Admission Application
Dear Veteran:

Thank you for your interest in Virginia Veterans Care Center. We take great pride in caring for those who have cared for us!

Attached you will find the information and forms you will need to begin the administration process.

Please fill out the following and return to us, either by mail, email, or fax.

1. **The Application.** Please answer all the questions you can. Be sure to sign the last page.

2. **A copy of your Honorable Discharge or a DD 214.** Do not send originals.

3. **A copy of your Medicare card, Medicaid card, or any additional insurance cards you have in effect.** Our Business Office will contact your insurance company(s) to investigate what benefits you may have.

4. **A copy of your Power of Attorney Papers and your Advance Directive, if you have them.** If you do not have a power of attorney, please arrange for someone to assist you in financial and medical decisions.

5. **Medical History.** Contact your present Physician and request that he/she fax your medical information for the previous 6 months to (540) 982-1907. This is not necessary if coming from a hospital or nursing home.

6. **Physical Form.** There is also a Physical Form enclosed, but this physical must be done within 30 days of your admission to Virginia Veterans Care Center. Please wait until we know you are going to be living here before you have a physical done.

Please feel free to call me at 540-982-2860 or email at heather.whiteheart@dvs.virginia.gov if I can answer any questions. I will be happy to assist anyway I can.

Sincerely,

**Heather Whiteheart**

Heather Whiteheart
The Virginia Veterans Care Center opened on Veterans Day, 1992. We are proud to care for Virginia’s Veterans. Our staff is dedicated to providing the best quality of life to the Veterans who served us. Whether it is a short stay for rehab or for long-term care, the Virginia Veterans Care Center offers individualized services in a safe, caring, and professional environment. Virginia Veterans Care Center is a smoke free facility.

Care Levels
- Skilled Nursing
- Intermediate Nursing
- Alzheimer’s/ Dementia
- Hospice

Nursing Staff
Registered Nurses, Licensed Practical Nurse and Certified Nursing Assistants provide 24-hour care to our residents

Amenities
- Library
- Barber Shop
- Chapel
- Paved wheelchair paths
- 20 acres of park-like grounds and nature trails

Features
- In- house physical, occupational, and speech therapy
- Special Veteran and patriotic programs throughout the year
- Events by local Veteran Services
- Therapeutic activities such as pet therapy, bingo, fishing trips, outings, and weekly shopping trips
- Transportation to community and sporting events, and medical appointments

The staff is fantastic and provides excellent care for my dad. They communicate well with my family about my dad’s care.—Susan H.

I cannot emphasize enough as to how welcoming everyone was. We were met with smiling faces and compassion. VVCC is extremely clean, organized, and friendly. My dad was treated with the utmost of dignity. The VVCC is located on an absolutely beautiful setting. Dad loved to be taken outside and watch the deer and squirrels. I never once worried about the care my dad was receiving at the VVCC. I could lay my head down at night knowing he was being well taken care of.—Terri H.

I like everything here! I have made a lot of friends and the food is delicious. I especially like the bacon, eggs, and sausage gravy. The staff take excellent care of me. I took a golf cart ride around the property the other day and it was beautiful. I thoroughly enjoy living here! — Marvin P.
Application for Admission

PERSONAL INFORMATION

Applicant's full name: ____________________________

First          Middle          Last

Phone Number (___) ____________________________

Mothers Maiden Name: __________________________

Home Address ____________________________

City ____________________________ State ___ Zip ___

Virginia resident?  □ Yes  □ No

How long? __________ □ Months  □ Years

Where did you enter the service? ____________________________

City ____________________________ State ___

Do you smoke?  □ Yes  □ No

Date of Birth ___/___/____

Age ___ Sex ___ Social Security # ______

Marital Status  □ Single  □ Married  □ Widowed  □ Divorced  □ Separated  □ Never Married

Mother's Maiden Name ____________________________

Your Place of Birth: ____________________________

Applicant coming to VVCC from ____________________________

Do you smoke?  □ Yes  □ No

Desired arrival date ___/___/____

Expected Level of Care:  □ Assisted Living  □ Nursing Home  □ Dementia Care

MILITARY INFORMATION

Military Service:  □ Coast Guard  □ Army  □ Navy  □ Marine Corps  □ Air Force

Service Number ____________________________

Type of Discharge: ____________________________

Date entered into service  ___/___/____  Date separated from service  ___/___/____

Do you have a copy of your DD-214?  □ Yes  □ No

Have you received treatment at a VA Hospital?  □ Yes  □ No

Where: ____________________________

Are you Service Connected?  □ Yes  □ No

What percentage? ____________________________

HEALTH INFORMATION

Have you ever been treated for mental illness (es)?  □ Yes  □ No  If yes, dates of treatment and name facility

Have you ever been treated for drug or alcohol problems?  □ Yes  □ No  If yes, dates of treatment and name facility

Hospital stays during last 6 months?  □ Yes  □ No  If yes, dates of treatment and name facility

Resident of healthcare center in the last year?  □ Yes  □ No  If yes, dates of treatment and name facility

Virginia Veterans Care Center 2018
FINANCIAL RESOURCES

APPLICANT'S PAYMENT SOURCE

☐ Private funds  I have adequate personal funds available to cover at least _______ months of care.

☐ Medicare (number) ____________________________________________________________

☐ Medicare Supplemental insurance (name of carrier) ________________________________

☐ Medicaid (number) ____________________________________________________________

☐ We have applied for Medicaid?  ☐ Yes  ☐ No  What County did you apply in: ________________________________

APPLICANT'S SOURCE OF MONTHLY INCOME

☐ Retirement/Pension $ ________________________________

☐ Social Security Income (SSA) $ ____________________________

☐ Veterans benefits $ ________________________________

☐ Supplemental Security Income (SSI) $ ____________________________

☐ Other (identify) ________________________________________________ $ _______________

APPLICANT'S ASSETS

☐ Real Estate (type/location/value) ______________________________________________

☐ Bank accounts (checking, savings, CDs, IRAs, other) (value) ____________________________

☐ Life Insurance policies
  Type/carryer ____________________________________ Cash value $ ________________
  Type/carryer ____________________________________ Cash value $ ________________

☐ Burial and/or Irrevocable Trust  ☐ Yes  ☐ No

Has applicant transferred ownership of any type of assets in the past 5 years?  ☐ Yes  ☐ No

If yes, asset and date of transfer ____________________________

Social Security check is made payable to the applicant?  ☐ Yes  ☐ No

If no, name of representative payee ________________________________ Relationship ____________________________

Representative's address: ____________________________________________________________

City ____________________________ State __________________ Zip ____________________________
**RESPONSIBLE PARTY**

A Responsible Party is held responsible for paying for the Veteran’s stay with the Residents Funds.

Responsible Party ____________________________________________  
First                      Middle                      Last  

Relationship to Applicant: ____________________________________________  

Address ____________________________________________  City  State  Zip  

Telephone (home) ____________________________  (cell) ____________________________  (work) ____________________________  

**Power of Attorney (POA)?** ☐ Yes  ☐ No  (If yes, include copy with application packet) 

**Are you a Court Appointed Guardian?** ☐ Yes  ☐ No  (If yes, include copy with application packet) 

POA Name ____________________________

POA Address ____________________________________________  City  State  Zip  

POA Telephone (home) ____________________________  (cell) ____________________________  (work) ____________________________  

I/We hereby confirm that all information stated herein is current and correct to the best of my/our knowledge, and no requested information has been withheld or misrepresented. I/We authorize Virginia Veterans Care Center to verify any of the information herein. I/We understand that falsification of the stated information may jeopardize admission into the VVCC. I/We understand that all information will be kept confidential by Virginia Veterans Care Center and will not be released without my/our written permission.

__________________________________________  Date  

**Applicant’s or Authorized Representative’s Signature**

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**REQUIRED ADMISSION SUPPLEMENTS**

To start the application process, the following documents are also required:

1. The **last 6 months** of the applicant’s medical history, faxed from all the applicant’s health providers. Ask Dr’s office or VA to fax information to (540) 982-1907.

2. A **copy** of both the front and back the applicant’s insurance cards, e.g., Medicare, Medicaid and Blue Cross/Blue Shield.

3. A **copy** of Veteran’s DD-214 or Honorable Discharge.

4. A **copy** of any legal guardianship papers or Power of Attorney documentation.

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**Please mail Application and Additional Supplements to:**  
**Virginia Veterans Care Center**  
**Admissions Director**  
**4550 Shenandoah Ave.**  
**Roanoke, VA 24017**

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**Have questions or need assistance?**  
**Call 540-982-2860**  
**Ask For**  
**The Admissions Department**

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Virginia Veterans Care Center 2018
REPORT OF PHYSICAL EXAMINATION FOR PLACEMENT

Must be completed by physician within 30 days prior to admission. If admission is delayed beyond 30 days, addendum will be requested.

NAME ___________________ PHONE ___________ DATE OF EXAM __________
ADDRESS ___________________________________________________________
__________________________________________________________
Resident's Height _______ Weight _________ BP ________
Current Diagnoses/Problems
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Significant Medical History
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General physical condition/systems review:
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Is this person:
_____ Ambulatory  (physically and mentally capable of self-preservation by evacuating in response to an emergency to a refuge area as defined by the Uniform Statewide Building code without the assistance of another person, or from the structure itself without the assistance of another person if there is no such refuge area within the structure, even if such a resident may require the assistance of a wheelchair, walker, cane, prosthetic device or a single verbal command to evacuate).
_____ Nonambulatory  (by reason of physical or mental impairment is not capable of self-preservation without the assistance of another person).
REPORT OF PHYSICAL EXAMINATION FOR PLACEMENT

Name ______________________________

Diet Education Needed: ______________________________

Current Activity ______________________________

Current Treatment Orders ______________________________

ALLERGIES (medication, food, other): ______________________________

Current Scheduled Medications (including OTC products):
List PRN medications on page 3 or 4.

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
<th>Reason for prescribing</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Unless VVCC is notified of changes, these orders will be used for admission orders.

Signature of MD ________________________ Date ____________
REPORT OF PHYSICAL EXAMINATION FOR PLACEMENT
PRN MEDICATIONS

Name ______________________________

PRN medications must include symptoms/indication for use, exact timeframes the
medication is to be given in a 24-hour period, and directions for what to do if symptoms persist.
All PRN medications must be available individually for each resident.

VVCC has adopted the following over the counter medications to alleviate symptoms
of temporary conditions. If symptoms are not relieved or worsen, the PCP or VAMC ER
physician will be notified. Please check approved orders or write in others.

1. For mild pain or temp. of 101° or higher:
   □ Tylenol 650 mg. PO every four hours PRN. Maximum of 6 doses per 24 hours.

2. For constipation:
   □ Milk of Magnesia 30 ml. PO daily PRN
   □ Fleet's enema x 1 PRN

3. For diarrhea:
   □ Licensed nurse to check for fecal impaction.
   □ If none present, may give Imodium AD 2 caplets PO. May repeat 1 caplet after each
     loose stool up to a maximum dose of 16 mg. (8 caplets) within a 24 hour period.

4. For nausea, vomiting, acid indigestion, or upset stomach:
   □ Mylanta 15 ml. PO every 2 hours PRN for acid indigestion.
   □ Emetrol 15 ml. every 15 minutes PRN for nausea and vomiting up to a maximum of 5
doses in 24 hours.

5. For cough/cold symptoms:
   □ Guaifenesin-DM Sugar-Free 10ml. PO every 4 hours PRN. Maximum of 4 doses in
24 hour period.

6. For difficulty sleeping:
   □ Benadryl 25mg. PO at bedtime PRN

7. For minor skin tears and abrasions:
   □ Clean area with Normal Saline daily until healed. Apply Bacitracin Ointment and clean
     dry dressing daily.

8. For shortness of breath:
   □ Check vital signs and pulse ox, start O2 at 2 LPM, and notify MD.

Unless VVCC is notified of changes, these orders will be used for admission orders.

Signature of MD ______________________________ Date ____________
REPORT OF PHYSICAL EXAMINATION FOR PLACEMENT
OTHER SCHEDULED OR PRN MEDICATIONS

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency/Max per 24 hour period</th>
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<tbody>
<tr>
<td>Specific indication for use</td>
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<td></td>
<td>If symptoms persist</td>
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<tr>
<td>Name</td>
<td>Dose</td>
<td>Route</td>
<td>Frequency/Max per 24 hour period</td>
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<tr>
<td>Specific indication for use</td>
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<td>If symptoms persist</td>
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<tr>
<td>Name</td>
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<td>Specific indication for use</td>
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<td>If symptoms persist</td>
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<td>Specific indication for use</td>
<td></td>
<td></td>
<td>If symptoms persist</td>
</tr>
</tbody>
</table>

Unless VVCC is notified of changes, these orders will be used for admission orders.

Signature of MD ___________________________ Date ________
REPORT OF PHYSICAL EXAMINATION FOR PLACEMENT

Name _________________________________

Does this individual have any of the following conditions or care needs?

<table>
<thead>
<tr>
<th>Condition/Care Need</th>
<th>Yes</th>
<th>No</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventilator dependency</td>
<td></td>
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<tr>
<td>Pressure Ulcer, Stage III or IV</td>
<td></td>
<td></td>
<td>If stage III ulcer, is it healing?</td>
</tr>
<tr>
<td>IV therapy or IV injections</td>
<td></td>
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<td>If intermittent IV therapy, check yes and indicate expected time period</td>
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<tr>
<td>Airborne infectious disease that requires isolation or special precautions</td>
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<tr>
<td>Psychotropic medications without appropriate diagnosis and treatment plans</td>
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<tr>
<td>Nasogastric tubes</td>
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<tr>
<td>Gastric tubes</td>
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<td></td>
<td>If yes, is the person capable of independently feeding himself and caring for the tube and site?</td>
</tr>
<tr>
<td>Presents imminent physical threat or danger to self or others</td>
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<td></td>
<td>In need of immediate assessment by a qualified mental health professional.</td>
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<tr>
<td>Requires continuous licensed nursing care</td>
<td></td>
<td></td>
<td>Licensed nurse must provide specific needed care each shift.</td>
</tr>
</tbody>
</table>

Does applicant have a history of mental health problems requiring intervention in the past year?

__________________________________________________________________________

Has the applicant exhibited any of these behavior(s) in the past year requiring assessment, treatment, or monitoring? Yes _____ No _____ If yes, check behaviors identified:

- Physically assaulting others
- Gesturing a threat of assault
- Verbalizing a threat of harm to self or others
- Suicidal ideation or attempts
- Verbalizing an unrealistic fear of being harmed by others
- Destroying property that exposes self or others to harm
- Wandering inside or outside current residence
- Being intrusive in the personal space of others
- Putting objects or liquids in the mouth that are mistaken as food or consumable fluids
- Increased physical activity such as floor pacing that might indicate anxiety or stress
- Increased or confusing speech pattern or communications that might indicate a disorder of thought process
- Decreased physical activity such as staying in bed, not eating, or not communicating that might indicate depression
- Self-neglect – bathing, grooming, clean clothing, clean environment
- Pattern of alcohol abuse
- Pattern of drug abuse or misuse
- Compulsive behavior patterns
- Other

__________________________________________________________________________

Is applicant capable of making financial decisions? _____ Medical decisions? _____

Signature of MD ____________________________ Date ____________
REPORT OF PHYSICAL EXAMINATION FOR PLACEMENT
TUBERCULOSIS SCREENING EVALUATION

Name ______________________________________

Date of most recent Mantoux tuberculin skin test __________

Result: mm of induration ________________

☐ Applicant previously tested positive
☐ Previously treated __________________________

Is person exhibiting any TB-like symptoms? Yes ____ No ____

If TB skin test is 10mm or greater (5mm in HIV infected), previously positive, or if TB-like symptoms exist, respond to the following:

   Date of last chest x-ray ________________ (Attach report)

   Was chest x-ray suggestive of active TB? Yes____ No ____

   If yes, were sputum smears collected for AFB? Yes ____ No ____

   Were three consecutive smears negative for AFB? Yes ____ No ____

Based on the above, is this individual free of communicable TB? Yes ____ No ____

Name of licensed MD, nurse practitioner, or local health department official completing evaluation.

   Print Name __________________________ Phone __________________

   Signature _____________________________ Date ______________
# Daily Room Rates

**Effective 02-01-2020**

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Semi-Private Room Rate</th>
<th>Private Room Rate</th>
<th>VA Per Diem Facility Credit</th>
<th>Resident Cost for Semi-Private Room After</th>
<th>Resident Cost for Private Room After Credit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nursing Facility</strong></td>
<td>$252.36</td>
<td>$288.36</td>
<td>$112.36</td>
<td>$140.00*</td>
<td>$176.00*</td>
</tr>
<tr>
<td><strong>Alzheimer Special Care Unit</strong></td>
<td>$252.36</td>
<td>$288.36</td>
<td>$112.36</td>
<td>$140.00*</td>
<td>$176.00*</td>
</tr>
</tbody>
</table>

* A facility credit may be applied to the accounts of eligible residents