Ohio Veterans Home
3416 Columbus Avenue
Sandusky, OH 44870

OHIO VETERANS HOMES
Serving those who served

Ohio Veterans Home
2003 Veterans Boulevard
Georgetown, OH 45121

# 2023
# 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 citizen of Ohio for one year or more at the date of application.
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, be 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 provide information in a timely manner may prevent accurate and efficient application processing.

OVH uses information regarding treatment, healthcare and 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 that action was already taken to comply with it. Unless I revoke this authorization in writing, it will expire two 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.

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# Admission Application

**This Admission Application, along with the additional required documents listed on page 5, may be emailed, faxed or dropped off to the facility of your choice. Please check the Home to which you're applying, below.**

☐ **SANDUSKY HOME**

## SANDUSKY ADMISSIONS OFFICE

3416 Columbus Avenue
Sandusky, OH 44870

### Nursing Home

Email: Kimberly.Zeadker@dvs.ohio.gov
Phone: 567-998-3680 | Fax: 419-624-0753

### Domiciliary

Email: Christina.Hansen@dvs.ohio.gov
Phone: 567-998-3559 | Fax: 419-609-2577

☐ **GEORGETOWN HOME**

## GEORGETOWN ADMISSIONS OFFICE

2003 Veterans Boulevard
Georgetown, OH 45121

Email: Ruth.Gelter@dvs.ohio.gov
Phone: 937-378-2900, ext. 2724
1-866-644-6838, option #1
Fax: 419-609-2571 *or* 937-378-2918

## APPLICANT INFORMATION

| | | | | |
|---|---|---|---|---|
| FIRST NAME | | MIDDLE NAME | LAST NAME | |
| JR./SR. | PREFERRED NAME | | EMAIL ADDRESS | |
| SOCIAL SECURITY # | GENDER ☐ M ☐ F | D.O.B (mm/dd/yr) | PLACE OF BIRTH | RELIGIOUS PREFERENCE |
| DO YOU HAVE MEDICARE "A"? ☐ YES ☐ NO<br>DO YOU HAVE MEDICARE "B"? ☐ YES ☐ NO<br>DO YOU HAVE MEDICAID? ☐ YES ☐ NO | | DO YOU HAVE OTHER MEDICAL INSURANCE? ☐ YES ☐ NO<br>IF YES, NAME OF COMPANY | | |
| HAVE YOU LIVED AT THE OHIO VETERANS HOME IN THE PAST? ☐ YES ☐ NO<br>IF YES, WHEN? | | | MARITAL STATUS | |
| SPOUSE'S NAME (INCLUDE MAIDEN) | | SPOUSE'S SOCIAL SECURITY # | SPOUSE'S D.O.B. | |
| PRESENT LOCATION OF APPLICANT | | | CURRENT TELEPHONE # (10 digits) | |
| CURRENT MAILING ADDRESS | | CITY/STATE | COUNTY | ZIP |
| BRANCH OF SERVICE | RANK | SERVICE # | LENGTH OF SERVICE | |
| DATE OF ENLISTMENT(S) | | DATE OF DISCHARGE(S) | DISCHARGE TYPE | |

WAR(S) SERVED

☐ WWII ☐ KOREA ☐ VIETNAM ☐ GULF ☐ GWOT ☐ OTHER _____

SERVICE CONNECTED DISABILITY: ☐ YES ☐ NO IF YES, PERCENTAGE _____

OHIO VETERANS HOMES
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# Admission Application

**APPLICANT'S NAME** _____

## CRIMINAL BACKGROUND INFORMATION

| | | | |
|---|---|---|---|
| CRIMINAL CONVICTIONS? (Misdemeanor & Felony) ☐ YES ☐ NO | IF YES, ENTER DATE(S) | **ATTACHMENTS** (Attach police report, convictions, other documentation of arrest, if available) | **EXPLANATION** (Attach a narrative explanation of the offense and why you are not "a substantial risk of harm to the health, safety, or well-being of residents, their families, visitors, volunteers or Ohio Veterans Homes staff.") |
| TYPE OF CONVICTIONS? (Misdemeanor & Felony) | CTY & ST WHERE CONVICTED | CRIMINAL CHARGES PENDING? ☐ YES ☐ NO | TYPE OF CHARGES (Include specific ORC citations) |
| COUNTY, STATE & COURT WHERE CHARGED | | ON PROBATION/PAROLE? ☐ YES ☐ NO | PROBATION/PAROLE OFFICER NAME |
| PROBATION/PAROLE OFFICER FULL ADDRESS | | PROBATION/PAROLE OFFICER PHONE # (10 digits) | |
| REQUIRED TO REGISTER AS A SEX OFFENDER? ☐ YES ☐ NO | | CURRENTLY REGISTERED IN YOUR ☐ COMMUNITY ☐ COUNTY ☐ STATE | |

## PRIMARY EMERGENCY CONTACT

| | | | |
|---|---|---|---|
| FIRST NAME | MIDDLE INIT. | LAST NAME | RELATIONSHIP |
| FULL ADDRESS | | EMAIL ADDRESS | |
| PRIMARY TELEPHONE # (10 digits)<br>CELL _____<br>HOME _____<br>WORK _____ | | ALTERNATE TELEPHONE # (10 digits)<br>CELL _____<br>HOME _____<br>WORK _____ | |

## SECONDARY EMERGENCY CONTACT

| | | | |
|---|---|---|---|
| FIRST NAME | MIDDLE INIT | LAST NAME | RELATIONSHIP |
| FULL ADDRESS | | EMAIL ADDRESS | |
| PRIMARY TELEPHONE # (10 digits)<br>CELL _____<br>HOME _____<br>WORK _____ | | ALTERNATE TELEPHONE # (10 digits)<br>CELL _____<br>HOME _____<br>WORK _____ | |

## Documents Required to Complete

# The Ohio Veterans Home Admission Application

**If you checked "YES" to any of the items listed below, a copy of that document must be attached.**

**APPLICANT'S NAME** _____

| | | |
|---|---|---|
| 1. | Military Enlistment Record and Honorable Discharge or DD214. | ☐ YES ☐ NO |
| 2. | Social Security card and photo I.D. | ☐ YES ☐ NO |
| 3. | Applicant's birth certificate.<br>Birth certificate for any legal dependent children, under 23 years of age, currently enrolled fulltime in school or college. | ☐ YES ☐ N/A<br>☐ YES ☐ N/A |
| 4. | Current marriage certificate or Divorce Decree. | ☐ YES ☐ N/A |
| 5. | Medicare and Medicaid cards and any other Health Insurance cards (including any prescription/medication coverage).<br>**NOTE: 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 Department of Veterans 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?<br>**NOTE: Attach letter.** | ☐ YES ☐ NO |
| 12. | I am applying for admission to the Ohio Veterans Homes. I have been a citizen of the State of Ohio for one year or more at the date of application. | ☐ 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. 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 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 Boulevard**
**Georgetown, OH 45121**
**937-378-2900 ext. 2715**

# Schedule of Services

**The Ohio Veterans Homes** 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, ext. 2715, to obtain an estimate of your projected monthly assessment.**

## ASSESSMENT RATES - Effective 07/01/22

| Level-of-Care | Maximum Rate per Month* (Eligible for VA per diem) | Maximum Rate per Day* (Eligible for VA per diem) | Maximum Rate per Month* (Not eligible for VA per diem) | Maximum Rate per Day* (Not eligible for VA per diem) |
|---|---|---|---|---|
| Domiciliary (Independent Living) | $687.00 | $22.59 | $2,235.52 | $73.50 |
| Domiciliary + (Supervised Living) | $1,751.00 | $57.57 | $3,299.52 | $108.48 |
| Nursing Home Regular Care Units | $2,762.00 | $90.81 | | |
| Nursing Home Special Care Units | $3,444.00 | $113.23 | | |

***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**.

**APPLICANT'S NAME** _____ **SS # (Last 4 Digits)** _____

## INCOME INFORMATION - INITIAL INTAKE

| INCOME | PRIOR YR. VETERAN | CURRENT YR. VETERAN | | | PRIOR YR. SPOUSE | CURRENT YR. SPOUSE |
|---|---|---|---|---|---|---|
| Social Security (Gross per month) | | | | | | |
| VA Pension (per month) | | | | | | |
| VA Compensation (per month) | | | | | | |
| Retirement (Gross per month) | | | | | | |
| Interest/Dividends (per month) | | | | | | |
| Other (Gross per month) | | | | | | |
| **TOTAL MONTHLY INCOME** | | | | | | |

## ASSET INFORMATION - INITIAL INTAKE

| | | VETERAN | | BOTH | | SPOUSE | |
|---|---|---|---|---|---|---|---|
| **ASSETS** | **ACCOUNT # (Last 4 Digits)** | **AS OF 12/31 BALANCE** | **CURRENT BALANCE** | **INTEREST EARNED AS OF 12/31** | **INTEREST EARNED CURRENT YTD** | **AS OF 12/31 LAST YR BALANCE** | **CURRENT YTD BALANCE** |
| Cash & Checking Accounts | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| Savings, CDs & Money Markets, etc. | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| IRA & 401K Accounts | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| Stocks & Bonds | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| Real Property (not including residence) (market value less) | | | | | | | |
| | | | | | | | |
| Other Property/assets not shown elsewhere | | | | | | | |
| | | | | | | | |
| **TOTAL ASSETS & INTEREST EARNED** | | | | | | | |

## DEBT INFORMATION - INITIAL INTAKE

*Any debts/loans that will reduce the value of Other Property listed above.*

| DEBTS/LOANS | | PRIOR YR. VETERAN | CURRENT YR. VETERAN | | | PRIOR YR. SPOUSE | CURRENT YR. SPOUSE |
|---|---|---|---|---|---|---|---|
| Medical Ins Premium ☐ YES ☐ NO | If YES, amt: | | | | | | |
| Medicare B Premium ☐ YES ☐ NO | If YES, amt: | | | | | | |
| Medicare D Premium ☐ YES ☐ NO | If YES, amt: | | | | | | |
| Medicare A Premium ☐ YES ☐ NO | If YES, amt: | | | | | | |
| Total MI Prem - Vet: | | | | Total MI Prem - Spouse: | | | |
| Total MI Premium Vet & Spouse | Last Yr Total: | | | This Yr Total: | | | |

Is the Veteran or Spouse required to file taxes? ☐ YES ☐ NO 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 Guardian _____ Date _____

## This Form is to be Completed by the Examining Physician of the Applicant.

# Applicant 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.

**APPLICANT'S NAME** _____ **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's Disease

**RESPIRATORY**

- ☐ Emphysema
- ☐ Asthma
- ☐ COPD
- ☐ Pneumonia

**SENSORY**

- ☐ Cataract
- ☐ Glaucoma

**EDEMA**

- ☐ Localized not pitting
- ☐ Other

**MENTAL HEALTH** *(If any of the below 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 & DIAGNOSIS**

_____

_____

_____

**ALLERGIES** _____

_____

**If Applicant has been hospitalized for any reason or received mental health or substance abuse treatment within the past three 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 _____ Recent Surgery Date _____

Weight _____ Recent Fracture Date _____

B/P _____ Area of Fracture _____

Pulse _____ Any Pressure Areas _____

Respiration _____ Recent Weight Loss? ☐ YES ☐ NO

Temperature _____

Does the Applicant have a history of positive TB skin tests? ☐ 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 _____

COVID-19 Vaccine #1 (Include date, type of vaccine) _____

COVID-19 Vaccine #2 (Include date, type of vaccine) _____

COVID-19 Booster (Include date, type of vaccine) _____

Last COVID-19 test (Include date, type – PCR or Rapid) _____

Provide a copy of your Vaccine Card

Have you ever had COVID-19? ☐ YES ☐ NO If YES, date tested positive _____

Comments _____

## VERIFICATION OF DISABILITY & 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 # (10 digits)** | **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 |

Do you believe the individual is capable of making healthcare decisions for him/herself? ☐ YES ☐ NO

If NO, please explain. _____

Do you believe the individual is capable of managing his/her finances and property? ☐ YES ☐ NO

If NO, please explain. _____

**NEED FOR SUPERVISION TO PREVENT HARM**

_____ 24 HOURS PER DAY

_____ WANDERING

_____ FALL RISK

_____ PERIODIC SUPERVISION

_____ NO SUPERVISION NEEDED

_____ EXIT SEEKING

| **Physician Signature** | **Physician Name Printed** | **Date** |
|---|---|---|