Ohio Veterans Home
3416 Columbus Avenue
Sandusky, OH 44870

Ohio Veterans Home
2003 Veterans Boulevard
Georgetown, OH 45121

2019
Admission Application

The Ohio Veterans Homes are a state agency comprised of two facilities in Ohio, a home located in Sandusky (approximately 60 miles west of Cleveland) and a home located in Georgetown (approximately 45 miles east of Cincinnati). Both homes offer a quality of life which emphasizes privacy, encourages independence, provides comfort, 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, Memory Care (Dementia/Alzheimer) 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 Homes, the applicant must meet the following criteria:

1. The applicant must have been a resident of Ohio for at least one year.
2. The applicant's most recent discharge must show that he/she is an honorably discharged or separated under honorable conditions 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 Armed Forces Expeditionary Medal or the Vietnam Service Medal.
4. The applicant must have a disability due to disease, wounds or otherwise and, 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 veteran 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: Once admitted the resident will be responsible to pay maximum assessment rates until all income and asset information is obtained by the Ohio Veterans Homes.

Refer to SCHEDULE OF SERVICES for maximum rates. The assessment is based on a formula prescribed by the Ohio Revised Code and Ohio Administrative Code. The monthly assessment covers all meals, primary medical care, 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/beautician services and telephone. Residents also may incur some co-payment charges and be financially responsible for skilled care services, depending on their length of stay in skilled care, secondary insurance, Medicare eligibility, etc.

OHIO VETERANS HOMES
ADMISSION AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Applicant: _____

Applicant Date of Birth: _____ Applicant Social Security Number: _____

I am voluntarily requesting and authorizing release and disclosure[1] of *my medical records*[2] from:

□ all medical sources[3] or Other: _____

to the Ohio Veterans Homes (OVH) for my admission application. The following information may be released: (ex. clinical summaries, lab reports, nurses' notes, or *all medical records*):

_____

I give specific authorization to disclose the following:

□ All Medical Records, including (initial or check all that apply)

_____ Psychotherapy records
_____ Drug and alcohol treatment
_____ HIV status and treatment

Or All medical records, except: _____

_____

While providing information is voluntary, failure to timely provide information may prevent accurate and timely application processing.

OVH uses information for things like treatment, healthcare & business operations, and quality improvement if I am accepted, and to help process my application and paperwork (including eligibility for support from Department of Veterans Affairs (VA), Medicare, etc.). Some additional forms for outside organizations may apply (e.g. VA form 10-5345, 10-10EZ, 10-10SH, etc.).

I understand I do not have to sign this authorization. If I do, I can always revoke it in writing to OVH, except to the extent action was already taken to comply with it. Unless I revoke this authorization in writing, it will expire 2 years after an admission decision. Treatment, payment, enrollment, or eligibility for benefits is not conditioned on signing this authorization.

Re-Disclosure – I understand that after information disclosure, there is always a risk of unauthorized re-disclosure, and privacy laws may no longer protect it. OVH respects and complies with state and federal privacy laws including 45 CFR 160 & 164, 42 USC 290.

A photocopy, fax or electronic copy of this release is as valid as the original. OVH does not receive compensation from use or disclosure of medical records. A copy of this form is easily available for me to receive.

_____ _____/_____/_____

Signature of Applicant / Responsible Party / Legal Representative **Date**

*If Legal Representative signs on behalf of applicant, list title (e.g., Guardianship, Power of Attorney, etc.):

_____

[1] Disclosures include oral, written, electronic, or other means of giving OVH my medical / treatment records.

[2] All Medical Records includes Physician Orders, History & Physical, Mental/Behavioral Health Records, Nurses Notes, Discharge Summary, Addiction/Alcohol, Dietary Notes, Medication List, Progress Notes, Immunization Record, Laboratory Results, Care Plans

[3] For example, hospitals, clinics, labs, physicians, psychiatrists/therapists, treatment providers, outpatient care, insurance companies, government agencies, long-term care facilities, or anyone else having my medical / treatment records.

ADMISSION APPLICATION

This Admission Application along with the additional required documents listed on page 5, may be e-mailed, faxed or dropped off to the facility of your choice:

ADMISSIONS OFFICE
Ohio Veterans Homes
3416 Columbus Avenue
Sandusky, OH 44870
Nursing Home
e-mail: Kimberly.Zeadker@dvs.ohio.gov
Phone: 567-998-3680
Fax: 419-624-0753
Domiciliary
e-mail: Christina.Hansen@dvs.ohio.gov
Phone: 567-998-3559
Fax: 419-609-2577

SANDUSKY HOME_____

ADMISSIONS OFFICE
Ohio Veterans Homes
2003 Veterans Boulevard
Georgetown, OH 45121

Phone: 937-378-2900, Ext. 2724
1-866-644-6838, Option # 1
Fax: 937-378-2918

GEORGETOWN HOME_____

APPLICANT INFORMATION				
FIRST NAME	MIDDLE NAME	LAST NAME	JR./SR.	PREFERRED NAME
SOCIAL SECURITY NO.	GENDER M F	DATE OF BIRTH (mm/dd/yr)	PLACE OF BIRTH	RELIGIOUS PREFERENCE
DO YOU HAVE MEDICARE "A"? □ YES □ NO DO YOU HAVE MEDICARE "B"? □ YES □ NO DO YOU HAVE MEDICAID?		OTHER MEDICAL INSURANCE? □YES □NO IF YES, NAME OF COMPANY:		
HAVE YOU LIVED AT THE OHIO VETERANS HOME IN THE PAST? YES □ IF YES, WHEN? NO □			MARITAL STATUS	
SPOUSE'S NAME (INCLUDE MAIDEN)	SPOUSE'S SSN		SPOUSE'S D.O.B.	
PRESENT LOCATION OF APPLICANT	CURRENT TELEPHONE NUMBER			
CURRENT MAILING ADDRESS	CITY/STATE	COUNTY	ZIP	
BRANCH OF SERVICE	RANK	SERVICE NO.	LENGTH OF SERVICE	
DATE OF ENLISTMENT(S)	DATE OF DISCHARGE(S)	DISCHARGE TYPE		
WAR(S) SERVED: □ WWII □ KOREA □ VIETNAM □ GULF □ GWOT □ OTHER				

OHIO VETERANS HOME ADMISSION APPLICATION

APPLICANT'S NAME:_____

CRIMINAL BACKGROUND INFORMATION		
CRIMINAL CONVICTIONS? (Misdemeanor & Felony) □ YES □ NO	IF YES, ENTER DATE(S)	TYPE OF CONVICTION(S)? (Misdemeanor & Felony)
COUNTY & STATE WHERE CONVICTED	CRIMINAL CHARGES PENDING? □ YES □ NO	TYPE OF CHARGES
COUNTY, STATE & COURT WHERE CHARGED	ON PROBATION/PAROLE? □ YES □ NO	PROB/PAROLE OFFICER NAME
PROB/PAROLE OFFICER FULL ADDRESS	PROB/PAROLE OFFICER TELEPHONE NO. ( )	
REQUIRED TO REGISTER AS A SEX OFFENDER? □ YES □ NO	CURRENTLY REGISTERED IN YOUR □ COMMUNITY □ COUNTY □ STATE	

PRIMARY EMERGENCY CONTACT			
LAST NAME	FIRST NAME	M/I	RELATIONSHIP
FULL ADDRESS			
EMAIL ADDRESS			
PRIMARY PHONE NUMBER Cell:_____ Home: _____ Work: _____	ALTERNATE PHONE NO. Cell:_____ Home: _____ Work: _____		

SECONDARY EMERGENCY CONTACT			
LAST NAME	FIRST NAME	M/I	RELATIONSHIP
FULL ADDRESS			
EMAIL ADDRESS			
PRIMARY PHONE NO. Cell:_____ Home: _____ Work: _____	ALTERNATE PHONE NO. Cell:_____ Home: _____ Work: _____		

DOCUMENTS REQUIRED TO COMPLETE
THE OHIO VETERANS HOME ADMISSION APPLICATION

<u>If you checked "YES" to any of the questions below, a copy of that document must be attached</u>

_____

APPLICANT'S NAME

1.	Military Enlistment Record and Honorable Discharge or DD214	☐ Yes	
2.	Social Security card and photo I.D.	☐ Yes	
3.	Applicant's birth certificate. Birth certificate for any legal dependent children, under 23 years of age, currently enrolled full-time in school or college.	☐ Yes ☐ Yes	☐ N/A ☐ N/A
4.	Current marriage certificate or Divorce Decree, if applicable	☐ Yes	☐ N/A
5.	Medicare and Medicaid cards and any other Health Insurance cards, (including any prescription/medication coverage). **Copy of both sides needed.**	☐ Yes	☐ No
6.	Does applicant have a Financial Power of Attorney (POA)?	☐ Yes	☐ No
7.	Does applicant have a Healthcare Power of Attorney (POA)?	☐ Yes	☐ No
8.	Does applicant have a Guardian?	☐ Yes	☐ No
9.	Does applicant have a Living Will?	☐ Yes	☐ No
10.	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?	☐ Yes	☐ No
11.	Does applicant have a Service Connected Disability Award Letter from the Department of Veterans Affairs? Attach letter.	☐ Yes	☐ No
12.	I am applying for admission to the Ohio Veterans Homes. I have been a resident of the State of Ohio for one year.	☐ Yes	☐ No

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 Homes to complete a financial background check to obtain any information concerning my financial records which includes the U.S. Department of Veterans Affairs (VA), Social Security and other financial institutions. <u>If admitted, I understand that all income, regardless of source, will be considered in the determination of my assessment</u>. 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 Homes.

_____ _____

Signature of Applicant, POA, Guardian or Spouse **Date**

Ohio Veterans Home
Treasury Department
3416 Columbus Avenue
Sandusky, OH 44870
567-998-3941

Ohio Veterans Home
Treasury Department
2003 Veterans Blvd.
Georgetown, OH 45121
937-378-2900, ext. 2715

SCHEDULE OF SERVICES

The Ohio Veterans Home assesses a fee for the cost of care in accordance with Ohio Revised Code 5907.13 and Rule 5907-5-01 of the Ohio Administrative Code. Each resident is assessed a fee based on their ability to pay and the level of care to which they will be admitted as determined by the Home, not to exceed the maximum rates as established by the Director of the Ohio Department of Veterans Services.

The table below provides the current maximum rates for each level of care.

In order to determine whether, based on your verified income and assets, you qualify for a lower assessment, please contact the Ohio Veterans Home Treasury Department. Call the Financial Office, in Sandusky: 567-998-3941; in Georgetown: 937-378-2900, extension 2715, to obtain an estimate of your projected monthly assessment.

ASSESSMENT RATES – Effective 05/01/19

Levels of Care	Maximum Rate per Month (eligible for per diem)*	Maximum Rate per Day (eligible for per diem)*	Maximum Rate per Month (not eligible for per diem)*	Maximum Rate per Day (not eligible for per diem)*
Domiciliary	$608.00	$19.99	$2,048.53	$67.35
Domiciliary +	$1,547.00	$50.86	$2,987.53	$98.22
Nursing Home	$2,441.00	$80.25		
Nursing Home Memory Care Unit	$3,043.00	$100.04		

***Eligibility/ineligibility as determined by the U.S. Department of Veterans Affairs.**
All rates subject to change; notification of any changes will be provided at least 60 days in advance of such change.

Name of Applicant		SS# (Last 4 Digits)					
Income, Asset and Debt Information - Initial Intake							
Income:		**Prior Year Veteran**	**Current Yr. Veteran**			**Prior Year Spouse**	**Current Yr Spouse**
Social Security (per month) (Gross)							
VA Pension (per month)							
VA Compensation (per month)							
Retirement (Gross per month)							
Interest / Dividends(per month)							
Other (Gross Per Month)							
Total Monthly Income							
		Veteran		**Both**		**Spouse**	
		As of 12/31	**Current**	**Interest**	**Interest**	**As of 12/31**	**Current**
Assets:				**Earned**	**Earned**	**Last Year**	**Year To Date**
	Account # Last 4 Digits	**Balance**	**Balance**	**as of 12/31**	**Current YTD**	**Balance**	**Balance**
Cash & Checking Accounts							
Savings, CDs & Money Markets, etc.							
IRA & 401K Accounts							
Stocks & Bonds							
Real Property (not including residence) (market value less							
Other Property or assets not shown elsewhere							
Total Assets & Total Interst earned							
Any debts/loans that will reduce the value of the Other Property listed above							
Medical Insurance Premium	**If Yes the Amount**			**Medical Ins Premium**			
Medicare B Premium	**If Yes the Amount**			**Medicare B Premium**			
Medicare D Premium	**If Yes the Amount**			**Medicare D Premium**			
Medicare A Premium	**If Yes the Amount**			**Medicare A Premium**			
	Total MI Prem - Vet			**Total MI Prem - Spouse**			
Total MI Premium Vet & Spouse	**Last Year Total**			**This Year Total**			
Is the Veteran or Spouse Required to File Taxes?			**If Yes Please Attach prior years**				
My signature below signifies that the information presented on this form is correct to the best of my knowledge.							
Signature of Veteran, POA, or Guradian _____				Date			

THIS FORM IS TO BE COMPLETED BY THE EXAMINING PHYSICIAN OF THE APPLICANT.

APPLICANTS HISTORY AND PHYSICAL EXAM FORM

The Department of Veterans Affairs, as well as the Ohio Revised code, require that upon application to the Ohio Veterans Homes 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.

Name of Applicant:_____
Date:_____
Diagnosis: _____
_____

CHECK ANY AND ALL THAT APPLY:

Heart/Circulation

- ☐ Arteriosclerotic Heart Disease
- ☐ Cardiac Dysrhythmia
- ☐ Congestive Heart Failure
- ☐ Hypertension
- ☐ Hypotension
- ☐ Peripheral Vascular Disease
- ☐ Other Cardiovascular Disease

Neurological

- ☐ Alzheimer
- ☐ Dementia
- ☐ Aphasia
- ☐ Multiple Sclerosis
- ☐ Parkinson Disease

Respiratory

- ☐ Emphysema/Asthma/COPD
- ☐ Pneumonia

Sensory

- ☐ Cataract
- ☐ Glaucoma

Edema

☐ Localized not pitting ☐ Other

Mental Health

If any of these 3 checkboxes are checked, 6 months of progress notes are needed.

☐ Alcohol ☐ Mental Health
☐ Drugs

Other

- ☐ Anemia
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes Mellitus
- ☐ Hypothyroidism
- ☐ Osteoporosis
- ☐ Septicemia

OTHER CURRENT CONDITIONS: _____

_____

MEDICATION, DOSAGE, ROUTE, FREQUENCY AND DIAGNOSIS:

_____

_____

_____

ALLERGIES:

_____

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 and current medications. List method and frequency of actual administrations. If diagnosis does not justify medications ordered, please explain.

HOSPITALIZATION:

Date of most recent admission: _____ Discharge date: _____

Reason for hospitalization: _____

VITAL SIGNS:

Height: _____

Weight: _____

B/P: _____

Pulse: _____

Respiration: _____

Temperature: _____

Recent Surgery Date:

_____

Recent Fracture Date:

_____

Area of Fracture:

_____

Any Pressure Areas:

_____

Recent Weight Loss: □ Yes □ No

Does the Applicant have a history of a positive TB skin test: □ Yes □ No

If yes, include a copy of a current chest X-ray report.

Date of most recent:

Pneumo Vaccine: _____ Prevnar 13: _____

Flu Vaccine: _____ Zoster: _____

Tdap: _____ Shingrix: _____

Td: _____

VERIFICATION OF DISABILITY AND INABILITY TO EARN A LIVING:

By my signature entered below, I have completed a physical and 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 Signature Physician Name Printed Date

_____

Phone & Fax # Address City State Zip

THIS FORM IS TO BE COMPLETED BY THE EXAMINING PHYSICIAN OF THE APPLICANT

ACTIVITIES OF DAILY LIVING (ADL) ASSESSMENT

• Bathing:	□ Assist	□ Supervision	□ Independent
• Dressing:	□ Assist	□ Supervision	□ Independent
• Hair Care:	□ Assist	□ Supervision	□ Independent
• Nail Care:	□ Assist	□ Supervision	□ Independent
• Oral Care:	□ Assist	□ Supervision	□ Independent
• Eating:	□ Assist	□ Supervision	□ Independent
• Toileting:	□ Assist	□ Supervision	□ Independent
• Ambulation:	□ Assist	□ Supervision	□ Independent
• Wheelchair Mobility:	□ Assist	□ Supervision	□ Independent
• Transfers:	□ Assist	□ Supervision	□ Independent
• Bed Mobility:	□ Assist	□ Supervision	□ Independent
• Medication Administration:	□ Assist	□ Supervision	□ Independent

NEED FOR SUPERVISION TO PREVENT HARM:

_____ 24 HOURS PER DAY
_____ WANDERING
_____ FALL RISK
_____ PERIODIC SUPERVISION
_____ NO SUPERVISION NEEDED

Signature of examining Physician Print name of Physician Date