A Facility of
State of Georgia
Department of Veterans Service

Georgia War Veterans Home

2249 Vinson Highway
Milledgeville, Georgia 31061
(478) 445-4516

The Facility is
Operated by

Dear Prospective Applicant,

Thank you for your interest in the Georgia War Veterans Home located in Milledgeville, Georgia. We are a 24/7 skilled nursing facility. In case you are not aware, there is also a Georgia War Nursing Home located in Augusta, Georgia. You are welcome to apply to both facilities simultaneously, but will need to request each facility's application separately.

The Georgia War facilities (Milledgeville and Augusta) are owned by the Georgia Department of Veterans Service. They are funded by the state of Georgia tax revenues, some federal funding provided by the United States Department of Veterans Affairs, and the balance is a co-payment by the patient and/or family, or legally appointed guardian.

As of February 1, 2024, the daily rate will be $30.29 for those veterans that are less than 70% service connected. Veterans who are 70-100% service connected live at the home without paying the daily rate.

The applicant must have served on active duty during an approved wartime period and have been discharged under other than dishonorable conditions. Please be aware the length and type of service must meet criteria established by the United States Department of Veterans Affairs. This is generally evidenced by providing a copy of the applicant's DD-214. Veterans that served during WWII will not have a DD-214. These veterans should have documents that include an oriented "portrait" that indicates their name, rank, dates of service, awards, and medals, along with other information that is possibly included as a code in the bottom left corner of the WW-55, WD AGO 53 or 55, or WW 53-55. The second document listed resembles an award certificate. It usually has an eagle on it depending on the branch of service. This is the Honorable Discharge certificate. Copies of both documents are required.

If you are unable to locate the veteran's DD-214 or proof of active duty and honorable discharge papers, you may request copies from the Personnel Archives in St. Louis, MO at http://www.archives.gov/veterans/military-service-records/. Some records in the archives were lost in a fire. If the veteran's records were lost, they will send a sealed Certification of Military Service which is acceptable proof of service. You may also contact your nearest Georgia Department of Veteran Service office to facilitate this request.

The applicant must not need to be sustained by line-operated mechanical means (e.g., electrical respirator, ventilator, external pace makers, dialysis machines, PICC lines, ports A-V fistula or other life support apparatuses.

If the veteran meets the stated criteria, then they are eligible to complete an application and submit it for review and consideration. Once we receive a **complete application package**, it usually takes about two weeks for a decision on approval or denial is concluded.

Use this page as a check-off list for all required items to be turned in to the GWVH Office of Admissions to make the application complete.

The Following application forms are attached for your use:

1. **VS Form 27-173** Application for Admission to Georgia War Veterans Home (please read carefully the Terms & Conditions found on page 3).
2. **VS Form 27-106** Applicant Activities of Daily Living Survey Form-anyone who is capable of answering these questions about the veteran may complete and sign this form. Please answer each question to the best of your ability.
3. **1010-EZ**-Application for Health Benefits-If the veteran is already registered with the VA Hospital, a computerized version of this form may be printed by the VA. **If you choose to turn in the printed version with the veteran's application, please disregard the following: The veteran or legal healthcare agent must sign where indicated at the bottom of page 3 of this form.**
4. **1010 SH-Medical Certification**-(note: This form must be entirely completed by a physician).
5. **Funeral Home Designation Form**-must be completed as part of the application.
6. **VA Form 10-5345**-Request for and authorization to release health information.
7. **Payment Agreement**-must be signed and dated by veteran or responsible party.
8. **Proof of Immunizations (if available) including:** *Covid series including booster, Flu vaccine, Prevnar (pneumonia vaccine), Tetanus.

In addition to completing the attached forms, the following items are needed to finalize the application process:

1. Copy of the most recent (must be within the last three months) History & Physical, medication list, and lab work.
2. A copy of any medical records, including discharge summaries, from inpatient hospitalizations, in the last 3 months.
3. If the veteran is currently in a nursing home, please provide the name of the facility and the date of admission.
4. DD-214 and any award letters or discharges from military service.
5. Proof of entire household income.
6. Power of Attorney for Healthcare and/or Advance Directive for Healthcare documentation-only the veteran or the healthcare agent or legal guardian is allowed to sign the application. A copy of the documentation must accompany the application. If the veteran is only able to make a "mark," signatures of 2 witnesses must be included.
7. Living Will (if applicable).
8. Colored copies of insurance cards, Medicare card, Driver's License or Voter Registration card, social security card, and VA card (all copies need to be of front and back).
9. Copy of Covid Vaccination Card with Lot #'s
10. List of doctors and any upcoming appointments and home medications.
11. Proof of Residency-applicants must show Georgia residency for the immediate two years prior to making application or five out of the last fifteen. To prove residency, you can submit a copy of voter registration, or Georgia income taxes that show filings from the time requirements listed previously.

Additional Medical Information

*If the veteran is currently in the hospital, please have that facility send copies of the veteran's admission History and Physical exam as well as nurses' notes and doctor's orders.

*If the veteran is currently in a nursing home, please have that facility send us copies of the veteran's nurses' notes and doctor's orders from the past 30 days.

*If none of the previous situations apply, please have the veteran's Primary Care Physician send us copies of the most recent outpatient progress notes or any information that will prove the veteran's need for skilled nursing care.

*If the veteran attends mental health sessions, please request the most recent notes to be sent to our office.

GEORGIA WAR VETERANS HOME
DAILY FEE 2024
$ 30.29

MAKE CHECK OR MONEY ORDER PAYABLE TO

GA DEPT OF VETERANS SERVICE

No cash will be accepted for payment! However, cash can be deposited into the resident's trust fund account, provided one has been set up.

WE CAN NOT ACCEPT CREDIT CARD PAYMENTS OR ELECTRONIC TRANSFERS. ALL PAYMENTS ARE TO BE MADE IN THE FORM OF A CHECK OR MONEY ORDER.

PAYMENT DROP BOXES ARE LOCATED IN MSU AT THE NURSES STATION, AS WELL AS IN THE WOOD AND VINSON BUILDINGS ON THE FIRST FLOOR NEXT TO THE INFORMATION DESK. EACH BOX IS BLACK WITH GA DEPT OF VETERAN SERVICES PAYMENT DROP BOX LABEL ON THE FRONT. LIFT THE TOP AND DROP IN CHECKS OR MONEY ORDERS ONLY. RETURNED CHECK WILL RESULT IN MANDATORY CASHIER'S CHECKS OR MONEY ORDERS FROM THAT POINT FORWARD. NO EXCEPTIONS.

MAIL PAYMENT TO:

GEORGIA WAR VETERANS HOME
P.O. BOX 1412
MILLEDGEVILLE, GA. 31059-1412

Month	Amount
January	$909.85
February	$878.41
March	$938.99
April	$908.70
May	$938.99
June	$908.70
July	$938.99
August	$938.99
September	$908.70
October	$938.99
November	$908.70
December	$938.99

The above rate is outlined for your information only and is subject to change. **Kenyada Braddy, Financial Counselor, 478-445-5749, Wheeler Building Suite D-109.**

Please mail, email or fax documents to:

Georgia War Veterans Home
Attn: Catherine Dean, Admission Director **OR** Cherri Royster, Admissions Director
2249 Vinson Highway
Wheeler Building, Suite D 120
Milledgeville, GA 31061

Contact Information

Catherine Califf-Dean, Admissions Director
Phone: 478-445-4295
Fax: 478-445-4524 or 478-445-5190
Email: catherine.dean@stginternational.com
OR
Cherri Royster, Admissions Director
Phone: 478-234-1809
Fax: 478-445-4524 or 478-445- 5190
Email: cherri.royster@stginternational.com

Virtual Tour Link:

https://www.seeit360.com/georgia-war-veterans-home

Thank you for your interest in Georgia War Veterans Home in Milledgeville, Georgia.

Department of Veterans Service

Floyd Veterans Memorial Building, Suite E-970
Atlanta, GA 30334-4800

APPLICATION FOR ADMISSION TO A GEORGIA WAR VETERANS HOME

These facilities provide Nursing Home services ONLY and are **not** hospitals!

CHECK BOX to indicate facility to which admission is sought; MAIL one (1) copy of the completed application to the Admissions Coordinator at the address indicated immediately below:

GEORGIA WAR VETERANS NURSING HOME ADMISSIONS COORDINATOR 1101 Fifteenth Street Augusta, Georgia 30901-3196 Phone: (706) 721-2405	☐	GEORGIA WAR VETERANS HOME ADMISSIONS COORDINATOR 2249 Carl Vinson Highway Milledgeville, Georgia 31061 Phone: (478) 445-4295	☐

PART I - PERSONAL INFORMATION

1. Applicant: ______________________________
   Last First Middle (Maiden)
2. Legal Address: ______________________________
   Number Street City State Zip Code
3. Present Address: ______________________________
   Number Street City State Zip Code
4. Telephone Number where you can be contacted: ______________
5. VA Claim Number: ____________ 6. Applicant Social Security Number: ____________
7. Date of Birth: ______________ 8. Age: ____________
9. a. Military Dates of Service: ____________ (Attach Documentation) b. Military Retired Pay: YES ☐ NO ☐
10. Name and address of person to be notified in case of emergency:
   Name: ______________________________
   Last First Middle
   Address: ______________________________
   Number Street City State Zip Code
   Relationship: ____________ Home Telephone: ____________ (Include Area Code) Work: ____________ (Include Area Code)

Veterans Service Office Use ONLY
Verified by: DD 214: ☐ VA: ☐ Other: ☐ ______________ (If "Other," Explain)

Application forms and assistance should be obtained from the nearest office of the Georgia Department of Veterans Service, or from the Augusta or Milledgeville State Veterans Homes. Applicants are advised there may be a delay to allow time for processing applications for eligibility and a waiting list may exist because of bed or funding limitations.

PART II - INFORMATION ON LEGAL RESIDENCY

1. Do you now live in Georgia? YES ☐ NO ☐
2. Do you meet the residency requirement? (Must meet at least one.)
   a. Have you been a resident of this state for a minimum of two years? YES ☐ NO ☐
   b. Have you been a resident of this state for at least five years out of the last 15 years? YES ☐ NO ☐
3. The following documentary evidence supports my claim of residency *:

- ☐ Georgia Income Tax Forms (Returns)
- ☐ Georgia Driver License (in conjunction with other documents)
- ☐ Voter Registration Card (if dated)
- ☐ School Attendance Records
- ☐ Employer Statement on Letterhead
- ☐ Deed (Cannot be used without property tax statements showing Homestead Exemption Code.)
- ☐ Homestead Exemption
- ☐ Record on file in a GDVS Office
- ☐ **Other (List):** ____________________
- ☐ **Other (List):** ____________________

*PLEASE ATTACH DOCUMENTATION TO THE APPLICATION

4. Name and address of a person who can certify under oath you meet the residency requirement.

Name: ______________________________
Last First Middle

Address: ______________________________
Number Street City State Zip Code

Relationship: ____________________

Home Telephone: ____________________ Work Telephone: ____________________
(Include Area Code) (Include Area Code)

PART III - TERMS & CONDITIONS OF ADMISSION

1. To be eligible for admission, applicants must meet the requirements listed below in accordance with 38 CFR Part 51, of the U.S. Department of Veterans Affairs (VA), January 6, 2000, as amended; Georgia State Laws; and Georgia Department of Veterans Service policies as outlined in Georgia Department of Veterans Service Department Directive 27.119, State Veterans Home Program, as amended:

a. Applicant must be domiciled in Georgia and have actually resided in Georgia for at least two years or five out of the preceding 15 years immediately preceding the date of application.

b. The applicant must be a "war veteran." The term war veteran (see DD 27.119 for complete definition) means any veteran who was discharged under other than dishonorable conditions and who served on active duty in the Armed Forces of the United States or on active duty in a Reserve Component of the Armed Forces of the United States during wartime or during the period beginning January 31, 1955 and ending on August 1, 1990.

c. Applicant must be approved as "eligible for care and treatment" by the VA.

d. An applicant with contagious diseases, behavioral, psychiatric problems or other diagnoses the care and treatment for which may exceed the capability of the homes to provide will be reviewed before a decision will be made on accepting the veteran for admission to the homes. However, the facilities are unable to care for some cases of the diseases. When the contagious, infectious disease, behavioral, psychiatric problems or other diagnoses the care and treatment for which may exceed the capability of the homes to provide are resolved, under control, or it is determined the home has the capability to provide the care and treatment required, the applicant may be considered for admission based on facility resources.

e. Applicant must not need to be sustained by line-operated mechanical means (e.g., electrical respirator, external pace makers, dialysis machines, or other life support apparatuses).

f. Applicant must not be in need of hospital level of services (e.g., surgery, transfusions, intravenous infusion of drugs or fluids).

g. Applicant must not be participating in medical research programs that have special medical, treatment or transportation requirements.

h. Applicant must not have criminal charges pending, nor be under restraint or control from any court of law or law enforcement agency.

2. Residents will be required to:

a. Pay some expenses incurred by regulation (e.g., Medicare or health insurance co-pays and deductibles).

b. Pay all costs of transportation to and from the home (e.g., medical or other appointments, special outings, and etc.), unless specifically provided by the VA or the Georgia Department of Veterans Service.

c. **Abide by the rules and regulations established for resident conduct in the resident handbook and other individual policies, rules and regulations that may from time to time be published by the home, the Georgia Department of Veterans Service, or the VA with the understanding that violations will result in discharge from the home.** Operation of a motor vehicle on the premises of the homes is not permitted for residents.

d. Accept transfer to other medical facilities (including those operated by the VA), if the medical considerations indicate and pay all costs of transportation, unless provided by the VA or the Georgia Department of Veterans Service.

e. Accept discharge from the home when medical or administrative review determines such action to be appropriate and in accordance with the medical needs of the patient.

f. Recognize that each of the homes will be operated in full compliance with the Civil Rights Act without discrimination on the basis of a person's race, color, religion, national origin, sex, handicap or age.

PART IV - APPLICANT DECLARATION

Under penalty of law, the undersigned hereby certifies and declares that all answers to questions in this application and the attached documents are correct to the best of my knowledge and belief, that all questions are fully understood and that all questions and answers have been read by me or read and explained to me and that I understand and accept the terms and conditions required in Part III of this application. **FURTHER, I understand misleading statements on this application and any attached forms or documents will be grounds for non-admission to the home or discharge from the home.**

Signature of Veteran or Designated Representative (Designated Representative Signatures MUST BE Accompanied By A Power of Attorney or Guardianship Documentation)	Date

Signature of Witness #1	Signature of Witness #2

(Two Witnesses Required ONLY If Veteran Or Designated Representative Signs With A Mark Of An "X.")

Required Documents to Accompany the Completed Application (CHECK ITEMS INCLUDED):

- ☐ VS Form 27-173, Application for Admission to Georgia War Veterans Home
- ☐ VS Form 27-106, Applicant Activities of Daily Living Survey Form
- ☐ VS Form 27-303, State Veterans Home Payment Agreement
- ☐ VA Form 10-10EZ, Application for Health Benefits (with POA/Guardianship papers, as necessary)
- ☐ VA Form 10-10SH, State Home Program Application for Veteran Care Medical Certification*
- ☐ DD Form 214 or equivalent discharge document
- ☐ Most recent medical summary from primary physician
- ☐ Most recent hospital discharge summary (when available)

* This form must not be more than 30 days old. It must include a statement by the referring physician that the applicant is or is not chronically ill and whether the applicant has a history of psychiatric disorders or behavioral problems.

PART V - VFSO REPRESENTATIVE DECLARATION

Under penalty of law, the undersigned hereby certifies and declares that the applicant provided the documentary evidence listed in Part II, as required by the Georgia Department of Veterans Service, to support fulfillment of the residency requirement identified in Parts II & III of this application.

Signature of Georgia Department of Veterans Service Representative	Date
VFSO Office Location	(Area Code) Telephone Number

Department of Veterans Service

Floyd Veterans Memorial Building
Atlanta, Georgia
30334

State Veterans' Home Payment Agreement

Date: ______________________

Name of Veteran Patient: ______________________

First Initial of Last Name and Last Four of Social Security Number: __________

Mailing Addresses for Georgia's State Veterans' Homes

(Check the block " ☐ " for the appropriate State Veterans' Home)

☐	Georgia War Veterans Nursing Home 1101 15th Street Augusta, Georgia 30901-3196 ATTN: Executive Director	☒	Georgia War Veterans Home 2249 Carl Vinson Highway Milledgeville, Georgia 31061 ATTN: Executive Director

Introduction

This is a Georgia State Veterans Home Payment Agreement (Agreement) by and between the Georgia Department of Veterans Service, the Georgia War Veterans Nursing Home in Augusta, Georgia, or the Georgia War Veterans Home in Milledgeville, Georgia and the undersigned veteran patient and/or responsible party(s). This is a legal document creating rights and obligations for each person, or party signing the Agreement. Please read the Agreement carefully before you sign it. This agreement is required by Chapter 690-1-1-.03(7), Fee for Residency in a Facility of the Georgia State War Veterans' Home, Georgia's Administrative Rules and Regulations, November 1, 2012.

Period of the Agreement

This agreement shall be effective on the date first indicated above, or the date of admission to the indicated State Veterans' Home, whichever occurs later. In accordance with Chapter 690-1-1-.03(7) it shall remain in effect for the period of time the veteran patient named above remains a resident of the State Veterans' Home indicated above.

References to the Parties

We believe this Agreement will be more easily understood if we use, where practical, personal pronouns in referring to the parties to this Agreement. References to "we", "our", "home", the "Facility", and to "our Facility" are references to the Georgia Department of Veterans Service, the Georgia War Veterans Nursing Home, or the Georgia War Veterans Home. References to "you" and "your" are references to any person signing this Agreement.

Agreement as Veteran Patient or Responsible Party.

A **Veteran Patient** is an individual who meets the eligibility requirements for residency in a State Veterans' Home as stated in Georgia law and is the actual patient who resides in or will reside in the facility.

A **Responsible Party** is an individual who voluntarily agrees to honor certain specified obligations of financial liability of the Veteran Patient. If you sign this Agreement as the Responsible Party you are accepting responsibility for the Veteran Patient and any debts that may be incurred by the Veteran Patient at the facility related to payment of the Daily Fee and the monthly invoice.

Billing and Changes in Rates

Our current Daily Fee on the date of this agreement is $ 30.29 . We shall provide you with at least 30 days written notice of any increase in the Daily Fee. You agree to pay us our Daily Fee for each day of nursing facility care and services we provide to the Veteran Patient. Such payment shall be made one month at a time. We shall provide you with monthly invoices itemizing total charges incurred by you of the Daily Fee times the number of days the veteran patient was a resident in the home during the month. Invoices will be issued at the beginning of the month of residency in the home and each subsequent month. Payments will be due and payable no later than 10 days following the date of invoice. In the event of death or permanent discharge, fees paid for days not used will be refunded to the Veteran Patients' responsible party; however, any and all outstanding amounts owed will be due and payable within 10 days after the beginning of the month following the death or permanent discharge of the veteran patient. Payments for partial months will be calculated from the first day of the month through the day prior to death or permanent discharge of the Veteran Patient. Our current Daily Fee is expected for bed holds, including but not limited to, hospitalizations and therapeutic leaves. We neither extend credit nor accept payment in installment. (Chapter 690-1-1, Georgia's Administrative Rules)

Advance Payment upon Admission

New admissions to the facility will make payments to the home for the amount of the Daily Fee from the day/date of admission through the last day of

the month of admission. Subsequent monthly invoices will be submitted to the Veteran Patients and/or Responsible Parties in accordance with standard invoicing and business procedures.

Collection Costs and Attorneys' Fees

We require you or your Responsible Party to agree, as a condition of admission and continued stay in our Facility, to pay attorney's fees or any other costs incurred in collecting payment for the nursing facility care and services we provide to you.

Services

The basic Daily Fee includes payment for healthcare providers (physicians, nurse practitioners, physician's assistants), nursing services and lodging, linens (routine laundry service of them), routine nursing supplies, regular meals and snacks, routine therapies, routine equipment, social services, activities, and routine items which are required to meet your needs. It does not include personal services (such as personal laundry service), haircuts or personal items.

Acknowledgements

By signing below, I/we acknowledge my/our understanding and agreement to the stipulations and requirements outlined in this payment agreement.

Veteran Patient and/or Responsible Party:

______________________________ [Signature of Veteran Patient/If able to sign]

______________________________ [Date]

______________________________ [Print Name]

______________________________ [Signature of Responsible Party/Spouse]

______________________________ [Date]

______________________________ [Print Name]

State Veterans' Home Representative:

______________________________ [Signature]

______________________________ [Date]

______________________________ [Print Name]

[Abbreviated Home Name]: GWVH-Milledgeville

Department of Veterans Affairs

INSTRUCTIONS FOR COMPLETING ENROLLMENT APPLICATION FOR HEALTH BENEFITS

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

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

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

You may use ANY of the following to request assistance:

- Ask VA to help you fill out the form by calling us at 1-877-222-VETS (8387).
- Go to www.va.gov/health-care for information about VA health benefits.
- Contact the Enrollment Coordinator at your local VA health care facility.
- Contact a National or State Veterans Service Organization.

Definitions of terms used on this form:

- SERVICE-CONNECTED (SC): A VA determination that an illness or injury was incurred or aggravated in the line of duty, in the active military, naval or air service.
- COMPENSABLE: A VA determination that a service-connected disability is severe enough to warrant monetary compensation.
- NONCOMPENSABLE: A VA determination that a service-connected disability is not severe enough to warrant monetary compensation.
- NONSERVICE-CONNECTED (NSC): A Veteran who does not have a VA determined service-related condition.

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

Directions for Sections I - III:

Section I - General Information: Answer all questions.

Type of Benefit Applying For:

- **Enrollment** - Veterans applying for enrollment for the Full Medical Benefits Package provide in 38 C.F.R. 17.38 must meet the eligibility requirements of 38 C.F.R. 17.36.
- **Registration** - For Registrations, only complete Sections I, II, and III. Enrollment not required - Veterans requesting an eligibility assessment, clinical evaluation, care or treatment pursuant to a special treatment authority provided in 38 C.F.R. 17.37:
  - Care for a Veteran with a VA service connected disability rating of 50% or greater
  - Care for a VA rated service connected disability
  - Care for psychosis or other mental illness
  - Care for Military Sexual Trauma treatment (MST)
  - Catastrophically Disabled Examination
  - A veteran who was discharged or released from active military service for a disability incurred or aggravated in the line of duty can receive VA care for the 12-month period following discharge or release
  - Care for a Veteran participating in VA's vocational rehabilitation program under 38 U.S.C. 31

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

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

Directions for Sections IV-IX:

Section IV - Dependent Information: Include the following:

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

Section V - Employment Information:

- Veterans Employment Status
- Date of Retirement
- Company Name
- Company Address
- Company Phone Number

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

Financial Disclosure Requirements Do Not Apply To:

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

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

Section VII - Previous Calendar Year Gross Annual Income of Veteran, Spouse and Dependent Children
Report:

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

Do Not Report:

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

Section VIII - Previous Calendar Year Deductible Expenses

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

Section IX - Consent to Copays and to Receive Communications

By submitting this application, you are agreeing to pay the applicable VA copayments for care or services (including urgent care) as required by law. You also agree to receive communications from VA to your supplied email, home phone number, or mobile number. However, providing your email, home phone number, or mobile number is voluntary.

Submitting Your Application

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

Where do I send my application?
Mail the original application and supporting materials to the Health Eligibility Center, 2957 Clairmont Road, Suite 200, Atlanta, GA 30329.

PAPERWORK REDUCTION ACT AND PRIVACY ACT INFORMATION

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 30 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Privacy Act Information: VA is asking you to provide the information on this form under 38 U.S.C. Sections 1705,1710, 1712, and 1722 in order for VA to determine your eligibility for medical benefits. Information you supply may be verified from initial submission forward through a computer-matching program. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices and in accordance with the VHA Notice of Privacy Practices. Providing the requested information is voluntary, but if any or all of the requested information is not provided, it may delay or result in denial of your request for health care benefits. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify Veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

OMB Control No. 2900-0091
Estimated Burden Avg. 30 min.
Expiration Date: 06/30/2024

Department of Veterans Affairs

VA DATE STAMP
(For VHA Use Only)

APPLICATION FOR HEALTH BENEFITS

SECTION I - GENERAL INFORMATION

Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)

TYPE OF BENEFIT(S) APPLYING FOR:

☐ **ENROLLMENT** - VA Medical Benefits Package (Veteran meets and agrees to the enrollment eligibility criteria specified at 38 CFR 17.36)
☐ **REGISTRATION** *(Complete Sections I, II, and III)* - VA Health Services (Veterans meets the "Enrollment not required" eligibility criteria specified at 38 CFR 17.37)

1A. VETERAN'S NAME *(Last, First, Middle Name)*	1B. PREFERRED NAME	2. MOTHER'S MAIDEN NAME

3A. BIRTH SEX: ☐ MALE ☐ FEMALE

3B. SELF-IDENTIFIED GENDER IDENTITY: ☐ MAN ☐ WOMAN ☐ TRANSGENDER MAN ☐ TRANSGENDER WOMAN ☐ NON-BINARY ☐ PREFER NOT TO ANSWER ☐ A GENDER NOT LISTED HERE

4. ARE YOU HISPANIC OR LATINO? ☐ YES ☐ NO

5. WHAT IS YOUR RACE? *(You may check more than one. Information is required for statistical purposes only.)*
☐ ASIAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ WHITE
☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ CHOOSE NOT TO ANSWER

6. SOCIAL SECURITY NO.

7A. DATE OF BIRTH *(mm/dd/yyyy)*	7B. PLACE OF BIRTH *(City and State)*	8. PREFERRED LANGUAGE	9. RELIGION

10A. MAILING ADDRESS *(Street)*	10B. CITY	10C. STATE	10D. ZIP CODE	10E.COUNTY

10F. HOME TELEPHONE NO. *(optional)* *(Include Area Code)*	10G. MOBILE TELEPHONE NO. *(optional)* *(Include Area Code)*	10H. E-MAIL ADDRESS *(optional)*

11A. HOME ADDRESS *(Street)*	11B. CITY	11C. STATE	11D. ZIP CODE	11E.COUNTY

12. CURRENT MARITAL STATUS
☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED

13A. NEXT OF KIN NAME	13B. NEXT OF KIN ADDRESS	13C. NEXT OF KIN RELATIONSHIP

13D. NEXT OF KIN TELEPHONE NO. *(Include Area Code)*	14A. EMERGENCY CONTACT NAME	14B. EMERGENCY CONTACT TELEPHONE NO. *(Include Area Code)*

15. DESIGNEE - INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH *(Note: This does not constitute a will or transfer of title)*

16. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? *(for listing of facilities visit www.va.gov/find-locations)*

17. WOULD YOU LIKE FOR VA TO CONTACT YOU TO SCHEDULE YOUR FIRST APPOINTMENT? ☐ YES ☐ NO

APPLICATION FOR HEALTH BENEFITS *Continued*

VETERAN'S NAME *(Last, First, Middle)*

SOCIAL SECURITY NUMBER

SECTION II - MILITARY SERVICE INFORMATION

1A. LAST BRANCH OF SERVICE

1B. LAST ENTRY DATE *(mm/dd/yyyy)*

1C. FUTURE DISCHARGE DATE *(mm/dd/yyyy)*

1D. LAST DISCHARGE DATE *(mm/dd/yyyy)*

1E. DISCHARGE TYPE

1F. MILITARY SERVICE NUMBER

2. MILITARY HISTORY *(Check yes or no)*	YES	NO		YES	NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?	☐	☐	F. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	☐	☐
B. ARE YOU A FORMER PRISONER OF WAR?	☐	☐	G. DID YOU SERVE IN AN AGENT ORANGE LOCATION BETWEEN JANUARY 9, 1962 AND JULY 31, 1980?	☐	☐
C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?	☐	☐	H. DID YOU SERVE IN AN IONIZING RADIATION LOCATION AND PARTICIPATE IN ANY NUCLEAR TESTING, TREATMENTS, OR CLEAN UP?	☐	☐
D. WERE YOU DISCHARGED OR RETIRED FROM MILITARY FOR A DISABILITY INCURRED IN THE LINE OF DUTY?	☐	☐	I. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	☐	☐
E. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998?	☐	☐	J. DID YOU SERVE ON ACTIVE DUTY AT LEAST 30 DAYS AT CAMP LEJEUNE FROM AUGUST 1, 1953 THROUGH DECEMBER 31, 1987?	☐	☐

SECTION III - INSURANCE INFORMATION *(Use a separate sheet for additional information)*

1. ENTER YOUR HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER *(include coverage through spouse or other person)*

2. NAME OF POLICY HOLDER

3. POLICY NUMBER

4. GROUP CODE

5. ARE YOU ELIGIBLE FOR MEDICAID? *(Federal health insurance for low income adults)*
☐ YES ☐ NO

6A. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A?
☐ YES ☐ NO

6B. EFFECTIVE DATE *(mm/dd/yyyy)*

6C. MEDICARE NUMBER:

SECTION IV - DEPENDENT INFORMATION *(Use a separate sheet for additional dependents)*

1. SPOUSE'S NAME *(Last, First, Middle Name)*

1A. SPOUSE'S SOCIAL SECURITY NUMBER

1B. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)*

1C. SPOUSE'S SELF-IDENTIFIED GENDER IDENTITY
☐ MAN ☐ WOMAN ☐ TRANSGENDER MAN
☐ TRANSGENDER WOMAN ☐ NON-BINARY
☐ PREFER NOT TO ANSWER ☐ A GENDER NOT LISTED HERE

1D. DATE OF MARRIAGE *(mm/dd/yyyy)*

1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP if different from Veteran's)*

2. CHILD'S NAME *(Last, First, Middle Name)*

2A. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)*

2B. CHILD'S SOCIAL SECURITY NO.

2C. DATE CHILD BECAME YOUR DEPENDENT *(mm/dd/yyyy)*

2D. CHILD'S RELATIONSHIP TO YOU *(Check one)*
☐ SON ☐ DAUGHTER ☐ STEPSON ☐ STEPDAUGHTER

2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18?
☐ YES ☐ NO

2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR?
☐ YES ☐ NO

2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(e.g., tuition, books, materials)*

3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT?
☐ YES ☐ NO

SECTION V - EMPLOYMENT INFORMATION

1A. VETERAN'S EMPLOYMENT STATUS *(Check one)*.
☐ FULL TIME ☐ PART TIME ☐ NOT EMPLOYED ☐ RETIRED

1B. DATE OF RETIREMENT *(mm/dd/yyyy)*

1C. COMPANY NAME. *(Complete if employed or retired)*

1D. COMPANY ADDRESS *(Complete if employed or retired - Street, City, State, ZIP)*

1E. COMPANY PHONE NUMBER *(Complete if employed or retired) (Include area code)*

APPLICATION FOR HEALTH BENEFITS *Continued*	VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

SECTION VI - FINANCIAL DISCLOSURE

Disclosure allows VA to accurately determine whether certain Veterans will be charged copays for care and medications, their eligibility for other services and enrollment priority. Veterans are not required to disclose their financial information. Veterans who choose not to disclose financial information may not be eligible for enrollment or may be responsible for any applicable VA copayments, if they are enrolled. **Recent Combat Veterans (e.g., OEF/OIF/OND)** may answer YES in Section VI and complete Sections VII and VIII to have their priority for enrollment and financial eligibility for travel assistance, cost-free medications and/or medical care for services unrelated to military experience.

☐ **No, I do not wish to provide financial information in Sections VII through VIII.** If I am enrolled, I agree to pay applicable VA copayments. Sign and date the form in the Assignment of Benefits section.

☐ **Yes, I will provide my household financial information for last calendar year.** Complete applicable Sections VII and VIII. Sign and date the form in the Assignment of Benefits section.

SECTION VII - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN

(Use a separate sheet for additional dependents)

	VETERAN	SPOUSE	CHILD 1
1. GROSS ANNUAL INCOME FROM EMPLOYMENT *(wages, bonuses, tips, etc.)* EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
3. LIST OTHER INCOME AMOUNTS *(e.g., Social Security, compensation, pension, interest, dividends)* EXCLUDING WELFARE.	$	$	$

SECTION VIII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE *(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home) VA will calculate a deductible and the net medical expenses you may claim.*	$
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES (INCLUDING PREPAID BURIAL EXPENSES) FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD *(Also enter spouse or child's information in Section VI.)*	$
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES *(e.g., tuition, books, fees, materials) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.*	$

SECTION IX - CONSENT TO COPAYS AND TO RECEIVE COMMUNICATIONS

By submitting this application, you are agreeing to pay the applicable VA copayments for care or services (including urgent care) as required by law. You also agree to receive communications from VA to your supplied email, home phone number, or mobile number. However, providing your email, home phone number, or mobile number is voluntary.

ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section 1729 and 42 U.S.C. 2651, the Department of Veterans Affairs (VA) is authorized to recover or collect from my health plan (HP) or any other legally responsible third party for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse. Furthermore, I hereby assign to the VA any claim I may have against any person or entity who is or may be legally responsible for the payment of the cost of medical services provided to me by the VA. I understand that this assignment shall not limit or prejudice my right to recover for my own benefit any amount in excess of the cost of medical services provided to me by the VA or any other amount to which I may be entitled. I hereby appoint the Attorney General of the United States and the Secretary of Veterans' Affairs and their designees as my Attorneys-in-fact to take all necessary and appropriate actions in order to recover and receive all or part of the amount herein assigned. I hereby authorize the VA to disclose, to my attorney and to any third party or administrative agency who may be responsible for payment of the cost of medical services provided to me, information from my medical records as necessary to verify my claim. Further, I hereby authorize any such third party or administrative agency to disclose to the VA any information regarding my claim.

ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS WHICH DEFINE WHO CAN SIGN ON BEHALF OF THE VETERAN.

SIGNATURE OF APPLICANT *(Sign in ink)* ______________________ **DATE** *(mm/dd/yyyy)* ____________

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT STATEMENT:

The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if information needed to locate records for release is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10A7 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

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

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

PATIENT'S MAILING ADDRESS (*Including City, State and Zip Code*)

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

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

☐ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ EMPLOYMENT ☐ OTHER *(Please specify below):*

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

- ☐ HEALTH SUMMARY *(Prior 2 Years)*
- ☐ PATIENT MEDICAL RECORDS *(Dates)*: __________
- ☐ INPATIENT DISCHARGE SUMMARY *(Dates)*: __________
- ☐ PROGRESS NOTES:
  - ☐ SPECIFIC CLINICS *(Name & Date Range)*: __________
  - ☐ SPECIFIC PROVIDERS *(Name & Date Range)*: __________
  - ☐ DATE RANGE: __________
- ☐ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: __________
- ☐ LAB RESULTS:
  - ☐ SPECIFIC TESTS *(Name & Date)*: __________
  - ☐ DATE RANGE: __________
- ☐ RADIOLOGY REPORTS *(Name & Date)*: __________
- ☐ LIST OF ACTIVE MEDICATIONS: __________
- ☐ VACCINATION *(Dose, Lot Number, Date & Location)*: __________
- ☐ ADMINISTRATIVE RECORDS: __________
- ☐ OTHER *(Describe)*: __________

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

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

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

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

☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

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

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

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

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

EXPIRATION: Without my express revocation, the authorization will automatically expire *(select one of the following)*:

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

☐ ON *(mm/dd/yyyy)* ______________ *(enter a future date other than date signed by patient)*

☐ UNDER THE FOLLOWING CONDITION(S): ______________________________

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
LEGAL REPRESENTATIVE SIGNATURE *(if applicable) (Sign in ink)*	DATE *(mm/dd/yyyy)*
PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED *(mm/dd/yyyy)*	RELEASED BY:

Georgia War Veterans Home
2249 Vinson Highway
Milledgeville, GA 31061

Instructions for the 10-10SH Form

Please give this page and the following 10-10 SH form (page 1 & 2) to your primary care provider to complete. This form must be signed by a physician ONLY.

Provider: Please return the 10-10 SH form with the following items

*Most recent History and Physical

*Lab work

*Medication List

*Upcoming appointment schedule

*All medical documentation must be current (within the last 3 months)

DO NOT LEAVE ANY OF THE VITAL INFORMATION SPACES BLANK AS ALL OF THE INFO IS REQUIRED BY THE VA FOR CONSIDERATION FOR ADMISSION. DO NOT PUT "SEE ATTACHED" ANYWHERE ON THE FORM.

The provider is to return the completed form to the GWVH Office of Admissions with the above-mentioned documentation to:

GWVH Office of Admission
2249 Vinson Highway
Milledgeville, GA 31061

OR

Fax to: Catherine Califf-Dean or Cherri Royster at 478-445-4524

OR

Email to: catherine.dean@stginternational.com or cherri.royster@stginternational.com

If you have any questions, please contact Catherine Califf-Dean at 478-445-4295 or Cherri Royster at 478-234-1809 for assistance.

OMB Approval No. 2900-0160
Estimated Burden: Avg. 20 min.
Expiration Date: 10-31-2023

STATE HOME PROGRAM APPLICATION FOR VETERAN CARE MEDICAL CERTIFICATION

PART I - ADMINISTRATIVE

1. STATE HOME FACILITY: Georgia War Veterans Home

2. DATE ADMITTED *(MM/DD/YYYY)*:

3. STATE HOME FACILITY ADDRESS *(Street, City, State and Zip Code)*: 2249 Vinson Highway, Milledgeville, GA 31061

4. RESIDENT'S NAME *(Last, First, Middle)*:

5. SOCIAL SECURITY NUMBER:

6. GENDER ☐ M ☐ F

7. AGE

8. DATE OF BIRTH *(MM/DD/YYYY)*

9. ADVANCED MEDICAL DIRECTIVE ☐ NO ☐ YES

10. HAS THE VETERAN PROVIDED FINANCIAL DISCLOSURE FOR PURPOSES OF DETERMINING ELIGIBILITY FOR DOMICILIARY PER DIEM PAYMENTS?
☐ YES ☐ NO ☐ N/A **10-10EZ or 10-10EZR IS REQUIRED TO BE SUBMITTED EITHER IN PAPER FORM OR ELECTRONICALLY WITH THE 10-10SH**

PART II - HISTORY AND PHYSICAL *(Use separate sheet if necessary)*

11. HISTORY

12. HEIGHT	13. WEIGHT	14. TEMP	15. PULSE	16. BP	17. HEAD/EYES/EAR/NOSE AND THROAT

18. NECK	19. CARDIOPULMONARY
20. ABDOMEN	21. GENITOURINARY
22. RECTAL	23. EXTREMITIES
24. NEUROLOGICAL	25. ALLERGY/DRUG SENSITIVITY

26. X-RAY/ LAB								
	CHEST X-RAY	DATE *(MM/DD/YYYY)*	RESULT	☐ N/A	CBC	DATE *(MM/DD/YYYY)*	RESULT	☐ N/A
	SEROLOGY							☐ N/A
	URINALYSIS	DATE *(MM/DD/YYYY)*	ALBUMIN		ACETONE		SUGAR	☐ N/A

CHECK ALL BOXES THAT APPLY OR CHECK N/A

27. IS DEMENTIA THE PRIMARY DIAGNOSIS ☐ YES ☐ NO ☐ N/A

28. IS THERE A DIAGNOSIS OF MENTAL ILLNESS ☐ YES ☐ NO ☐ N/A

29. HAS RESIDENT RECEIVED MENTAL HEALTH SERVICES WITHIN THE PAST 2 YEARS ☐ YES ☐ NO ☐ N/A

30. IS CLIENT A DANGER TO SELF OR OTHERS ☐ YES ☐ NO ☐ N/A

31. IS THERE ANY PRESSING EVIDENCE OF MENTAL ILLNESS SUCH AS:
☐ SCHIZOPHRENIA ☐ PARANOIA ☐ OTHER PSYCHOTIC OR MENTAL DISORDERS LEADING TO CHRONIC DISABILITY
☐ MOOD SWINGS ☐ SOMATOFORM DISORDER ☐ PANIC OR SEVERE ANXIETY DISORDER ☐ PERSONALITY DISORDER ☐ N/A

32. OXYGEN ☐ MASK ☐ PRN ☐ CONTINUOUS ☐ NASAL CANNULA ☐ N/A

33. FEEDING ☐ TUBE FEEDING ☐ OSTOMY ☐ TRACHEOSTOMY ☐ N/A

34. WOUND ☐ DECUBITUS ULCERS ☐ DRAINING WOUND ☐ WOUND CULTURED ☐ N/A

35. FOLEY CATHETER ☐ TEMPORARY ☐ PERMANENT ☐ N/A

36. REFERRING PHYSICIAN	37. PRIMARY DIAGNOSIS
38. SECONDARY DIAGNOSIS	39. TERTIARY DIAGNOSIS

40. ARE THE ADMITTING DIAGNOSIS RELATED TO A SERVICE CONNECTED CONDITION? ☐ YES ☐ NO ☐ UNKNOWN

41. TYPE OF CARE RECOMMENDED: ☐ SKILLED NURSING HOME CARE ☐ DOMICILIARY CARE ☐ ADULT DAY HEALTH CARE

42. MEDICATION AND TREATMENT ORDERS ON ADMISSION, CONTINUE ON SEPARATE SHEET IF NECESSARY

43. PRINTED OR TYPED NAME OF SVH PHYSICIAN/APRN/PA

44. SIGNATURE OF SVH PHYSICIAN/APRN/PA

Note: This field cannot be signed without first filling out item numbers 36 through 43. After signing, all fields in Part 2 will become locked and read only.

Department of Veterans Affairs

STATE HOME PROGRAM APPLICATION FOR VETERAN CARE MEDICAL CERTIFICATION

PART III - EVALUATION *(Select an appropriate number in each category)*

45. RESIDENT'S NAME *(Last, First, Middle)*	46. SOCIAL SECURITY NUMBER

Category	Options	Category	Options
COMMUNICATION	☐ 1. Transmits messages/receives information ☐ 2. Limited ability ☐ 3. Nearly or totally unable	**SPEECH**	☐ 1. Speaks clearly with others of same language ☐ 2. Limited ability ☐ 3. Unable to speak clearly or not at all
HEARING	☐ 1. Good ☐ 2. Hearing slightly impaired ☐ 3. Nearly or totally unable ☐ 4. Virtually/completely deaf	**SIGHT**	☐ 1. Good ☐ 2. Vision adequate - Unable to read/see details ☐ 3. Vision limited - Gross object differentiation ☐ 4. Blind
TRANSFER	☐ 1. No assistance ☐ 2. Equipment only ☐ 3. Supervision only ☐ 4. Requires human transfer w/wo equipment ☐ 5. Bedfast	**AMBULATION**	☐ 1. Independence w/wo assistive device ☐ 2. Walks with supervision ☐ 3. Walks with continuous human support ☐ 4. Bed to chair (total help) ☐ 5. Bedfast
ENDURANCE	☐ 1. Tolerates distances (250 feet sustained activity) ☐ 2. Needs intermittent rest ☐ 3. Rarely tolerates short activities ☐ 4. No tolerance	**MENTAL AND BEHAVIOR STATUS**	☐ 1. Alert ☐ A. Agreeable ☐ 2. Confused ☐ B. Disruptive ☐ 3. Disoriented ☐ C. Apathetic ☐ 4. Comatose ☐ D. Well motivated
TOILETING	☐ 1. No assistance ☐ 2. Assistance to and from transfer ☐ A. Bathroom ☐ 3. Total assistance including personal hygiene, help with clothes ☐ B. Bedside commode ☐ C. Bedpan	**BATHING**	☐ 1. No assistance ☐ A. Tub ☐ 2. Supervision Only ☐ B. Shower ☐ 3. Assistance ☐ C. Sponge bath ☐ 4. Is bathed
DRESSING	☐ 1. Dresses self ☐ 2. Minor assistance ☐ 3. Needs help to complete dressing ☐ 4. Has to be dressed	**FEEDING**	☐ 1. No assistance ☐ 2. Minor assistance, needs tray set up only ☐ 3. Help feeding/encouraging ☐ 4. Is fed
BLADDER CONTROL	☐ 1. Continent ☐ 2. Rarely incontinent ☐ 3. Occasional - once/week or less ☐ 4. Frequent - up to once a day ☐ 5. Total incontinence ☐ 6. Catheter, indwelling	**BOWEL CONTROL**	☐ 1. Continent ☐ 2. Rarely incontinent ☐ 3. Occasional - once/week or less ☐ 4. Frequent - up to once a day ☐ 5. Total incontinence ☐ 6. Ostomy
SKIN CONDITION	☐ 1. Intact ☐ 5. Decubitus ☐ 2. Dry/Fragile Number ______ ☐ 3. Irritations (Rash) Stage ______ ☐ 4. Open wound Note: Number & Stage fields will become available only when #2 through 5 are selected.	**WHEEL CHAIR USE**	☐ 1. Independence ☐ 2. Assistance in difficult maneuvering ☐ 3. Wheels a few feet ☐ 4. Unable to use ☐ N/A

47. SIGNATURE OF REGISTERED NURSE OR PHYSICIAN/APRN/PA	Note: After signing, all fields in Part 3 will become locked and read only.	48. DATE *(MM/DD/YYYY)*

PHYSICAL THERAPY *(To be completed by Physical Therapist or Physician/APRN/PA)* 49. Check if ☐ NEW REFERRAL ☐ CONTINUATION OF THERAPY ☐ N/A

50. SENSATION IMPAIRED	51. RESTRICT ACTIVITY	52. PRECAUTIONS	53. FREQUENCY OF TREATMENT
☐ YES ☐ NO	☐ YES ☐ NO	☐ CARDIAC ☐ OTHER *(Type other, specify)*	

54. TREATMENT GOALS: ☐ ACTIVE ☐ COORDINATING ACTIVITIES ☐ FULL WEIGHT BEARING ☐ WHEELCHAIR INDEPENDENT
☐ STRETCHING ☐ ACTIVE ASSISTIVE ☐ NON-WEIGHT BEARING ☐ PROGRESS BED TO WHEELCHAIR ☐ COMPLETE AMBULATION
☐ PASSIVE ROM ☐ PROGRESSIVE RESISTIVE ☐ PARTIAL WEIGHT BEARING ☐ RECOVERY TO FULL FUNCTION

55. ADDITIONAL THERAPIES	56. SIGNATURE OF AND TITLE OF THERAPIST OR PHYSICIAN/APRN/PA	Note: After signing, all fields under Physical Therapy will become locked and read only.	57. DATE *(MM/DD/YYYY)*
☐ O.T. ☐ SPEECH ☐ DIETARY			

PART IV - SOCIAL WORK ASSESSMENT *(To be completed by SVH Social Worker (SW) or Physician/APRN/PA)*

58. PRIOR LIVING ARRANGEMENTS	59. LONG RANGE PLAN

60. ADJUSTMENT TO ILLNESS OR DISABILITY, LIVING ENVIRONMENT AND MAKE COMPETENT DECISIONS	61. PRINT NAME OF SW OR PHYSICIAN/APRN/PA

62. SIGNATURE OF SW OR PHYSICIAN/APRN/PA	Note: After signing, all fields in Part 4 will become locked and read only.	63. DATE *(MM/DD/YYYY)*

64. REMARKS *(Attach additional sheets if necessary)*

Department of Veterans Service

Floyd Veterans Memorial Building, Suite E-970
Atlanta, GA 30334-4800

APPLICANT ACTIVITIES OF DAILY LIVING SURVEY FORM

This survey form is needed by the Admission Screening Committee to more accurately evaluate the amount and type of care needed by the applicant. **PLEASE CHECK THE APPROPRIATE ANSWER FOR EACH ITEM.** Incomplete or unsigned forms will delay processing of the application.

BEHAVIORS:

Item	YES	NO
Alert/Aware	YES ☐	NO ☐
Hostile Physically (Fights)	YES ☐	NO ☐
Yells	YES ☐	NO ☐
Wanders	YES ☐	NO ☐
Comatose (Unconscious)	YES ☐	NO ☐
Cooperative	YES ☐	NO ☐

WALKING:

Item	YES	NO
Walks by self	YES ☐	NO ☐
Uses cane or walker	YES ☐	NO ☐
Uses wheelchair	YES ☐	NO ☐
Stays in bed or chair	YES ☐	NO ☐
Falls frequently	YES ☐	NO ☐

MOVEMENT FROM BED TO CHAIR/TOILET:

Item	YES	NO
Moves by self	YES ☐	NO ☐
Has to be carried or helped	YES ☐	NO ☐
Shifts weight in chair by self	YES ☐	NO ☐
Turns self in bed	YES ☐	NO ☐
Able to use nurse call button	YES ☐	NO ☐

EXERCISE OF LIMBS:

Item	YES	NO
Moves arms by self	YES ☐	NO ☐
Moves legs by self	YES ☐	NO ☐
Receives physical therapy	YES ☐	NO ☐

DRESSING:

Item	YES	NO
Dresses upper body by self	YES ☐	NO ☐
Dresses lower body by self	YES ☐	NO ☐
Puts on socks and shoes by self	YES ☐	NO ☐
Receives occupational therapy	YES ☐	NO ☐

BATHING:

Item	YES	NO
Needs bed bath given	YES ☐	NO ☐
Takes tub bath by self	YES ☐	NO ☐
Takes shower by self	YES ☐	NO ☐
Resists bathing	YES ☐	NO ☐

EATING:

Item	YES	NO
Feeds self	YES ☐	NO ☐
Feeding tube	YES ☐	NO ☐
Eats complete meal	YES ☐	NO ☐

Diet type (specify): ______________________________

____

GROOMING:

Item	YES	NO
Shaves self	YES ☐	NO ☐
Brushes own teeth/dentures	YES ☐	NO ☐
Trims own nails	YES ☐	NO ☐

TOILETING:

Item	YES	NO
Bowel control	YES ☐	NO ☐
Bladder control	YES ☐	NO ☐
Urinary catheter (tube in bladder)	YES ☐	NO ☐
Colostomy (hole in abdomen)	YES ☐	NO ☐
Ileostomy (tube in bladder)	YES ☐	NO ☐

SKIN CONDITION:

Item	YES	NO
Dry skin	YES ☐	NO ☐
Bruises easily	YES ☐	NO ☐
Skin tears easily	YES ☐	NO ☐
Rash on body	YES ☐	NO ☐

Bedsores: How many? Where? ______________________________

____

BREATHING STATUS:

Item	YES	NO
Uses oxygen tanks/concentrator	YES ☐	NO ☐
Tracheostomy (hole in throat)	YES ☐	NO ☐
Needs suctioning	YES ☐	NO ☐
Can cough	YES ☐	NO ☐
Smokes/chews tobacco	YES ☐	NO ☐

SENSES:

Item	YES	NO
Poor vision	YES ☐	NO ☐
Blind	YES ☐	NO ☐
Wears glasses/contacts	YES ☐	NO ☐
Deaf	YES ☐	NO ☐
Wears hearing aid	YES ☐	NO ☐
Can talk/communicate	YES ☐	NO ☐

OTHER:

Item	YES	NO
Needs safety devices	YES ☐	NO ☐
Dentures	YES ☐	NO ☐
Artificial limbs or braces	YES ☐	NO ☐
Legal Guardian	YES ☐	NO ☐
Power of Attorney (POA)	YES ☐	NO ☐
Living Will	YES ☐	NO ☐
Durable POA for Healthcare	YES ☐	NO ☐
Georgia Advance Directive for Health Care	YES ☐	NO ☐

1. Do you now, or have you ever had a problem with alcohol? YES ☐ NO ☐

Explain. ____

____

2. Have you ever been hospitalized for alcoholism or related illness? YES ☐ NO ☐

Explain. ____

____

____

3. Do you now or have you ever had a problem with illicit drugs (marijuana, cocaine, etc.)? YES ☐ NO ☐

Explain. ____

____

4. Has applicant ever been treated for a psychiatric (mental) illness? YES ☐ NO ☐

Explain. (Diagnosis, Where, When) ______________________________

____

____

5. Is applicant currently participating in any experimental research therapy program? YES ☐ NO ☐

Explain. ____

____

Additional comments (describe daily routine, personality, habits, likes/dislikes, etc.):

____

____

____

____

Name: ______________________ ______________________
Signature

Relationship to applicant: ______________________ Date: ______________

Please return this form with your application. **FALSIFICATION OF INFORMATION MAY RESULT IN THE APPLICANT BEING DENIED ADMISSION OR DISCHARGED FROM THE NURSING HOME.**

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New Patient Acknowledgements

Patient Name: ___________________________ Birthdate ____________________________

Consent to Treatment

__________ Initial
I consent to and authorize TransPerfect Health Occupational & Physical Therapy and/or Speech Therapy to administrator rehabilitation therapy treatment. I understand and am informed that, as in the practice of medicine, rehabilitation therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment. I know it is up to me to inform my provider of rehabilitation therapy about any health problems or allergies I have, as well as medications I am taking. I understand that the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and/or treatment results from the rehabilitation therapy.

Notice of Privacy Practices

__________ Initial
I hereby acknowledge that I have been provided TransPerfect Health's Notice of Privacy Practices, which provides a detailed description of TransPerfect Health's uses and disclosures of my health information. I further acknowledge that a paper or electronic copy of the current notice is available upon request, and that I may request a copy of any amended Notice of Privacy Practices at any time.

Authorization to Release / Obtain Information

__________ Initial
Many of our patients' family members such as their spouses, significant others, or children call and request the results of evaluations, treatments, procedures, and financial information. TransPerfect Health's policy generally is not to share this information with anyone without the patient's consent. If you wish to have your medical information, clinical status, results, and/or financial information released to or discussed with any personal representative, please complete TransPerfect Health Corporation's HIPPA Authorization Form. You have the right to revoke this consent at any time, except where TransPerfect Health has already made disclosures in reliance on your prior consent.

Insurance Eligibility

__________ Initial
Verification of benefits is NOT a guarantee of payment. Payment is determined by your insurance company at the time a claim is received. We provide you with the information as it is outlined by your insurance company. It is your responsibility to fully understand your insurance benefits.

Financial Responsibility

__________ Initial
Payment is due at the time of or prior to treatment. I agree to pay all amounts to TransPerfect Health that are due for services rendered which are not otherwise paid for by my insurance plan on my behalf. In the event that my account is referred to a collection agency or an attorney, I further agree to pay all reasonable

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HEALTH

costs incurred to collect any amounts that are due for services rendered, including, without limitation, reasonable attorney's fees.

Payment Collection

__________ Initial

I understand TransPerfect Health is a no cash business. All pre-treatment payments will be collected electronically via debt or credit card. Payment method will remain on file throughout case duration and until claims & payments have been satisfied. Should there be a remaining patient balance, patient or responsible party will be charged with expected payment. No further services shall be rendered until payment has been satisfied.

Assignment & Release of Benefits

__________ Initial

I hereby appoint TransPerfect Health as my authorized representative, and assign to it my right, to file for, receive and recover any and all monies payable for the care which it rendered to me from any third-party claims' payment source, including my health insurer, Medicare, Medicaid or other governmental program (collectively, my "Plan"), while I was eligible to receive such claim payment. I authorize you to send and receive documentation related to my treatment to, and consent to your discussing my treatment with, my Plan. I authorize TransPerfect Health to take any and all actions necessary to assert and pursue my legal rights to receive such claim payment under the terms of my Plan through any appeals and/or grievances and/or litigation and/or arbitration available to me for such purpose. As the assignor of the foregoing payment amounts, I direct that such payment be sent by my Plan to TransPerfect Health and, in the case that payment is made by my Plan to me, I agree to remit such payment in full to TransPerfect Health not later than ten (10) days after my receipt.

Appointments / Cancellations

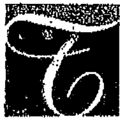
__________ Initial

We advise you to schedule your appointments in advance. Maintaining a consistent schedule ensures your best outcome for recovery. We expect you to keep all of your appointments with TransPerfect Health and require 24 hours' notice if you are unable to keep an appointment. Failure to comply may result in a $50.00 charge. These charges are not reimbursed by any insurance company. This charge is at the discretion of TransPerfect Health. Please contact cancellation@transperfect.com or call your provider to notify of cancellation or need to reschedule.

The undersigned patient or Responsible Party acknowledges that he/she has read and agrees to the information printed above.

______________________________	______________________________	__________
Signature of Patient or Patient Representative	Patient Name	Date

____
Representative Relationship



TRANSPERFECT
H E A L T H

Notice of Privacy Practices

This Notice provides an overview of the privacy practices of TransPerfect Health (also referred to in this Notice as "TransPerfect," "we," "us," and/or "our"). The privacy practices described in this Notice will be followed by all TransPerfect Health healthcare professionals, employees, staff, trainees, students, volunteers, and business associates. If you have any questions about this Notice, please contact our Privacy Officer. This Notice describes how protected health information, as defined below, about you may be used and disclosed and how you can get access to this protected health information. This Notice is not a complete listing of how we use and disclose your protected health information. This Notice applies to all protected health information held in any form by TransPerfect Health. Please review this Notice carefully. Protected health information (also referred to in this Notice as "medical record," "health information," and/ or "information") is your individually identifiable information, whether in electronic, paper, or oral form, which may include, but is not limited to, your geographic information, your demographic information, information on healthcare services you have received or may receive in the future, your healthcare insurance benefits, full-face photographs and any comparable images of you, and any unique numbers that may identify you.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we hold. To request a copy of your medical record, please contact our Medical Records Department at medicalrecord@transperfect.com or ask your provider.
- We will provide a copy or summary of your health information, usually within 30 days of request. A cost-based fee may be associated.

Ask us to correct your medical record

- You can ask us to correct your health information which you think is incorrect or incomplete by submitting the request in writing to the Privacy Officer, along with proper documentation to support the request. We may say "no" to your request, but will provide justification in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way such as a home or office phone or to send mail to a different address.
- We will honor all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may decline if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will agree unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list accounting the times we've shared your health information for 6 years prior to request date, who we shared it with, and why.
- We include all disclosures except for those about treatment, payment, healthcare operations, & certain other disclosures such as those you requested. We'll provide one account per year for free but a reasonable, cost-based fee for additional requests within 12 months.

Get a copy of this privacy Notice

- You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. We will provide.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and acts for you before we take any action.

File a complaint if you feel your rights are violated

- You may file a complaint with our Privacy Officer or the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a preference for how we share your information in the situations described below, please inform your provider or contact our Privacy Officer regarding, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

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In these cases, we never share your information unless you give us written permission:

- Marketing purposes and sale of your information

If you are not able to tell us your preference, for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Our Uses and Disclosures

We typically use or share your health information in the following ways. To:

Treat you

- We can use your health information and share it with other professionals who are treating you without your consent. Example: The physical therapist treating you for an injury shares your treatment notes with your physician.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary, without your consent. Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities without your consent. Example: We give information about you to your health insurance plan so it will pay for your services.
- We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services to ensure TransPerfect Health is complying with federal privacy laws.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

TransPerfect Health Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this Notice and provide you a copy of this Notice.
- We will not use or share your information other than as described in this Notice unless you tell us we can in writing by completing and signing our HIPAA Authorization Form. If you tell us we can use or share your information other than as described in this Notice, you may change your mind at any time by informing us of the change in writing.

Note on Incidental Disclosures

Despite our implementation of reasonable and appropriate safeguards to protect the privacy of your protected health information, your protected health information may be incidentally disclosed in connection with otherwise permissible or required uses or disclosures of your information The HIPAA Privacy Rule permits such incidental disclosures of your protected health information.

Changes to the Terms of this Notice

We can change the terms of this Notice without first notifying you, and the changes will apply to all information we have about you. The new Notice will be available upon request, in our office, and on our website.

TransPerfect Health
1250 Broadway
New York, NY 10001
Privacy Officer
Phone: +1 646.589.6769
Email: privacy@transperfect.com

Georgia War Veterans Home

Veterans Transportation Declaration

Resident Name: ______________________________ **Date:**____________________________

To: Executive Director, Georgia War Veterans Home

During my residence in the Georgia War Veterans Home (GWVH) and for requested transportation to medical appointments only at facilities outside the Georgia War Veterans Home, I hereby make the following choices regarding a transportation provider and payment options signified by my initials and signature at the bottom.

LOCAL TRANSPORTATION OPTIONS: (Please initial next to the selected option)

_____: OPTION 1: For transportation to local medical providers, I would like GWVH to schedule the transportation with a reliable, non-emergent transportation carrier or taxi-cab service, whichever is necessary dependent on my medical conditions. I agree to pay the transportation carrier or agree to authorize payment from my resident trust fund account.

_____: OPTION 2: For transportation to local medical providers, I choose to make my own arrangements for transportation with my family or a 3rd party vendor. I understand I will be responsible for paying the costs of transportation directly to the 3rd party vendor.

DISTANT TRANSPORTATION OPTIONS: (Please initial next to the selected option)

_____: OPTION 1: For transportation to Dublin VAMC, Atlanta VAMC, Augusta VAMC, or other distant independent medical providers, I would like GWVH to schedule the transportation with a reliable, non-emergent transportation carrier or taxi-cab service, whichever is necessary dependent on my medical conditions. I agree to pay the transport carrier or agree to authorize payment from my resident trust fund account.

_____: OPTION 2: For transportation to Dublin VAMC, Atlanta VAMC, Augusta VAMC, or other distant independent medical providers, I choose to make my own arrangements for transportation with my family or a 3rd party vendor. I understand I will be responsible for paying the costs of transportation directly to the 3rd party vendor.

Notice: The Georgia War Veterans Home is unable to provide transportation by stretcher. Any appointments requiring the use of a stretcher are the financial responsibility of the resident.

Resident/Responsible Party Signatures:

______________________________ Resident's Name (Print)	______________________________ GWVH Representative Name (Print)
______________________________ Resident's Signature	______________________________ GWVH Representative's Signature
______________________________ Resident's Representative Name (Print)	**Georgia War Veterans Home** Legal Name of Healthcare Facility
______________________________ Resident's Representative Signature	______________________________ Date

Georgia War Veterans Home

2249 Vinson Highway

Milledgeville, Georgia 31061

Office of Admissions 478-445-4295

Funeral Home Designation

*This form is required to be filled out as part of the application.

Name of Veteran:

____

Date of Birth: _______________________________________

Social Security Number (last 4 digits only): ________________

Funeral Home Information:

Name: ____

Street Address: ____

City/State/Zip:____

Telephone #: (Including Area Code): ____________________________________

_________________________________ _________________________

Signature of Veterans or Responsible Party Date

*This form must be filled in as part of the admissions packet. There must be a burial plan in place before the admission of the veteran.

Georgia War Veterans Home

2249 Vinson Highway

Milledgeville, Georgia 31061

Office of Admission: 478-445-4297

No Weapons/Drugs/Alcohol Allowed Agreement

No resident shall have in their possession a firearm or potential weapon. This includes items that could be used as a potential weapon, such as knives, saws, power tools, razor blades, etc. Residents are also banned from having alcohol, illicit drugs, prescription drugs, or over-the-counter drugs in their room, on their person, or on state grounds. Medications are to be stored in the medication carts and distributed by nursing staff only.

To maintain the safety of patients and staff, the Georgia War Veterans Home conducts routine health and wellness checks throughout the facility. During these checks, if staff members find prohibited items, they will be bagged, labeled, and secured in the building for pickup by the veteran's family members or will be disposed of if that is your wish.

If any of these items are found to be had by veterans on state property, it will be grounds for immediate discharge from the Georgia War Veterans Home.

If you have any further questions or concerns, feel free to contact the facility. Sign on the line below as acknowledgement of receipt and understanding.

Veteran Name (Print): ______________________________

Veteran Signature & Date: ______________________________

Responsible Party (Print): ______________________________

Responsible Party Signature & Date: ______________________________

OMB Approval Number 2900-0556
Estimated Burden Avg: 30 minutes
Expiration Date: 04/30/2024

VA ADVANCE DIRECTIVE
DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND LIVING WILL

INSTRUCTIONS

This advance directive form is an official document where you can write down your preferences for your health care. If someday you can't make health care decisions for yourself anymore, this advance directive can help guide the people who will make decisions for you.

You can use this form to:

- Name specific people to make health care decisions for you
- Describe your preferences for how you want to be treated
- Describe your preferences for medical care, mental health care, long-term care, or other types of health care

You may complete some, none, or all sections of this form. If you need more space for any part of the form, you may attach extra pages. Be sure to initial and date every page that you attach. You also must initial the sections you complete and sign the form. If you are unable to initial or sign the form because of a physical impairment, you can place an "X", thumbprint, or stamp on the form instead of your initials and signature. If a physical impairment prevents you from doing any of these things, you can ask someone else who is with you to sign, place an "X", thumbprint, or stamp on the form.

When you complete this form, it's important that you also talk to a member of your health care team, family, and other loved ones to explain what you meant when you filled out the form. A member of your health care team can help you with this form and can answer any questions that you have.

PART I: PERSONAL INFORMATION

NAME *(Last, First, Middle)*:		DATE OF BIRTH *(mm/dd/yyyy)*:
STREET ADDRESS:		
CITY, STATE, ZIP:		
HOME PHONE WITH AREA CODE:	WORK PHONE WITH AREA CODE:	MOBILE PHONE WITH AREA CODE:

Privacy Act Information and Paperwork Reduction Act Notice

The information requested on this form is solicited under the authority of 38 C.F.R. §17.32. It is being collected to document your preferences for your health care in the event that you can't speak for yourself anymore. The information you provide may be disclosed outside the VA as permitted by law. Possible disclosures include those that are described in the "routine uses" identified in the VA system of records 24VA10P2, Patient Medical Records-VA, published in the Federal Register inaccordance with the Privacy Act of 1974. This is also available in the Compilation of Privacy Act Issuances. You may choose to fill out this form or not.But without this information, VA health care providers may not understand your preferences as well. If you don't fill out this form, there won't be any effect on the benefits you are entitled to receive. The Paperwork Reduction Act of 1995 requires us to let you know that this information collection follows the clearance requirements of section 3507 of this Act. We estimate that it will take you about 30 minutes to fill out this form, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information you write down. A Federal agency may not conduct or sponsor, and a person is not required to respond to a collection of information, unless it displays a current valid OMB control number. The OMB Control No. for this information collection is 2900-0556.

NAME *(Last, First, Middle)*:	DATE OF BIRTH *(mm/dd/yyyy)*:

PART II: DURABLE POWER OF ATTORNEY FOR HEALTH CARE

This section of the advance directive form is called a Durable Power of Attorney for Health Care. It lets you appoint a specific person to make health care decisions for you in case you can't make decisions for yourself anymore. This person will be called your Health Care Agent.

Your Health Care Agent should be someone:

- You trust
- Who knows you well
- Who is familiar with your values and beliefs

If you get too sick to make decisions for yourself, your Health Care Agent will have the authority to make all health care decisions for you. This includes decisions to admit and discharge you from any hospital or other health care institution. Your Health Care Agent can also decide to start or stop any type of health care treatment. He or she can access your personal health information, and medical records, including information about whether you have been tested for HIV or treated for AIDS, sickle cell anemia, substance abuse or alcoholism.

NOTE: If you wish to give general permission for VA to share your medical records or health information with others, you can complete VA Form 10-5345 (Request for and Authorization to Release Medical Records or Health Information). You can get VA Form 10-5345 from your VA health care provider or you can get it using a computer from this website **http://www4.va.gov/vaforms/medical/pdf/vha-10-5345-fill.pdf**.

A - HEALTH CARE AGENT

Place your initials in the box next to your choice. Choose only one.

Initials	I don't wish to appoint a Health Care Agent right now. (Skip this section and go to Part III, Living Will.)
Initials	I appoint the person named below to make decisions about my health care if I can't decide for myself anymore.

Name *(Last, First, Middle)*:		Relationship to Me:
Street Address:		
City, State, Zip:		
Home Phone with Area Code:	Work Phone with Area Code:	Mobile Phone with Area Code:

B - ALTERNATE HEALTH CARE AGENT

Fill out this section if you want to appoint a second person to make health care decisions for you, in case the first person isn't available.

Initials	If the person named above can't or doesn't want to make decisions for me, I appoint the person named below to act as my Health Care Agent.

Name *(Last, First, Middle)*:		Relationship to Me:
Street Address:		
City, State, Zip:		
Home Phone with Area Code:	Work Phone with Area Code:	Mobile Phone with Area Code:

NAME *(Last, First, Middle)*:	DATE OF BIRTH *(mm/dd/yyyy)*:

PART III: LIVING WILL

This section of the advance directive form is called a Living Will. This section of it lets you write down how you want to be treated in case you aren't able to decide for yourself anymore. Its purpose is to help others decide about your care.

A - SPECIFIC PREFERENCES ABOUT LIFE-SUSTAINING TREATMENTS

In this section, you can indicate your preferences for life-sustaining treatments in certain situations. Some examples of life-sustaining treatments are:

- CPR (cardiopulmonary resuscitation)
- a breathing machine (mechanical ventilation)
- kidney dialysis
- a feeding tube (artificial nutrition and hydration)

Think about each situation described on the left and ask yourself, "In that situation, would I want to have life-sustaining treatments?" Place your initials in the box that best describes your treatment preference. You may complete some, all, or none of this section. Choose only one box for each statement.

	Yes. I would want life-sustaining treatments.	I'm not sure. It would depend on the circumstances.	**No.** I would not want life-sustaining treatments.
If I am unconscious, in a coma, or in a vegetative state and there is little or no chance of recovery.	Initials	Initials	Initials
If I have permanent, severe brain damage that makes me unable to recognize my family or friends (for example, severe dementia).	Initials	Initials	Initials
If I have a permanent condition where other people must help me with my daily needs (for example, eating, bathing, toileting).	Initials	Initials	Initials
If I need to use a breathing machine and be in bed for the rest of my life.	Initials	Initials	Initials
If I have pain or other severe symptoms that cause suffering and can't be relieved.	Initials	Initials	Initials
If I have a condition that will make me die very soon, even with life-sustaining treatments.	Initials	Initials	Initials
Other:	Initials	Initials	Initials

NAME *(Last, First, Middle)*:	DATE OF BIRTH *(mm/dd/yyyy)*:

B - MENTAL HEALTH PREFERENCES

This section is optional. You may skip this section if you do not have a serious mental health problem or if you do not want to write down your preferences for mental health care. If you have a serious mental health condition, you might want to write down medications that have worked for you in the past and that you would want again, or you might want to write down the mental health facilities or hospitals that you like and those that you don't like. If you need more space, you may attach extra pages and use this space to refer to attached pages. Be sure to initial and date every page that you attach.

C - ADDITIONAL PREFERENCES

This section is optional. In this space, you can write other important preferences for your health care that aren't described somewhere else in this document. For example, these might be social, cultural, or faith-based preferences for care, or preferences about treatments such as feeding tubes, blood transfusions, or pain medications. If you need more space, you may attach extra pages and use this space to refer to attached pages. Be sure to initial and date every page that you attach.

NAME *(Last, First, Middle)*:	DATE OF BIRTH *(mm/dd/yyyy)*:

D - HOW STRICTLY YOU WANT YOUR PREFERENCES FOLLOWED

Place your initials in the box next to the statement that reflects how strictly you want others to follow your preferences. Choose only one.

Initials	I want my preferences, as expressed in this Living Will, to serve as a general guide. I understand that in some situations, the person making decisions for me may decide something different from the preferences I express above, if they think it's in my best interests.
Initials	I want my preferences, as expressed in this Living Will, to be followed strictly, even if the person making decisions for me thinks that this isn't in my best interests.

PART IV: SIGNATURES

A - YOUR SIGNATURE

By my signature below, I certify that this form accurately describes my preferences.

SIGNATURE *(Sign in ink)*:	DATE *(mm/dd/yyyy)*:

B - WITNESSES' SIGNATURES

Two people must witness your signature. Witnesses to the patient's signing of an advance directive are attesting by their signatures only to the fact that they saw the patient or designated third party sign the VA Advance Directive form. Neither witness may, to the witness' knowledge, be named as a beneficiary in the patient's estate, appointed as health care agent in the advance directive, or financially responsible for the patient's care. Nor may a witness be the designated third party who has signed the VA Advance Directive form at the direction of the patient and in the patient's presence.

Witness #1

I personally witnessed the signing of this advance directive. I am not the designated third party who signed this VA Advance Directive form at the direction of the patient and in the patient's presence. I am not appointed as Health Care Agent in this advance directive. I am not financially responsible for the care of the patient making this advance directive. To the best of my knowledge, I am not named as a beneficiary in the patient's estate.

SIGNATURE *(Sign in ink)*:	DATE *(mm/dd/yyyy)*:

Name *(Printed or Typed)*:

Street Address:

City, State, Zip:

Witness #2

I personally witnessed the signing of this advance directive. I am not the designated third party who signed this VA Advance Directive form at the direction of the patient and in the patient's presence. I am not appointed as Health Care Agent in this advance directive. I am not financially responsible for the care of the patient making this advance directive. To the best of my knowledge, I am not named as a beneficiary in the patient's estate.

SIGNATURE *(Sign in ink)*:	DATE *(mm/dd/yyyy)*:

Name *(Printed or Typed)*:

Street Address:

City, State, Zip:

NAME *(Last, First, Middle)*:	DATE OF BIRTH *(mm/dd/yyyy)*:

PART V: SIGNATURE AND SEAL OF NOTARY PUBLIC *(Optional)*

This VA Advance Directive form is valid in VA facilities without being notarized. However, you may need to have it notarized to be legally binding outside the VA health care setting. Space for a Notary's signature and seal is included below.

On this _____ day of ____________________ , in the year of ______ , personally appeared before me

____,

known by me to be the person who completed this document and acknowledged it as their free act and deed.

IN WITNESS WHEREOF, I have set my hand and affixed my official seal in the County of ____________________,

State of ________________________ , on the date written above.

Notary Public: ____ Commission Expires: ____________

[SEAL]