



## OHIO VETERANS' HOME AGENCY

### Admission Application

January 2009

**The Ohio Veterans' Home Agency (OVHA)** is a state agency comprised of two facilities, a home located in Sandusky, Ohio (approximately 60 miles west of Cleveland) and a home located in Georgetown, Ohio (approximately 45 miles east of Cincinnati). Both homes offer a quality of life which emphasizes privacy, encourages independence, provides comfort and security, and meets social needs. All residents have the freedom and convenience of a small community as well as the comforts of a home-like setting.

Both homes are licensed nursing homes providing Standard Care, Special Care (Alzheimer/Dementia) and Skilled Care. In addition, the Sandusky home also offers independent living (Domiciliary) and limited supervised care (Domiciliary Plus) for those not requiring the level of care provided to nursing home residents.

Applications may be made directly to the Sandusky or the Georgetown home. In addition, the applicant may apply for the first available bed of either home. Once admitted, residents may apply and seek approval for transfer from one facility to another. If such transfer is approved, the resident will be responsible for all costs related to the transfer.

#### **ELIGIBILITY**

To be eligible for admission into the Ohio Veterans' Home Agency, the applicant must meet the following criteria:

1. The applicant must have been a resident of Ohio for 5 years prior to application.
2. The applicant must be an honorably discharged veteran of the United States Armed Forces.
3. The applicant must have served on active duty (other than for training) during a period of war or declared armed conflict **OR** have been a recipient of the Purple Heart, Armed Forces Expeditionary Medal, Navy/Marine Corps Expeditionary Medal, or the Vietnam Service Medal.
4. The applicant must have a disability due to disease, wounds or otherwise, and are, by reason of such disability, incapable of earning a living.

**Please note:** applicants meeting the above criteria for admission shall not be admitted if:

1. In the opinion of the home's Medical Director, the home to which the veterans is seeking admission does not provide care adequate to meet the physical, mental, or psychosocial needs of the applicant; or
2. The applicant, by virtue of one or more criminal convictions for violent crimes and/or sex crimes, has demonstrated that he/she represents a substantial risk of harm to the health, safety, or well-being of residents, their families, visitors, volunteers or agency staff.

#### **COSTS**

Refer to SCHEDULE OF FEES for maximum rates. The assessments are based on a formula prescribed by the Ohio Revised Code and Ohio Administrative Code. The monthly assessment covers all meals, OVH provided medical services, VA formulary medications and most medical supplies. Residents may incur additional expenses not covered in their monthly assessment. These include, but are not limited to, charges for personal choice medication not covered in the VA formulary; optometric, dental, and podiatric services and supplies; lab and radiology services; barber and beautician services; telephone; and cable television. Residents may also incur some co-payment charges for skilled care services, depending on their length of stay in skilled care, secondary insurance, Medicare eligibility, etc.

#### **MEDICARE PRESCRIPTION DRUG PLANS (MEDICARE PART D)**

The prescription drug benefit provided as part of the VA health care benefit and the prescription drug plan at the Ohio Veterans' Home Agency *both* meet or exceed Medicare criteria. This means that VA prescription drug coverage and the prescription drug plan at the Ohio Veterans' Home Agency are at least as good as the Medicare Part D coverage and provides "creditable coverage" for purposes of Medicare.

## Requirements for Placement in the Sandusky's Domiciliary or DOM +

<u>CRITERIA</u>	INDEPENDENT (Domiciliary)	SUPERVISED (Domiciliary Plus)
<b>Independent performance of Activities of Daily Living (ADLs):</b>		
<b>1. Bathe, groom and dress self</b>	YES	YES
<b>2. Independently travel to the dining room for all meals</b>	YES	YES
<b>3. Follow medical treatments and appointments</b>	YES	WITH REMINDERS
<b>4. Do own personal laundry</b>	YES	LIMITED ASST*
<b>5. Dust &amp; mop room tile floor</b>	YES	LIMITED ASST.
<b>6. Clean &amp; dust room furniture</b>	YES	LIMITED ASST.
<b>7. Clean &amp; dust room windows, sill</b>	YES	LIMITED ASST.
<b>8. Clean own toilet, sink and mirrors</b>	YES	LIMITED ASST.
<b>9. Make bed daily and change linen at least weekly</b>	YES	YES
<b>10. Ability to transfer without assistance</b>	YES	YES
<b>11. Control bowel &amp; bladder or capacity to use appropriate medical device or personal apparel</b>	YES	YES
<b>12. Consistent self-administration of medications and obtaining refills</b>	YES	WITH REMINDERS**
<b>Other Requirements:</b>		
<b>1. Ability to follow medical treatment plan/interventions and keep scheduled appointments</b>	YES	WITH REMINDERS
<b>2. Sufficient decision making ability to seek medical assistance, when necessary</b>	YES	WITH REMINDERS
<b>3. Oriented to time, place and person</b>	YES	YES

\* *Limited laundry assistance is available*

\*\**Nursing staff may administer resident's medications if all other criteria for Domiciliary Plus are met*

# Ohio Veterans' Home Agency

## NOTICE OF PRIVACY PRACTICES

### Summary Notice

Effective Date April 14, 2003

We, the Ohio Veterans' Home Agency (OVHA), are providing you with the OVHA Notice of Privacy Practices. This Summary Notice provides a summary of the OVHA Notice of Privacy Practices and briefly states:

- How your health information may be used and disclosed;
- Your rights regarding your health information; and
- Our legal duty to protect the privacy of your health information

### *Your Health Information*

Health information is any information we create or receive about you and your past, present, or future:

- Physical or mental health or condition,
- Health Care, or
- Payment for health care provided.

### *How We May Use and Disclose Your Health Information*

In most cases, your written authorization is needed for us to use or disclose your health information. However, Federal law allows us to use and disclose your health information without your permission for certain purposes, including the following:

- |  |   |  |
|--|---|--|
| - Treatment                                  | - Payment   | - Health Operations                                |
| - Eligibility and Enrollment for VA Benefits | - Law Enforcement   | - Coroner or Funeral Activities (with limitations) |
| - Public Health                              | - National Security   | - Judicial or Administrative Proceedings           |
| - Research (with strict limitations)         | - Services  | - Health Care Oversight                            |
| - Abuse Reporting                            | - Correctional Facilities   | - Military Activities                              |
| - Workers' Compensation                      | - When Required by Law  | - Health or Safety Activities                      |
| - Patient Directories                        | - Family Members or Others Involved in your Care (with limitations) |  |

All other uses and disclosures of your health information will not be made without your prior written authorization.

### *Your Privacy Rights*

You have the right to:

- Review your health information;
- Obtain a copy of your health information;
- Request your health information to be amended or corrected;
- Request that we not use or disclose your health information;
- Request that we provide your health information to you in an alternative way or at an alternative location in a confidential manner;
- Accounting or list of disclosures of your health information; and
- Receive our OVHA Notice of the Privacy Practices upon request.

**Changes** We reserve the right to change the OVHA Notice of Privacy Practices. The revised privacy practices will be effective for all health information we already have about you, as well as information we receive in the future. We will send to your last address of record, and otherwise make available to you, a copy of the revised Notice within 60 days of any change.

**Complaints** If you are concerned that your privacy rights have been violated, you may file a complaint to OVHA or to the Secretary of the U.S. Department of Health and Human Services. To file a complaint with OVHA you may contact Greg Kowalski, Legal Counsel at the address on the next page or by calling 419 625-2454 ext. 1253. Complaints do not have to be in writing, though it is recommended. You will not be penalized or retaliated against for filing a complaint.

**NOTE:** A large print version of this Notice is available upon request.



# Ohio Veterans' Home Agency

3416 Columbus Avenue  
Sandusky, Ohio 44870

## **NONDISCRIMINATION POLICY**

As a recipient of Federal financial assistance, the Ohio Veterans' Home Agency does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, or national origin, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by the Ohio Veterans' Home Agency directly or through a contractor or any other entity with which the Ohio Veterans' Home Agency arranges to carry out its programs and activities.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91.

In case of questions, please contact:

Ms. Naomi R. Twine, EEO Officer & 504 Coordinator  
Ohio Veterans' Home Agency  
419-625-2454



# Ohio Veterans' Home Agency

3416 Columbus Ave  
Sandusky, Oh 44870

## HIPAA Consent Form

**To the Applicant** \_\_\_\_\_, **and/or Applicant's Legal Guardian:** The purpose of this form is to allow the Ohio Veterans' Home Agency to facilitate the application for admission process by obtaining Protected Health Information necessary to process veteran's application for admission to the Ohio Veterans' Home Agency. By signing this form, the applicant voluntarily gives his/her consent to the Ohio Veterans' Home Agency to request from the applicant's health care provider(s) such Protected Health Information that, in the opinion of the Ohio Veterans' Home Agency is necessary to complete the application process.

**To the Applicant's Health Care Provider:** The undersigned applicant, in conjunction with his/her application for admission to the Ohio Veterans' Home Agency, hereby voluntarily consents to the release by the applicant's health care provider(s) to the Ohio Veterans' Home Agency of any Protected Health Information about the applicant that the health care provider may have in its possession, including, but not limited to, patient assessments and diagnoses, result of examinations, laboratory work, MRIs, EKGs, CAT Scans, x-rays, and psychiatric and/or psychological reports.

\_\_\_\_\_  
Signature of Applicant, Power of Attorney or Legal Guardian

\_\_\_\_\_  
Date

**(Please return this signed form along with the completed Admission Application packet.)**

**READ AND INITIAL EACH BLOCK**

- 1. Initial here → \_\_\_\_\_ I am or have been a resident of Ohio for a minimum of 5 years.
- 2. Initial here → \_\_\_\_\_ If I am admitted to the Ohio Veterans’ Home Agency (OVHA), I agree to pay the prescribed amount of fees as set forth by Ohio law.
- 3. Initial here → \_\_\_\_\_ If I am admitted to the OVHA, and I receive aid and attendance or homebound benefits from the US Department of Veterans Affairs, I understand that I must pay the entire amount of these benefits to the OVHA.
- 4. Initial here → \_\_\_\_\_ If I am admitted to the OVHA, I understand that I must enroll and maintain enrollment in both Medicare A and B, if and when I am eligible.
- 5. Initial here → \_\_\_\_\_ I have fully disclosed the details of the following:
  - \_\_\_ A. Medical history, including any and all medical treatments
  - \_\_\_ B. Psychiatric treatment or counseling (if applicable)
  - \_\_\_ C. Past and/or current substance abuse treatment(s) (if applicable)
  - \_\_\_ D. Criminal convictions, probation, parole, or mandatory county registration
- 6. Initial here → \_\_\_\_\_ I have received, read, and understand the Privacy Act Statement – Health Care Records as part of this application.
- 8. Initial here → \_\_\_\_\_ I understand that the OVHA may disclose or obtain medical, surgical and/or substance abuse information necessary to the US Department of Veterans Affairs or any health care facility so that I may maintain residency in the OVHA.
- 9. Initial here → \_\_\_\_\_ If I am admitted to the OVHA, I give my consent for medical treatment and surgical procedures under the auspices of the facility Medical Director.

**By my signature below, I attest to the complete accuracy and truthfulness of my statements entered on this application for admission to the Ohio Veterans’ Home Agency. I further state that I have given the Home an honest self-disclosure to the best of my ability and knowledge. In accordance with the O.R.C. 2921.13 (Falsification) falsifying this application could result in application being denied, involuntary discharge from the facility, prosecution or any combination of the three. I also understand that a background check may be required prior to my admission, at the Home’s expense, and that my finger prints are necessary to accomplish this. I waive all provisions of law forbidding law enforcement agencies and/or past employers, from disclosing any information which they acquired relevant to my admission. I consent that they may disclose such information to the Ohio Veterans’ Home Agency Police Department and/or the Ohio Veterans’ Home Agency Admissions Department for which I am applying for admission.**

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
SIGNATURE OF POA OR GUARDIAN (if applicable)

\_\_\_\_\_  
DATE

**Mail completed forms along with the additional required documents listed on page 9 to the facility of choice:**

Admissions Office  
Ohio Veterans’ Home  
3416 Columbus Avenue  
Sandusky, OH 44870  
800-572-7934

Admissions Office  
Ohio Veterans’ Home  
2003 Veterans Boulevard  
Georgetown, OH 45121  
866-644-6838

**Assistance in completing the forms, obtaining required documents, setting up appointments, and transportation may be obtained from your County Veterans Service Office.**

# Ohio Veterans' Home Agency

## APPLICATION FOR ADMISSION

**SANDUSKY HOME** \_\_\_\_\_  
 Nursing Home Standard Care \_\_\_\_\_  
 Nursing Home SCU (Alzheimer) Care \_\_\_\_\_  
 Domiciliary \_\_\_\_\_ Domiciliary Plus \_\_\_\_\_

**SELECT FACILITY  
 AND LEVEL OF CARE  
 NEEDED**

**GEORGETOWN HOME** \_\_\_\_\_  
 Nursing Home Standard Care \_\_\_\_\_  
 Nursing Home SCU (Alzheimer) Care \_\_\_\_\_

### APPLICANT INFORMATION

FIRST NAME	MIDDLE NAME	LAST NAME	JR./SR.
SOCIAL SECURITY NO.	GENDER M      F	PREFERRED NAME	DATE OF BIRTH (mm/dd/yr)

### MILITARY SERVICE INFORMATION

BRANCH OF SERVICE	RANK	SERVICE NO.	LENGTH OF SERVICE
DATE OF ENLISTMENT	DATE OF DISCHARGE		DISCHARGE TYPE
WARS SERVED IN?			
<input type="checkbox"/> WWII <input type="checkbox"/> KOREA <input type="checkbox"/> VIETNAM <input type="checkbox"/> GULF <input type="checkbox"/> OTHER _____			

### SOCIAL INFORMATION

MARITAL STATUS	DATE OF MARRIAGE (mm/dd/yr)
SPOUSES'S SOCIAL SECURITY NO.	SPOUSE'S DATE OF BIRTH
DO YOU HAVE MEDICARE "A"? <input type="checkbox"/> YES <input type="checkbox"/> NO DO YOU HAVE MEDICARE "B"? <input type="checkbox"/> YES <input type="checkbox"/> NO	OTHER MEDICAL INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, NAME OF COMPANY:
RELIGIOUS PREFERENCE	
<input type="checkbox"/> PROTESTANT <input type="checkbox"/> CATHOLIC <input type="checkbox"/> ISLAM <input type="checkbox"/> JEWISH <input type="checkbox"/> BAPTIST OTHER _____	

PREVIOUS OCCUPATION (Do not write retired.)

NAME OF APPLICANT'S CURRENT RESIDENCE	CURRENT RESIDENCE TELEPHONE NO. (      )		
CURRENT MAILING ADDRESS	CITY/STATE	COUNTY	ZIP
FATHER'S NAME		MOTHER'S MAIDEN NAME	

### HOW DID YOU HEAR ABOUT US? (PLEASE CHECK)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> COUNTY VETERAN SERVICE OFFICER | <input type="checkbox"/> OVH VIDEO     | <input type="checkbox"/> VETERAN ORGANIZATION |
| <input type="checkbox"/> CHURCH/MINISTER                | <input type="checkbox"/> SOCIAL WORKER | <input type="checkbox"/> NEWSPAPER ARTICLE    |
| <input type="checkbox"/> OVH SPEAKER/PRESENTATION       | <input type="checkbox"/> WEBSITE       | <input type="checkbox"/> BROCHURE             |
| <input type="checkbox"/> OTHER _____                    |  |   |

## DEMOGRAPHIC INFORMATION

PRIOR RESIDENCY AT THE OHIO VETERANS' HOME AGENCY? YES <input type="checkbox"/> NO <input type="checkbox"/>	CITY & STATE OF BIRTH
--	-----------------------

<b>RACE</b> <input type="checkbox"/> AMERICAN INDIAN/ALASKAN NATIVE	<input type="checkbox"/> ASIAN/PACIFIC ISLANDER	<input type="checkbox"/> BLACK, NOT OF HISPANIC ORIGIN	<input type="checkbox"/> HISPANIC	<input type="checkbox"/> WHITE, NOT OF HISPANIC ORIGIN
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CRIMINAL CONVICTIONS? (Misdemeanor & Felony)  <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, ENTER DATE(S)	TYPE OF CONVICTION(S)? (Misdemeanor & Felony)
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COUNTY & STATE WHERE CONVICTED	CRIMINAL CHARGES PENDING  <input type="checkbox"/> YES <input type="checkbox"/> NO	TYPE OF CHARGES
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COUNTY & STATE WHERE CHARGED	ON PROBATION/PAROLE?  <input type="checkbox"/> YES <input type="checkbox"/> NO	PROB/PAROLE OFFICER NAME
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PROB/PAROLE OFFICER FULL ADDRESS	PROB/PAROLE OFFICER TELEPHONE NO.  (      )
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REQ. TO REGISTER AS A SEX OFFENDER WITH LOCAL PD?  <input type="checkbox"/> YES <input type="checkbox"/> NO	CURRENTLY REGISTERED IN YOUR  <input type="checkbox"/> COMMUNITY <input type="checkbox"/> COUNTY <input type="checkbox"/> STATE
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### PERSONAL/EMERGENCY CONTACT #1

LAST NAME	FIRST NAME	M/I	RELATIONSHIP
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FULL ADDRESS
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PRIMARY PHONE NO.  (      )	ALTERNATE PHONE NO.  (      )
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### PERSONAL/EMERGENCY CONTACT # 2

LAST NAME	FIRST NAME	M/I	RELATIONSHIP
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FULL ADDRESS
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PRIMARY PHONE NO.  (      )	ALTERNATE PHONE NO.  (      )
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## DOCUMENTS REQUIRED FOR ADMISSION

\_\_\_\_\_  
APPLICANT'S NAME

### IF YOU ANSWERED "YES", PLEASE ATTACH COPIES

1.	Discharge Certificate or <b>DD 214 (military discharge document)</b>	<input type="checkbox"/> Yes	
2.	Birth Certificate for legal dependent children, under 23 years old, currently enrolled full-time in school or college	<input type="checkbox"/> Yes	<input type="checkbox"/> N/A
3.	Current marriage certificate or divorce decree	<input type="checkbox"/> Yes	<input type="checkbox"/> N/A
4.	Current and previous year-end Bank Statements for <b>ALL</b> accounts in the name of applicant, spouse and any other legal dependents (including but not limited to checking, savings, money market, stocks, bonds, certificate of deposits, IRA's etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	Medicare Cards and any other Health Insurance cards, (including any prescription/medication coverage). <b>Copy of both sides needed.</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.	PAY VOUCHERS and any Award Letters that show <b>GROSS EARNINGS</b> (refers to income prior to any deductions) for Retirement, Annuities, Social Security, VA Benefits, Workers Compensation Awards and any Disability Benefits, etc	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	Proof of cost of Medical Insurance Premiums	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8.	Copy of Previous Year Income Tax form (including supporting documentation such as 1099's, W2's, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9.	Does applicant have a Financial Power of Attorney (POA)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10.	Does applicant have a Healthcare Power of Attorney (POA)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11.	Does applicant have a Guardian?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12.	Does applicant have a Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13.	Does applicant have a Fiduciary appointed by the Dept. of Veteran Affairs, or a Representative Payee appointed by the Social Security Administration, to manage their benefits?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**NOTE: APPLICANT WILL NOT BE PLACED ON THE WAITING LIST UNTIL**

**ALL ABOVE INFORMATION IS PROVIDED!**

I am applying for admission to the Ohio Veterans' Home Agency. I have been a resident of the State of Ohio for five years. All of the statements on this application are true and complete to the best of my knowledge. I hereby give permission to the Ohio Veterans' Home Agency to complete a financial background check to obtain any information concerning my financial records which include the US Department of Veterans Affairs (VA), Social Security, and other financial institutions. **If admitted, I understand that all income, regardless of source, will be considered in the determination of my assessment.** I understand that all personal expenses and/or prior existing debts are my responsibility. I agree to follow the resident rules of conduct and all policies and procedures of the Ohio Veterans' Home Agency.

\_\_\_\_\_  
SIGNATURE OF APPLICANT, POA OR GUARDIAN

\_\_\_\_\_  
DATE

<b>NAME OF APPLICANT:</b> _____	<b>SSN#:</b> _____
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**Income and Asset Information**

		2009		2009	2009
<b>INCOME:</b>		<b>Current Yr.</b>		<b>Current Yr</b>	<b>Current Yr</b>
		<b>Applicant</b>		<b>Spouse</b>	<b>Legal Dependents</b>
Social Security (per month) (Net)					
VA Pension (per month)					
VA Compensation (per month)					
Retirement (Gross per month)	Source:				
Rental/Business Income					
Other (Gross Per Month)	Source:				
Other (Gross Per Month)	Source:				

			<b>Applicant's</b>		<b>Spouse's</b>
<b>ASSETS:</b>		<b>Applicant's</b>	<b>Interest</b>	<b>Spouse's</b>	<b>Interest</b>
	<b>ACCOUNT #</b>	<b>Balance</b>	<b>Earned</b>	<b>Balance</b>	<b>Earned</b>
		<b>CURRENT</b>	<b>for 2008</b>	<b>CURRENT</b>	<b>for 2008</b>
<b>Cash</b>					
<b>Checking Accounts:</b>					
Bank:					
Bank:					
<b>Savings, CDs &amp; Money Markets, etc.</b>					
Bank:					
Bank:					
<b>IRA &amp; 401K Accounts</b>					
Company:					
Company:					
<b>Stocks &amp; Bonds</b>					
Company:					
Company:					
<b>Real Property (not including residence) (market value less encumbrances)</b>					
<b>Monthly Medical Insurance Premium (other than Medicare)?</b>		<b>Y or N</b>	<b>If Yes, Amount for Applicant:</b>		\$
			<b>Amount for Spouse:</b>		\$
<b>Is the Applicant or Spouse Required to File Taxes?</b>		<b>Y or N</b>	<b>If Yes Please attach.</b>		

By signature below signifies that the information presented on this form is correct to the best of my knowledge.  
(Must be signed for application to be processed)

Signature of Applicant, POA, or Guardian \_\_\_\_\_

Date of Signature \_\_\_\_\_

**TO BE COMPLETED BY THE APPLICANT'S PHYSICIAN**

APPLICANT'S NAME: \_\_\_\_\_

<b>CARE STATUS</b>		<b>INDEPENDENT</b>	<b>NEEDS ASSISTANCE</b>	<b>UNABLE TO DO</b>
<b>PERSONAL HYGIENE</b>	BATHING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	SHAVING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	ORAL HYGIENE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>DRESSING</b>	UPPER EXTREMITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	TRUNK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	LOWER EXTREMITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>FEEDING</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>ACTIVITIES OF DAILY LIVING</b>	KEEP ROOM CLEAN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	DO OWN LAUNDRY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	HANDLE OWN FUNDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	TAKE OWN MEDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	WALK ONE BLOCK TO AND FROM MEALS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>MOBILITY</b>  (Check Items Used)	SITTING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	STANDING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	TRANSFERRING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	WALKING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	STAIRS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	WHEELCHAIR	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	ELEC. WHEELCHAIR	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	GERICHAIR	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	ELECTRIC SCOOTER	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	CANE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	WALKER	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<b>BOWELS BLADDER</b>	<input type="checkbox"/> CONTINENT	<input type="checkbox"/> INCONTINENT		
	<input type="checkbox"/> CONTINENT	<input type="checkbox"/> INCONTINENT		
<b>SPECIAL NEEDS</b>	<input type="checkbox"/> CATHETER (SIZE _____) <input type="checkbox"/> DIALYSIS (Indwelling or Supra-pubic) _____ <input type="checkbox"/> COLOSTOMY (SIZE _____) <input type="checkbox"/> C-PAP <input type="checkbox"/> G-TUBE (SIZE _____) <input type="checkbox"/> BI-PAP <input type="checkbox"/> TRACHEOSTOMY _____ <input type="checkbox"/> OXYGEN <input type="checkbox"/> CHEMO/RADIATION <input type="checkbox"/> IV <input type="checkbox"/> VENT			

**TO BE COMPLETED BY APPLICANT'S PHYSICIAN**

**APPLICANT'S NAME** \_\_\_\_\_

**DATE OF LAST FALL** \_\_\_\_\_

**RECENT SURGERY? (DATE)** \_\_\_\_\_

**RECENT FRACTURES? (DATE)** \_\_\_\_\_

**ANY PRESSURE AREAS?** \_\_\_\_\_

<p align="center"><b>APPLIANCES</b></p>	<p><input type="checkbox"/> PROSTHESIS                      <input type="checkbox"/> DENTURES                      <input type="checkbox"/> GLASSES</p> <p><input type="checkbox"/> HEARING AID                      <input type="checkbox"/> OTHER _____</p>
<p align="center"><b>BEHAVIOR/ ORIENTATION</b></p>	<p><input type="checkbox"/> ORIENTED                      <input type="checkbox"/> INAPPROPRIATE OR ANTISOCIAL</p> <p><input type="checkbox"/> ANXIOUS                      <input type="checkbox"/> CONFUSED/DISORIENTED</p> <p><input type="checkbox"/> FEARFUL                      <input type="checkbox"/> WANDERS</p> <p><input type="checkbox"/> QUIET                      <input type="checkbox"/> WITHDRAWN</p> <p><input type="checkbox"/> FRIENDLY                      <input type="checkbox"/> SPECIAL PSYCHO-SOCIAL NEEDS</p> <p><input type="checkbox"/> ALERT                      <input type="checkbox"/> NOISY/LOUD</p> <p><input type="checkbox"/> MEMORY DEFICIT                      <input type="checkbox"/> AGGRESSIVE/COMBATIVE</p> <p><input type="checkbox"/> DEPRESSED                      <input type="checkbox"/> VERBALLY ABUSIVE</p> <p><input type="checkbox"/> ALCOHOL ABUSE                      <input type="checkbox"/> HISTORY OF DRUG ABUSE</p> <p><input type="checkbox"/> SMOKER                      <input type="checkbox"/> MENTAL ILLNESS</p> <p><input type="checkbox"/> FORGETFUL</p> <p>Additional comments regarding behavior</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p align="center"><b>COMMUNICATION ABILITY</b></p>	<p><b>CAN SPEAK</b>                      <input type="checkbox"/> YES   <input type="checkbox"/> NO   ENGLISH   <input type="checkbox"/> YES   <input type="checkbox"/> NO</p> <p><b>CAN WRITE</b>                      <input type="checkbox"/> YES   <input type="checkbox"/> NO</p> <p><b>UNDERSTANDS SPEAKING</b>                      <input type="checkbox"/> YES   <input type="checkbox"/> NO   ENGLISH   <input type="checkbox"/> YES   <input type="checkbox"/> NO</p> <p><b>UNDERSTANDS GESTURES</b>                      <input type="checkbox"/> YES   <input type="checkbox"/> NO</p> <p><b>UNDERSTANDS WRITING</b>                      <input type="checkbox"/> YES   <input type="checkbox"/> NO</p>

Dear Examining Physician:

The Department of Veterans Affairs as well as the Ohio Revised Code require that upon application to the Ohio Veterans' Home Agency the applicant be determined, by medical authority, to be disabled by disease, wounds or otherwise, and is, by reason of such disability, incapable of earning a living.

APPLICANT'S NAME: \_\_\_\_\_

DIAGNOSES (If psychiatric, please attach recent progress notes)		
PRIMARY:		
SECONDARY		
OTHERS		
IF APPLICANT HAS BEEN HOSPITALIZED FOR ANY REASON OR RECEIVED MENTAL HEALTH OR SUBSTANCE ABUSE TREATMENT WITHIN THE PAST THREE (3) MONTHS, PLEASE ATTACH MEDICAL RECORDS		
PHYSICIAN'S ORDERS & CURRENT MEDICATIONS. LIST METHOD & FREQUENCY OF ACTUAL ADMINISTRATIONS. IF DIAGNOSIS DOES NOT JUSTIFY MEDICATIONS ORDERED, PLEASE EXPLAIN.		
MEDICATION	FREQUENCY	DIAGNOSIS
Does the applicant have a HISTORY of a positive TB Skin Testing    YES _____    NO _____		
DATE - most recent: PNEUMOCOCCAL VACCINE _____    TETANUS _____    FLU VACCINE _____		
VERIFICATION OF DISABILITY AND INABILITY TO EARN A LIVING By my signature entered below, it is my professional opinion that the above named veteran applicant is disabled by disease, wounds or otherwise, and is by reason of such disability incapable of earning a living.		
PHYSICIAN'S SIGNATURE _____		DATE _____
PHYSICIAN'S NAME (PRINTED) _____		PHONE NO. _____
ADDRESS _____		
Street	City	State      Zip Code