



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: DVH Admissions at (302) 622-4155 .

Admissions Department  
Delaware Veterans Home  
100 Delaware Veterans Boulevard  
Milford, DE 19963  
302-424-8572

**Delaware Veterans Home Mission Statement:**  
Provide outstanding long-term care services to Delaware veterans that uphold dignity and respect while sustaining and improving their quality of life.



Department of State  
**Delaware Veterans Home**

100 Delaware Veterans Boulevard  
Milford, Delaware 19963  
(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	\$138.29	\$181.71	\$5,451.30
Private	\$355.00	\$138.29	\$216.71	\$6,501.30

**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
<b>PHOTO ID: Driver's License State ID issued ID OR Military ID</b>	
<b>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 )</b>	
<b>DD214 (Honorable Discharge form from the military) A copy of the DD214 can be requested from the Commission for Veterans Affairs: 302-739-2792</b>	
<b>Financial Power of Attorney documentation or Guardianship document</b>	
<b>Medical Power of Attorney Documentation</b>	
<b>Advance Directives/Living Will</b>	
<b>10-10ez – VA Health Benefits Form Must be fully completed and signed</b>	
<b>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.</b>	
<b>Proof of Delaware Residency for the past 1 year (e.g. tax returns, property records)</b>	
<b>Veterans with Service Connected Disability, need copy of this award letter</b>	
<b>Provide medical records from primary physician for one year up to present.</b>	
<b>Provide all hospital records related to admission to another placement</b>	
<b>Provide records from any specialist providers seen. (ie. psychiatry, behavioral health, physical, occupational, speech therapy)</b>	
<b>Provide medication list (all prescribing providers ) from your pharmacy</b>	
<b>Vaccination record including Covid Vaccine documentation</b>	
<b>Please tell us how you heard about us:</b>	

**\*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:  To obtain information from:

Name of Agency/Person/Organization	Address

Dates of treatment: \_\_\_\_\_ to \_\_\_\_\_

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

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Discharge summary  | <input type="checkbox"/> Physician orders            | <input type="checkbox"/> Nurse's notes           |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Laboratory results          | <input type="checkbox"/> Therapies               |
| <input type="checkbox"/> Doctor notes       | <input type="checkbox"/> Radiology Reports           | <input type="checkbox"/> Current medications     |
| <input type="checkbox"/> Consultations      | <input type="checkbox"/> Social work                 | <input type="checkbox"/> Substance Abuse records |
| <input type="checkbox"/> HIV/STD records    | <input type="checkbox"/> Genetic information records | <input type="checkbox"/> 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.

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Signature of applicant

Date

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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.

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 Signature of applicant Date

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 Signature of Responsible party Date