

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.

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 \$153.00 per day based on Veterans Administration approval of patient per diem payment of \$87.00. If not approved, the daily rate is \$240.

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

SITTER AND BARFOOT VETERANS CARE CENTER
APPLICATION FOR ADMISSION

RESIDENT INFORMATION					
FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX		
SOCIAL SECURITY NUMBER			PREFERRED NAME		
GENDER	BIRTH DATE	AGE	MARITAL STATUS	RELIGIOUS PREFERENCE	
PREVIOUS OCCUPATION (Do not write retired)				PHONE	
CURRENT ADDRESS			CITY	STATE	COUNTY
PLACE OF BIRTH			VIRGINIA RESIDENT? Y N		PREVIOUS ADDRESS
			HOW LONG?		
			US CITIZEN? Y N		
SERVICE INFORMATION					
BRANCH OF SERVICE			RANK		SERVICE NUMBER
DATE OF ENLISTMENT		DATE OF DISCHARGE			DISCHARGE TYPE:
WARS SERVED IN? (Please circle)					
WWII KOREA VIETNAM GULF OTHER:					
MEDALS:					
SERVICE CONNECTED DISABILITY? Y N				IF SO, WHAT PERCENT?	
REFERRAL INFORMATION					
HOW DID YOU HEAR ABOUT US?					
COUNTY VETERAN SERVICE OFFICER <input type="checkbox"/>			WEB SITE <input type="checkbox"/>		
CHURCH/MINISTER <input type="checkbox"/>			VETERAN ORGANIZATION <input type="checkbox"/>		
SOCIAL WORKER <input type="checkbox"/>			OTHER: <input type="checkbox"/>		
HOSPITAL <input type="checkbox"/>					
NAME:					

PLEASE LET US KNOW WHO WE SHOULD THANK!

**SITTER AND BARFOOT VETERANS CARE CENTER
APPLICATION FOR ADMISSION**

RESPONSIBLE PARTY	
(Must be someone OTHER than Resident!)	
NAME:	COMPLETE MAILING ADDRESS:
RELATIONSHIP:	E-Mail Address:
PHONE:	<input type="checkbox"/> NEXT OF KIN?
HOME	<input type="checkbox"/> POWER OF ATTORNEY?
CELL	<input type="checkbox"/> COURT APPOINTED GUARDIAN?
OFFICE	<input type="checkbox"/> VA FIDUCIARY?
FIRST EMERGENCY CONTACT	
NAME:	COMPLETE MAILING ADDRESS:
RELATIONSHIP:	E-Mail Address:
PHONE:	<input type="checkbox"/> NEXT OF KIN?
HOME	<input type="checkbox"/> POWER OF ATTORNEY?
CELL	<input type="checkbox"/> COURT APPOINTED GUARDIAN?
OFFICE	<input type="checkbox"/> VA FIDUCIARY?
SECOND EMERGENCY CONTACT	
NAME:	COMPLETE MAILING ADDRESS:
RELATIONSHIP:	E-Mail Address:
PHONE:	<input type="checkbox"/> OTHER:
HOME	<input type="checkbox"/> POWER OF ATTORNEY?
CELL	<input type="checkbox"/> COURT APPOINTED GUARDIAN?
OFFICE	<input type="checkbox"/> VA FIDUCIARY?
FINANCIAL RESOURCES	
<input type="checkbox"/>	PRIVATE FUNDS (Adequate funds available to cover \$6,000/month for 6 months)
<input type="checkbox"/>	MEDICARE A
<input type="checkbox"/>	MEDICARE B
<input type="checkbox"/>	MEDICARE D IDENTIFY: (Aetna, Humana, etc.)
<input type="checkbox"/>	PRIVATE INSURANCE IDENTIFY: (TriCare, Anthem)
<input type="checkbox"/>	LONG TERM CARE INSURANCE IDENTIFY: (Genworth, John Hancock, etc.)
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? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHAT COUNTY?
WHO IS YOUR CASE MANAGER/SOCIAL WORKER?	PHONE:
IF YOU ALREADY HAVE MEDICAID PLEASE PROVIDE YOUR MEDICAID NUMBER:	

SITTER AND BARFOOT VETERANS CARE CENTER
APPLICATION FOR ADMISSION

FINANCIAL

ANTICIPATED STAY: **SHORT TERM REHA** **Long Term Care**

APPLICANT'S SOURCE OF MONTHLY INCOME

- | | | | |
|--------------------------|------------------------------------|----------|----------|
| <input type="checkbox"/> | RETIREMENT PENSION | \$ _____ | \$ _____ |
| <input type="checkbox"/> | INVESTMENT INCOME | \$ _____ | \$ _____ |
| <input type="checkbox"/> | SOCIAL SECURITY (SSA) | | \$ _____ |
| <input type="checkbox"/> | CIVIL SERVICE ANNUITY | | \$ _____ |
| <input type="checkbox"/> | SUPPLEMENTAL SECURITY INCOME (SSI) | | \$ _____ |
| <input type="checkbox"/> | OTHER: | \$ _____ | \$ _____ |

APPLICANT'S ASSETS (Include Current Balance or Value)

REAL ESTATE (Specify Type/Location)

TYPE:

TYPE:

PERSONAL PROPERTY (Specify Type)

TYPE:

TYPE:

BANK INFORMATION

BANK:

- | | | | | | |
|--------------------------|-------------------|--------------------------|--------------|--------------------------|----------------|
| <input type="checkbox"/> | CHECKING \$ _____ | <input type="checkbox"/> | CD \$ _____ | <input type="checkbox"/> | OTHER \$ _____ |
| <input type="checkbox"/> | SAVINGS \$ _____ | <input type="checkbox"/> | IRA \$ _____ | | |

INSURANCE POLICIES, ANNUITIES, ETC. (Cash Value)

TYPE:

TYPE:

APPLICANT'S CHOICE OF:

FUNERAL HOME (Must pick one):

HOSPITAL:

CHURCH:

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?

REASON:

ADMITTED:

DISCHARGED:

SKILLED NURSING STAY IN THE LAST 6 MONTHS?

IF YES, NAME AND ADDRESS OF FACILITY:

DATES OF STAY?

REASON:

ADMITTED:

DISCHARGED:

PHYSICIAN INFORMATION

PRIMARY CARE PHYSICIAN:

PHONE:

ADDRESS:

SPECIALTY:

OTHER PHYSICIAN:

PHONE:

ADDRESS:

SPECIALTY:

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

**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, or dental benefits. The information provided on this form will be used by VA to determine your eligibility for medical benefits and on average will take 45 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.

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

COMPENSABLE: A VA determination that a service-connected disability is 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 - IV.****Directions for Sections I - IV:**

Section I - General Information: Answer all questions

Section II - 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.

Section III - Employment Information: If you are employed or retired, answer all questions.

Section IV - 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.

Directions for Sections V - IX:

Section V - Financial Disclosure: ONLY NSC and 0% NONCOMPENSABLE SERVICE-CONNECTED VETERANS MUST COMPLETE THIS SECTION TO DETERMINE ELIGIBILITY AND COPAY RESPONSIBILITIES IF THEY ARE NOT:

- a former Prisoner of War or;
- in receipt of a Purple Heart or;
- a recently discharged Combat Veteran or;
- discharged for a disability incurred or aggravated in the line of duty or;
- receiving VA service-connected disability compensation or;
- receiving VA pension or;
- in receipt of Medicaid benefits

Failure to provide financial information, if required to do so, may result in denial of VA health care enrollment.

Continued ...

Section VI - Dependent Information: Your spouse and dependent social security number(s) are required so we can verify their financial and insurance information through a computer-matching program.

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

Section VIII - Previous Calendar Year Deductible Expenses: Answer applicable questions

Section IX - Previous Calendar Year Net Worth: Answer applicable questions

NOTE: All other Veterans may wish to provide this financial assessment to determine, **as applicable**, their eligibility for cost-free medication for their NSC conditions, beneficiary travel eligibility and/or waiver of the beneficiary travel deductible requirement.

Additional Information for Completing your application ...

Answer all questions in the appropriate sections. If you need more space to answer a question, attach a sheet of paper to the form containing your name and Social Security Number. If you need more room to respond to a question, write "Continuation of Item" and write the section and question number.

Section II - Insurance Information.

Include information for all health insurance policies that cover you, this includes coverage that is provided through a spouse or significant other. If you have more than one health insurer, provide this information on a separate sheet of paper and attach to the application. If you have access to a copier, attach a copy of your insurance cards, Medicare card and/or Medicaid card (Medicaid is a federal/state health insurance program for certain low-income people). Bring these cards with you to each health care appointment.

Section IV - 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 indicate that you received a Purple Heart Medal, we will check our records for confirmation of your status. If we are unable to confirm your Purple Heart status, we will ask you to provide VA a copy of your DD-214 or other military service records or orders indicating your award. To reduce processing time, you may submit a copy of this documentation with your application.

Section V - Financial Disclosure.

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 and agree to make co-payments for treatment of your NSC conditions. If a financial assessment is used to determine your eligibility for cost-free medication, travel assistance or waiver of deductible, and you do not disclose your financial information, you may not be eligible for these benefits.

Section VI - 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 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.

Continued ...

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 payment; 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 expenses of last illness and burial expenses, e.g., prepaid burial, paid by the veteran for spouse or dependent(s).

Section IX - Previous Calendar Net Worth.

Your net worth is the market value of all the interest and rights you have in any kind of property. However net worth does not include your single-family residence and a reasonable lot area surrounding it. It also does not include the personal things you use every day like your vehicle, clothing and furniture.

Submitting your application.

1. Read Section X, Paperwork Reduction and Privacy Act Information, Section XI Consent to Copays and Section XII, Assignment of Benefits.
2. In Section XII, 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 your local VA health care facility. You can find the address by calling VA at 1-877-222-VETS (8387), or on the Internet at <http://www.va.gov>.



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 <i>(Last, First, Middle Name)</i>		2. OTHER NAMES USED	3. MOTHER'S MAIDEN NAME	4. GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
5. ARE YOU SPANISH, HISPANIC, OR LATINO? <input type="checkbox"/> YES <input type="checkbox"/> NO	6. WHAT IS YOUR RACE? <i>(You may check more than one.) (Information is required for statistical purposes only.)</i> <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> ASIAN <input type="checkbox"/> WHITE <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER			
7. SOCIAL SECURITY NUMBER	8. VA CLAIM NUMBER	9. DATE OF BIRTH <i>(mm/dd/yyyy)</i>		
9A. PLACE OF BIRTH <i>(City and State)</i>		10. RELIGION		
11. PERMANENT ADDRESS <i>(Street)</i>		11A. CITY	11B. STATE	11C. ZIP CODE <i>(9 digits)</i>
11D. COUNTY	11E. HOME TELEPHONE NUMBER <i>(Include area code)</i>		11F. E-MAIL ADDRESS	
11G. CELLULAR TELEPHONE NUMBER <i>(Include area code)</i>		12. TYPE OF BENEFIT(S) APPLYING FOR <i>(You may check more than one)</i> <input type="checkbox"/> ENROLLMENT/HEALTH SERVICES <input type="checkbox"/> DENTAL		
13. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? <i>(for listing of facilities visit www.va.gov/directory)</i>		14. DO YOU WANT AN APPOINTMENT WITH A VA DOCTOR OR PROVIDER AS SOON AS ONE BECOMES AVAILABLE? <input type="checkbox"/> YES <input type="checkbox"/> NO I am only enrolling in case I need care in the future.		
15. CURRENT MARITAL STATUS <i>(Check one)</i> <input type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> UNKNOWN				
16. NAME, ADDRESS AND RELATIONSHIP OF NEXT OF KIN		16A. NEXT OF KIN'S HOME TELEPHONE NUMBER <i>(Include area code)</i>		
		16B. NEXT OF KIN'S WORK TELEPHONE NUMBER <i>(Include area code)</i>		
17. NAME, ADDRESS AND RELATIONSHIP OF EMERGENCY CONTACT <i>(if different than 16)</i>		17A. EMERGENCY CONTACT'S HOME TELEPHONE NUMBER <i>(Include area code)</i>		
		17B. EMERGENCY CONTACT'S WORK TELEPHONE NUMBER <i>(Include area code)</i>		

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

1. ENTER HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER <i>(include coverage through spouse or other person)</i>				
2. NAME OF POLICY HOLDER	3. POLICY NUMBER	4. GROUP CODE	5. ARE YOU ELIGIBLE FOR MEDICAID? <input type="checkbox"/> YES <input type="checkbox"/> NO	5A. EFFECTIVE DATE <i>(mm/dd/yyyy)</i>
6. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A? <input type="checkbox"/> YES <input type="checkbox"/> NO		6A. EFFECTIVE DATE <i>(mm/dd/yyyy)</i>		
7. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART B? <input type="checkbox"/> YES <input type="checkbox"/> NO		7A. EFFECTIVE DATE <i>(mm/dd/yyyy)</i>		
8. NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD		9. MEDICARE CLAIM NUMBER		

APPLICATION FOR HEALTH BENEFITS, Continued		VETERAN'S NAME <i>(Last, First, Middle)</i>		SOCIAL SECURITY NUMBER	
SECTION III - EMPLOYMENT INFORMATION					
1. VETERAN'S EMPLOYMENT STATUS <i>(Check one)</i> If employed or retired, complete item 1A <input type="checkbox"/> FULL TIME <input type="checkbox"/> NOT EMPLOYED <input type="checkbox"/> PART TIME <input type="checkbox"/> RETIRED Date of retirement <i>(mm/dd/yyyy)</i>			1A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER		
2. SPOUSE'S EMPLOYMENT STATUS <i>(Check one)</i> If employed or retired, complete item 2A <input type="checkbox"/> FULL TIME <input type="checkbox"/> NOT EMPLOYED <input type="checkbox"/> PART TIME <input type="checkbox"/> RETIRED Date of retirement <i>(mm/dd/yyyy)</i>			2A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER		
SECTION IV - MILITARY SERVICE INFORMATION					
1. LAST BRANCH OF SERVICE		1A. LAST ENTRY DATE	1B. LAST DISCHARGE DATE	1C. DISCHARGE TYPE	1D. MILITARY SERVICE NUMBER
2. CHECK YES OR NO		YES	NO	YES	NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?		<input type="checkbox"/>	<input type="checkbox"/>	E. DO YOU NEED CARE OF CONDITIONS POTENTIALLY RELATED TO SERVICE IN SWASIA DURING THE GULF WAR?	
B. ARE YOU A FORMER PRISONER OF WAR?		<input type="checkbox"/>	<input type="checkbox"/>	F. WERE YOU EXPOSED TO AGENT ORANGE WHILE SERVING IN VIETNAM?	
C. DID YOU SERVE IN COMBAT AFTER 11/11/1988?		<input type="checkbox"/>	<input type="checkbox"/>	G. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?	
D. WAS YOUR DISCHARGE FROM MILITARY FOR A DISABILITY INCURRED OR AGGRAVATED IN THE LINE OF DUTY?		<input type="checkbox"/>	<input type="checkbox"/>	H. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	
D1. ARE YOU RECEIVING DISABILITY RETIREMENT PAY INSTEAD OF VA COMPENSATION?		<input type="checkbox"/>	<input type="checkbox"/>	I. DO YOU HAVE A SPINAL CORD INJURY?	
SECTION V - 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; however, VA is not currently enrolling <u>new</u> applicants who decline to provide their financial information unless they have other qualifying eligibility factors. Recent combat Veterans are eligible for enrollment without disclosing their financial information but like other Veterans may provide it to establish their eligibility for travel assistance, cost-free medication and/or medical care for services unrelated to military experience.					
<input type="checkbox"/> No, I do not wish to provide financial information in Sections VI through IX. I understand that VA is not enrolling <u>new</u> applicants who do not provide this information and who do not have other qualifying eligibility factors [i.e., a former Prisoner of War; in receipt of a Purple Heart; a recently discharged Combat Veteran (e.g., OEF/OIF who were discharged within the past 5 years or were discharged more than 5 years ago and applying for enrollment by Jan. 27, 2011); discharged for a disability incurred or aggravated in the line of duty; receiving VA service-connected disability compensation; receiving VA pension; or in receipt of Medicaid benefits.] <i>Sign and date the form in Section XII.</i>					
<input type="checkbox"/> Yes, I will provide my household financial information for last calendar year. Complete applicable sections VI through IX. <i>Sign and date the form in Section XII.</i>					
SECTION VI - DEPENDENT INFORMATION (Use a separate sheet for additional dependents)					
1. SPOUSE'S NAME <i>(Last, First, Middle Name)</i>			2. CHILD'S NAME <i>(Last, First, Middle Name)</i>		
1A. SPOUSE'S MAIDEN NAME OR OTHER NAMES USED			2A. CHILD'S RELATIONSHIP TO YOU <i>(Check one)</i> <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter		
1B. SPOUSE'S SOCIAL SECURITY NUMBER		2B. CHILD'S SOCIAL SECURITY NUMBER	2C. DATE CHILD BECAME YOUR DEPENDENT <i>(mm/dd/yyyy)</i>		
1C. SPOUSE'S DATE OF BIRTH <i>(mm/dd/yyyy)</i>	1D. DATE OF MARRIAGE <i>(mm/dd/yyyy)</i>	2D. CHILD'S DATE OF BIRTH <i>(mm/dd/yyyy)</i>			
1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER <i>(Street, City, State, ZIP - if different from Veteran's)</i>			2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? <input type="checkbox"/> YES <input type="checkbox"/> NO		
			2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? <input type="checkbox"/> YES <input type="checkbox"/> NO		
3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR ENTER THE AMOUNT YOU CONTRIBUTED TO THEIR SUPPORT.			2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING <i>(e.g., tuition, books, materials)</i>		
SPOUSE \$		CHILD \$		\$	

APPLICATION FOR HEALTH BENEFITS, Continued	VETERAN'S NAME <i>(Last, First, Middle)</i>	SOCIAL SECURITY NUMBER
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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 <i>(wages, bonuses, tips, etc.)</i> EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	\$	\$	\$
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	\$	\$	\$
3. LIST OTHER INCOME AMOUNTS <i>(e.g., Social Security, compensation, pension interest, dividends)</i> . EXCLUDING WELFARE.	\$	\$	\$

SECTION VIII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE <i>(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home)</i> 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 <i>(Also enter spouse or child's information in Section VI.)</i>	\$
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES <i>(e.g., tuition, books, fees, materials)</i> DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.	\$

SECTION IX - PREVIOUS CALENDAR YEAR NET WORTH *(Use a separate sheet for additional dependents)*

	VETERAN	SPOUSE	CHILD 1
1. CASH AMOUNT IN BANK ACCOUNTS <i>(e.g., checking, savings accounts, certificates of deposit, individual retirement accounts, stocks and bonds)</i>	\$	\$	\$
2. MARKET VALUE OF LAND AND BUILDINGS MINUS MORTGAGES AND LIENS. <i>(e.g., second home and non-income producing property. Do not count your primary home.)</i>	\$	\$	\$
3. VALUE OF OTHER PROPERTY OR ASSETS <i>(e.g., art, rare coins, collectables)</i> MINUS THE AMOUNT YOU OWE ON THESE ITEMS. INCLUDE VALUE OF FARM, RANCH OR BUSINESS ASSETS. Exclude household effects and family vehicles.	\$	\$	\$

SECTION X - 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 45 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 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.

SECTION XI - CONSENT TO COPAYS

By signing this application you are agreeing to pay the applicable VA copays for treatment or services of your NSC conditions as required by law.

SECTION XII - ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section 1729, VA is authorized to recover or collect from my health plan (HP) 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.

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
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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

Part B Therapy Cap Questionnaire

Sitter & Barfoot Veteran Care Center

This information is needed to assure that the admitted resident and/or designee will not incur any unknown costs from participation in therapy services. Ultimately the resident and/or designee is responsible for any un-met deductible, co-insurance or exhaustion of therapy cap monies due to inaccurate or incomplete information.

Resident Name: _____

Resident Number: _____

1. Have you received therapy this calendar year in your home?

Yes _____ No _____ Part B Billed \$ _____

If yes:

Do you know the name and phone number of the Home Health Agency that provided the therapy?

Name of the Home Health Agency/phone #

Do you know what type of therapy you received?

PT OT ST

2. Have you received therapy this calendar year in another nursing home?

Yes _____ No _____ Part B Billed \$ _____

If yes:

Do you know the name and phone number of the nursing home?

Name of Nursing Home/phone #

Do you know what type of therapy you received?

PT OT ST

3. Have you received therapy this calendar year in an outpatient clinic that is not part of a hospital?

Yes _____ No _____ Part B Billed \$ _____

If yes:

Do you know the name and phone number of the clinic?

Name of the clinic/phone #

Do you know what type of therapy you received?

PT OT ST

4. Have you received therapy this calendar year in an Assisted Living Facility?

Yes _____ No _____ Part B Billed \$ _____

If yes:

Do you know the name and phone number of the facility?

Name of Assisted Living Facility/phone #

Do you know what type of therapy you received?

PT OT ST

5. Do you have a Power Wheelchair or Scooter?

Yes _____ No _____

(Please do not bring it in until the Rehab Depart. assesses your ability to operate a vehicle of this type)