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 utilizing **Respite/Rehabilitative** services at 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 Respite or Rehabilitative services 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	302-424-6003	DOSDVH_Admissions@delaware.gov

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Daily Room & Board rate includes:

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

Accepted Forms of Payment

- 70%-100% Service Connection Rating
- Long-Term Medicaid
- Conventional Medicare covers up to 100 days of Short-Term & Rehabilitation related stays only
- Private Pay

We are not currently able to accept Managed Medicare products

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#:

SERVICE TYPE REQUESTED

Respite Care ☐

Rehabilitation ☐

Physical ◯ *Speech* ◯ *Occupational* ◯

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:

Orientation

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 ☐

Vision

Clear: Yes ☐ No ☐

Legally Blind: Yes ☐ No ☐

Glasses Needed: Yes ☐ No ☐

Hearing

Clear: Yes ☐ No ☐

Impaired: Yes ☐ No ☐

Deaf: Yes ☐ No ☐

Hearing Aides: Yes ☐ No ☐

Dental

Own Teeth: Yes ☐ No ☐

Missing Teeth: Yes ☐ No ☐

Dentures Used: Yes ☐ No ☐

If Yes: Upper ☐ Lower ☐

Preferred Code Status

If the applicant is not breathing, what are the wishes regarding their care?

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	***Check all that apply*** 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	***Check all that apply*** 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	***Check all that apply*** 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	*Where "Incontinent Garments" are needed, please identify the preferred type:* 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	$	Select
Pension	$	Select
VA Pension	$	Select
Dividend/Interest	$	Select
Other	$	Select

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