

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

Dear Applicant and Family,

Thank you for your interest in becoming a resident of the Delaware Veterans Home. This application includes a checklist (on page 3) and an authorization for medical release (on page 4) to assist you in gathering the necessary documents.

To be considered for residency at the Delaware Veterans Home, applicants must meet the following minimum requirements:

- Honorable discharge from active service (peacetime or wartime) with a minimum of 181 days of service **OR**
 - National Guard overseas with active service for a minimum of 181 days **OR**
 - Reservist with a minimum of 181 days of active service **OR**
 - Any National Guard Service or Reservist who is eligible for retirement pay at the age of 60 **OR**
 - Be a Gold Star family member
- AND**
- Reside in the State of Delaware for at least one year before applying for admission
 - Have a medically determined need for a long-term level of care

As part of our review process, applicants may be scheduled for a pre-admission interview assessment with members of the DVH clinical team.

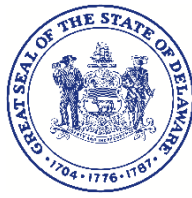
Please include all supporting documents with your application to avoid delays. Note that all applications are valid for 90 days from the date of submission to DVH. If the application is not fully completed within that time period, it will be closed, and the applicant must restart the process. This helps us serve Delaware's veterans as efficiently as possible, minimizing delays.

Completed applications, along with the required documents, can be submitted through the following methods:

APPLICATION SUBMISSION		
MAIL	FAX	EMAIL
Att: DVH Admissions The Delaware Veterans Home 100 Delaware Veterans Blvd. Milford, DE 19963	302-424-6033	DOSDVH_Admissions@delaware.gov

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



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Daily Room & Board rate includes:

- Activities
- Basic Cable
- Bed & Bath Linens
- Housekeeping
- Meals
- Routine Nursing Care
- Social Services
- Telephone

Acceptable Forms of Payment

- 0%-69% Service Connection Rating, VA covers that percentage, the applicant is responsible for the remaining balance
- 70%-100% Service Connection Rating, VA covers stay
- Long-Term Medicaid
- Medicare covers up to 100 days of short-term & rehabilitation related stays only Private Pay
- Private Pay - Applicant must evidence having 249K readily available in conventional checking or savings

The tables below provide a projected snapshot of what is covered by various payment methods:

Veterans Service Connection Rated 70% - 100%

<i>Lodging Type</i>	<i>Daily Rate</i>	<i>VA Per Diem</i>	<i>Veteran's Cost Per Day</i>	<i>30-day month cost</i>
Semi-Private	\$ 320.00	\$ 148.71	\$ 171.29	\$ 5,138.70
Private	\$ 320.00	\$ 148.71	N/A	\$ 5,138.70

Veterans Service Connection Rated less than 70%

<i>Lodging Type</i>	<i>Daily Rate</i>	<i>VA Per Diem</i>	<i>Veteran's Cost Per Day</i>	<i>30-day month cost</i>
Semi-Private	\$ 320.00	\$ 148.71	\$ 171.29	\$ 5,138.70

VA rates reflected are projected and subject to change

Long-Term Medicaid (Evidence of Approval Required)

Medicaid Cover	Medicaid Does Not Cover
Activities & Programming	Beauty/Barber Services
ADL Assistance	Cable TV
Incontinent Supplies	Elective Medical Services
Lab & Diagnostic Services	Guest Meals
Laundry	Personal Luxury Items
Medical Equipment	Private Duty Sitter
Medical Supplies	Private Room upgrade not deemed medically necessary
Medically Necessary Therapies (Speech, OT & PT)	Special food outside of the dietary plan
Medically Necessary Supplies	Telephone
Medication	
Nursing Care	
Physicians Visits	
Room & Board	
Routine Personal Hygiene	
Specialized Diets	

Note: Similar to most states, residents of Delaware must contribute a portion of their monthly income towards patient liability. Medicaid pays the remainder of the contracted rate.

Medicare (Traditional/Part A)

Traditional Medicare Covers	Traditional Medicare Does Not Cover
Short-Term Skilled Care	Long-Term Skilled Care
<u>Payment Structure</u> Day 1-20: 100% covered Day 21-100: patient will have a copay Day 101: No coverage	
Qualifying Hospital Stay	Room & Board beyond 100 days
Daily Therapy Need (OT, PT, SP, IV, Wound Care, etc.)	Private Lodgings not deemed medically necessary
Semi-Private Room	Personal Items
Skilled Nursing Care	Television
Medically Necessary Supplies	Phone
Medication related to the condition	Beauty & Barber Services
Enteral & Parenteral Nutrition	Comfort Items
Medical Social Services	Non-Skilled Care
Dietary Counseling	Long-Term Dementia Care
Medical Equipment Used	
Lab Work & X-rays related to stay	
Medically Necessary Ambulance Transport	

Note: Traditional Medicare only pays for short-term skilled care & rehabilitation. Coverage will cease if/when the need for "skilled care" is no longer required, even if the resident remains in the facility.

Billing Information:

Billing statements are mailed out on the 5th day of each month. Payments are due by the 25th of the month. Billing statement charges may include barber/beautician services, laundry, transportation, pharmacy, and copays, where applicable.

To guarantee the highest level of accuracy, we will provide cost-related quotes only after a comprehensive review of an application. This practice helps to ensure that we deliver the most precise and tailored information possible

Application Check List

Please submit copies of each item on the checklist along with your application:

ITEM	Place a check if enclosed
PHOTO ID • Driver's License • State ID • Military ID	
Insurance Cards: A copy of the front and back of all active insurance cards is needed: • Medicare Part A and B, • Medicaid (proof of Medicaid application decision or card is required) • Supplemental Insurance (Ex: Tricare, Medicare Part D, AARP)	
Applicant's DD21 4 (Form evidencing military discharge status). A copy of the DD21 4 can be requested from the Delaware Office of Veterans Services: 302-739-2792	
Financial Power of Attorney or Guardianship document	
Medical Power of Attorney Documentation	
Advance Directives/Living Will	
1010EZ - VA Health Benefits Form: included in this application and must be fully completed and signed	
Bank Statements (last 3 consecutive months): Statements must include the 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 satisfy the co-payment.	
Proof of Delaware Residency for the past 1 year (Ex: tax returns, property records)	
Veterans with a service-connected disability must provide a copy of their award letter.	
Medical Release of Information (pg. 4) – Kindly complete only the sections highlighted in yellow and ensure that the document is signed by the individual providing authorization	
Please tell us how you heard about us:	

Failure to provide required documentation timely will result in processing delays & deferred internal review.

APPLICANT: MEDICAL PROVIDER INFORMATION

List all providers seen in the past six months, including those seen one time.

PROVIDER NAME	ADDRESS	PHONE	LAST APPT DATE

MEDICAL COVERAGE

- Does applicant have Medical/Prescription Coverage: Yes No

Primary Coverage

Company Name:

Insurance Name:

Policy#:

Group#:

Secondary Coverage

Company Name:

Insurance Name:

Policy#:

- Does the applicant currently have Medicaid: Yes No
- Does the applicant have Medicare Part D prescription coverage: Yes No
- If yes, PDP ID#:

APPLICANT INFORMATION

DEMOGRAPHICS

Last Name: **First Name:** **MI:** **Preferred Name:**
Age: **DOB:** **SS#:**
Address **City:** **State:** **Zip:**
County: **Length of time in the state of Delaware:** Yrs Mths
Length of time at current address: Yrs Mths
Telephone: Home: **Cell:** **Email:**
Marital Status: Single Married Divorced Widowed Legally Separated
Spouse Name: **Religion:**
Preferred/Native Language:

Type of Care Requested: Intermediate/Skilled Nursing Care Secured Memory Care Unit
Do you have pets? Yes No **If yes, type & name:**
Primary occupation when working: **Other Occupation (s):**

MILITARY SERVICE

Service Branch: Air Force Army Coast Guard Marines National Guard
Navy Space Force Gold Star Spouse Gold Star Parent
Service Start Date: **Service Discharge Date:**
Discharge Type:
Wartime Service: WW I WW II Korean War Vietnam Gulf War Peace Time
Prior POW? Yes No
Service-Connected Disability: Yes No %
Serviced by Wilmington VA in the past 5 years: Yes No

I, the undersigned, hereby acknowledge that the information provided herein is accurate. I understand that failing to disclose correct 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.

Applicant/Signee Signature **Date** **Signee Name (Print)**

Relationship to Applicant

Is the signature the applicant's documented Power of Attorney? Yes No

HEALTH HISTORY

• Does the applicant have any internal or external medical devices? Yes No
If so, please explain

• Has the applicant had any surgeries performed in the past year? Yes No
If so, please explain:

<u>Orientation</u>		
Alert to Self:	Yes	No
Alert to Place:	Yes	No
Alert to Time:	Yes	No
Disoriented:	Yes	No
Lethargic:	Yes	No
Cooperative:	Yes	No
Combative:	Yes	No

<u>Dental</u>		
Own Teeth:	Yes	No
Missing Teeth:	Yes	No
Dentures Used:	Yes	No
<i>If Yes:</i> Upper Lower		

<u>Vision</u>		
Clear:	Yes	No
Legally Blind:	Yes	No
Glasses Needed:	Yes	No

<u>Hearing</u>		
Clear:	Yes	No
Impaired:	Yes	No
Deaf:	Yes	No
Hearing Aides:	Yes	No

<u>Preferred Code Status</u>
<i>If the applicant is not breathing, what are the wishes regarding their care?</i>
Apply Life Saving Measures: Yes No
Do Not Resuscitate: Yes No
Do Not Resuscitate, provide Comfort Care: Yes No

- How does the applicant prefer to spend their day?
- Applicants' preferred time of day: Morning Afternoon Evening
- Applicant Preference: Socializing with others Spend time alone Both No Preference
- Does the applicant have food allergies? Yes No

Activities of Daily Living (ADL)	
Skill	Applicant Need
Ambulating (Moving)	Is assistance needed: Yes No
Bed Mobility	Is assistance needed: Yes No
Grooming	<u>Check all that apply</u> Is assistance needed: Yes No Brushing Teeth: Yes No Shaving: Yes No Washing Face: Yes No Handwashing: Yes No Combing Hair: Yes No Nail Trimming (Fingers & Toes): Yes No
Dressing	<u>Check all that apply</u> Is assistance needed: Yes No
Communication	Verbal Unclear Non-Verbal
Dining	Is assistance needed: Yes No
Diet Type	Regular Cardiac Diabetic Renal Faith-Based Other
Basic Hygiene	Is assistance needed: Yes No
Bladder & Bowel Continence	<u>Check all that apply</u> Continent: Yes No Occasionally Incontinent: Yes No Frequently Incontinent: Yes No Incontinent: Yes No
Toileting	Is assistance needed: Yes No
Toileting Supplies	Incontinent Garments Bed Pan Bedside Commode Raised Toilet Seat
Toileting Garments Used	<i>Where "Incontinent Garments" are needed, please identify the preferred type:</i> Briefs Pull-Up Depends



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 request and exchange information with:

Name of Provider/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	_____	Care Plans	_____	Mental Health Records	_____
Other:	_____				

Purpose of Release of Information: **To enable the performance of clinical assessment criteria for admission to DVH**

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 Signee or Applicant

Date

Signee Name (Print)

Relationship to Applicant

For DVH Use Only

Resident Medical Record Number: _____ Released by: _____ Date _____

Received by: _____ Date _____

PAIN MANAGEMENT

Does the applicant experience frequent pain? Yes No

Location of Pain:

Does the applicant take medication daily for pain? Yes No

If so, select dosage schedule: As Needed Non-Medication Other:

If non-verbal, how does the applicant communicate discomfort?

FALL HISTORY

- Does the applicant have balance issues?: Yes No
- Has the applicant had a recent “near fall” (ex., stumbling, fall into wall and/or furnishings)?: Yes No
If yes, please explain, including information on what prevented the actual fall:

- Has the applicant had a recent “fall” (ex., land on the ground)?: Yes No
If yes, please explain:

How often do falls occur? Never Rarely Intermittent Often

Explain if you checked “rarely, intermittent, or often”:

Last Fall Date:

Have falls resulted in (check all that apply):

No Injury Injury Minor Skin Tear Bruising Major Injury Fracture Dislocation
Subdural Hematoma Emergency Room Visit Date: Location:

THERAPY

What interventions are in place to reduce/prevent falls:

None Cane Walker Wheelchair Other

Therapy (select all that apply): Physical Occupational Speech

Most Recent Treatment Date:

Therapy Provider Name & Location:

Company: Provider Name:

Address: City: State: Zip:

MENTAL HEALTH

- Has the applicant participated in mental/behavioral health treatment: Yes No
- If yes, Most Recent Treatment: Date: From: To:
Provider Name & Location: Company:
Provider: :
Address:
City: State: Zip:
- Has the applicant received treatment for substance abuse: Yes No
- Is the applicant currently involved in the legal system: Yes No
- Is the applicant a registered sex offender: Yes No
- Does the applicant have a history of Trauma or Sexual Abuse: Yes No
- Does the applicant display negative behaviors towards self or others: Yes No
- Does the applicant have a history of suicidal attempts: Yes No

LEGAL INFORMATION

- Does the applicant have: Power of Attorney: Yes No Guardian of Affairs: Yes No
Advance Directive: Yes No Living Will: Yes No

Health Care Power of Attorney

Name:

Address:

City State: Zip:

Phone:

Financial Power of Attorney

Name:

Address:

City State: Zip:

Phone:

Responsible Billing Party

Name:

Address:

City State: Zip:

Phone:

Emergency Contact

Name:

Address:

City State: Zip:

Phone:

FINANCIAL INFORMATION

This section comprises a series of detailed financial questions designed to provide an accurate representation of the applicant's finances. This information is crucial to ensure there is no interruption in payment for services rendered by the Delaware Veterans Home.

The following questions focus solely on the applicant's income. For all income and accounts listed below, please provide the most recent bank statements for the past three (3) months and any award letters where applicable.

Income

SOURCE	AMOUNT	FREQUENCY
Social Security	\$	
Pension	\$	
VA Pension	\$	
Dividend/Interest	\$	
Other	\$	

Bank Account (s)

ACCOUNT HOLDER NAME	BANKING INSTITUTION	ACCOUNT NUMBER	JOINTLY HELD	BALANCE
			Yes No	\$
			Yes No	\$
			Yes No	\$
			Yes No	\$
			Yes No	\$

Life Insurance/Burial

- Do you have a pre-paid burial plan? Yes No

If yes, provide company information: Company:

Address:

City:

State:

Zip:

Phone:

- Does the applicant have life insurance policies? Yes No

Authorization for Release: 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 per the admissions process.

Applicant/Signee Signature

Date

Signee Name (Print)

Relationship to Applicant