Virginia Department of Veterans Services

1601 Broad Rock Blvd.
Richmond, VA 23224

Sitter & Barfoot Veterans Care Center

Sitter & Barfoot Veterans Care Center (SBVCC)

The Sitter & Barfoot Veterans Care Center (SBVCC), established in the winter of 2008, is a 160 bed, all private rooms, state of the art model for short and long term healthcare. Sitter & Barfoot is conveniently located on the same campus as the Hunter Holmes McGuire Veterans Hospital in south Richmond. The mission of the SBVCC is to provide high quality, compassionate and comprehensive nursing care to Commonwealth of Virginia residents who are Veterans. This facility accepts Medicare, Medicaid and Private Pay funds for payment.

For our residents who call Sitter & Barfoot home, we offer spacious private rooms with a private bath and walk-in shower. Our wholesome meals are served in our spacious dining room. Special diets are available for all requirements and all are supervised by our registered dietician. Also centrally located are a library, canteen, game room and craft room offering different activities and snacks to suit the needs and tastes of our residents. For those who enjoy spending time outside, there is a beautifully landscaped and enclosed courtyard.

For those residents in need of a short term, post-hospital nursing and rehabilitation stay, we offer a broad range of intensive therapeutic services designed to maximize the functional abilities of our patients. The Rehabilitation gym boasts state of the art equipment and is staffed with Physical Therapists, Occupational Therapists and Speech Therapists who will design and implement a unique, individualized plan of care for each resident.

Our 40 bed Alzheimer's wing provides specially trained staff and programming for patients with Alzheimer's or related thought process disorders. The specially designed unit allows residents to move freely in a safe and secure environment, including two courtyards.

Eligibility and Admissions:

Eligible applicants are veterans who:

1. **Resident of Virginia at the time of admission**
2. **Honorably Discharged**
3. **Have a skilled nursing need**

Upon meeting the eligibility requirements, the applicant will be provided an application packet and if necessary, the applicants name will be placed on our Potential Admissions Waiting List. Included in the application package is a form 10-10EZ. Please complete even if you have recently completed one for the VA. The 10-10EZ must be signed by the veteran or the veteran's POA.

Admissions will also request copies of these documents from the family:

1. **Copy of DD-214, or proof of military service must be obtained prior to admission.**
2. **Medicare Card**
3. **Medicare Part D Insurance Card**
4. **Secondary Insurance Card (if applicable)**
5. **Medicaid Card (if applicable)**
6. **Power of Attorney or Guardian Documentation**
7. **Living Will**

Current medical information will need to be gathered by the family for the Admissions department from the appropriate agencies. These documents consist of but are not limited to:

1. **Current History and Physical**
2. **Lab Work**
3. **List of Medications (for at least last 14 days if coming from the hospital)**
4. **Chest x-ray or TB skin test**
5. **All Nursing , Rehabilitation and Therapy notes**
6. **Physicians Discharge Orders**

The rate for SBVCC is currently $162.00 per day based on Veterans Administration approval of patient per diem payment of $98.00. If not approved, the daily rate is $260.

Sitter & Barfoot is a NON-SMOKING facility

For more information about SBVCC please contact:

Johnny Oglesby
Admissions Coordinator
804-371-8434
804-230-2057 – Fax
John.Oglesby@dvs.virginia.gov

SITTER & BARFOOT VETERANS CARE FACILITY

Medical Review Sheet

To aid in the placement of our future patients we will need the following documents:

Admissions From Hospital/SNF

- Current Physician orders
- Current MAR's
- Current Nurse's Notes
- Chest X-ray/PPD (done within 30 days prior to placement)
- Recent Labs
- Current Physician Notes and Rehab progress notes
- History & Physical (Current)
- Completed MAP 96 and UAI (1204 from McGuire)
- Psych Eval/Progress Notes
- Operative Reports
- Consultations
- DNR (if applicable)
- **Discharge Summary/Physicians Discharge Orders**

Admissions From Home

- Current Physician Referral
- Chest X-ray or PPD completed within the past 30 days
- Office visits progress notes if available (Current)
- Completed MAP 96 and UAI

All admissions require copies of the following documents:

- Copy of DD214
- Copy of Medicare card
- Copy of Medicare Part D Insurance Card
- Copy of Secondary Insurance Card (if applicable)
- Copy of Medicaid Card (if applicable)
- Copy of Power of Attorney or Guardian Documentation
- Copy of Living Will

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION RECORDS

I hereby authorize SITTER & BARFOOT VETERANS CARE CENTER (Providers name) to disclose my individual identifiable health information as described below.

_____ _____ _____

Patients Name Social Security Number Date of Birth

Name and address of person(s) or organization(s) requesting the records, if different from the patient:

_____
_____
_____
_____

Name and address of person(s) or Organization to receive the records:

_____
_____
_____
_____

_____ I will review the records at the provider's location. following

_____ I wish to have the following records copied, And I will pick them up at the provider's location.

____ I am requesting that the provider copy the records, and send the records to the above address.

Information Requested (please initial)

I am requesting the following records from the patient's medical records that were created between ____/____/____ and ____/____/____;

__ Dietary Notes
__ Activity Notes
__ Nursing Notes
__ Physician Notes
__ Physician Progress Notes
__ Care Plans
__ Discharge Summary
__ X-ray Reports
__ Lab Results
__ Social Service Notes
__ Therapy Notes
__ Other:_____
__ Other:_____

Purpose in which records will be used:_____.

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION RECORDS (CONT.)

__ I am the patient noted above
__ I am the patient's legal decision maker under state law and I am entitled to receive the medical records under state law.
__ I am the patient attorney-in-fact, and I have attached to this authorization a valid Power of Attorney or Durable Power of Attorney for Health Care (DPAHC) that grants me the power to request the patient's medical record.
__ I am the patient's legal Guardian, and I have attached to this authorization a valid appointment of guardianship from a probate court.
__ If the patient is deceased: I am the executor/administrator of the patients estate, and I have attached to this authorization a valid appointment as such from a probate court.
__ The patient has executed a legally binding instrument granting me the authority to obtain his/her medical records, and I have attached a copy of this instrument to this authorization.
__ The patient's legally authorized representative has executed a legally binding instrument granting me the authority to obtain the patient's medical record. I have attached a copy of the instrument granting me such authority, as well as evidence that the person who executed that instrument had the legal authority to do so(example: a power of attorney or probate court order).

UNDERSTANDINGS AND AGREEMENTS OF REQUESTOR

1. This authorization is voluntary.
2. This authorization will expire two months from the date of my signature below.
3. I understand that I may revoke this authorization at any time by notifying the provider in writing, but if I do, it will have no effect on any actions taken prior to receiving the revocation.
4. I agree to waive all claims against the providers for the release of the requested information.
5. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protection , afforded by the provider if the recipient of the information is not a health plan, health care provider, healthcare clearing house, or a business associate that has the contract with the provider.
6. The provider may not place conditions on treatment, payment, enrollment or eligibility for benefits on whether I sign an authorization when the prohibition on conditioning of authorizations applies.

7. I understand that I must provide the Provider with at least twenty-four hour (24) hours notice before coming to the provider
8. I understand that after I have reviewed the records, I must provide the Provider with two (2) working days advance notice of any copies of the record that I would like to pick up at the providers location.
9. I understand that if I requested that record to be copied and sent to me that the provider would make a good faith effort to send those records to me in a reasonable amount of time.
10. I understand that if I wish to have copies of records made, then the Provider will access a fee for copying the records.
11. The Provider will notify me of the total amount due for copying and shipping of the requested records: I agree that the Provider will only send me the requested information once it has received payment in full for those costs.

_____	_____	_____
SIGNATURE OF REQUESTOR	PRINT NAME	DATE

SITTER AND BARFOOT VETERANS CARE CENTER

APPLICATION FOR ADMISSION

RESIDENT INFORMATION			
FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX
SOCIAL SECURITY NUMBER		PREFERRED NAME	

SERVICE INFORMATION	
SERVICE CONNECTED DISABILITY? Y N	IF SO, WHAT PERCENT?

RESPONSIBLE PARTY AND FIRST EMERGENCY CONTACT
(Must be someone OTHER than Resident!)

NAME:	COMPLETE MAILING ADDRESS:	
RELATIONSHIP:	E-Mail Address:	
PHONE:	☐	NEXT OF KIN?
HOME	☐	POWER OF ATTORNEY?
CELL	☐	COURT APPOINTED GUARDIAN?
OFFICE	☐	VA FIDUCIARY?

SECOND EMERGENCY CONTACT

NAME:	COMPLETE MAILING ADDRESS:	
RELATIONSHIP:	E-Mail Address:	
PHONE:	☐	NEXT OF KIN?
HOME	☐	POWER OF ATTORNEY?
CELL	☐	COURT APPOINTED GUARDIAN?
OFFICE	☐	VA FIDUCIARY?

THIRD EMERGENCY CONTACT

NAME:	COMPLETE MAILING ADDRESS:	
RELATIONSHIP:	E-Mail Address:	
PHONE:	☐	OTHER:
HOME	☐	POWER OF ATTORNEY?
CELL	☐	COURT APPOINTED GUARDIAN?
OFFICE	☐	VA FIDUCIARY?

FINANCIAL RESOURCES

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

☐ MEDICARE A ☐ MEDICARE REPLACEMENT POLICY _____ NAME OF INSURANCE

☐ MEDICARE B

☐ MEDICARE D _____ NAME OF INSURANCE

☐ PRIVATE INSURANCE _____ NAME OF INSURANCE

☐ LONG TERM CARE INSURANCE _____ NAME OF INSURANCE

SITTER AND BARFOOT VETERANS CARE CENTER

APPLICATION FOR ADMISSION

MEDICAID

IF YOU DO NOT HAVE AT LEAST 6 MONTHS OF LIQUID ASSETS AVAILABLE TO YOU ($40,000) THEN YOU SHOULD APPLY FOR MEDICAID IN THE COUNTY IN WHICH YOU CURRENTLY RESIDE.

ARE YOU APPLYING FOR MEDICAID? ☐ YES ☐ NO | IF YES, WHAT COUNTY?

WHO IS YOUR CASE MANAGER/SOCIAL WORKER? PHONE:

IF YOU ALREADY HAVE MEDICAID PLEASE PROVIDE YOUR MEDICAID NUMBER:

FINANCIAL

ANTICIPATED STAY: SHORT TERM REHAB ☐ LONG TERM CARE ☐

APPLICANT'S SOURCE OF MONTHLY INCOME

☐	RETIREMENT PENSION	$_____	$_____
☐	INVESTMENT INCOME	$_____	$_____
☐	SOCIAL SECURITY (SSA)		$_____
☐	CIVIL SERVICE ANNUITY		$_____
☐	SUPPLEMENTAL SECURITY INCOME (SSI)		$_____
☐	OTHER:	$_____	$_____

APPLICANT'S ASSETS (Include Current Balance or Value) If Applicant Rents, Please Indicate N/A

REAL ESTATE (Specify Type/Location)

TYPE:

TYPE:

PERSONAL PROPERTY (Specify Type)

TYPE:

TYPE:

BANK INFORMATION

BANK:

☐ CHECKING $_____ ☐ CD $_____ ☐ OTHER $_____

☐ SAVINGS $_____ ☐ IRA $_____

INSURANCE POLICIES, ANNUITIES, ETC. (List Only Those With A Cash Value)

TYPE:

TYPE:

SITTER AND BARFOOT VETERANS CARE CENTER

APPLICATION FOR ADMISSION

CLINICAL	
HOSPITAL STAY DURING THE LAST 6 MONTHS?	
IF YES, NAME AND ADDRESS OF HOSPITAL:	
DATES OF STAY? ADMITTED: DISCHARGED:	REASON:
SKILLED NURSING STAY IN THE LAST 6 MONTHS?	
IF YES, NAME AND ADDRESS OF FACILITY:	
DATES OF STAY? ADMITTED: DISCHARGED:	REASON:
APPLICANT'S CHOICE OF:	
FUNERAL HOME (Must pick one):	
HOSPITAL:	
ARE YOU APPLYING FOR ADMISSON TO OUR DEMENTIA UNIT?: YES/NO	

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. WE DISPENSE FROM OUR OWN PHARMACY AND CANNOT ACCEPT MEDICATIONS FROM A SOURCE OTHER THAN OUR PHARMACY.

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 SitterBarfoot Veterans Care Center (SBVCC) to verify any of the above information. I/We understand that falsification of the stated information may jeopardize admission into SBVCC. All information will be kept confidential by SBVCC, and will not be released without my written permission.

_____ _____

SIGNATURE DATE

Department of Veterans Affairs

INSTRUCTIONS FOR COMPLETING ENROLLMENT APPLICATION FOR HEALTH BENEFITS

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

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

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

You may use ANY of the following to request assistance:

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

Definitions of terms used on this form:

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

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

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

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

Getting Started:

ALL VETERANS MUST COMPLETE SECTIONS I - III.

Directions for Sections I - III:

Section I - General Information: Answer all questions.

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

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

Directions for Sections IV-VI:

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

Financial Disclosure Requirements Do Not Apply To:

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

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

Continued ...

Section IV - Dependent Information: Include the following:

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

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

Report:

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

Do Not Report:

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

Section VI - Previous Calendar Year Deductible Expenses.

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

Section VII - Submitting your application.

1. Read Paperwork Reduction and Privacy Act Information, Section VIII Consent to Copays and Assignment of Benefits.
2. In Section VIII, 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.
3. Attach any continuation sheets, a copy of supporting materials and your Power of Attorney documents to your application.

Where do I send my application?

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

PAPERWORK REDUCTION ACT AND PRIVACY ACT INFORMATION

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

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

OMB Approved No. 2900-0091
Estimated Burden Avg. 30 min.

Department of Veterans Affairs

APPLICATION FOR HEALTH BENEFITS

SECTION I - GENERAL INFORMATION

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

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

2. MOTHER'S MAIDEN NAME

3. GENDER ☐ MALE ☐ FEMALE

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

5. WHAT IS YOUR RACE? *(You may check more than one. Information is required for statistical purposes only.)* ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ ASIAN ☐ WHITE ☐ NATIVE AMERICAN OR OTHER PACIFIC ISLANDER

6. SOCIAL SECURITY NUMBER

7. DATE OF BIRTH *(mm/dd/yyyy)*

7A. PLACE OF BIRTH *(City and State)*

8. PERMANENT ADDRESS *(Street)*

8A. CITY

8B. STATE

8C. ZIP CODE

8D. COUNTY

8E. HOME TELEPHONE NUMBER *(Include area code)*

8F. MOBILE TELEPHONE NUMBER *(Include area code)*

8G. E-MAIL ADDRESS

9. CURRENT MARTIAL STATUS ☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED

10. I AM ENROLLING TO OBTAIN MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT ☐ YES ☐ NO

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

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

SECTION II - MILITARY SERVICE INFORMATION

1. LAST BRANCH OF SERVICE

1A. LAST ENTRY DATE

1B. LAST DISCHARGE DATE

1C. DISCHARGE TYPE

2. MILITARY HISTORY *(Check yes or no)*	YES	NO		YES	NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?	☐	☐	E. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998?	☐	☐
B. ARE YOU A FORMER PRISONER OF WAR?	☐	☐	F. DID YOU SERVE IN VIETNAM BETWEEN JANUARY 9, 1962 AND MAY 7, 1975?	☐	☐
C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?	☐	☐	G. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?	☐	☐
D. WERE YOU DISCHARGED OR RETIRED FROM MILITARY FOR A DISABILITY INCURRED IN THE LINE OF DUTY?	☐	☐	H. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	☐	☐
			I. 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? ☐ YES ☐ NO

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

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

APPLICATION FOR HEALTH BENEFITS, Continued

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

SOCIAL SECURITY 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. DATE OF MARRIAGE *(mm/dd/yyyy)*

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

3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT?

☐ YES ☐ NO

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

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

2B. CHILD'S SOCIAL SECURITY NUMBER

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)*

SECTION V - 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 VI - 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 VII - CONSENT TO COPAYS AND TO RECEIVE COMMUNICATIONS

By submitting this application you are agreeing to pay the applicable VA copays for treatment or services of your NSC conditions as required by law. You also agree to receive communications from VA to your supplied email or mobile number.

ASSIGNMENT OF BENEFITS

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

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

SIGNATURE OF APPLICANT _____ DATE _____

Sitter & Barfoot Veterans Care Center

Advance Directive & Do Not Resuscitate Orders

What is an advance directive?

An advance directive tells your doctor what kind of care you would like to have if you become unable to make medical decisions (if you are in a coma, for example). If you are admitted to the hospital, the hospital staff will probably talk to you about advance directives.

A good advance directive describes the kind of treatment you would want depending on how sick you are. For example, the directives would describe what kind of care you want if you have an illness that you are unlikely to recover from, or if you are permanently unconscious. Advance directives usually tell your doctor that you don't want certain kinds of treatment. However, they can also say that you want a certain treatment no matter how ill you are.

Advance directives can take many forms. Laws about advance directives are different in each state. Virginia has an advance directive form. This form can be obtained from the social workers at Sitter & Barfoot Veterans Care Center.

What is a living will?

A living will is one type of advance directive. It is a written, legal document that describes the kind of medical treatments or life sustaining treatments you would want if you were seriously or terminally ill. A living will doesn't let you select someone to make decisions for you.

What is a durable power of attorney for health care?

A durable power of attorney (DPA) for healthcare is another kind of advance directive. A DPA states whom you have chosen to make healthcare decisions for you. It becomes active any time you are unconscious or unable to make medical decisions. A DPA is generally more useful than a living will. But a DPA may not be a good choice if you don't have another person you trust to make these decisions for you.

Living wills and DPAs are legal in most states. Even if they aren't officially recognized by the law in your state, they can still guide your loved ones and doctor if you are unable to make decisions about your medical care. Ask your doctor, lawyer or state representative about the law in your state.

What is a do not resuscitate order?

A do not resuscitate (DNR) order is another kind of advance directive. A DNR is a request not to have cardiopulmonary resuscitation (CPR) if your heart stops or if you stop breathing. (Unless given other instructions, hospital staff will try to help all patients whose heart has stopped or who have stopped breathing.) You can use an advance directive form or tell your doctor that you don't want to be resuscitated. In this case, a DNR order is put in your medical chart by your doctor. DNR orders are accepted by doctors and hospitals in all states.

Should I have an advance directive?

By creating an advance directive, you are making your preferences about medical care known before you're faced with a serious injury or illness. This will spare your loved ones the stress of making decisions about your care while you are sick. Any person 18 years of age or older can prepare an advance directive.

People who are seriously or terminally ill are more likely to have an advance directive. For example, someone with terminal cancer might write that she does not want to be put on a respirator if she stops breathing. This action can reduce her suffering, increase her peace of mind and increase her control over her death. However, even if you are in good health, you might want to consider writing an advance directive. An accident or serious illness can happen suddenly, and if you already have a signed advance directive, your wishes are more likely to be followed.

How can I write an advance directive?

You can write an advance directive in several ways:

- Use a form provided by your doctor.
- Write your wishes down by yourself.
- See the social worker at Sitter & Barfoot Veterans Care Center.
- Call your health department or state department on aging to get a form.
- Call a lawyer.
- Use a computer software package for legal documents.

Advance directives and living wills do not have to be complicated legal documents. They can be short, simple statements about what you want done or not done if you can't speak for yourself. Remember, anything you write by yourself or with a computer software package should follow your state laws.

You may also want to have what you have written reviewed by your doctor or a lawyer to make sure your directives are understood exactly as you intended. When you are satisfied with your directives, the orders should be notarized if possible, and copies should be given to your family and your doctor.

Can I change my advance directive?

You may change or cancel your advance directive at any time, as long as you are considered of sound mind to do so. Being of sound mind means that you are still able to think rationally and communicate your wishes in a clear manner. Again, your changes must be made, signed and notarized according to the laws in your state. Make sure that your doctor and any family members who knew about your directives are also aware that you have changed them.

If you do not have time to put your changes in writing, you can make them known while you are in the hospital. Tell your doctor and any family or friends present exactly what you want to happen. Usually, wishes that are made in person will be followed in place of the ones made earlier in writing. Be sure your instructions are clearly understood by everyone you have told.

Information source: American Academy of Family Physicians

I have reviewed Advance Directive & Do Not Resuscitate information.

_____ _____

Signature of Responsible Party Date

_____ _____

SBVCC Staff/Title Date

OMB Number: 2900-0260
Estimated Burden: 3 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO eHEALTH EXCHANGE

Privacy Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with The Health Insurance Portability and Accountability Act, (HIPAA) 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However if the information containing the Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, eHealth Exchange will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA10P2 "Patient Medical Record -VA" , and 168VA10P2 “Virtual Lifetime Electronic Record (VLER), and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you do not, the eHealth Exchange will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. VA may also use this information on this form to identify Veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

Patient Full Name
Last: (print) _____ **First:** _____ **Middle:** _____

Birth Date (mm/dd/yyyy): _____ **SSN:** _____ **Gender:** ☐ **Male** ☐ **Female**

Requestor Name: VA Approved eHealth Exchange Participants

Information Requested:

Pertinent health information from electronic health record.

I request and authorize my VA health care facility to release my protected health information (PHI) for treatment purposes only to the communities that are participating in the eHealth Exchange. This information may consist of the diagnosis of Sickle Cell Anemia, the treatment of or referral for Drug Abuse, treatment of or referral for Alcohol Abuse or the treatment of or testing for infection with Human Immunodeficiency Virus. This authorization covers the diagnoses that I may have upon signing of the authorization and the diagnoses that I may acquire in the future including those protected by 38 U.S.C. 7332.

This authorization will remain in effect for the period of five years. 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 my VA health care facility. Redisclosure of my electronic health records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected.

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.

_____ _____
Signature of Patient **Date**