



Jones & Cabacoy Veterans Care Center (JCVCC)

The Jones & Cabacoy Veterans Care Center (JCVCC) was named in honor of two local heroes, Lieutenant Colonel William A. Jones and Staff Sergeant Christopher F. Cabacoy, both recognized for their bravery and dedication to our country.

Our 128-bed community offers skilled nursing care, short-term rehabilitation, long-term care, and memory care services. Nestled among peaceful woods with walking trails and a scenic pond, our center features two neighborhoods divided into eight households of sixteen residents each. Every household includes its own dining room, kitchenette, day room, and access to an adjoining courtyard, creating a true home-like atmosphere. Each veteran enjoys a spacious private room with a personal restroom and walk-in shower for comfort and independence.

Our rehabilitation program supports veterans recovering before returning home, offering personalized therapy plans focused on strength, confidence, and independence. Long-term care residents receive continuous support and tailored therapy services; including physical, occupational, and speech therapies, to maintain and enhance daily living.

Our state-of-the-art therapy center provides modern equipment in a warm, encouraging environment, while our memory care neighborhood offers safety, structure, and compassionate programming for those living with Alzheimer's or other memory-related conditions. Residents enjoy freedom within a secure setting, including a beautiful, enclosed courtyard.

With 24-hour nursing care and an on-site pharmacy, available exclusively at Virginia State Veterans Homes, families can trust that every need is met with skill, efficiency, and kindness.

At Jones & Cabacoy, every veteran is part of our family. Whether staying for short-term recovery or long-term living, our home is a place where care feels personal, every voice is valued, and each day is lived with dignity and love.

Eligibility requirements:

1. *Be a resident of the state of Virginia or at the time of enlisting into the military.*
2. *Be an honorably discharged Veteran from active duty. At least 6 months active duty before September 1980 and at least 2 years active duty after that. Reserve time or National Guard time only does not qualify.*
3. *Be within our scope of service or what we are able to take care of medically and need nursing home level of care.*

Important Documents Needed for VA Verification

- DD-214
- Current award letter (only if you have one)

The current rate for JCVCC is \$450.10/day. The VA will review your information and based on your eligibility, your rate may be reduced or covered completely by the VA.

Documentation to be considered for Admissions

Admissions from SNF/Hospital	Admissions from Home
<ul style="list-style-type: none">✓ History & Physical✓ Current MAR/TAR✓ Current Nurse's Notes x 2 weeks✓ Recent Labs within 30 days (if available)✓ Current Physician/Rehab progress notes - within the past 30 days✓ Immunization Record✓ Weight summary✓ Psych Eval/Progress Notes (if applicable)✓ Operative Reports (if applicable)✓ DNR (if applicable)✓ Discharge Summary/Orders✓ TB and COVID test will be completed upon admission	<ul style="list-style-type: none">✓ History & Physical - within past 30 days✓ Current Medication List✓ Current Physician Referral✓ Office visit progress notes if available (current)✓ Recent hospitalization notes (if applicable)✓ DNR (if applicable)✓ Completed UAI, DMAS-95, DMAS-96 (If Medicaid or will be applying for Medicaid after spending down)✓ TB and COVID test will be completed upon admission

JCVCC ADMISSION APPLICATION

RESIDENT INFORMATION

First Name	Middle Name	Last Name	Suffix
Social Security #	Sex Female Male	Preferred Name	Date of Birth
Mother's Maiden Name	Place of Birth	Previous Occupation (<i>don't write retired</i>)	
Preferred Language		Religious Preference (<i>if no write none</i>)	
Homes Address	City	State	Zip
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Never Married			
Ethnicity		Anticipated Stay? Short-Term <input type="checkbox"/> Long-Term Care	

SERVICE INFORMATION * Must have served active-duty time

Service-Connected Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what percentage?
Military Branch <input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Air Force <input type="checkbox"/> Coast Guard <input type="checkbox"/> Marines <input type="checkbox"/> Space Force	

RESPONSIBLE PARTY AND FIRST EMERGENCY CONTACT

Name	Email Address		
Address	City	State	Zip
Phone	Home	Cell	Office
Relationship: Next of Kin <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Court Appointed Guardian <input type="checkbox"/> VA Fiduciary <input type="checkbox"/>			

SECOND EMERGENCY CONTACT

Name	Email Address		
Address	City	State	Zip
Phone	Home	Cell	Office
Relationship: Next of Kin <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Court Appointed Guardian <input type="checkbox"/> VA Fiduciary <input type="checkbox"/>			

THIRD EMERGENCY CONTACT

Name	Email Address		
Address	City	State	Zip
Phone	Home	Cell	Office
Relationship: Next of Kin <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Court Appointed Guardian <input type="checkbox"/> VA Fiduciary <input type="checkbox"/>			

FINANCIAL RESOURCES

PRIVATE FUNDS (Adequate funds available to cover \$14,000/month for 6 months)

Medicare # Medicare A <input type="checkbox"/> Medicare B <input type="checkbox"/> Medicare D <input type="checkbox"/>	Medicare Replacement Name of Carrier
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Private Insurance Name Policy #	Long Term Care Insurance Name Policy #
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****IF YOU DO NOT HAVE AT LEAST 6 MONTHS OF LIQUID ASSETS AVAILABLE TO YOU THEN YOU SHOULD APPLY FOR MEDICAID IN THE COUNTY IN WHICH YOU CURRENTLY RESIDE**

Are you applying for Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so what county?
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If you have a Medicaid case manager/social worker, please provide the contact information below.

Name	Email	Phone
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If you have Medicaid, please provide the number.

Medicaid #	
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***Only fill out if you are paying privately.**

Applicant's Monthly Income		Applicant's Assets (Current balance/value, if rent write N/A)	
Retirement Income	\$	Real Estate Type	Balance / Value / NA (rent)
Investment Income	\$	Home	\$
Social Security (SSA)	\$	Vacation Home	\$
Civil Service Annuity	\$	Other	\$
Supp Security Income (SSI)	\$	Personal Property (car, boat etc.)	Balance / Value / NA (rent)
Other	\$		\$
Other	\$		\$

Bank Information- Current Balance

Checking	Savings	CD	IRA	Other _____
\$	\$	\$	\$	\$

Insurance Policies, Annuities etc. (List only those with cash value)

Type _____	Type _____	Type _____	Type _____
\$	\$	\$	\$

CLINICAL

Falls in the last 6 months?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	How many? _____
Injuries from the falls?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	

If yes, explain please explain injuries.

Skilled nursing stay in the last 6 months? If yes, please fill out the below information.

Name Address Date Admitted _____ Date Discharged _____ Reason for admission
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Name Address Date Admitted _____ Date Discharged _____ Reason for admission
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Applicant's choice

Funeral Home (**Must choose one**)

Hospital (*We will inform EMS of preference but can't guarantee where EMS will take patients*)

IMPORTANT INFORMATION

***PLEASE NOTE THAT MEDICARE ALLOWS UP TO 100 DAYS PER BENEFIT PERIOD. IF YOU HAVE BEEN IN ANOTHER SKILLED NURSING FACILITY WITHIN THE LAST 60 DAYS YOU WILL NOT HAVE THE FULL 100 DAYS AVAILABLE. YOU MAY NOT UTILIZE ALL 100 DAYS IN ANY GIVEN SKILLED NURSING STAY.**

***PLEASE DO NOT BRING ANY MEDICATIONS INTO THE FACILITY UNLESS REQUESTED. WE DISPENSE FROM OUR OWN PHARMACY AND CANNOT ACCEPT MEDICATIONS FROM A SOURCE OTHER THAN OUR PHARMACY.**

***PLEASE DO NOT BRING POWERED WHEELCHAIR/SCOOTER AT TIME OF ADMISSION. THE RESIDENT MUST BE SCREENED BY THE REHABILITATION DEPARTMENT BEFORE THE USE OF THESE IN THE CENTER TO MAKE SURE IT IS OPERATED SAFETLY.**

DECLARATION OF CONFIRMATION

I/We hereby confirm that all information stated in this document is current and correct to the best of my/our knowledge and no requested information has been withheld or misrepresented. I/We authorize Jones & Cabacoy Veterans Care Center (JCVCC) to verify any of the above information. I/We understand that falsification of the stated information may jeopardize admission into JVCC. All information will be kept confidential by JVCC and will not be released without written permission.

Resident/Responsible Party

Date

Resident/Responsible Party Signature

Date