Veterans Home of California (VHC) Admission Application

APPLICATION PREFACE AND GENERAL QUALIFICATIONS

Welcome to the application process, the path to becoming a resident at one of California's extraordinary Veterans Homes. We encourage all eligible veterans to apply for admission. California's Veterans Homes are operated as an expression of gratitude toward our State's Veterans.

To save time, before you start to fill out the application form, check to see that you meet the basic qualifications for admission. In brief, these qualifications are:

1. **You are age 55 or over or, you have a disability.**
2. **You served in the military and you were honorably discharged.**
3. **You are still able to live independently or you qualify for a higher level of care offered at one of the Homes (contact the specific Home for clarification on qualifying for a higher level of care).**
4. **You are a California resident.**
5. **You are able to live with and get along with other people in a structured communal environment.**
6. **Prior to admission to a Veterans Home, and while a resident at the Home, veterans must be enrolled in a qualified health insurance plan that covers long-term care, and specialty medical care, including but not limited to:**
   - **Medicare Part A**
   - **Medicare Part B, Part D**
   - **Medi-Cal**
   - **TRICARE (including dental) or CHAMPVA**
   - **USDVA Health Care**
   - **Commercial Insurance (Blue Cross, Blue Shield, etc).**
   - **Other health coverage including Long Term Care or comparable insurance**

Members not enrolled in a sufficient insurance plan must have an application in process and acknowledge that they will be placed on self-pay status (responsible for all outside medical expenses) until health coverage is obtained. Furthermore members who fail to enroll in Medicare Part B and/or Part D will be responsible for all medical services provided by those coverage's.

Further information about the Homes, photo galleries, and instructions on filling out this application and the admission process can be found online. Go to www.calvet.ca.gov > click on Vet Homes> and select the Home of your choice for information about that Home. Downloadable and printable copies of the Application for the Veterans Home of California are also available.

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TABLE OF CONTENTS AND PREFACE

If you need help completing this application or have questions, you can call any of the phone numbers listed on page A-4.

This application package has three sections. The applicant completes sections A and B and section C is completed by a physician. All responses in each section are required.

Section	**Completed By:**
Section A: Background Information	completed by Applicant
Section B: Authorization for Use and/or Disclosure of Resident/Patient Health Information	completed by Applicant
Section C: Physician's Medical Certificate	completed by Physician

PREFACE

This application should be completed to the best of your ability. It is the first step in gaining residency to a California Veterans Home. CalVet recommends you take the following steps if you wish to expedite the admissions process:

1. Contact your physician as soon as possible and set up an appointment to complete Section C. Note that Section C is valid for 6 months once signed.

2. In addition to filling out and including Section B, use Section B to request the most recent 12 months of medical history from your physician's office, hospitals, and all other health care providers. Include the documents with your application package. Usually the slowest part of the application process is that the Home must request and wait for your medical records to arrive at the Admissions office. We recommend that you obtain copies of your medical records and send them directly to the Admissions office to avoid delays.

For your application to be considered complete, please submit a copy of the following documents with your application package.

A copy of:

Form DD-214, Certificate of Release or Discharge From Active Duty
Proof of California Residency, (see page A-1, California Residency)
Copies of the front and back side of all your health insurance cards (Medicare, Medi-Cal, TRICARE, USDVA Health Care etc.).
Most recent 12 months of medical history

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BACKGROUND INFORMATION

A

Personal Information

Full name _____
Last First Middle

Social Security number _____Date of birth_____

Driver license number _____State_____

Home address _____
Street City State Zip Code

Mailing address (if different from above) _____

Home phone _____Other phone _____

Place of birth _____U.S. citizen? ☐Yes ☐ No
If not a U.S. citizen, resident alien number: _____

Are you: _____Male _____Female

Marital Status

Are you currently married? ☐Yes ☐No
If yes, please answer the following questions:

How long have you been married to your current spouse? _____

Is your spouse a veteran? ☐Yes ☐No

Is your spouse also applying for admission to a Veterans Home? ☐Yes ☐No

Spouse's full name _____
Last First Middle

California Residency

Initial here _____ I am a bona fide resident of the State of California. **I am submitting a copy** of the following proof of my residency (please check one or more).

☐ Valid California Drivers License
☐ California Department of Motor Vehicle Identification Card
☐Registered Voter Status
☐Utility Bill that shows the applicant's residence
☐Paying California State Income Taxes as a resident
☐ Letter from County Veteran Service Officer or a VA representative
☐ Other: Explain: _____

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BACKGROUND INFORMATION

A

Military Service Information

What name did you serve under in the military?
Full name_____
Last First Middle
What branch of service were you in? _____
What was your military service number? _____
What were your dates of active duty service?
From _____ until _____ Type of discharge _____
From _____ until _____ Type of discharge _____

Are you retired from the military? ☐Yes ☐No

Are you the surviving spouse of a Medal of Honor recipient or POW? ☐Yes ☐No

Veterans' Benefits Information

Have you ever applied for U.S. Department of Veterans Affairs (VA) benefits? ☐Yes ☐No
If yes, what is your VA claim number if known? Claim no.: _____

Do you have any service-connected disabilities? ☐Yes ☐No
If yes, what is the military disability percentage? _____

Do you receive non-service-connected pension benefits? ☐Yes ☐No

Do you or your spouse currently have a Cal-Vet loan? ☐Yes ☐No
(Note: On admission, Cal-Vet will be notified.) If yes: Contract no.: _____

Criminal Background Information

UPON ACCEPTANCE, YOU MAY BE FINGERPRINTED AND HAVE A CALIFORNIA DEPARTMENT OF JUSTICE CRIMINAL HISTORY SEARCH CONDUCTED

Have you ever had any criminal convictions? ☐Yes ☐No
If yes, provide the following: _____
Date Type of conviction
_____
County State

Do you have any criminal charges pending? ☐Yes ☐No

If yes, describe: _____

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BACKGROUND INFORMATION

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Are you currently on probation or parole? ☐Yes ☐No

If yes: _____

Name of probation/parole officer

_____

Address Phone number

_____

County State

Are you required by law to register with local law enforcement? ☐Yes ☐No

Are you currently registered with your local law enforcement as required? ☐Yes ☐No

If yes: _____

County State

Medical Information

Have you received any medical, psychiatric, alcohol or drug treatment at any medical facility?

☐Yes ☐No

If yes, which one(s)?

1._____

Name Address

_____

City/State Zip Code Dates

2._____

Name Address

_____

City/State Zip Code Dates

3._____

Name Address

_____

City/State Zip Code Dates

4._____

Name Address

_____

City/State Zip Code Dates

5._____

Name Address

_____

City/State Zip Code Dates

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BACKGROUND INFORMATION

A

Have you ever applied for admission or lived in any state Veterans Home? ☐Yes ☐No

If yes, where? _____

When? Name From _____ Address until _____ City/State Zip Code

Comments (add additional sheets if necessary):

_____

_____

_____

_____

_____

CalVet offers long-term care in eight Veterans Homes, listed below. Please mark your preference for which Homes(s) you are interested in applying to. Mark "1" for your first choice, "2" for your second choice, and so on. If you are not interested in that Home, mark an "X" next to "I do not wish to apply for this location." Once your application is accepted and completed at your first choice, that Home will forward your application package, including medical information, to the other Home(s).

Preference # (Please mark 1 – 8)		**or "X"**	**If you are not interested in this location**
Barstow	#_____	or [ ]	"I do not wish to apply for this location."
Chula Vista	#_____	or [ ]	"I do not wish to apply for this location."
Fresno	#_____	or [ ]	"I do not wish to apply for this location."
Lancaster	#_____	or [ ]	"I do not wish to apply for this location."
Redding	#_____	or [ ]	"I do not wish to apply for this location."
Ventura	#_____	or [ ]	"I do not wish to apply for this location."
West Los Angeles	#_____	or [ ]	"I do not wish to apply for this location."
Yountville	#_____	or [ ]	"I do not wish to apply for this location."

If you would like help filling out your application or have any questions, we will be happy to answer them:

Barstow	760-252-6281	or	Toll Free 800-746-0606	*Fax: 760-252-6379
Chula Vista	619-482-6013	or	Toll Free 888-857-2146	*Fax: 619-205-1110
Lancaster	661-974-8141	or	Toll Free 888-272-6030	*Fax: 661-974-8198
Ventura	805-659-7502	or	Toll Free 888-272-2104	*Fax: 805-659-7559
West Los Angeles	424-832-8202	or	Toll Free 877-605-1332	*Fax: 424-832-8205
Yountville	707-944-4601	or	Toll Free 800-404-8387	*Fax: 707-948-2525
Redding	530-224-3800	or	Toll Free 855-769-5791	*Fax: 530-222-7599
Fresno	559-493-4224	or	Toll Free 855-769-5792	*Fax: 559-493-4299

*If faxing your application, it is required to retain the original signatures for submission prior to admission.

_____ _____

SIGNATURE DATE

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Authorization for Use and/or Disclosure of Resident/Patient Health Information

B

Treatment, payment, enrollment, or eligibility for benefits will not be conditioned upon my providing or refusing to provide this authorization.

I hereby authorize _____
(NAME OF HOSPITAL OR PHYSICIAN YOU ARE REQUESTING RECORDS FROM)

_____
(ADDRESS)

_____
(CITY) (STATE) (ZIP)

to disclose to

_____
(NAME OF VETERANS HOME YOU ARE APPLYING TO)

_____
(ADDRESS)

_____
(CITY) (STATE) (ZIP)

Records and information pertaining to

_____
(NAME OF PATIENT) (MEDICAL RECORD NUMBER) (DATE OF BIRTH)

DURATION: This authorization shall become effective immediately and shall remain in effect until (Date) _____or for one year from the date of signature.

REVOCATION: This Authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the requester or others have relied upon this Authorization.

RE-DISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.

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Authorization for Use and/or Disclosure of Resident/Patient Health Information

B

SPECIFY RECORDS: Check the box(es) and initial to specify the type of information to be disclosed

☐ MEDICAL INFORMATION _____ (specify below)
INITIAL

☐ PSYCHIATRIC INFORMATION
[Cal. Wel. & Inst. Code 5328]

_____ _____
SIGNATURE DATE

☐ DRUG/ALCOHOL INFORMATION
[42 C.F.R. 2.11 & 2.12]

_____ _____
SIGNATURE DATE

☐ RESULTS OF AN HIV BLOOD TEST
(Health and Safety code section 121020)

_____ _____
SIGNATURE DATE

☐ OTHER INFORMATION _____ (specify below)
INITIAL

Specify the records to be disclosed: _____

_____

_____

The requester may use the health information authorized on this form for medical screening purposes only as outlined in Section C as part of their application for admission to a California Veterans Home. A copy of this authorization will be given to the requestor.

Signature: _____ Date:_____/_____/_____.

If signed by other than resident/patient, indicate relationship: _____
[Ref. 45 C.F.R. 164.508; Cal Civil Code 56.11]

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Physician's Medical Certificate

C

This section to be completed by a physician and is designed to assess the resource needs for health care of the patient.

THIS CERTIFICATION IS VALID FOR **SIX MONTHS**. ALL INFORMATION MUST BE CURRENT AND COMPLETE TO AVOID DELAYS IN PROCESSING YOUR PATIENT'S APPLICATION

PHYSICIAN'S REPORT FOR ADMISSION

I. FACILTY INFORMATION *(To be completed by the licensee/designee)*

1. NAME		2. TELEPHONE ( )
3. ADDRESS	CITY	ZIP CODE
4. LICENSEE'S NAME	5. TELEPHONE	6. FACILITY LICENSE NUMBER

II. RESIDENT/PATIENT INFORMATION *To be completed by the resident/resident's responsible person)*

1. NAME	2. BIRTH DATE	3. AGE

III. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(To be completed by resident/resident's legal representative)

I hereby authorize release of medical information in this report to the facility named above

1. SIGNATURE OF RESIDENT AND/OR RESIDENT'S LEGAL REPRESENTATION

2. ADDRESS	3. DATE

IV. PATIENT'S DIAGNOSIS *(To be completed by physician)*

NOTE TO PHYSICIAN: The person named above is either a resident or prospective resident of one of six (6) California Veterans Homes. The information that you provide about this person is required by law to assist in determining whether the person is appropriate for care in one or more of these facilities. It is important that all questions be answered.
(*Please attach separate pages if needed*.)

1. DATE OF EXAM	2. SEX	3. HEIGHT	4. WEIGHT	5. BLOOD PRESSURE

6. **TUBERCULOSIS (TB) TEST**

a. Date TB Test Given	b. Date TB Test Read	c. Type of TB Test	d. Please Check if TB Test is: Negative Positive

e. Results: mm _____ f. Action Taken (if positive): _____

_____

g. Chest X-ray Results: _____

h. Please Check One of the Following:

☐ Active TB Disease ☐ Latent TB Infection ☐ No Evidence of TB Infection or Disease

PRIMARY DIAGNOSIS:

a. Treatment/medication (type and dosage)/equipment:

b. Can patient manage own treatment/medication/equipment? ☐ Yes ☐ No

c. If not, what type of medical supervision is needed?

8. SECONDARY DIAGNOSIS(ES):

a. Treatment/medication (type and dosage)/equipment:

b. Can patient manage own treatment/medication/equipment? ☐ Yes ☐ No

c. If not, what type of medical supervision is needed?

9. CHECK IF APPLICABLE TO 7 OR 8 ABOVE:

☐ Mild Cognitive Impairment: Refers to people whose cognitive abilities are in a "conditional state" between normal aging and dementia.

☐ Dementia: The loss of intellectual function (such as thinking, remembering, reasoning, exercising judgement and making decisions) and other cognitive functions, sufficient to interfere with an individual's ability to perform activities of daily living or to carry out social or occupational activities.

10. CONTAGIOUS/INFECTIOUS DISEASE:

a. Treatment/medication (type and dosage)/equipment:

b. Can patient manage own treatment/medication/equipment? ☐ Yes ☐ No

c. If not, what type of medical supervision is needed?

11. ALLERGIES:

a. Treatment/medication (type and dosage)/equipment:

b. Can patient manage own treatment/medication/equipment? ☐ Yes ☐ No

c. If not, what type of medical supervision is needed?

12. OTHER CONDITIONS:

a. Treatment/medication (type and dosage)/equipment:

b. Can patient manage own treatment/medication/equipment? ☐ Yes ☐ No

c. If not, what type of medical supervision is needed?

13. PHYSICAL HEALTH STATUS	**YES**	**NO**	**ASSISTIVE DEVICE** (If applicable)	**EXPLAIN**
a. Auditory Impairment				
b. Visual Impairment				
c. Wears Dentures				
d. Wears Prosthesis				
e. Special Diet				
f. Substance Abuse Problem				
g. Use of Alcohol				
h. Use of Cigarettes				
i. Bowel Impairment				
j. Bladder Impairment				
k. Motor Impairment/Paralysis				
l. Requires Continuous Bed Care				
m. History of Skin Condition or Breakdown				

14. MENTAL CONDITION	YES	NO	EXPLAIN
a. Confused/Disoriented			
b. Inappropriate Behavior			
c. Aggressive Behavior			
d. Wandering Behavior			
e. Sundowning Behavior			
f. Able to Follow Instructions			
g. Depressed			
h. Suicidal/Self-Abuse			
i. Able to Communicate Needs			
j. At Risk if Allowed Direct Access to Personal Grooming and Hygiene Items			
k. Able to Leave Facility Unassisted			
15. CAPACITY FOR SELF-CARE	**YES**	**NO**	**EXPLAIN**
a. Able to Bathe Self			
b. Able to Dress/Groom Self			
c. Able to Feed Self			
d. Able to Care for Own Toileting Needs			
e. Able to Manage Own Cash Resources			
16. MEDICATION MANAGEMENT	**YES**	**NO**	**EXPLAIN**
a. Able to Administer Own Prescription Medications			
b. Able to Administer Own Injections			
c. Able to Perform Own Glucose Testing			
d. Able to Administer Own PRN Medications			
e. Able to Administer Own Oxygen			
f. Able to Store Own Medications			

17. AMBULATORY STATUS:

a. This person is considered: ☐ Ambulatory ☐ Nonambulatory ☐ Bedridden

Nonambulatory: Means persons unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshal, or to an oral instruction relating to fire danger, and persons who depend upon mechanical aids such as crutches, walkers, and wheelchairs. (Health & Safety Code Section 13131)

Bedridden: Means either requiring assistance in turning and repositioning in bed, or being unable to independently transfer to and from bed, except in facilities with appropriate and sufficient care staff, mechanical devices if necessary, and safety precautions. No resident shall be admitted or retained in a residential care facility for the elderly if the resident is bedridden, other than for a temporary illness or for recovery from surgery. (Health & Safety Code Section 1569.72)

b. If resident is nonambulatory, this status is based upon:

☐ Physical Condition ☐ Mental Condition ☐Both Physical and Mental Condition

c. If a resident is bedridden, check one or more of the following and describe the nature of the illness, surgery or other cause:

☐ Illness: _____

☐ Recovery from Surgery: _____

☐ Other: _____

NOTE: An illness or recovery is considered temporary if it will last 14 days or less.

d. If a resident is bedridden, how long is bedridden status expected to persist?

1. _____(number of days)

2. _____(estimated date illness or recovery is expected to end or when resident will no longer be confined to bed)

3. If illness or recovery is permanent, please explain:_____

_____

_____

_____

e. Is resident receiving hospice care?

☐ No ☐ Yes If yes, specify the terminal illness: _____

18. PHYSICAL HEALTH STATUS: ☐ Good ☐ Fair ☐ Poor

19. COMMENTS:

20. PHYSICIAN'S NAME AND ADDRESS (PRINT)

21. TELEPHONE	**22. LENGTH OF TIME RESIDENT HAS BEEN YOUR PATIENT**
23. PHYSICIAN'S SIGNATURE	**24. DATE**