNOWLEDGE THAT EACH OF THEM HAS READ AND UNDERSTOOD THIS ADMISSION CONTRACT, AND THAT EACH OF THEM VOLUNTARILY CONSENTS TO ALL OF ITS TERMS

_____ _____

Resident Printed Name

Date: _____ Address: _____

_____

AND/OR

_____ _____

Resident's Representative *(if any)* Printed Name

Date_____ Address: _____

_____

Resident Representative executes this Contract in the capacity/capacities checked below and shall provide Evidence of Resident's representative capacity / capacities at the time of signing this Contract:

- Guardian appointed by court. Includes:
  - Guardian of the person for the purposed of admitting Resident to the SNSVH, or
  - Guardian of property for purposes of handling Resident's finances, or
  - Both
- Attorney-In-Fact under validly executed power of attorney
- Conservator of the estate approved by court
- Trustee underwritten trust agreement
- Resident's Representative designated in writing by Resident to exercise rights protected under the Social Security Act and other purposes permitted by law.
- Resident's Representative, as defined in rules and regulations implementing the Omnibus Reconciliation Act of 1987 (OBRA), amending 42 U.S.C. § 1395, et. seq., having legal access to Resident's income or resources
- Resident's Representative Payee within the meaning of the Social Security Act who receives Social Security benefits for and on behalf of Resident.

- Immediate Family Member (Specify: _____)

By: _____ _____

SNSVH Representative **Printed Name**

Date: _____

_____ _____

INITIAL DATE

Southern Nevada State Veterans Home
Financial Responsibility Agreement

Name of Resident: _____

Resident ID Number: _____

Resident and/or Resident's representative, if any, shall be financially responsible for all medical and other services, equipment and supplies necessary for Resident's personal use that is not within the parameters of insurance reimbursements or routinely provided by the SNSVH. This shall remain in effect until confirmation of cancellation of Medicare Advantage Plan has been acknowledged by Medicare. Resident and/or Resident's representative agrees to pay for qualified equipment, supplies and services furnished directly by the SNSVH or by others to Resident.

This includes but is not limited to:

Therapy evaluation and treatment

Physician visits

Laboratory testing

Imaging (x-ray, ultrasound)

Prescribed medications

_____ _____

Signature of Resident/Representative Date

_____ _____

Print Name of Resident/Representative Date

_____ _____

Admissions Coordinator Date

SOUTHERN NEVADA STATE VETERANS HOME
MEDICARE SECONDARY PAYER

PART I

1. Are you receiving Black Lung (BL) Benefits? **(BL is primary payer only for claims related to BL.)**
   Yes ☐ Date benefits began: MM/DD/CCYY _____.
   No ☐

2. Are the services to be paid by a government research program? **(Government research program will pay primary benefits for these services.)**
   Yes ☐
   No ☐

3. Has the Department of Veterans Affairs **(DVA) authorized and agreed to pay for your care at this facility? (DVA is primary for these services.)**
   Yes ☐
   No ☐

4. Was the illness/injury due to a work-related accident/condition? **(WC is primary payer only for claims for work-related injuries or illness.)**
   Yes ☐ Date of injury/illness: MM/DD/CCYY _____ **Complete below/Go to PART III.**
   No ☐ **Go to PART II.**

   Name and address of workers' compensation plan (WC) plan:
   _____
   _____
   _____
   _____
   Policy or identification number: _____
   Name and address of your employer:
   _____
   _____
   _____

PART II

1. Was illness/injury due to a non-work-related accident?
   Yes ☐ Date of accident: MM/DD/CCYY _____.
   No ☐ **Go to PART III.**

2. Is no-fault insurance available? (No-fault insurance is insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident.)
   Yes ☐ **Complete below.**
   No ☐

   Name and address of no-fault insurer(s) and no-fault insurance policy owner:
   _____
   _____
   _____

_____
_____
_____
Insurance claim number(s): _____

3. Is liability insurance available? (Liability insurance is insurance that protects against claims based on negligence, inappropriate action or inaction, which results in injury to someone or damage to property.)
   Yes ☐ **Complete below.**
   No ☐

   Name and address of liability insurer(s) and resident's representative:
   _____
   _____
   _____
   _____
   _____
   _____
   Insurance claim number(s): _____

No-fault insurer is primary payer only for those services related to the accident. Liability insurance is primary payer only for those services related to the liability settlement, judgment, or award.
Go to PART III.

PART III

1. Are you entitled to Medicare based on:
   ☐ Age? **Go to PART IV.**
   ☐ Disability? **Go to PART V.**
   ☐ End-Stage Renal Disease (ESRD)? **Go to PART VI.**

   Please note that both "Age" and "ESRD" OR "Disability" and "ESRD" may be selected simultaneously. An individual cannot be entitled to Medicare based on "Age" and "Disability" simultaneously. Please complete ALL "PARTS" associated with the resident's selections.

PART IV - AGE

1. Are you currently employed?
   Yes ☐ **Complete below.**
   No ☐ If applicable, date of retirement: MM/DD/CCYY _____
   No ☐ Never employed.

   Name and address of your employer:
   _____
   _____
   _____

2. Do you have a spouse who is currently employed?
   Yes ☐ **Complete below.**
   No ☐ If applicable, date of retirement: MM/DD/CCYY _____
   No ☐ Never employed.

Name and address of your spouse's employer:

_____

_____

_____

If the resident answered "No" to both questions 1 and 2, Medicare is primary unless the resident answered "Yes" to questions to questions in PART 1 OR PART II. Do not proceed further.

3. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment?
   - Yes ☐ Both.
   - Yes ☐ Self.
   - No ☐ Spouse.
   - No ☐ **Stop. Medicare is primary payer unless the resident answered "Yes" to the questions in PART 1 or PART II.**

4. If you have GHP coverage based on your own current employment, does your employer that sponsors or contributes to the GHP employ 20 or more employees?
   - Yes ☐ **GHP is primary. Complete below.**
   - No ☐

   Name and address of GHP:

   _____

   _____

   _____

   Policy identification number:_____
   (This number is sometimes referred to as the health insurance benefit package number.)

   Group identification number: _____

   Membership number:_____
   (Prior to the Health Insurance Portability and Accountability Act (HIPAA), this number was frequently the individual's Social Security Number (SSN); it is the unique identifier assigned to the policyholder/resident.)

   Name of policyholder/named insured: _____
   Relationship to resident: _____

5. If you have GHP coverage based on your spouse's current employment, does your spouse's employer that sponsors or contributes to the GHP, employ 20 or more employees?
   - Yes ☐ **GHP is primary. Complete below.**
   - No ☐

   Name and address of GHP:

   _____

   _____

   _____

   Policy identification number:_____
   (This number is sometimes referred to as the health insurance benefit package number.)

Group identification number: _____

Membership number:_____
(Prior to the Health Insurance Portability and Accountability Act (HIPAA), this number was frequently the individual's Social Security Number (SSN); it is the unique identifier assigned to the policyholder/resident.)

Name of policyholder/named insured: _____
Relationship to resident: _____

If the resident answered "No" to both questions 4 and 5, Medicare is primary unless the resident answered "Yes" to questions in PART I or PART II.

PART V – DISABILITY

1. Are you currently employed?
   - Yes ☐ **Complete below.**
   - No ☐ If applicable, date of retirement: MM/DD/CCYY _____
   - No ☐ Never employed.

   Name and address of your employer:
   _____
   _____
   _____

2. Do you have a spouse who is currently employed?
   - Yes ☐ **Complete below.**
   - No ☐ If applicable, date of retirement: MM/DD/CCYY _____
   - No ☐ Never employed.

   Name and address of your employer:
   _____
   _____
   _____

3. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment?
   - Yes ☐ Both.
   - Yes ☐ Self.
   - No ☐ Spouse.
   - No ☐

4. Are you covered under the GHP of a family member other than your spouse?
   - Yes ☐ **Complete below.**
   - No ☐

   Name and address of your family member's employer:
   _____
   _____
   _____

If the resident answered "No" to questions 1, 2, 3, and 4, STOP. Medicare is primary unless the resident answered "Yes" to questions in PART I or PART II.

5. If you have GHP coverage based on your own current employment, does your employer that sponsors or contributes to the GHP employ 100 or more employees?
   Yes ☐ **GHP is primary. Complete below.**
   No ☐

   Name and address of GHP:

   _____
   _____
   _____

   Policy identification number:_____
   (This number is sometimes referred to as the health insurance benefit package number.)

   Group identification number: _____

   Membership number:_____
   (Prior to the Health Insurance Portability and Accountability Act (HIPAA), this number was frequently the individual's Social Security Number (SSN); it is the unique identifier assigned to the policyholder/resident.)

   Name of policyholder/named insured: _____
   Relationship to resident: _____

6. If you have GHP coverage based on your spouse's current employment, does your spouse's employer that sponsors or contributes to the GHP, employ 100 or more employees?
   Yes ☐ **GHP is primary. Complete below.**
   No ☐

   Name and address of GHP:

   _____
   _____
   _____

   Policy identification number:_____
   (This number is sometimes referred to as the health insurance benefit package number.)

   Group identification number: _____

   Membership number:_____
   (Prior to the Health Insurance Portability and Accountability Act (HIPAA), this number was frequently the individual's Social Security Number (SSN); it is the unique identifier assigned to the policyholder/resident.)

   Name of policyholder/named insured: _____
   Relationship to resident: _____

7. If you have GHP coverage based on a family member's current employment, does your family

member's employer, that sponsors or contributes to the GHP, employ 100 or more employees?

Yes ☐ **GHP is primary. Complete below.**
No ☐

Name and address of GHP:

_____
_____
_____

Policy identification number:_____
(This number is sometimes referred to as the health insurance benefit package number.)

Group identification number: _____

Membership number:_____
(Prior to the Health Insurance Portability and Accountability Act (HIPAA), this number was frequently the individual's Social Security Number (SSN); it is the unique identifier assigned to the policyholder/resident.)

Name of policyholder/named insured: _____
Relationship to resident: _____

If the resident answered "No" to questions 5, 6 and 7, Medicare is primary unless the resident answered "Yes" to questions in PART I or PART II.

PART VI – ESRD

1. Do you have group health plan (GHP) coverage?
   Yes ☐ **If applicable, complete below.**
   No ☐ **Stop. Medicare is primary.**

Name and address of GHP:

_____
_____
_____

Policy identification number:_____
(This number is sometimes referred to as the health insurance benefit package number.)

Group identification number: _____

Membership number:_____
(Prior to the Health Insurance Portability and Accountability Act (HIPAA), this number was frequently the individual's Social Security Number (SSN); it is the unique identifier assigned to the policyholder/resident.)

Name of policyholder/named insured: _____
Relationship to resident: _____

Name and address of employer, if any, from which you receive GHP coverage:

_____

_____
_____

If applicable, you spouse's GHP information:
Name and address of GHP:

_____
_____
_____

Policy identification number:_____
(This number is sometimes referred to as the health insurance benefit package number.)

Group identification number: _____

Membership number:_____
(Prior to the Health Insurance Portability and Accountability Act (HIPAA), this number was frequently the individual's Social Security Number (SSN); it is the unique identifier assigned to the policyholder/resident.)

Name of policyholder/named insured: _____
Relationship to resident: _____

Name and address of employer, if any, from which you receive GHP coverage:

_____
_____
_____

2. Have you received a kidney transplant?
   Yes ☐ Date of transplant: MM/DD/CCYY _____
   No ☐

3. Have you received maintenance dialysis treatment?
   Yes ☐ Date dialysis began: MM/DD/CCYY _____. See below.
   No ☐

   If you participated in a self-dialysis training program, provide date training started:
   MMDD/CCYY _____

4. Are you within the 30-month coordination period that starts MM/DD/CCYY _____?
   Yes ☐
   No ☐ **Stop. Medicare is Primary.**

   (The 30-month coordination period starts the first day of the month an individual is eligible for Medicare (even If not yet enrolled in Medicare) because of kidney failure (usually the fourth month of dialysis). If the individual is participating in a self-dialysis training program or has a kidney transplant during the 3- month waiting period, the 30-month coordination period starts with the first day of the month of dialysis or kidney transplant.)

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?
   Yes ☐
   No ☐

6. Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?
   Yes ☐ **Stop. GHP continues to pay primary during the 30-month coordination period.**
   No ☐ **Initial entitlement based on age or disability.**

7. Does the working aged or disability MSP provision apply (i.e., is the GHP already primary based on age or disability entitlement)?
   Yes ☐ **Stop. GHP continues to pay primary during the 30-month coordination period.**
   No ☐ **Medicare continues to pay primary.**

If no MSP data are found in the Common Working File (CWF) for the beneficiary, the provider still asks the types of questions above and provides any MSP information on the bill using the proper uniform billing codes. This information will then be used to update CWF through the billing process.

_____
Resident or Resident's Representative (please print)

_____ _____
Resident or Resident's Representative Signature Date

Southern Nevada State Veterans Home
Assignment of Insurance Benefits

Resident Name: _____ MRN: _____

The parties authorize that payment be made directly to the facility for the benefits paid by insurance policies on behalf of the resident. The parties hereby irrevocably assign all such benefits to the facility in an amount not to exceed the charges for the facility's services. Where the resident's care at the facility is covered by a third party insurance, Medicare, or other private insurance, the parties shall be responsible for paying all charges not paid by any third party payer, Medicare or any other private insurance, including any co-insurance or deductive amounts required, unless these charges are covered by Medicaid.

_____ _____

Resident/Resident's Representative Date

_____ _____

Facility Representative Date

Southern Nevada State Veterans Home
Co-Payment Agreement

Medicare

The maximum benefit period for Medicare covered skilled services is 100 days per benefit period. Beginning the 21st day of coverage, the resident is responsible for a daily co-insurance payment, unless the resident is covered by Medicaid. (If covered by Medicaid, a patient liability is due and this amount is determined by Medicaid.)

1-20 Days	Medicare covers charges at 100%
21-100 Days	Veteran resident is responsible for $125.00 per day co-insurance payment to the facility*
	Non-veterans resident is responsible for $170.50 per day co-insurance payment to the facility**

*The co-insurance amounts established by the Federal Government exceeds the daily rate for a veteran at Southern Nevada State Veterans Home.

**Co-payment amounts are established by the Federal Government and are adjusted on an annual basis.

Signature of: ____Resident ____Responsible Party
____Legal Representative ____Authorized Agent

_____ _____
Signature Date

_____ _____
Resident Name Admit Date

SOUTHERN NEVADA STATE VETERANS HOME
INFLUENZA VACCINE INFORMED CONSENT- RESIDENT

Name (Please Print)	Room #	Date of Birth	MRN

THE FLU - Influenza is a respiratory infection caused by viruses. When people get influenza, they may have fever, chills, headaches, dry cough or muscle aches. Illness may last several days to a week or more and complete recovery is usual. However, complications may lead to pneumonia or death in some people.

It is not possible to estimate the risk of an individual getting the influenza this year, but for the elderly and for people with diabetes or heart, lung or kidney diseases, influenza may be especially serious. For health care workers, immunization may help prevent transmission to patients.

THE VACCINE - An injection of influenza vaccine will not give you influenza because the vaccine is made from killed viruses. The vaccine is made from viruses selected by the Office of Biologics, Food and Drug Administration and the Public Health Services.

RISK AND POSSIBLE SIDE EFFECTS - Side effects of influenza vaccine are generally mild in adults and occur at low frequency. These reactions consist of tenderness at the injection site, fever, chills, headaches or muscular aches. These symptoms last up to forty-eight hours.

SPECIAL PRECAUTIONS - Persons who are allergic to eggs, chickens, chicken feathers or chicken dander should not receive this vaccine until they have consulted their personal physicians. Persons with fever should not receive this vaccine. Persons who have received another type of vaccine within the past fourteen days should see their personal physicians before receiving this vaccine. If you have any questions, please ask or call.

DECLINATION

I have received information concerning the risk and benefits of being vaccinated for influenza; In addition I have received the Vaccination Information Statement for influenza vaccination and had the opportunity to discuss and ask questions concerning the risk and benefits of vaccination with a Southern Nevada State Veterans Home Registered Nurse. Being fully informed of these risks and benefits I decline to receive the influenza vaccine at this time. I understand that if at a later date, within the influenza season, I decide to receive the influenza vaccination it will be provided, if available and medically indicated, upon receipt of my request and consent.

_____

Signature of Resident or Resident's Representative Date Declined

CONSENT

I have read the above information, received the Vaccination Information Statement (VIS) for influenza vaccination revised July 16, 2013, and have had an opportunity to ask questions. I understand the benefits and risks of flu vaccinations as described. I request that the vaccine be given to me or to the person named below for whom I am authorized to sign.

_____

Signature of Resident or Resident's Representative Date Received VIS

ADMINISTRATION RECORD

Date _____ Time _____ Temperature _____ Nurse Administering Signature _____

_____ 0.5 ml IM _____LOT# _____ EXP Date _____

Vaccine Brand Name Site Lot # from Vial EXP date of vial

PNEUMONIA (PNEUMOCOCCAL) INFORMED VACCINE CONSENT

_____

Name (Please Print) **Room#** **Date of Birth** **MRN#**

Pneumococcal Vaccine is indicated for immunization against Pneumonia caused by those pneumococcal types included in the vaccine.

Immunization is indicated in the following individuals:

- persons over 65 years of age
- persons aged over 2 years with chronic cardiovascular disease, chronic pulmonary disease, diabetes mellitus, alcoholism, chronic liver disease, cerebrospinal fluid leaks, asplenia, or American Indian
- persons over the age of 2 years who are immunocompromised due to HIV, leukemia, lymphoma, Hodgkin's, multiple myeloma, generalized malignancy, chronic renal failure or nephrotic syndrome, those receiving chemotherapy or corticosteroids and recipients of organ or bone marrow transplants

CONTRAINDICATIONS:

- hypersensitivity to any component of the vaccine or phenol (a preservative) or reaction to prior injection of the vaccine
- previous vaccination with the pneumococcal vaccine (except if over 65 years of age now and at last vaccination was under 65 and over 5 years since that last vaccination, or for those over 2 years of age who are at the highest risk of serious pneumococcal infections).
- vaccination during chemotherapy or radiation therapy
- persons undergoing any immunosuppressive therapy must check with their physician for precise timing of receipt of vaccine
- any febrile respiratory illness or other active infection, except when in the opinion of the physician, withholding the vaccine entails even greater risk.

ADVERSE REACTIONS:

- local reactions at injection site including soreness, warmth, redness or swelling
- arthritis, arthralgia, rash, hives and malaise have been reported
- low grade fever, less than 102 degrees F, occurs occasionally.

CONSENT:

I have read the above information before signing this consent to immunization. I assume all risk and liability, and release the **Southern Nevada State Veterans Home** and all Medical Staff of any responsibility associated with receiving the pneumonia (pneumococcal) vaccine.

Signature: _____Date: _____

I have **not previously been immunized** with the pneumococcal vaccine except as advised above: (initial) _____

DECLINATION:

A Southern Nevada State Veterans Home Registered Nurse has explained to me the benefits and effectiveness of the pneumococcal vaccination, as well as the risk and contraindications listed above. Considering the information presented to me I am declining to receive the pneumococcal vaccination.

Signature: _____Date: _____

Witness: _____Date:_____

ADMINISTRATION RECORD

Date _____ Time _____ Temperature _____ Nurse Administering Signature _____

_____ 0.5 ml IM _____LOT# _____ EXP Date _____

Vaccine Brand Name Site Lot # from Vial EXP date of vial

VACCINE INFORMATION STATEMENT

Influenza (Flu) Vaccine (Inactivated or Recombinant): *What you need to know*

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Influenza ("flu") is a contagious disease that spreads around the United States every year, usually between October and May.

Flu is caused by influenza viruses, and is spread mainly by coughing, sneezing, and close contact.

Anyone can get flu. Flu strikes suddenly and can last several days. Symptoms vary by age, but can include:

- fever/chills
- sore throat
- muscle aches
- fatigue
- cough
- headache
- runny or stuffy nose

Flu can also lead to pneumonia and blood infections, and cause diarrhea and seizures in children. If you have a medical condition, such as heart or lung disease, flu can make it worse.

Flu is more dangerous for some people. Infants and young children, people 65 years of age and older, pregnant women, and people with certain health conditions or a weakened immune system are at greatest risk.

Each year **thousands of people in the United States die from flu**, and many more are hospitalized.

Flu vaccine can:

- keep you from getting flu,
- make flu less severe if you do get it, and
- keep you from spreading flu to your family and other people.

2 Inactivated and recombinant flu vaccines

A dose of flu vaccine is recommended every flu season. Children 6 months through 8 years of age may need two doses during the same flu season. Everyone else needs only one dose each flu season.

Some inactivated flu vaccines contain a very small amount of a mercury-based preservative called thimerosal. Studies have not shown thimerosal in vaccines to be harmful, but flu vaccines that do not contain thimerosal are available.

There is no live flu virus in flu shots. **They cannot cause the flu.**

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against three or four viruses that are likely to cause disease in the upcoming flu season. But even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Flu vaccine cannot prevent:

- flu that is caused by a virus not covered by the vaccine, or
- illnesses that look like flu but are not.

It takes about 2 weeks for protection to develop after vaccination, and protection lasts through the flu season.

3 Some people should not get this vaccine

Tell the person who is giving you the vaccine:

- **If you have any severe, life-threatening allergies.** If you ever had a life-threatening allergic reaction after a dose of flu vaccine, or have a severe allergy to any part of this vaccine, you may be advised not to get vaccinated. Most, but not all, types of flu vaccine contain a small amount of egg protein.
- **If you ever had Guillain-Barré Syndrome (also called GBS).** Some people with a history of GBS should not get this vaccine. This should be discussed with your doctor.
- **If you are not feeling well.** It is usually okay to get flu vaccine when you have a mild illness, but you might be asked to come back when you feel better.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4 Risks of a vaccine reaction

With any medicine, including vaccines, there is a chance of reactions. These are usually mild and go away on their own, but serious reactions are also possible.

Most people who get a flu shot do not have any problems with it.

Minor problems following a flu shot include:

- soreness, redness, or swelling where the shot was given
- hoarseness
- sore, red or itchy eyes
- cough
- fever
- aches
- headache
- itching
- fatigue

If these problems occur, they usually begin soon after the shot and last 1 or 2 days.

More serious problems following a flu shot can include the following:

- There may be a small increased risk of Guillain-Barré Syndrome (GBS) after inactivated flu vaccine. This risk has been estimated at 1 or 2 additional cases per million people vaccinated. This is much lower than the risk of severe complications from flu, which can be prevented by flu vaccine.
- Young children who get the flu shot along with pneumococcal vaccine (PCV13) and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Ask your doctor for more information. Tell your doctor if a child who is getting flu vaccine has ever had a seizure.

Problems that could happen after any injected vaccine:

- People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting, and injuries caused by a fall. Tell your doctor if you feel dizzy, or have vision changes or ringing in the ears.
- Some people get severe pain in the shoulder and have difficulty moving the arm where a shot was given. This happens very rarely.
- Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at about 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination.

As with any medicine, there is a very remote chance of a vaccine causing a serious injury or death.

The safety of vaccines is always being monitored. For more information, visit: **www.cdc.gov/vaccinesafety/**

5 What if there is a serious reaction?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or unusual behavior.

  Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 and get the person to the nearest hospital. Otherwise, call your doctor.
- Reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

VAERS does not give medical advice.

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382** or visiting the VICP website at **www.hrsa.gov/vaccinecompensation**. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider. He or she can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/flu**

Vaccine Information Statement

Inactivated Influenza Vaccine

08/07/2015

42 U.S.C. § 300aa-26

Office Use Only

VACCINE INFORMATION STATEMENT

Pneumococcal Polysaccharide Vaccine

What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Vaccination can protect older adults (and some children and younger adults) from **pneumococcal disease**.

Pneumococcal disease is caused by bacteria that can spread from person to person through close contact. It can cause ear infections, and it can also lead to more serious infections of the:

- Lungs (pneumonia),
- Blood (bacteremia), and
- Covering of the brain and spinal cord (meningitis). Meningitis can cause deafness and brain damage, and it can be fatal.

Anyone can get pneumococcal disease, but children under 2 years of age, people with certain medical conditions, adults over 65 years of age, and cigarette smokers are at the highest risk.

About 18,000 older adults die each year from pneumococcal disease in the United States.

Treatment of pneumococcal infections with penicillin and other drugs used to be more effective. But some strains of the disease have become resistant to these drugs. This makes prevention of the disease, through vaccination, even more important.

2 Pneumococcal polysaccharide vaccine (PPSV23)

Pneumococcal polysaccharide vaccine (PPSV23) protects against 23 types of pneumococcal bacteria. It will not prevent all pneumococcal disease.

PPSV23 is recommended for:

- All adults 65 years of age and older,
- Anyone 2 through 64 years of age with certain long-term health problems,
- Anyone 2 through 64 years of age with a weakened immune system,
- Adults 19 through 64 years of age who smoke cigarettes or have asthma.

Most people need only one dose of PPSV. A second dose is recommended for certain high-risk groups. People 65 and older should get a dose even if they have gotten one or more doses of the vaccine before they turned 65.

Your healthcare provider can give you more information about these recommendations.

Most healthy adults develop protection within 2 to 3 weeks of getting the shot.

3 Some people should not get this vaccine

- Anyone who has had a life-threatening allergic reaction to PPSV should not get another dose.
- Anyone who has a severe allergy to any component of PPSV should not receive it. Tell your provider if you have any severe allergies.
- Anyone who is moderately or severely ill when the shot is scheduled may be asked to wait until they recover before getting the vaccine. Someone with a mild illness can usually be vaccinated.
- Children less than 2 years of age should not receive this vaccine.
- There is no evidence that PPSV is harmful to either a pregnant woman or to her fetus. However, as a precaution, women who need the vaccine should be vaccinated before becoming pregnant, if possible.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4 Risks of a vaccine reaction

With any medicine, including vaccines, there is a chance of side effects. These are usually mild and go away on their own, but serious reactions are also possible.

About half of people who get PPSV have mild side effects, such as redness or pain where the shot is given, which go away within about two days.

Less than 1 out of 100 people develop a fever, muscle aches, or more severe local reactions.

Problems that could happen after any vaccine:

- People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting, and injuries caused by a fall. Tell your doctor if you feel dizzy, or have vision changes or ringing in the ears.
- Some people get severe pain in the shoulder and have difficulty moving the arm where a shot was given. This happens very rarely.
- Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at about 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination.

As with any medicine, there is a very remote chance of a vaccine causing a serious injury or death.

The safety of vaccines is always being monitored. For more information, visit: **www.cdc.gov/vaccinesafety/**

5 What if there is a serious reaction?

What should I look for?

Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or unusual behavior.

Signs of a **severe allergic reaction** can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would usually start a few minutes to a few hours after the vaccination.

What should I do?

If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 or get to the nearest hospital. Otherwise, call your doctor.

Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor might file this report, or you can do it yourself through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

VAERS does not give medical advice.

6 How can I learn more?

- Ask your doctor. He or she can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)** or
  - Visit CDC's website at **www.cdc.gov/vaccines**

SOUTHERN NEVADA STATE VETERANS HOME
E-MAIL CONSENT FORM

Resident Name: _____ MRN: _____

1. RISK OF USING E-MAIL

Southern Nevada State Veterans Home (SNSVH) offers families and resident's representative the opportunity to communicate by e-mail. Transmitting resident information by e-mail, however, has a number of risks that should be considered before using e-mail. These include, but are not limited to, the following risks:

a. E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.
b. E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
c. E-mail senders can easily misaddress an email.
d. E-mail is easier to falsify than handwritten or signed documents.
e. Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems.
g. E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
h. E-mail can be used to introduce viruses into computer systems.
i. E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL

SNSVH will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, SNSVH cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by SNSVH's intentional misconduct. Thus, the resident's representative must consent to the use of e-mail for resident information. Consent to the use of e-mail includes agreement with the following conditions:

a. All e-mails to or from the resident's representative concerning diagnosis or treatment will be printed out and made part of the resident's medical record. Because they are part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those e-mails.
b. SNSVH may forward e-mails internally to SNSVH staff and agents necessary for diagnosis, treatment, reimbursement, and other handling. SNSVH will not, however, forward emails to independent third parties without prior written consent, except as authorized or required by law.
c. Although SNSVH will endeavor to read and respond promptly to an e-mail from the resident's representative, SNSVH cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, the resident's representative shall not use e-mail for medical emergencies or other time sensitive matters.
d. If the e-mail requires or invites a response from SNSVH, and the resident's representative has not received a response within a reasonable time period, it is the resident's representative responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.
e. The resident's representative should not use e-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
f. The resident's representative is responsible for informing SNSVH of any types of information that should not be sent by e-mail, in addition to those set out in 2(e) above.
g. The resident's representative is responsible for protecting his/her password or other means of access to e-mail. SNSVH is not liable for breaches of confidentiality caused by the resident's representative or any third party.
h. SNSVH shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.

3. INSTRUCTIONS

To communicate by e-mail, the resident's representative shall:

a. Limit or avoid use of his/her employer's computer.
b. Inform SNSVH of changes in his/her email address.
c. Put the Resident's name in the body of the e-mail.
d. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g., billing question).
e. Review the e-mail to make sure it is clear and that all relevant information if provided before sending to SNSVH.
f. Inform SNSVH that the resident's representative received an e-mail from SNSVH.
g. Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his/her computer password.
h. Withdraw consent only by e-mail or written communication to SNSVH.

4. PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between SNSVH and me, and consent to the conditions herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that SNSVH may impose to communicate with patients by e-mail.

Resident Representative Name:

_____

Resident Representative Signature:

_____

Date: _____

_____

Witness Signature Date

If unable to return signed form via e-mail, please fax it to 702-332-6769 or mail it to the facility at:

Southern Nevada State Veterans Home
Attn: Tamara Walcott, HIM Director
100 Veterans Memorial Drive
Boulder City, NV 89005

Department of Veterans Services
6630 S. McCarran Blvd Suite C204
Reno, Nevada 89509
(775) 688-1653 • Fax (775) 688-1656

STEVE SISOLAK
Governor

ATD-828

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
SOUTHERN 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 Residents and Resident's Representative:

Our home, Southern Nevada State Veterans Home, has subscribed to Providigm's abaqis Quality Management System. Abaqis will help us to proactively perform Quality Assurance and Performance Improvement (QAPI) activities in order to improve the care and service that we give to our residents.

What does this mean for you and your family? As part of this process, we may solicit your feedback with an interview. We would love your honest feedback, and appreciate your participation in our Quality Assurance and Performance Improvement Initiatives.

We will be using abaqis to assess our care and correct identified issues. This includes assessing residents' quality of life (managing pain, maintaining dignity, respecting resident choice) and quality of care issues (managing weight loss, infections, rehabilitation following acute injury or illness, assessing whether there are enough staff to meet resident needs, and preventing readmission to hospital) among others in order to ensure that residents are getting the best possible care.

Providigm's abaqis Quality Management System will be in addition to our ongoing Pinnacle Quality Insight customer satisfaction surveys conducted by an independent company.

We are committed to continually strive to improve the care that we give to the resident, and to ensure that our quality systems are sound.

Sincerely,

Linda Gelinger
Administrator

SOUTHERN NEVADA STATE VETERANS HOME
PRIVACY ACT STATEMENT-HEALTHCARE RECORDS

This form is not a consent form to release or use health care information pertaining to you.

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN)

Sections 1819(f), 1919(f), 1819(b) (3) (A), and 1864 of the Social Security Act.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

This form provides you the advice required by The Privacy Act OF 1974. The personal information will facilitate tracking of changes in your health and functional status over time for purpose of evaluating and assuring the quality of care provided by nursing homes that participate in Medicare or Medicaid.

3. ROUTINE USES

The primary use of this information is to aid in the administration of the survey and certification of Medicare/Medicaid long term care facilities and to study the effectiveness and quality of care given in those facilities. This system will also support regulatory, reimbursement, policy, and research functions. This system will collect the minimum amount of personal data needed to accomplish its stated purpose.

The information collected will be entered into the Long Term Care Minimum Data Set (LTC MDS) system of records. Information from this system may be disclosed, under specific circumstances, to: (1) a congressional office from the record of an individual in response to an inquiry from the congressional made at the request of that individual; (2) the Bureau of Census; (3) the Department of Justice; (4) an individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease of disability, or the restoration of health; (5) contractors working for CMS to carry out Medicare/Medicaid functions, collating or analyzing data, or to detect fraud or abuse; (6) an agency of a State government for purposes of determining , evaluating and/or assessing overall or aggregate cost, effectiveness, and/or quality of health care services provided in the State; (7) another Federal agency to fulfill a requirement of a Federal statute that implements a health benefits program funded in whole or in part with Federal funds or to detect fraud or abuse; (8) Peer Review Organizations to perform Title XI or Title XVIII functions, (9) another entity that makes payment for or

oversees administration of health care services for preventing fraud or abuse under specific conditions.

4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

For Nursing Home residents residing in a certified Medicare/Medicaid nursing facility the requested information is mandatory because of the need to assess the effectiveness and quality of care given in certified facilities and to assess the appropriateness of provided services and resultant reimbursement may not be possible.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

_____

Resident or Resident's Representative Signature

_____

Date

Southern Nevada State Veterans Home
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required by law to maintain the privacy of health information that identifies you, called protected health information (PHI), and to provide you with notice of our legal duties and privacy practices regarding PHI. Southern Nevada State Veterans Home is committed to the protection of your PHI and will make reasonable efforts to ensure the confidentiality of your PHI, as required by statute and regulation. We take this commitment seriously and will work with you to comply with your right to receive certain information under HIPAA.

Southern Nevada State Veterans Home's Use and Disclosure of PHI

As permitted under HIPAA, the following categories explain the types of uses and disclosures of PHI that we may make. Some of the uses and disclosures described may be limited or restricted by state laws or other legal requirements. Please contact our Privacy Officer, using the contact information provided at the end of this notice, for specific information regarding the State of Nevada.

- **For treatment** - We may use or disclose PHI for treatment purposes, including disclosure to physicians, nurses, medical students, pharmacies, and other health care professionals who provide you with health care services and/or are involved in the coordination of your care.

- **For payment** – We may use or disclose PHI to bill and collect payment for medical services we provide. For example, we may provide PHI to your health plan to receive payment for the health care services provided to you.

- **For health care operations** -We may use or disclose PHI for health care operations purposes. These uses and disclosures are necessary, for example, to evaluate the quality of our medical care, accreditation functions and for Southern Nevada State Veterans Home's operation and management purposes. We may also disclose PHI to other health care providers or health plans that are involved in your care for their health care operations. For example, we may provide PHI to manage disease, or to coordinate health care or health benefits.

- **Appointment reminders and health-related benefits and services –**We may use and disclose your PHI to schedule appointments with providers of care outside our facility, or request health information from said providers.

- **To individuals involved in your care or payment for your care** - We may disclose PHI to a person who is involved in your care or helps pay for your care, such as a family member or friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort. As allowed by federal and state law, we may disclose the PHI of minors to their parents or legal guardians.

- **Business associates** - We may disclose PHI to our business associates to perform certain business functions or provide certain business services to Southern Nevada State Veterans Home. For example, we may use another company to perform billing services on our behalf. All of our business associates are required to maintain the privacy and confidentiality of your PHI. In addition, at the request of your health care provider or health plan, we may disclose PHI to their business associates for purposes of performing certain business functions or health care services on their behalf. For example, we may disclose PHI to a business associate of Medicare for purposes of medical necessity review and audit.

- **Disclosure for judicial and administrative proceedings**- Under certain circumstances, we may disclose your PHI in the course of a judicial or administrative proceeding, including in response to a court or administrative order, subpoena, discovery request, or other lawful process.

- **Law enforcement**- We may disclose PHI for law enforcement purposes, including reporting of certain types of wounds or physical injuries or in response to a court order, warrant, subpoena or summons, or similar process authorized by law. We may also disclose PHI when the information is needed: 1) for identification or location of a suspect, fugitive, material witness or missing person, 2) about a victim of a crime, 3) about an individual who has died, 4) in relation to criminal conduct on Southern Nevada State Veterans Home premises, or 5) in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

- **As required by law** – We must disclose your PHI if required to do so by federal, state, or local law.

- **Public Health** - We may disclose PHI for public health activities. These activities generally include: 1) disclosures to a public health authority to report, prevent or control disease, injury, or disability; 2) disclosures to report births and deaths, or to report elder abuse or neglect; 3) disclosures to a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity, including reporting reactions to

medications or problems with products or notifying people of recalls of products they may be using; 4) disclosures to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and 5) disclosures to an employer about an employee to conduct medical surveillance in certain limited circumstances concerning workplace illness or injury.

- **Disclosure about victims of abuse, neglect, or domestic violence**- We may disclose PHI about an individual to a government authority, including social services, if we reasonably believe that an individual is a victim of abuse, neglect, or domestic violence.

- **Health oversight activities** - We may disclose PHI to a health care oversight agency for activities authorized by law such as audits, civil, administrative, or criminal investigations and proceedings/actions, inspections, licensure/disciplinary actions, or other activities necessary for appropriate oversight of the health care system, government benefit programs, and compliance with regulatory requirements and civil rights laws.

- **Coroners, medical examiners, and funeral directors**- We may disclose PHI to a coroner, medical examiner, or funeral director for the purpose of identifying a deceased person, determining cause of death, or for performing some other duty authorized by law.

- **Personal Representative** - We may disclose PHI to your personal representative, as established under applicable law, or to an administrator, executor, or other authorized individual associated with your estate.

- **Serious threat to health or safety** - We may disclose PHI if necessary to prevent or lessen a serious and/or imminent threat to health or safety to a person or the public or for law enforcement authorities to identify or apprehend an individual.

- **Research** – We may use and disclose PHI for research purposes. Limited data or records may be viewed by researchers to identify patients who may qualify for their research project or for other similar purposes, as long as the researchers do not remove or copy any of the PHI. Before we use or disclose PHI for any other research activity, one of the following will happen: 1) a special committee will determine that the research activity poses minimal risk to privacy and that there is an adequate plan to safeguard PHI; 2) if the PHI relates to deceased individuals, the researchers give us assurances that the PHI is necessary for the research and will be used only as part of the research; or 3) the researcher will be provided only with information that does not identify

you directly.

- **Government functions**- In certain situations, we may disclose the PHI of military veterans, as required by military command authorities. Additionally, we may disclose PHI to authorized officials for national security purposes, such as protecting the President of the United States, conducting intelligence, counter-intelligence, other national security activities, and when requested by foreign military authorities. Disclosure will be made only in compliance with U.S. Law.

- **Workers' compensation** - As authorized by applicable laws, we may use or disclose PHI to comply with workers' compensation or other similar programs established to provide work related injury or illness benefits.

- **De-identified Information and Limited Data Set** – We may use and disclose health information that has been "de-identified" by removing certain identifiers making it unlikely that you could be identified. We also may disclose limited health information, contained in a "limited data set." The limited data set does not contain any information that can directly identify you. For example, a limited data set may include your city, county and zip code, but not your name or street address.

Other Uses and Disclosures of PHI

For purposes not described above, including uses and disclosures of PHI for marketing purposes and disclosures that would constitute a sale of PHI, we will ask for your written authorization before using or disclosing your PHI. If you signed an authorization form, you may revoke it, in writing, at any time, except to the extent that action has been taken in reliance on the authorization.

Information Breach Notification

We are required to provide patient notification if we discover a breach of unsecured PHI unless there is a demonstration, based on a risk assessment, that there is a low probability that the PHI has been compromised. You will be notified without unreasonable delay and no later than 60 days after discovery of the breach. Such notification will include information about what happened and what can be done to mitigate any harm.

Patient Rights Regarding PHI

Subject to certain exceptions, HIPAA establishes the following patient rights with respect to PHI**:**

- **Right to Receive a Copy of the Southern Nevada State Veterans Home Notice of Privacy Practices** - You have a right to receive a copy of our Notice of Privacy Practices at any time by contacting us at 702-332-6784

and asking for the HIPAA Privacy Officer, or by sending a written request to: HIPAA Privacy Officer, Southern Nevada State Veterans Home 100 Veterans Memorial Drive, Boulder City, NV 89005. This notice will also be posted on the Southern Nevada State Veterans Home Internet site at https://veterans.nv.gov/

- **Right to Request Limits on Uses and Disclosures of your PHI** - You have the right to request that we limit: 1) how we use and disclose your PHI for treatment, payment, and health care operations activities; or 2) our disclosure of PHI to individuals involved in your care or payment for your care. We will consider your request, but is not required that we agree to it unless the requested restriction involves a disclosure that is not required by law to a health plan for payment or health care operations purposes and not for treatment, and you have paid for the service in full out of pocket. If we agree to a restriction on other types of disclosures, we will state the agreed restrictions in writing and will abide by them, except in emergency situations when the disclosure is for purposes of treatment.

- **Right to Request Confidential Communications** - You have the right to request that we communicate with you about your PHI at an alternative address or by an alternative means. We will accommodate reasonable requests.

- **Right to See and Receive Copies of Your PHI –** You generally have the right to access and receive a copy of PHI that may be used to make decisions about your care or payment for your care. For PHI for which you have a right of access, you have the right to access and receive your PHI in an electronic format if it can be readily produced in such format, and to direct us to transmit a copy to an entity or person you designate, provided such designation is clear, conspicuous and specific.

- **Right to Receive an Accounting of Disclosures** - You have a right to receive a list of certain instances in which we disclosed your PHI. This list will not include certain disclosures of PHI, such as (but not limited to) those made based on your written authorization or those made prior to the date on which Southern Nevada State Veterans Home was required to comply. If you request an accounting of disclosures of PHI that were made for purposes other than treatment, payment, or health care operations, the list will include disclosures made in the past six years, unless you request a shorter period of disclosures. If you request an accounting of disclosures of PHI that were made for purposes of treatment, payment or health care operations, the list will include only those disclosures made in the past three years for which an accounting is required by law, unless you request a shorter period of disclosures.

- **Right to Correct or Update your PHI -**If you believe that your PHI contains a

mistake, you may request, in writing, that we correct the information. If your request is denied, we will provide an explanation of the reasoning for our denial.

How to Exercise Your Rights

To exercise any of your rights described in this notice, you must send a written request to: HIPAA Privacy Officer, Southern Nevada State Veterans Home, 100 Veterans Memorial Drive, Boulder City, NV 89005.

How to Contact Us or File a Complaint

If you have questions or comments regarding our Notice of Privacy Practices, or have a complaint about our use or disclosure of your PHI or our privacy practices, please call 702-332-6784 and ask for the HIPAA Privacy Officer, or send a written request to: HIPAA Privacy Officer, Southern Nevada State Veterans Home 100 Veterans Memorial Drive, Boulder City, NV 89005. You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. We will not take retaliatory action against you for filing a complaint about our privacy practices.

Changes to the Southern Nevada State Veterans Home Notice of Privacy Practices

We reserve the right to make changes to this notice and to our privacy policies from time to time. Changes adopted will apply to any PHI we maintain about you. We are required to abide by the terms of our notice currently in effect. When changes are made, we will update this notice and post the information on the Home's website at https://veterans.nv.gov/. Please review this site periodically to ensure that you are aware of any such updates.

SOUTHERN NEVADA STATE VETERANS HOME
NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT

Resident Name: _____ MR#: _____

I have been given a copy of the facility's Notice of Privacy Practices which describes how my health information is used and shared. I understand that the facility has the right to change the notice at any time. I may obtain a current copy by contacting the facility Privacy Officer or by visiting the facility website at:

http://www.veterans.nv.gov

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

_____ _____
Signature of Resident or Resident's Representative Date

_____
Print Name

_____
Relationship to Resident

(For Facility Use Only) Complete this section if you are unable to obtain a signature.

1. If the resident or resident's representative is unable or unwilling to sign this acknowledgement or the acknowledgement is not signed for any other reason, state the reason:
   _____
   _____
2. Describe the steps taken to obtain the resident's (or resident's representative's) signature on the acknowledgement:
   _____
   _____

Completed by:

_____ _____
Signature of Facility Representative Date

_____
Print Name

Southern Nevada State Veterans Home
Request to Restrict Disclosure of Protected Health Information

Resident Name_____ Date_____ Number_____

I request that Southern Nevada State Veterans Home restrict the use and disclosure of my protected health information as checked below:

☐ Do not release my health information if the uses or disclosures of this information are to carry out treatment, payment or health care operations.
☐ Do not disclose my health information, my location or my death to the family members, friends, or relatives I have named below: _____ _____ _____
_____ _____ _____
☐ Do not disclose my name or health information for the purposes of fundraising or marketing.
☐ Do not include my name in the Facility Directory
☐ Other_____
☐ None of the above

I hereby recognize the following conditions of my requested restrictions concerning the use and disclosure of my protected health information.

- I understand that Southern Nevada State Veterans Home (SNSVH) has sixty (60) days from the date of this request to respond unless I am provided with a notice that an extension is necessary. I understand that extension may not exceed thirty (30) days.
- I understand that that SNSVH is not required to agree to this request for restriction of my health information and that I will be notified in writing of any denial of such requests as well as how I may appeal any such denial.
- I understand that SNSVH's agreement to honor a part of my request does not mean that SNSVH agrees to all of my restriction requests.
- I understand that if SNSVH agrees to honor my request, or any part of my request, such restrictions will remain in effect until I agree in writing to revoke the restriction or until the provider notifies me in writing that it is terminating this agreement.
- I understand that should SNSVH terminate this agreement, the use or disclosure of my protected health information will only apply to information created or maintained after the date of this request.
- I understand that this agreement does not apply to the release of my health information for emergency treatment situations but SNSVH will request that the organization or individual receiving such information honor my request not to use or disclose such information to others.
- I understand that this agreement does not apply if such release of information is required by law.
- I understand that this agreement does not apply under certain public health activities, e.g. obligations of the provider to report certain infectious diseases, injuries or death.
- I understand that this agreement does not apply in the reporting of my health information to law enforcement officians or state agencies relative to abuse, neglect, violence or other crimes.
- I understand that this agreement does not apply when use of disclosure of my health information is to a health oversight agency such as a state or veterans survey agency, for a law enforcement investigation proceeding, a judicial or administrative proceeding, certain research activities, or to coroners or funeral directors for the purpose of identifying a body or determining the cause of death.
- I understand that SNSVH may inform other individuals, organizations, and entities about the existence of my restrictions, as long as such action does not disclose any health information about me.
- I understand that any agreed upon restrictions are binding only for this SNSVH and will not apply to any of the provider's business associates.
- I understand that I may revoke this request at any time by informing the provider with my written notice of such revocation.

Date	Printed Name of Resident	Signature of Resident or Resident's Representative
		Signature of Provider Representative

PROVIDER RESPONSE TO REQUEST:
Southern Nevada State Veterans Home agrees to accept:
☐ All of your requests ☐ Only the following requests:
_____

☐ Your request is **DENIED** due to the following: _____

Date	Printed Name of HIPAA Privacy Officer	Signature of HIPAA Privacy Officer
	Tamara Walcott, RHIA, CHPS	

You may file an appeal of this denial with Southern Nevada State Veterans Home Privacy Officer at 100 Veterans Memorial Drive, Boulder City, Nevada 89005 (702) 332-6733.

Termination of Restriction

____The above named resident agreed to terminate this restriction on: _____

____The above named resident was notified on _____ (date) that this restriction was terminated.

Resident was notified: (check appropriate box)

___In person

___By telephone

Date: _____

Name of person notified: _____

___By mail (signed certified mail notification received)

_____ _____

Tamara Walcott, RHIA, CHPS Date
HIPAA Privacy Officer

Southern Nevada State Veterans Home
Application for a Resident Trust Fund

Name of Resident: _____ SSN: _____

Resident ID Number _____

Conservator/Payee/Beneficiary _____

I, the undersigned, request an account with the Southern Nevada Veterans Home (SNSVH) Resident Trust Fund (RFT.)

I understand that I may deposit money in my account with the RTF which the SNSVH shall receive, hold, safeguard and manage. I further understand I may have any or all of my various sources of income sent to me at the SNSVH and deposited into my RTF account.

I understand I may access my monies in the RTF by contacting the business office during posted "banking" hours and abiding by the following limitations:

a. Residents may withdraw up to $100 cash per day without prior notice.

b. Requests for more than $100 cash may require up to 3 business days to process due to a limited amount of cash on hand.

c. A request for a check may require 3 business days to process.

d. Withdrawals CANNOT exceed the resident's balance.

I further understand I may authorize payments to the SNSVH from my account.

I understand interest will only be paid on balances over $50.00.

I understand that a receipt will be furnished to me after each deposit and/or withdrawal to or from my trust account. I understand I will receive a quarterly statement showing all current transactions involving my trust fund account.

This agreement shall remain in effect until I request cancellation or until my death or discharge from the Southern Nevada State Veterans Home.

_____ _____

Resident/Representative or Power of Attorney Date

_____ _____

Witness Date

Southern Nevada State Veterans Home
Resident Trust Fund General Information

Residents of the Southern Nevada State Veterans Home (SNSVH) have the right to manage their financial affairs and personal property. Upon receipt of written authorization from a resident or his/her legal representative, the SNSVH will hold any personal funds deposited with the Southern Nevada State Veterans Home in the Resident Trust Fund (RTF). Following is a description outlining how the SNSVH will safeguard, manage and account for personal funds deposited in the RTF:

1. There will be a complete and separate accounting for each resident's personal funds.

2. Funds will be pooled and deposited in an interest bearing account.

    a. This account will be maintained separate from any operating accounts of the SNSVH.

    b. Any interest earned will be credited to resident accounts according to an equal distribution of each of resident's share.

3. Within one business day of a request, the resident or their representative will be permitted to inspect the individual resident's file.

    a. A duplicate copy of the file may be obtained free of charge by submitting a written request to the Southern Nevada State Veterans Home.

4. Funds may be deposited to the RTF through:

    a. Check made out to the SNSVH Resident Trust Fund with the resident's name clearly indicated in the memo section.

    b. Cashier service available in the Business Office.

    c. Bedside cashier service available to residents unable to visit the business office.

    d. Retirement and benefit checks sent to the SNSVH from various sources (i.e., Social Security, VA, company pensions, etc.) **Note:** The SNSVH recommends this approach.

5. The resident or their representative may provide written authorization to pay, from their Resident Trust Fund, for services provided by the Southern Nevada State Veterans Home. **Note:** The SNSVH recommends this approach.

6. Withdrawals may be made from the RTF through:

    a. Cashier service available in the Business Office during posted "banking" hours. Additional times may be available for special circumstances.

    b. Bedside cashier service available to residents unable to visit the business office.

Southern Nevada State Veterans Home
Resident Trust Fund General Information

c. If a resident is adjudicated incompetent under state law or is determined to be incapable of understanding his/her rights by their physician, the responsibilities related to disbursements shall pass to the residents guardian, next of kin or sponsoring agency.

7. Withdrawal restrictions:

    a. Residents may withdraw up to $100 cash per day without prior notice.

    b. Requests for more than $100 cash may require up to 3 business days to process due to a limited amount of cash on hand.

    c. A request for a check may require 3 business days to process.

    d. Withdrawals CANNOT exceed the resident's balance.

8. The SNSVH will furnish a written receipt for all RTF transactions.

9. The Southern Nevada State Veterans Home will provide a quarterly statement showing the current balance and an itemized listing of all transactions during the quarter.

    a. If needed, an interim statement may be requested.

10. To assure the security of all residents' personal funds deposited with the Resident Trust Fund, funds are deposit in an insured financial institution and the Southern Nevada State Veterans Home is self-insured through the State of Nevada.

11. For residents receiving Medicaid benefits the SNSVH will:

    a. Provide a monthly statement to the State Medicaid Office as required.

    b. Notify the resident and/or their responsible party when their account is within $200.00 of exceeding the maximum allowable resource limit as set by Medicaid.

12. Upon permanent discharge or transfer of a resident, the SNSVH will apply funds in the resident's RTF account towards the final bill (Medicaid residents excluded). Any remaining funds will be sent by check to the appropriate party along with a final statement within 30 days.

13. Upon the death of a resident, the SNSVH will apply funds in the resident's RTF account towards the final bill (Medicaid residents excluded). Any remaining funds will be sent by check to the appropriate party, as determined by N.R.S. § 146.080 and/or Nevada probate law, along with a final statement within 30 days.

14. Special Provisions per Nevada Medicaid:

Southern Nevada State Veterans Home
Resident Trust Fund General Information

a. Personal Needs Allowance is the amount of money deducted from the recipient's monthly income when the cost of care is calculated. The personal needs allowance is $35 per month and is intended for the exclusive use of the recipient as he/she desires for personal items such as clothing, cigarettes, hair styling, etc.

b. When a recipient is discharged to an independent living arrangement or expires mid-month, PL is prorated by the Welfare District Office and a notice is sent regarding PL adjustment. The nursing facility must refund any remaining balance to the recipient or their legal representative as required.

c. When a Medicaid recipient expires, the facility should at no time tell the personal representative that the recipient's personal trust fund is theirs to keep.

d. The facility must not use any remaining money from the recipient's personal trust fund after the recipient has expired for outstanding debts owed the facility.

e. Medicaid recipients may choose to spend their personal funds on items of personal care such as professional beauty or barber services or specialty items not covered by Medicaid. In this instance, the recipient must authorize payment for the specialty items in writing.

f. Conveyance of trust funds deposited with the SNSVH to the residents family member or guardian must be preceded by completion of the "Petition to Claim Decedent's Personal Funds" form.

g. If a guardian or next of kin does not claim personal funds of resident up death, SNSVH will convey personal trust funds according to the Medicaid Services Manual, Chapter 500, Section 503.14 (B)(paragraph 5) dated September 8, 2003: "42 CRF 483.10 requires the facility to convey the resident's personal trust fund deposited with the facility within 30 days of the death of the resident, along with a final accounting to the individual or probate jurisdiction administering the resident's estate. If the public administrator's office does not represent the Medicaid recipient, and/or refuses to accept the personal trust fund, the fund may be sent directly to the MER Unit with a Check Release Form. The Check Release Form must accompany all checks mailed to the MER Unit or the checks will be returned to the facility. The Check Release Form can be found at http://dhcfp.state.nv.us.

15. By signing the APPLICATION FOR A SNSVH RESIDENT TRUST FUND**,** the Resident authorizes the Southern Nevada State Veterans Home to accept, hold, safeguard, manage and account for their personal funds in accordance with the SNSVH Resident Trust Fund policy. The Resident also grants permission to the SNSVH to open mail related to the aforementioned matters pursuant to 42 C.F.R. Para 483.10, NAC 449.74461 and NAC 449.74463. The Resident has the right to revoke this authorization at any time upon written notice to the Southern Nevada State Veterans Home. Residents are not required to participate in the Resident Trust Fund. However, the Southern Nevada State Veterans Home recommends participation for ease of access to your funds and monitoring to ensure requirements are met relating to any assistance programs you are or may be eligible for.

Department of Veterans Services
6630 S. McCarran Blvd Suite C204
Reno, Nevada 89509
(775) 688-1653 • Fax (775) 688-1656

STEVE SISOLAK
Governor

ATD-828

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
SOUTHERN 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 Residents and Resident's Representative:

Your feedback is vital to our mission of "Serving Nevada's Heroes." Therefore, we have entered into a partnership with Pinnacle Consulting to conduct interviews with residents and/or their representative about their experience with the Southern Nevada State Veterans Home.

We value your opinion and encourage you to be honest about us when contacted by a Pinnacle representative. Your feedback will provide the tools we need to continually improve our quality of care and enhance our relationship with you.

Nationally, the Veterans Home Program partners with Pinnacle Consulting as well as other Veterans Home nationwide. Your feedback also conducts customer satisfaction feedback surveys for a variety of other healthcare related businesses and adheres to all state and federal confidentiality regulations.

Again, the information you share will be used to improve our overall quality of care, strengthen our commitment to Nevada's heroes, and enhance your experience with us. Thank you in advance for your participation.

If you have any questions or concerns regarding this partnership, please feel free to contact me at (702) 332-6711.

Sincerely,

Linda Gelinger
Administrator

Department of Veterans Services
6630 S. McCarran Blvd Suite C204
Reno, Nevada 89509
(775) 688-1653 • Fax (775) 688-1656

STEVE SISOLAK
Governor

ATD-841

Department of Veterans Services
6900 N. Pecos Road, Room 1C238
North Las Vegas, Nevada 89086
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Dear Resident or Resident's Representative:

Long-term care facilities, such as the Southern Nevada State Veterans Home (SNSVH) are mandated by the Federal Government to have a preventative maintenance program in place to assure that all equipment operated by the resident is in safe operating condition. SNSVH has many residents who operate powered wheelchairs within the Home. As noted above, we are required to establish procedures to assure these wheelchairs are safe to operate. Consequently, in our continuing effort to maintain a safe environment in our Home, we require residents or their representative to have their powered wheelchair inspected according to the manufacturer's recommendations or at least annually.

If your powered wheelchair has NOT been checked by a qualified service center within the past year, please make arrangements to have it checked immediately. If it has been checked and verified safe to operate, please note the anniversary date of that safety check so it doesn't become delinquent in the future. To avoid any delay in the use of your powered wheelchair at the Home, please provide us with copies of current wheelchair service receipts.

Note: Residents whose powered wheelchairs have not been safety-serviced will be issued a manual wheelchair until arrangements have been made to have the wheelchair checked and approved for operation.

A number of individuals have asked if our maintenance team members can perform powered wheelchair safety checks. Unfortunately, none of our maintenance team members are certified to perform this duty. Consequently, we cannot accommodate requests to conduct preventative maintenance or safety checks on these items.

If you need assistance in identifying powered wheelchair service centers for annual preventative maintenance and safety checks, please contact Social Services or the Facilities Supervisor for a list of service centers.
Thank you for your understanding and assistance in this matter.

Warm Regards,

Linda Gelinger
Administrator

SOUTHERN NEVADA STATE VETERANS HOME
SMOKING AGREEMENT

NOTICE: AS OF OCTOBER 1ST, 2019, SOUTHERN NEVADA STATE HOME WILL BE A SMOKE FREE FACILITY.

Residents of the Southern Nevada State Veterans Home who smoke tobacco products and/or vaporizers/electronic cigarettes are assessed, upon admission and quarterly thereafter, for safe smoking. Based on the outcome of that individual assessment, residents may be allowed to smoke with or without supervision. Smoking areas are designated by proper signage.

A copy of the Home's smoking policy is being provided to you. You are responsible for abiding by the following rules:

- Smoke only in the designated areas outdoors.
- You may be required to smoke under supervision or wear a smoking apron for safety.
- Smoking is prohibited near or around where oxygen is in use.
- Smoking materials are to be stored appropriately and may be maintained and monitored at the nurses' station.
- Smoking materials are not to be shared with other residents.

By signing this form you are agreeing to abide by the above policy. Failure to abide by this smoking agreement could result in loss of smoking privileges or discharge from the Home.

_____	_____
SNSVH Representative	Resident Name (print)
_____	_____
Resident/Resident Representative Signature	Date

- **Original to be filed in the Medical Record**
- **Copy provided to the Resident**

Southern Nevada State Veterans Home
Medications/Ancillary Charges

Residents of the Southern Nevada State Veterans Home (SNSVH) will be responsible for the cost of their medications and ancillary expenses. SNSVH will not be responsible for costs associated with the non-provision or untimely provision of medications or ancillary services, regardless of the source. Services include, but not limited to:

- Physician services, x-rays, labs, and medications
- Cellular telephone
- Radio for the patient's personal use
- Personal comfort items, including, without limitation, smoking materials, notions, novelties and confections
- Reading material
- Clothing
- Gifts purchased on behalf of the patient
- Flowers and plants
- Items for social events and entertainment that are in addition to the program of activities
- Special services required for the care of the patient, including, without limitation, the services of a private nurse or aide
- A private room, unless a private room is required because of the medical condition of the patient
- Food that is specially prepared for the resident or requested in lieu of food that is regularly prepared by the facility
- Cosmetics and grooming items and services which are not required for routine personal hygiene. Hair Shop Costs:

Haircut (Men)	$12.00
Haircut (Women)	$14.00
Cut & Set	$27.00
Shampoo & Set	$17.00
Permanents	$42.00
Tint	$37.00
Beard Trim	$ 7.00

- Therapy charges not covered by insurance. The private pay rate is:

ST Evaluation -	$285	ST Treatment -	$80/Unit (15 min)
PT Evaluation -	$175	PT Treatment -	$40/Unit (15 min)
OT Evaluation -	$200	OT Treatment -	$40/Unit (15 min)

Please be aware that if you are currently enrolled in the Department of Veterans Affairs (DVA) Health Care system, your benefits will change from outpatient to inpatient upon admission to SNSVH. As a result, you will likely no longer be eligible for DVA outpatient benefits and services.

If you served during a wartime period and you meet certain income requirements, you may be eligible for DVA Aid and Attendance (A&A) payments. If it appears you are eligible for A&A, our Veterans Service Officer will be happy to assist you in making application. If the DVA determines you are eligible for A&A benefits, SNSVH will eventually receive your medications from the DVA. However, this benefit may take two (2) or more months to process. Therefore, you will be responsible for the cost of all medications and ancillary charges until those medications and services are provided. Once these benefits are provided, you may be responsible for a DVA co-payment.

If you have questions regarding Aid and Attendance, please contact the SNSVH Veterans Service Officer at (702) 332-6716.

I understand that I will be responsible for all physician services, medication costs, and ancillary charges and agree to pay such charges in full on a monthly basis.

Print Name _____

Signature _____ Date_____

Southern Nevada State Veterans Home
Resident Chargeable Items

Item Description	Product #	Cost	Per
Wet Wipes, AloeTouch	MSC263701	$2.31	Tub
Bariatric Brief	BARIBRIEF	$18.14	Bundle
Medium Brief FitRestore Ultra	FRP300	$6.94	Bundle
Large Brief FitRestore Ultra	FRP500	$7.54	Bundle
Extra Large Brief Fit Restore Ultra	FRP600	$9.04	Bundle
Medium Pull-Up	MSC13005A	$6.79	Bundle
Large Pull-Up	MSC13505A	$7.48	Bundle
Extra Large Pull-Up	MSC13600A	$9.76	Bundle
Underpads (Dri Flo Pads, Chucks)	MSC281248	$5.13	Bundle
Liner, Incontinent, FitRight	FITLINER500	$5.13	Bundle
Liner, Incontinent, Male Guard	MSCMG02	$8.06	Bundle
Liner, Incontinent, Capri Plus	BCPE03	$6.09	Bundle
Ensure Enlive Chocolate	R-L64283	$1.47	Bottle
Ensure Enlive Vanilla	R-L64286	$1.47	Bottle
Ensure Clear Mix Berry	R-L64900	$1.64	Bottle
Glucerna Vanilla	R-L64922	$1.64	Bottle
Glucerna Strawberry	R-L64925	$1.64	Bottle
Belt Security, Safety Soft	MDT822126	$10.40	Each
Protector Mitt	MDT823256	$9.36	Pair
Protector, Heel, Heelmedix SE	MDT82500CS	$33.65	Each
Gel Cushion	MSC263105	$22.53	Each
Binder, Abdominal LG/XL	ORT21110LXL	$10.09	Each
Binder, Abdominal SM/MD	ORT21110SM	$8.86	Each
Collagen Particles, Puracol Ultra LG (Wound Care)	MSC8801EPZ	$115.38	Box
Kit, Drainage, Pleurx, 1000ML	BXT507510H	$82.68	Kit
Colostomy Kit 1 1/2"	SQU022767	$43.09	Box
Wafer, Flex Stomahesive	SQU125266	$45.62	Box
Durable Pouch 2.75" Opaque 2PC Sur Fit Nat	SQU401504	$26.40	Box
Pouch, Urostomy, w/Accuseal 2PC 1 3/4"	SQU401544	$38.25	Box
Barrier, CVX, DURHS 1 3/4" FL, PC 1 1/4" 32MM	SQU413183	$89.89	Box
Eakin Cohesive Slims Seals	SQU839005BX	$43.05	Box
Ensure Coffee Latte	72372600	$1.52	Bottle
Male Urinal	95002900	$5.12	Each
Cetaphil Cream	18061400	$13.65	Jar
Lotion Sarna	98471500	$8.41	Bottle
Wheelchair Cushion	081175090	$14.95	Each
O2 Tank Holder	081227131	$20.77	Each
Ben-Gay	13892701	$7.91	Tube
Barrier Paste 2oz.	26504900	$7.42	Tube
Smoking Apron	60953000	$30.42	Each
Magnetic Alarm	MAG-3	$22.99	Each
Wheelchair Seat Pad Alarm	PADS1CHAIRSET	$49.99	Set
Bed Alarm	PADS2BED	$74.99	Set
Wheelchair Seat Belt Alarm	SB-1SET	$49.99	Set
Bag, Drainage, Urology 2000ML, AN	DYNC1674	$1.65	Bag
Tray, Foley Insertion Tray w/10ML SY	DYNC1810	$1.44	Each
Catheter, Foley Silver 18FR 10M	DYND141018	$7.94	Each
Strap, Catheter, Elastic Hook & Loop(SoftCath)	DYND16900	$1.26	Each

7/1/2019 (Prices are subject to change)

Southern Nevada State Veterans Home
Resident Chargeable Items

Humidifier, Prefilled, 350ML H2O	HCS00350	$2.24	Each
Nebulizer Kit, Mask Adult 7FT	HCS4485	$2.03	Each
Tubing, Oxygen Crush Res 7FT. CL	HCS4507	$0.76	Each
Cannula, Adult, Soft Touch 7FT	HCS4514	$0.55	Each
Cushion, Ear EZ Wrap for O2 Can	HCS0440	$1.26	Pair
Connector, Standard F/O2 Supply	HCS65100	$0.42	Each
Pad, Prep, Alcohol Sterile Medium	MDS090735	$1.45	Box
Holder, Drainage Bag, Poly/Cotton (Wheelchair)	MDT825150	$3.35	Each
Bag, Patient Set-Up Respiratory	NON026370	$0.22	Each
2X Large Pull-Up	MSC33700	$8.95	Bundle
Small Briefs - FitRight Extra	FITEXTRASM	$6.14	Bundle
Catheter, Silver 14FR 5cc	10291900	$11.00	Each
Catheter, Silver 16FR 5cc	65161900	$11.00	Each
Catheter, Silver 18FR 5cc	18651900	$11.00	Each
Catheter, Silver 20FR 5cc	20651912	$11.00	Each
Catheter, Silver 22FR 5cc	22651900	$11.00	Each
Catheter, Silver 24FR 5cc	65241900	$11.00	Each
Catheter, Foley Silver 20FR 10mL	DYND141020	$6.96	Each
Kleenex	NON245277	$0.70	Box
A&D +E Lotion	H-HAD13H	$3.85	Jar
Polysporin	OTC379801	$10.17	Tube
Hydrocortisone	CUR015431	$1.54	Tube
Drape, Utility	DYNJP2405	$0.67	Pack
Bandage Shortstretch 10cmx5m	MDS099004SS	$6.87	Roll
Dressing Therahoney	MNK0005	$2.23	Tube
Cleanser Foam No Rinse	MSC092104	$2.15	Bottle
Moisturizing Nourishing Lotion	MSC0924002	$1.22	Bottle
Hydraguard Cream	MSC092534	$3.69	Bottle
Antifungal Powder	MSC092603	$3.35	Bottle
Calazime Paste	MSC094544	$3.36	Bottle
Antifungal Cream w/Olivamine	MSC094604	$4.84	Bottle
Optifoam Dressing 4x4	MSC1244EP	$26.25	Box
Optifoam Dressing Thin 4x4	MSC1544EP	$27.42	Box
Versatel Dressing 3x4	MSC1834EP	$30.68	Box
Optifoam Gentle Sacrum 7x7	MSC2177EP	$36.67	Box
Optifoam Gentle 3x3	MSC2333EP	$24.61	Box
Optifoam Gentle 4x4	MSC2344EP	$37.94	Box
Optifoam Gentle Lite 1.6x2	MSC28162B	$12.72	Box
Optifoam Gentle Lite 3x3	MSC2833B	$17.02	Box
Bordered Gauze 4x4	MSC3244	$8.52	Box
Gauze Border 6x6	MSC3266	$15.30	Box
Cleanser Wound Skintegrity 8oz	MSC6008	$2.15	Bottle
Optilock Non-Adhesive Dressing	MSC6444EP	$21.09	Box
Dressing Aliginate Maxorb 4x4	MSC7044EP	$27.13	Box
Dressing Aliginate 4x4	MSC7344	$28.21	Box
Dressing Collagen Puracol 2x2	MSC8622EP	$56.27	Box
Dressing Collagen Puracol 4x4	MSC8744EPZ	$56.27	Box
Dressing Maxorb Extra 4x4.75	MSC9445EP	$78.19	Box
Dressing Optifoam 4x4	MSC9614EP	$48.08	Box

7/1/2019 (Prices are subject to change)

Southern Nevada State Veterans Home
Resident Chargeable Items

Dressing Gel Fiber Opticell AG+ 4x5 (5 per box)	MSC9845EP	$82.82	Box
Dressing Gel Fiber Opticell AG+ 4x5(10 per box)	MSC9845EPZ	$86.15	Box
Curad Sterile Idofoam	NON256145	$1.52	Bottle
Dressing Derma-Gel Hydrogel	NON8000	$85.90	Box
Bandage Cohesive Caring Tan, 4x5 NS	PRM086004	$0.86	Wrap
Bandage Cohesive Caring Tan, 4x5 LF NS	PRM088004	$0.97	Wrap
Plain Packing Strip 1/4"x5YD	NON255145	$1.44	Bottle
Cetaphil Lotion	80641500	$11.97	Bottle
Sensi-Care Protective Barrier	SQU325614	$8.94	Tube
Optifoam Gentle Lite, Bordered 4x4	MSC2844B	$23.22	Box
Catheter Ureth Coude 14FR 16"	42371930	$1.65	Each
Cold Packs	MDS138000	$0.43	Each
Sterile Water 1000ML	50012816	$1.92	Bottle
Specimen Catch 800ML	40141200	$0.37	Each
Yankauer Suction Vent	BXTK82	$1.42	Each
Suction Tubing	SWD301606	$1.10	Each
Ruler, Educare Wound (Paper) (Wound Care)	MSCEDURULER	$0.05	Each
SalJet Sterile Saline (Wound Care)	WLZ64938	$0.80	Each
Graduate Container	DYND80417	$0.21	Each
UPad Heavy Absorb 23x36	74363100	$5.56	Bundle
Nepro w/Carb 1000mL	ROS62669	$9.73	Bottle
Isosource 1.5 1000mL	NES18180100	$5.83	Bag
Cerave Moisturizer Cream	73181400	$13.26	Jar
Diabetisource 1.2 1000mL	NES6508100	$9.10	Bag
Z-Guard Paste (Wound Care use)	MSC092544	$4.38	Tube
Spike Set	10404600	$0.90	Each
60 Catheter Tip Syringe	11614630	$0.23	Each
Prevail Wipe Vitamin E Purple Top	71713100	$1.90	Pack
Xeroform Dressing 5x9	33602000	$51.55	Box
SurePrep Rapid Dry Barrier Film 28mL	MSC1528	$5.83	Each
Optifoam Gentle Silicone Border w/Liquitrap	MSC2377EP	$35.00	Box
Ensure Enlive Chocolate	ROS64283	$1.00	Bottle
Ensure Enlive Vanilla	ROS64286	$1.00	Bottle
Ensure Clear	ROS64900	$1.06	Bottle
Glucerna Strawberry	ROS64925	$1.15	Bottle
Mepilex Border Post-Op 4x12	96652100	$53.49	Box
Stabilization Device Statlock (In-Place Catheter)	10151900	$4.28	Each
Large Leg Bag	47221900	$0.49	Each
Barr Ring 2 OPN (Wound Care)	83924900	$4.58	Each
Glucerna Vanilla	ROS64922	$1.15	Bottle
Cath MAGIC3 Hydro 16FR16" (16Fr Cath)	50661910	$81.21	Box
Nutren 2.0	NES9871644146	$6.48	Bag
Wash Basin 6Qt.	DYND80347	$0.40	Each
Gauze Sponge 4"x4" 12 PLY	NON21424	$0.03	Each
Cover Roll	45552002	$15.13	Box
E-Tank	OXYGEN	$5.77	Tank
Optifoam Gentle Liquitrap Sacrum 7"x7"	MSC2377EP	$35.00	Box

7/1/2019 (Prices are subject to change)

Southern Nevada State Veterans Home
Resident Chargeable Items

Dressing Hydrofera Blue Classic 4"x4" -Wound Care	85132100	$129.63	Box
Iodosorb Gel 10gm (Wound Care Use)	21202100	$22.70	Each
Solution Saline 0.9% NACl 250mL	62701900	$1.35	Bottle
Water, Sterile 250mL	62601900	$1.36	Bottle

7/1/2019 (Prices are subject to change)

abacusRx PHARMACY 1516 W. Warm Springs, Road, Henderson, NV 89014 Phone (725)222-0334

OMB Approval No. 0938-0975

Medicare Prescription Drug Coverage and Your Rights

Your Medicare Rights:

You **have the right to request a coverage determination** from your Medicare drug plan if you disagree with information provided by the pharmacy. You also **have the right to request a special type of coverage determination called an "exception"** if you believe:

- you need a drug that is not on your drug plan's list of covered drugs. The list of covered drugs is called a "formulary;"
- a coverage rule (such as prior authorization or a quantity limit) should not apply to you for medical reasons; or • you need to take a non-preferred drug and you want the plan to cover the drug at the preferred drug price.

What you need to do:

You or your prescriber can contact your Medicare drug plan to ask for a coverage determination by calling the plan's toll-free phone number on the back of your plan membership card, or by going to your plan's website. You or your prescriber can request an expedited (24 hour) decision if your health could be seriously harmed by waiting up to 72 hours for a decision. Be ready to tell your Medicare drug plan:

1. The name of the prescription drug that was not filled. Include the dose and strength, if known.
2. The name of the pharmacy that attempted to fill your prescription.
3. The date you attempted to fill your prescription.
4. If you ask for an exception, your prescriber will need to provide your drug plan with a statement explaining why you need the off-formulary or non-preferred drug or why a coverage rule should not apply to you.

Your Medicare drug plan will provide you with a written decision. If coverage is not approved, the plan's notice will explain why coverage was denied and how to request an appeal if you disagree with the plan's decision.

Refer to your plan materials or call 1-800-Medicare for more information.

Phone: (702) 475-4297

What is a Gradual Dose Reduction (GDR)?

Gradual dose reductions (GDRs) are a standard of practice in skilled nursing facilities. There are government regulations for nursing facilities that require assessment for possible GDRs for certain medications that affect the brain (i.e. medications for distressed behaviors, anxiety, sleep, and depression). The Alzheimer's Association along with many physician groups also recommend GDRs to ensure that the medication is still needed and that the resident is receiving the lowest possible effective dose.

Gradually reducing the dose of a medication is a way to make sure someone is taking the lowest effective dose. Lower doses generally have less risk for side effects. Additionally, stopping the medication after it has been successfully lowered will tell us if the medication is still needed. This can be a safe practice in nursing facilities as the staff can watch throughout the process to ensure the changes are tolerated.

Some reasons to attempt GDRs and/or stop medications include:

- Medications are not able to fix behaviors caused by unmet needs or a side effect from another medication
- Use of many medications at the same time increases potential side effects and the risk for interactions between them
- Aging and illness can make medications stay in the body much longer and that increases the risk of side effects
- People with several different diseases are often more sensitive to medications and can have unusual reactions to them (especially older adults)

Medications, aging, and illness can make people more likely to fall, become confused, get infections or have other complications. For this reason, GDRs are an important process to make sure a medication is being used at the right dose, for the right reason, and for the right amount of time. Several team members are involved in determining if a GDR could be tried such as physicians, nursing staff, consultant pharmacists and others. The GDR process helps to ensure the lowest possible dose is being utilized which in turn helps minimize the potential side effects.

OMB Approval No. 2900-0160
Estimated Burden: 30 minutes

Department of Veterans Affairs

Request for Prescription Drugs from an Eligible Veteran in a State Home

To:	**VA Facility** VA SOUTHERN NEVADA HEALTHCARE SYSTEM	**From:**	**Name and Address of State Home** NEVADA STATE VETERANS HOME 100 Veterans Memorial Drive Boulder City, NV 89005

I am a veteran who was admitted to the NEVADA **State Nursing Home.**
I request that I be furnished with prescription drugs by the United States Department of Veterans Affairs as provided for in Title 38 of the Code of Federal Regulations, Section(s) 17.96 and/or 51.42.

I am eligible for this benefit by reason of being (check any of the following):

☐ (1) a veteran in receipt of increased VA compensation, or increased VA pension because I am permanently housebound or in need of regular aid and attendance.

☐ (2) a veteran in need of regular aid and attendance who was formerly in receipt of increased pension but whose pension has been discontinued solely by reason of excess income, and whose annual income does not exceed the maximum annual income limitation by more than $1,000.

☐ (3) a veteran who
(i) Has a singular or combined rating of 50 percent or 60 percent based on one or more service-connected disabilities or unemployability and is in need of such drugs and medicines; and
(ii) Is in need of nursing home care for reasons that do not include care for a VA adjudicated service-connected disability.

☐ (4) a veteran who
(i) Has a singular or combined rating of less than 50 percent, based on one or more service-connected disabilities, and is in need of such drugs and medicines for a service-connected disability, and
(ii) Is in need of nursing home care for reasons that do not include care for a VA adjudicated service-connected disability.

Signature of Veteran Applying for Benefit **Date of Application**

Applicant Information

Veteran's Name (last, first, and middle initial):

Veteran's Social Security Number:	**Date of Admission to the State Nursing Home:**

Date that A&A or Housebound was awarded by VA:

(a copy of this award ☐ is or ☐ is not attached with this request)

Diagnosis/Diagnoses for which the Applicant was Admitted to the State Nursing Home		
Diagnosis Code	**Diagnosis Name**	**Category of Eligibility from page 1** *(1, 2, 3 or 4)*

Name of Prescribing Physician: CRAIG JOGENSON, MD

Telephone Number: 702-332-6864

I certify that the following medications are prescribed for _____ .
Veteran's Name

_____
Signature of State Home Representative

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 this Act. We may not conduct or sponsor, and the respondent is not required to respond to, a collection unless it displays a valid OMB Control Number. The public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, gather the necessary facts and fill out the form. This information is collected under the authority of Title 38 CFR Parts 51 and 58. It is being collected under the medical benefits in the State Homes Program and will be used for that purpose.

Privacy Act Information: It is being collected to enable us to determine your eligibility for medical benefits and will be used for that purpose. The income and eligibility you supply may be verified through a computer matching program at any time and information may be disclosed outside the VA as permitted by law; possible disclosures include those described in the "routine uses" identified in the VA system of records 24VA136, Patient Medical Record-VA, published in the Federal Register in accordance with the Privacy Act of 1974. Disclosure is voluntary; however, the information is required in order for us to determine your eligibility for the medical benefit for which you have applied. Failure to furnish the information will have no adverse affect on any other benefits to which you may be entitled. Disclosure of Social Security number(s) of those for whom benefits are claimed is requested under the authority of Title 38, U.S.C., and is mandatory. Social Security numbers will be used in the administration of veterans benefits, in the identification of veterans or persons claiming or receiving VA benefits and their records and may be used for other purposes where authorized by Title 38, U.S.C., and the Privacy Act of 1974 (5 U.S.C. 552a) or where required by other statute

Southern Nevada State Veterans Home
Guidelines for the Provision of Medications by the VA

Veterans residing in the Southern Nevada State Veterans Home are eligible to receive from the Department of Veterans Affairs (VA), medications prescribed by a non-VA physician if:

1. The veteran receives increased compensation from VA because the veteran is housebound or needs regular aid and attendance as a result of the veteran's service-connected disabilities; or

2. The veteran receives increased pension from VA as a veteran of periods of war because the veteran is housebound or needs regular aid and attendance; or

3. The veteran previously received increased pension from VA, but VA discontinued the veteran's pension because of the veteran's income, and his/her current annual income does not exceed the maximum annual income limitation by more than $1,000; or

4. VA determines that the veteran is eligible for increased pension (i.e., if the veteran served during periods of war, meet applicable income limitation, and needs aid and attendance or are housebound), but the veteran receives compensation as the greater benefit.

Frequently asked questions and answers about VA medication eligibility while residing in the Southern Nevada State Veterans Home (SNSVH):

Q. Are POWs residing in the SNSVH eligible to receive prescriptions from the VA?
A. No, a POW must be receiving aid and attendance/housebound benefits to receive prescriptions from the VA that are written by a non-VA provider.

Q. Are veterans with a 60% or greater service connected disability automatically covered for medications while at SNSVH?
A. No, the policy provides for aid and attendance/housebound veterans only. Please note the above referenced guidelines. However, a veteran may elect to receive care at a VA specialty clinic for his/her service connected disability. The veteran can receive VA medications for the medical diagnosis related to his/her service connected disability.

Q. Is a veteran entitled to continue receiving his/her medications from the VA once he/she becomes a resident at the SNSVH?
A. No, the SNSVH is responsible for primary care and the medications necessary for that care. A veteran may not see a VA physician solely for the purpose of seeking prescription medications. If the veteran is residing at SNSVH, then the SNSVH is the primary provider. When applicable, supplemental insurance such as Medicaid can ease the veteran's financial burden for medications.

OMB Control No. 2900-0321
Respondent Burden: 5 minutes
Expiration Date: 08/31/2018

Department of Veterans Affairs

APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

Note - If you would prefer to have an individual assist you with your claim, you may use VA Form 21-22a, " Appointment of Individual as Claimant's Representative." VA Forms are available at www.va.gov/vaforms.

IMPORTANT - PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN ON REVERSE BEFORE COMPLETING THE FORM.

1. LAST-FIRST-MIDDLE NAME OF VETERAN

2. VA FILE NUMBER *(Include prefix)*

3A. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS *(See list on reverse side before selecting organization)*

054- Nevada Department of Veteran Services

3B. NAME AND JOB TITLE OF OFFICIAL REPRESENTATIVE ACTING ON BEHALF OF THE ORGANIZATION NAMED IN ITEM 3A *(This is an appointment of the entire organization and does not indicate the designation of only this specific individual to act on behalf of the organization)*

3C. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 3A

INSTRUCTIONS - TYPE OR PRINT ALL ENTRIES

4. SOCIAL SECURITY NUMBER (OR SERVICE NUMBER, IF NO SSN)

5. INSURANCE NUMBER(S) *(Include letter prefix)*

6. NAME OF CLAIMANT *(If other than veteran)*

7. RELATIONSHIP TO VETERAN

8. ADDRESS OF CLAIMANT *(No. and street or rural route, city or P.O., State and ZIP Code)*

9. CLAIMANT'S TELEPHONE NUMBERS *(Include Area Code)*

A. DAYTIME

B. EVENING

10. EMAIL ADDRESS *(If applicable)*

11. DATE OF THIS APPOINTMENT

12. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C.

By checking the box below I **authorize** VA to disclose to the service organization named on this appointment form any records that may be in my file relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia.

☐ I authorize the VA facility having custody of my VA claimant records to disclose to the service organization named in Item 3A all treatment records relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. Redisclosure of these records by my service organization representative, other than to VA or the Court of Appeals for Veterans Claims, is not authorized without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the service organization named above, either by explicit revocation or the appointment of another representative.

13. LIMITATION OF CONSENT - I authorize disclosure of records related to treatment for all conditions listed in Item 12 except:

☐ DRUG ABUSE ☐ INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)

☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

14. AUTHORIZATION TO CHANGE CLAIMANT'S ADDRESS - By checking the box below, I authorize the organization named in Item 3A to act on my behalf to change my address in my VA records.

☐ I authorize any official representative of the organization named in Item 3A to act on my behalf to change my address in my VA records. This authorization does not extend to any other organization without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I file a written revocation with VA; or (2) I appoint another representative, or (3) I have been determined unable to manage my financial affairs and the individual or organization named in Item 3A is not my appointed fiduciary.

I, the claimant named in Items 1 or 6, hereby appoint the service organization named in Item 3A as my representative to prepare, present and prosecute my claim(s) for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 1. I authorize VA to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 12 and 13), to my appointed service organization. I understand that my appointed representative will not charge any fee or compensation for service rendered pursuant to this appointment. I understand that the service organization I have appointed as my representative may revoke this appointment at any time, subject to 38 CFR 20.608. *Additionally, in some cases a veteran's income is developed because a match with the Internal Revenue Service necessitated income verification. In such cases, the assignment of the service organization as the veteran's representative is valid for only five years from the date the claimant signs this form for purposes restricted to the verification match.* Signed and accepted subject to the foregoing conditions.

THIS POWER OF ATTORNEY DOES NOT REQUIRE EXECUTION BEFORE A NOTARY PUBLIC

15. SIGNATURE OF VETERAN OR CLAIMANT *(Do Not Print)*

16. DATE SIGNED

17. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 3B *(Do Not Print)*

18. DATE SIGNED

VA USE ONLY	COPY OF VA FORM 21-22 SENT TO: ☐ VR&E FILE ☐ EDU FILE ☐ LG FILE ☐ INSURANCE FILE	DATE SENT	ACKNOWLEDGED *(Date)*	REVOKED *(Reason and date)*

NOTE: As long as this appointment is in effect, the organization named herein will be recognized as the sole representative for preparation, presentation and prosecution of your claim before the Department of Veterans Affairs in connection with your claim or any portion thereof.

RECOGNIZED SERVICE ORGANIZATIONS

Membership in an organization is not a prerequisite to appointment of the organization as claimant's representative.

The following is a listing of national, regional, or local organizations recognized by the Secretary of Veterans Affairs in the preparation, presentation, and prosecution of claims under laws administered by the Department of Veterans Affairs.

African American PTSD Association
American Legion
American Red Cross
AMVETS
American Ex-Prisoners of War, Inc.
American GI Forum, National Veterans Outreach Program
Armed Forces Services Corporation
Army and Navy Union, USA
Associates of Vietnam Veterans of America
Blinded Veterans Association
Catholic War Veterans of the U.S.A.
Disabled American Veterans
Fleet Reserve Association
Gold Star Wives of America, Inc.
Italian American War Veterans of the United States, Inc.
Jewish War Veterans of the United States
Legion of Valor of the United States of America, Inc.
Marine Corps League
Military Officers Association of America (MOAA)
Military Order of the Purple Heart
National Amputation Foundation, Inc.
National Association of County Veterans Service Officers, Inc.
National Association for Black Veterans, Inc.
National Veterans Legal Services Program
National Veterans Organization of America
Navy Mutual Aid Association
Paralyzed Veterans of America, Inc.
Polish Legion of American Veterans, U.S.A.
Swords to Plowshares, Veterans Rights Organization, Inc.
The Retired Enlisted Association
The Veterans Assistance Foundation, Inc.
The Veterans of the Vietnam War, Inc. & The Veterans Coalition
United Spanish War Veterans of the United States
United Spinal Association, Inc.
Veterans of Foreign Wars of the United States
Veterans of World War I of the U.S.A., Inc.
Vietnam Era Veterans Association
Vietnam Veterans of America
West Virginia Department of Veterans Assistance
Wounded Warrior Project

Although agency titles vary, the following States and possessions maintain veterans service agencies which are recognized to present claims.

Alabama	Hawaii	Minnesota	North Dakota	Tennessee
American Samoa	Idaho	Mississippi	Northern Mariana Islands	Texas
Arizona	Illinois	Missouri	Ohio	Utah
Arkansas	Iowa	Montana	Oklahoma	Vermont
California	Kansas	Nebraska	Oregon	Virginia
Colorado	Kentucky	Nevada	Pennsylvania	Virgin Islands
Connecticut	Louisiana	New Hampshire	Puerto Rico	Washington
Delaware	Maine	New Jersey	Rhode Island	West Virginia
Florida	Maryland	New Mexico	South Carolina	Wisconsin
Georgia	Massachusetts	New York	South Dakota	Wyoming
Guam	Michigan	North Carolina		

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. However, the requested information is considered relevant and necessary to recognize a service organization as your representative and/or identify disclosable records. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to recognize the service organization you name to act on your behalf in the preparation, presentation, and prosecution of claims for VA benefits (38 U.S.C. 5902). We will also use the information to identify any VA records that we may disclose to the service organization (38 U.S.C. 5701(b)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

Department of Veterans Affairs

NOTICE TO VETERAN/CLAIMANT OF VA FORMS THAT MAY ACCOMPANY AN ALTERNATE SIGNER CERTIFICATION FORM

IMPORTANT: The form(s) shown below will be accepted along with the attached VA Form 21-0972, *Alternate Signer Certification.* VA forms are available at **www.va.gov/vaforms**.

For **COMPENSATION,** the required forms are**:**

- **VA Form 21-526EZ**, *Application for Disability Compensation and Related Compensation Benefits*
- **VA Form 21-526b**, *Veteran's Supplemental Claim for Compensation*
- **VA Form 21-526c**, *Pre-Discharge Compensation Claim*

For **PENSION,** the required forms are:

- **VA Form 21-527EZ**, *Application for Pension*
- **VA Form 21-527**, *Income, Net Worth, and Employment Statement*
- **VA Form 21P-0969**, *Income and Asset Statement in Support of Claim for Pension or Parents' Dependency and Indemnity Compensation (DIC)*
- **VA Form 21P-4165**, *Pension Claim Questionnaire for Farm Income*
- **VA Form 21-8049**, *Request for Details of Expenses*
- **VA Form 21P-8416**, *Medical Expense Report*
- **VA Form 21-4185**, *Report of Income from Property or Business*
- ***ALL** forms known as Eligibility Verification Reports (EVR's)*

For **COMPENSATION AND/OR PENSION,** the required forms are:

- **VA Form 21-526**, *Veterans Application for Compensation and/or Pension*
- **VA Form 21-0966**, *Intent to File a Claim for Compensation and/or Pension, or Survivors Pension and/or DIC*

For **DEPENDENTS,** the required forms are:

- **VA Form 21-686c**, *Declaration of Status of Dependents*

For **SCHOOL AGE CHILD(REN) (Aged 18-23 Years and In School),** the required forms are:

- **VA Form 21-674,** *Request for Approval of School Attendance*

For **DEPENDENT PARENT(S),** the required forms are:

- **VA Form 21P-509**, *Statement of Dependency of Parent(s)*

For **INDIVIDUAL UNEMPLOYABILITY),** the required forms are:

- **VA Form 21-8940**, *Veteran's Application for Increased Compensation Based on Unemployability*

For **POST-TRAUMATIC STRESS DISORDER,** the required forms are:

- **VA Form 21-0781**, *Statement in Support of Claim for Service Connection for Post-Traumatic Stress Disorder (PTSD)* and **VA Form 21-0781a**, *Statement in Support of Claim for Service Connection for PTSD Secondary to Personal Assault*

For **SPECIALLY ADAPTED HOUSING OR SPECIAL HOME ADAPTATION,** the required forms are:

- **VA Form 26-4555**, *Application in Acquiring Specially Adapted Housing or Special Home Adaptation Grant*

For **AUTO ALLOWANCE,** the required forms are:

- **VA Form 21-4502**, *Application for Automobile or Other Conveyance and Adaptive Equipment*

For **SURVIVORS BENEFITS** the required forms are:

- **VA Form 21-534EZ**, *Application for DIC, Death Pension, and/or Accrued Benefi t*
- **VA Form 21-534**, *Application for Dependency and Indemnity Compensation, Death Pension, and Accrued Benefits by Surviving Spouse or Child*
- **VA Form 21-534a**, *Application for Dependency and Indemnity Compensation by a Surviving Spouse or Child - In-Service Death Only*
- **VA Form 21-535**, *Application for Dependency and Indemnity Compensation by Parent(s)*
- **VA Form 21-8924**, *Application of Surviving Spouse or Child for REPS Benefits (Restored Entitlement Program for Survivors)*

For **ACCRUED BENEFITS** the required forms are:

- **VA Form 21-601**, *Application for Accrued Amounts Due a Deceased Beneficiary*

For **PHILIPPINE CLAIMS** the required forms are:

- **VA Form 21-0704**, *Supplemental Income Questionnaire*
- **VA Form 21-4169**, *Supplement to VA Forms 21-526, 21-534, and 21-535*

For **BENEFITS FOR CERTAIN CHILDREN WITH DISABILITIES** the required forms are:

- **VA Form 21-0304**, *Application for Benefits for Certain Children with Disabilities Born of Vietnam and Certain Korea Service Veterans*

NOTE: For more information on VA benefits, visit our web site at **www.va.gov**, contact us at **http://iris.va.gov**, or call us toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the Federal relay number is 711.

OMB Control No. 2900-0849
Respondent Burden: 15 minutes
Expiration Date: 10/31/2019

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

ALTERNATE SIGNER CERTIFICATION

INSTRUCTIONS: This form is to be completed by the individual signing the benefit application form on behalf of the veteran/claimant. **Note**: For purposes of this form, the individual signing the form on behalf of the veteran/claimant is referred to as the "alternate signer." Your accurate and complete answers to the questions on this form are important to help VA complete the veteran/claimant's claim.

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

NOTE: You can ***either*** complete the form online or by hand. Please print your information using blue or black ink, neatly, and legibly to help process the form.

IMPORTANT: Submit this form along with the appropriate benefit application form. The application form depends on the benefit you are claiming on behalf of the veteran/claimant. Also, submit any supporting documents or evidence to help VA complete the claim. See page 1 for a list of appropriate benefit application forms.

1. VETERAN'S NAME *(First, middle initial, last)*

2. VETERAN'S SOCIAL SECURITY NUMBER – –

3. VA FILE NUMBER *(If applicable)*

4. VETERAN'S DATE OF BIRTH
Month – Day – Year

5. HAS THE VETERAN EVER FILED A CLAIM WITH VA?
☐ YES ☐ NO

6. VETERAN'S SERVICE NUMBER *(If applicable)*

SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION *(Complete This Section **If The Claimant** is Other Than The Veteran)*

7. CLAIMANT'S NAME *(First, middle initial, last)*

8. CURRENT MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*
No. & Street
Apt./Unit Number
City
State/Province
Country
ZIP Code/Postal Code –

9. CLAIMANT'S SOCIAL SECURITY NUMBER – –

10. CLAIMANT'S RELATIONSHIP TO VETERAN
☐ SPOUSE ☐ PARENT ☐ CHILD

11. CLAIMANT'S PREFERRED TELEPHONE NUMBER *(Include Area Code)* – –

12. CLAIMANT'S PREFERRED E-MAIL ADDRESS *(If applicable)*

SECTION III: ALTERNATE SIGNER'S IDENTIFICATION INFORMATION

13. ALTERNATE SIGNER'S NAME *(First, middle initial, last)*

14. CURRENT MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*
No. & Street
Apt./Unit Number
City
State/Province
Country
ZIP Code/Postal Code –

15. ALTERNATE SIGNER'S PREFERRED TELEPHONE NUMBER *(Include Area Code)* – –

16. ALTERNATE SIGNER'S PREFERRED E-MAIL ADDRESS *(If applicable)*

17. ALTERNATE SIGNER'S RELATIONSHIP TO VETERAN/CLAIMANT (***Note**: You must check at least one box)*

☐ A COURT-APPOINTED REPRESENTATIVE
☐ AN ATTORNEY IN FACT OR AGENT AUTHORIZED TO ACT ON BEHALF OF THE VETERAN/CLAIMANT UNDER DURABLE POWER OF ATTORNEY
☐ A PERSON WHO IS RESPONSIBLE FOR THE CARE OF THE VETERAN/CLAIMANT, TO INCLUDE BUT NOT LIMITED TO A SPOUSE OR OTHER RELATIVE
☐ A MANAGER OR PRINCIPAL OFFICER ACTING ON BEHALF OF AN INSTITUTION WHICH IS RESPONSIBLE FOR THE CARE OF THE VETERAN/CLAIMANT

VETERAN'S SSN ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION IV: VETERAN/CLAIMANT INFORMATION

18. VETERAN/CLAIMANT IS: *(Check **ALL** that apply)*

☐ UNDER 18 YEARS OF AGE

☐ MENTALLY INCOMPETENT TO PROVIDE SUBSTANTIALLY ACCURATE INFORMATION NEEDED TO COMPLETE THE CLAIMS FORM, OR TO CERTIFY THAT STATEMENTS MADE ON THE FORM ARE TRUE AND COMPLETE, OR

☐ PHYSICALLY UNABLE TO SIGN THE CLAIMS FORM

SECTION V: ALTERNATE SIGNER'S DECLARATION OF INTENT

I understand that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the veteran/claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing my authority to act for the veteran/claimant with a judge's signature and date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the veteran/claimant and my authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the veteran/claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.

19A. AUTHORIZED SIGNER'S SIGNATURE ***(Required) (Sign in ink)***	19B. DATE SIGNED *(MM,DD,YYYY)*

20. REMARKS *(If any)*

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine the appropriate application and provide it to the veteran/claimant.

RESPONDENT BURDEN: We need this information to determine entitlement to act as the alternate signer for a veteran/claimant in submitting a claim for VA benefits (38 U.S.C. 5101). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public.do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

Southern Nevada State Veterans Home
Clothing Needs on Admission

SNSVH encourages each resident to maintain a minimum of a 5 day supply of clothing in the facility (shirts, pants, dresses, skirts, blouse and undergarments, etc.) dependent on the needs of each individual resident. NSVH residents will also need shoes, slippers, sweaters, a jacket, hat, pajamas, sunglasses or other articles of clothing that will enhance the resident's comfort. Keep in mind, worn out clothing should be replaced, as needed.

I, _____, (resident/responsible party) have read and understand what articles of clothing are needed, that all clothing must be clearly marked, and that an inventory list must be developed prior to admission.

I also understand that if additional clothing is brought into the home it must be presented to nursing or social service personnel for labeling prior to being put away.

I acknowledge that the SNSVH launders resident personal clothes at no additional charge to our resident population, but cannot be responsible for lost or damaged personal clothing. I understand that families have the option of utilizing a private laundry service or taking resident personal clothes home to be laundered.

_____
Residents Name (please print)

_____ _____
Resident/Resident's Representative Signature Date

Southern Nevada State Veterans Home
Bed Rail Usage Acknowledgment

In an effort to protect the life, health, and well-being of all residents, the Southern Nevada State Veterans Home is committed to remaining a restraint-free Facility. Bed rails pose a risk of harm to all residents and, for some residents, may be considered a restraint. Unless physician's orders instruct the placement of bed rails for a particular resident, all beds in the Home will remain without rails.

Residents and families should be aware of the safety hazards related to bed side rails. In December 2009, two resident deaths occurred in nursing homes in Colorado from side rails used as assistive devices[1], even though they were designed to cover a quarter or less of the length of the resident's bed. Evidence does not support the notion that side rails will prevent or reduce falls. Indeed, many residents are at greater risk of a more severe injury, such as entrapment, strangulation, or even death. According to the Food and Drug Administration (FDA), there were 691 entrapment reports, between January 1, 1985 and January 1, 2006, which resulted in 413 deaths[2]. As a result, SNSVH prohibits the use of bed side rails, except in isolated cases.

Residents and their families are discouraged from requesting rails. In those isolated cases where a bed side rail may be indicated, a needs-assessment must be completed, a physician order must be obtained, a consent/negotiated risk agreement must be completed and signed, and the resident's care plan must specify their use.

If you have further questions about the bed rail usage policy at SNSVH, please consult your Neighborhood Nurse Manager.

With my signature below, I am acknowledging the Southern Nevada State Veterans Home's policies, procedures, and protocols relative to bed rails:

_____ _____

Signature of Resident or Resident's Representative **Date**

[1] Muramoto D. Assistive Devices and Potential Threats to Residents: a Surveyor's Perspective. Received 1/8/10 from the Colorado Department of Public Health & Environment.

[2] U.S. hospital bed system dimensional and assessment guidance to reduce entrapment (CDRH Doc. No. 1537).Food and Drug Administration. Rockville, Md.: March 2006

SOUTHERN NEVADA STATE VETERANS HOME
BED HOLD ACKNOWLEDGEMENT

Resident Name _____ MRN _____

Residents and/or their representative have the opportunity to reserve an assigned bed when a resident leaves the facility. An election to hold a resident's bed requires the facility to maintain the resident's personal effects in the particular living space that the resident has temporarily vacated for the period of time the bed hold is paid. Bed hold is defined as a payment made to reserve a vacant bed for a resident who takes any type of absence from the facility. An election to hold a resident's bed requires the facility to maintain the resident's personal effects in the living space that the resident has temporarily vacated for the period of time the bed hold is paid.

The maximum daily rate for a bed-hold is based on the current daily room fee. This daily rate will be reduced by revenues received from VA or other financial sources. Residents and their representatives should be aware that the Department of Veterans Affairs will pay for the first 10 days, beginning with day 11. The resident is responsible for the total daily room rate. Private insurances do not cover the cost of a bed hold. Should the resident seek assistance from these sources, it is the responsibility of the resident or representative to contact the insurance company to discuss reimbursement for a bed hold.

Cost of a Bed Hold	
For the first 10 days of absence:	
Veteran	$125.00/day
Veteran on Mandatory per Diem	Free
After the first 10 days of absence, beginning on Day 11:	
Veteran	$187.00/day
Veteran on Mandatory per Diem	$187.00/day (semi private)
Veteran on Mandatory per Diem	$212.00/day (private)
All Non-veterans (spouses and Gold Star parents) will be charged starting day of discharge	$187.00 (semi private) $212.00 (private)

A bed hold may only be exercised when a resident or their representative requests a hold and their resident account is current. A bed shall be held for such time as the resident chooses, providing the cost of the bed hold is prepaid to the Business office.

At the time a resident is transferred from the facility to a hospital or other health care facility upon physician's orders, or the resident leaves the facility for any other reason,

medical or otherwise, the staff of SNSVH will provide the resident a copy of the Bed-Hold Notification/Election form. Social Services will consult with the Business Office to obtain an estimate of the resident's cost to hold the bed during the resident's absence. In the case of an emergency transfer, Social Services will contact the resident or representative the next regular business day if the signed election form has not been obtained.

Medicaid Residents

Medicaid residents and their representative should be aware that Medicaid regulations do not provide for a bed hold under their provisions of care. In such a case, a bed hold can be arranged privately at a cost not to exceed the Medicaid determined monthly patient liability.

Residents who are on Medicaid and Clark County Contracts will have the opportunity to have their bed held at a cost not to exceed the Medicaid or Clark County determined monthly patient liability.

A bed hold may be exercised only when all of the following factors are met:

a. A Resident or their representative requests a bed hold.

b. The resident account is current.

c. The clinical management team determines that the facility is able to provide appropriate care to meet the needs of the resident.

d. The resident meets the eligibility guidelines for residency at the Southern Nevada State Veterans Home.

Declining to Hold a Bed

Should the resident or their representative decline to hold the resident's bed, the resident has the right, following a transfer to a hospital or a therapeutic leave, to be readmitted to the first available bed in a semi-private room in a neighborhood that provides the appropriate level of care for the resident's medical condition.

_____ _____

Signature of Resident/Resident's Representative Date

NEVADA DEPARTMENT OF VETERANS SERVICES
Serving Nevada's Heroes

Southern Nevada State Veterans Home
100 Veterans Memorial Drive, Boulder City, Nevada 89005 (702) 332-6864

Readmission Procedure and Bed Hold in Place

Mr./Mrs. _____ is a resident of the Southern Nevada State Veterans Home and d/t current medical condition This resident is being transported to _____ for further medical care and treatment.

Mr./Mrs. _____ currently is holding a bed at the Southern Nevada State Veterans Home, room _____ and is planning to return to the home after medical treatment has been completed and the resident is medically stable.

The following information will need to be faxed to the Southern Nevada State Veterans Home once the resident is approaching the discharge date from the facility:

- ☐ History and Physical
- ☐ Copy of the MARS
- ☐ Chest X-ray Report
- ☐ Latest Lab Results
- ☐ Consultation Reports/Wound Care and ID Notes/Isolation Level (Contact, Droplet, Etc.)
- ☐ Surgical Reports
- ☐ PT/OT/ST Evaluations, Nutritional/Dietician Evaluation, and Current Diet Orders
- ☐ Discharge/Transfer Summary – To be received PRIOR to transport back to the Home

Case Management – Please contact the Admissions Coordinator for readmission status at 702-332-6730 or fax (702) 332-6771. **Note:** The resident MUST ARRIVE back to the Southern Nevada State Veterans Home **by 8:00 p.m**. Gero-Psych readmissions are only done Monday through Thursday to ensure our resident can receive optimal quality of care upon their return to our facility which includes our pharmacy and psych services. However, accommodations can be made on a case by case basis.

On weekends, holidays, and week days after 5:00 p.m., please call the House Supervisor at (702) 239-8251, Fax (702) 332-6762.

Thank you for your care and concern of our resident and we look forward to working with you and your facility in their readmission process and return to the Southern Nevada State Veterans Home.

Rev. 03/29/19

Southern Nevada State Veterans Home
Family Notification

Resident _____ MRN _____

Family notification takes place when there is a change of condition, a new doctor's order for diagnostic testing, or a medication change. At times, diagnostic tests are completed for various reasons and the nursing team notifies the resident's representative of the results. It is our goal to provide as much information as possible to assist your ability to make informed decisions on the resident's behalf. However, we are aware that multiple phone calls can cause some disruption and anxiety, especially late in the evening. Unless it is an emergency, we will attempt to make all family notifications between the hours of 8:00 a.m. to 9:00 p.m., Pacific Standard Time.

Please help us create a level of information supplied to you that accommodates your wishes and needs. We can restrict nurse notification to only emergency/change of condition and physician orders that require permission. Some families have asked that we not inform them by telephone if it is simply to report normal results or do not require medical intervention.

We will continue to attempt to contact you 24/7 in any emergency situation, or for routine matters that require medical intervention during business hours.

Please sign below and indicate whether you prefer to be informed of all results and physician orders, or if you prefer to restrict notification to only abnormal test results and emergencies. You will continue to receive other notifications, such as room changes and interdepartmental notifications such as Activities and Social Services.

☐ Restrict telephone notification to emergency, permission required, and abnormal results.

☐ Please call me with all information regarding this resident.

_____
Resident's Representative Name (please print)

_____ _____
Resident's Representative Signature Date

Residents & Visitors:

It's okay to ask health care providers if they have cleaned their hands.

Infection: Don't Pass It On

www.publichealth.va.gov/InfectionDontPassItOn

Department of Veterans Affairs

Southern Nevada State Veterans Home
Waiver of Liability of Funds and Valuables

_____
Resident Name (please print)

I have been informed by a representative of Southern Nevada State Veterans Home of the potential for loss of personal property. I have been encouraged to keep a minimal amount of personal funds and valuable items within my possession to avoid theft or loss. I have been informed of the locked vault. I realize if I am holding cash or items of value, I am doing so at my risk. I have been encouraged to purchase theft/loss insurance. I have been informed that the grievance procedure is an available option in the resolution of lost and/or misplaced items.

_____ _____
Resident's Signature Date

_____ _____
Resident's Representative Date

_____ _____
Representative of SNSVH Date

Department of Veterans Services
6630 S. McCarran Blvd Suite C204
Reno, Nevada 89509
(775) 688-1653 • Fax (775) 688-1656

STEVE SISOLAK
Governor

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
SOUTHERN 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

March 29, 2019

Dear Resident's Representative,

As we implement our Emergency Management Plan that has been developed in conjunction with Clark County Emergency Management Office, we want to update our emergency contact information for you.

In the event of an emergency, we would like to have an alternate number for you on file, if we do not already have it. We would also like to have at least one other person listed that we could contact in the event of an emergency. It would also be helpful to list family members not residing in the general area and/or out of state.

Please remember that in the event of a catastrophic event, phone lines may be down and cell phones inoperable, so we will make every attempt to contact you to inform you of our plans to shelter-in-place or evacuate.

In the event of an evacuation, we have agreements with alternate care facilities to provide care for our residents until we can safely return to our facility. These locations are, but not limited to:

Mountain View Care Center
601 Adams Boulevard
Boulder City, NV 89005
(702) 293-5151

TLC Care Center
1500 W. Warm Springs
Henderson, NV 89014
(702) 547-6700

You also have the option to ***take your loved one home*** during planned evacuations. We would provide you with necessary medications, medical supplies, and other items needed. This would be discussed further with you, as we prepared for such an event.

We appreciate your support and cooperation in assisting us in our planning process to ensure our residents and staff members are protected during times of catastrophe.

If you should have any questions, please contact the Social Services Department at (702) 332-6784.

Please complete the information below for our records (print legibly):

Resident Name: _____

Resident's Representative: _____

Home Telephone: _____

Office Telephone: _____

Mobile Telephone: _____

Emergency Contact: _____

Home Telephone: _____

Office Telephone: _____

Mobile Telephone: _____

Emergency Contact: _____

Home Telephone: _____

Office Telephone: _____

Mobile Telephone: _____

Are you or someone in your family willing to take your loved one home during an evacuation?

☐ Yes ☐ No

Thank you,

Linda Gelinger
Administrator

Southern Nevada State Veterans Home
Advance Directive Information Acknowledgement

This is to acknowledge that I have been informed in writing in a language that I understand of my right to formulate and issue Advance Directives to be followed should I become incapacitated.

☐ **I have previously** formulated and issued Advance Directives. I understand it is my responsibility to provide to the facility copies of all pertinent documentation which verify those advance directives

☐ **I have chosen** to formulate and issue Advance Directives at this time

☐ **I do not choose** to formulate or issue any Advance Directives at this time

_____	_____	_____
Date	Signature of Resident	Printed Name of Resident
_____	_____	_____
Date	Signature of Resident's Representative	Printed Name of Resident's Representative

WAR on WOUNDS

11/16/16

RELEASE AND WAIVER FOR ACCESS TO INFORMATION

Functional Pathways of TN, LLC offers RightTrack™ to nursing home and acute care facilities to facilitate communications to patients and their loved ones. RightTrack™ has been designed to provide patients and their family members with health care information and periodic progress reports via email and text messaging. RightTrack™ provides users the opportunity to more effectively monitor the health condition and progress of loved ones at the facility.

RightTrack™ does not provide medical advice, diagnosis, or treatment. The patient's medical chart is the official record relating to the patient's condition and well-being. The information provided by RightTrack™ is not intended to and does not replace the facility's medical chart. To the extent there are any inconsistencies between the facility's medical chart relating to the patient and the information communicated on RightTrack™, the facility's medical chart relating to the patient is the official record.

The content on the RightTrack™ Site, such as text, graphics, images, and other materials contained on the RightTrack™ Site ("Content") is for informational purposes only. The Content is not intended to be a substitute for professional medical advice, diagnosis, or treatment. You and your loved one should always seek the advice of the treating physician or other qualified health care provider with any questions you have regarding a medical condition, diagnosis or treatment. You and your loved one must not disregard professional medical advice or delay in seeking medical advice because of something you or your loved one has read on the RightTrack™ Site!

If you believe you or your loved one has a medical emergency, call 911 immediately. Functional Pathways does not recommend or endorse any specific tests, physicians, products, procedures, opinions, or other information that may be mentioned on the RightTrack™ Site.

Reliance on any information provided by RightTrack™, Functional Pathways employees, others providing information on this Site or other visitors to this Site is solely at the risk of you and your loved one. You and your loved one agree that by using this Site neither Functional Pathways, Functional Pathways of Tennessee, LLC ("Functional Pathways"), nor the Facility can be liable to you, your loved one or any other third party for any of the information communicated by this Site under any circumstances, and you voluntarily and unconditionally agree to release, waive, acquit and forever discharge any such claim against Functional Pathways, Functional Pathways and the Facility. You and your loved one also agree that RightTrack™ is merely a convenient way for you and your loved one to receive information regarding your loved one's health condition; that neither Functional Pathways, Functional Pathways, nor the Facility can guarantee the accuracy of the information communicated on this Site; and you will not rely on any RightTrack™ communication for any reason, including as part of any court action relating to either you or your loved one or any other third party, under any circumstances. You further agree that RightTrack™ communications may not be used as evidence in any action against Functional Pathways, Functional Pathways or the Facility. You agree the consideration for your relinquishment of the foregoing rights is Functional Pathways's agreement to allow you

to us its services. If you refuse to agree to these conditions of usage and relinquishment of your rights, as set forth above, and do not sign this waiver agreeing to the conditions of usage, then you will not be permitted to gain access to the Right Track website.

Functional Pathways agrees that it will not utilize patient specific information or email address for marketing purposes. Functional Pathways further agrees not to sell such information to a third party.

This agreement contains the entire understanding between the parties hereto and supersedes all prior agreements, understandings, negotiations, statements and representations. This agreement may not be modified or amended in any manner without a written agreement signed and dated by all parties. The invalidity or unenforceability of any provision of the agreement shall not affect the validity or enforceability of any other provision.

IN WITNESS WHEREOF, the parties have knowingly and voluntarily executed this agreement as of this

_____day of_____, 20 .

_____

(Patient Name)

_____

(Patient/Power of Attorney/Responsible Party Name)

_____

(Patient/Power of Attorney/Responsible Party Signature)

_____

(RightTrack™'s Authorized Email Address)