DEPARTMENT OF STATE
DELAWARE VETERANS HOME
100 DELAWARE VETERANS BOULEVARD
MILFORD, DELAWARE 19963
(302) 424-6000
ADMINISTRATIVE OFFICES

Dear applicant and family,

Enclosed in this packet you will find application materials including a checklist to assist in gathering documentation required in order to complete processing of an admission request.

In order to be considered for residency to the Delaware Veterans Home, an applicant must meet each of the three minimum requirements listed below:

- Honorable discharge from active service (peacetime or wartime) with a minimum of 180 days of service.
- Any national Guard Service or Reservist who is eligible for retirement pay at the age of 60
- National Guard overseas with active service minimum of 180 days
- Reservist with a minimum of 181 days active service
- Must have resided in State of Delaware for at least one year prior to the application
- There must be a medically determined need for a skilled nursing level of care

Please ensure that all supporting documents are included with your application submission in order to prevent a delay in the processing of your request. For your convenience, a record release form is enclosed that you may have copies made of to give to your primary care and specialty providers that have been involved in your care for the previous year. During the application process, you will be scheduled for a pre-admission interview assessment with member(s) of the admission team.

Submissions may be mailed to the attention of the Admissions Department at the address below or you may have the records faxed to the attention: Sandra Redick RE: Admissions at (302) 622-4155 .

Sincerely,

Sandra Redick, LCSW
Social Services Administrator
Delaware Veterans Home Admissions
Delaware Veterans Home
100 Delaware Veterans Boulevard
Milford, DE 19963 O) 302-424-8572 F) 302-424-6009

Department of State
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(302) 424-6000
Administrative Offices

Rates for Room and Board Effective May 1, 2023

Room and Board Daily rate includes:

- Routine nursing care
- Meals
- Activities
- Housekeeping
- Bed and Bath linens
- Social services
- Telephone
- Basic cable

Skilled level	Daily Rate	VA Per Diem	Veteran's cost per day	30-day month
Semi-private	$320.00	$127.17	$192.83	$5,784.90
Private	$355.00	$127.17	$227.83	$6,834.90

Billing statements are mailed out the 5th of each month. Payments must be received by the 25th each month. Billing statement charges may include barber/beautician, laundry, transportation, pharmacy and copays, if applicable.

Application Check List

Please attach copies of each item below on check list with your application materials:

Item	Place check if enclosed
PHOTO ID: **Driver's License** **State ID issued ID OR Military ID**	
Insurance Cards: copy of front and back of each card **Medicare, Part A and B** **Medicaid (proof of Medicaid application)** **Supplemental Insurance; (ie. Tricare, Medicare part D, AARP)**	
DD214 (Honorable Discharge form from the military) A copy of the DD214 can be requested from the Commission for Veterans Affairs: 302-739-2792	
Financial Power of Attorney documentation or Guardianship document	
Medical Power of Attorney Documentation	
Advance Directives/Living Will	
10-10ez – VA Health Benefits Form Must be fully completed and signed	
Bank Statements (last 3 consecutive months) Statements must have account holder's name and contain all pages for each statement (e.g. checking, savings, money market, or other accounts that may be used to pay the daily rate or to pay the co-payment.	
Proof of Delaware Residency for the past 1 year (e.g. tax returns, property records)	
Veterans with Service Connected Disability, need copy of this award letter	
Provide medical records from primary physician for one year up to present.	
Provide all hospital records related to admission to another placement	
Provide records from any specialist providers seen. (ie. psychiatry, behavioral health, physical, occupational, speech therapy)	
Provide medication list (all prescribing providers) from your pharmacy	
Vaccination record including Covid Vaccine documentation	
Please tell us how you heard about us:	

***Missing documents will result in delayed processing of the application and or admission process**

Authorization for Release of Information
Delaware Veterans Home

In compliance with Federal Regulations (42 U.S.C. 4582 and 21 U.S.C. 1175) and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (45 C.F.R. Pts. 160 and 164)

Resident Name: _____ Date of Birth: _____

I, the undersigned, hereby authorize: Delaware Veterans Home

To release information to: [x] To obtain information from:

_____

Name of Agency/Person/Organization Address

Dates of treatment: _____ to _____

Description of Information to be provided: **(check all that apply)**

____ Discharge summary	____ Physician orders	____ Nurse's notes
____ History & Physical	____ Laboratory results	____ Therapies
____ Doctor notes	____ Radiology Reports	____ Current medications
____ Consultations	____ Social work	____ Substance Abuse records
____ HIV/STD records	____ Genetic information records	____ Mental Health records

Other: _____

Purpose of Release of Information: _____

_____

(Be as specific as possible)

This authorization is valid for the treatment period of: _____ Other (specify): _____

I understand that my records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Pts. 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it. I understand that my private health information, once disclosed to others, may be further disclosed to individuals or organizations not subject to HIPAA and may no longer be protected by HIPAA. **I understand that this authorization will automatically expire one (1) year from the date of my signature or immediately upon termination of treatment, unless otherwise specified above.**

_____ _____ _____ _____

Signature of Resident or Representative Date Print Name of Resident's Representative Relationship to Resident

For DVH Use Only

Resident Medical Record Number _____ Released by: _____ Date _____

Received by: _____ Date _____

SECTION I: INFORMATION ABOUT THE APPLICANT:

DEMOGRAPHICS:

1. Last name:_____ First name:_____ MI._____

2. Current address: _____ county _____
   City_____ state_____ zip _____
3. Telephone:
   H) _____ primary? ❑
   Mobile: _____ primary? ❑

4. Age _____ Date of Birth _____ Birthplace: city/state _____

5. Marital status: single ❑ married ❑ divorced ❑ widowed ❑ never married ❑ legally separated ❑date of separation _____

6. Religious preference _____ Social security number _____

7. How long have you lived at your current address? _____

8. How long have you lived in the state of Delaware? _____

9. What was your main occupation? _____

10. What is your native language? _____

MILITARY SERVICE:

1. Branch of service:
   Army ❑ Navy ❑ Marine Corps ❑ Air Force ❑ Coast Guard ❑ National Guard ❑

   Other: (specify) _____

2. Date entered into service: _____ date separated: _____

   War Era: WWI ❑ WWII Europe ❑ WWII south Pacific ❑ Korea ❑ Vietnam ❑

   Gulf War ❑ Peacetime ❑

3. Do you have a service-connected disability? Yes ❑ No ❑ If yes, what percent? _____
4. Were you a POW? Yes ❑ No ❑
5. Have you been seen at the VA in Elsmere within the last 5 years? Yes ❑ No ❑

TYPE OF CARE REQUESTED:

Dementia/special care wing ☐
Intermediate/ Skilled Nursing Care ☐

MEDICAL/LEGAL

1. Does anyone have power of attorney/guardianship for your affairs? Yes ☐ No ☐
   If yes, provide a copy with this application

   Name of Healthcare Power of attorney: _____
   Address: _____
   Phone number: _____

   Name of Financial Power of attorney: _____
   Address: _____
   Phone number: _____

   Responsible Billing Party: _____
   Address: _____
   Phone Number: _____

2. Do you have an Advance Directive or living will in place? Yes ☐ No ☐
3. Name of next of kin in the event of an emergency: _____
   Address: _____
   City/State/Zip: _____
   Home phone_____ work phone_____ mobile phone_____

4. Name of Primary care Physician: _____
   Address: _____
   City/State/Zip: _____
   Phone number _____
5. Do you have allergies? If so, specify:
   _____
6. Do you have private medical/prescription coverage? Yes ☐ No ☐
   Private Insurance _____
   Company name _____
   Policy Number _____
7. Have you enrolled in Medicare part D prescription coverage? Yes ☐ No ☐
   If yes, which one? _____ PDP ID# _____
8. Do you have community Medicaid? Yes ☐ No ☐ Number _____
   Long term Medicaid? Yes ☐ No ☐ Number _____

9. Do you have Long term care insurance? If so, company name _____
   Policy number _____

Please include a copy of your military discharge/ DD214, health insurance cards, driver's License and/or state ID and any other information with this form if you have not already submitted them.

I, the undersigned, hereby acknowledge that the information, as provided herein, is correct. I understand that failure to disclose accurate information could delay the admissions process. I give the Delaware veterans Home permission to contact necessary parties to discuss and verify the information enclosed in this application.

Signature of applicant Date

Signature of Responsible Party Date

SECTION II: Delaware Veterans Home Financial Questionnaire

The following section is a series of detailed financial questions. We ask these questions so that we may gain the most accurate picture of your current financial status. This is important in order to ensure continued payment of services received at the Delaware Veterans Home.

The following questions pertain to the applicant's income only. Do not list any combined income resources of a spouse or other relative. For all income and accounts listed below, please include award letters and most recent bank statements.

I. Income Resources:

a. Social Security $_____/mo
b. Pension $_____/mo
c. VA Pension $ _____/mo
d. Any other retirement or additional income $_____/mo
e. Dividends / Interest: $_____/mo

II. Bank Accounts:

Name of Bank	Account Number	Amount	Joint: Y/N	Name on Account

III. Real Estate:

1. Do you own or jointly own any real estate? Yes ❑ No ❑
   If yes, with whom and at what location? _____

2. Do you own any rental property? Yes ❑ No ❑
   If yes, what is the approximate value of the property? _____
   What is the monthly rental amount you receive in rent? _____
   Are there any judgements against the property? Yes ❑ No ❑
   What is the address of the property?
   _____

3. Have you sold or transferred any property within the past 5 years? Yes ❑ No ❑

IV. Life Insurance/ Burial:

1. Do you have a pre-paid burial plan? Yes ❑ No ❑
   If yes, where? _____

2. Do you have life insurance policies? Yes ❑ No ❑
   If so, please list them below. Indicate the face value, cash surrender value and beneficiary for each:

Policy Number	Beneficiary	Term or whole life	Face value	Cash surrender value

V. Additional Accounts or funds: Please list any CD's, mutual funds, stock, Bond or other financial accounts and the amount for each. If you need additional space, please attach them on separate sheet of paper.

Account Type (CD,Stock ,Trust)	Amount/ approximate Value	Location of account or name of bank	Date of issue

Authorization for Financial Information

I, the undersigned hereby acknowledge that the information, as provided herein is correct. I understand that failure to disclose accurate financial information may be grounds for legal action in accordance with prevailing federal, state and local statutes and regulations. I authorize the Delaware Veterans Home to verify information, as needed, as part of the admissions process.

_____

Signature of applicant Date

_____

Signature of Responsible party Date