

# Alabama State Veterans Home



Dear Veteran:

Thank you for your interest in the Alabama State Veterans Homes. Please review the enclosed information relative to terms of admission and discharge prior to completion of the application. This package has been assembled to provide you with the information necessary to aid us in determining eligibility and to expedite the total process. Submit the completed application directly to the home in which you are applying for admittance or you may return it to your County Veterans Service Office. **Note:** If choosing multiple homes, only one package needs to be submitted. The receiving home will share the application with the other homes checked on page 1 of the application. The Homes are located at the following address:

- 1) Bill Nichols State Veterans Home  
1784 Elkahatchee Road  
Alexander City, Alabama 35010  
(256) 329-3311
- 2) William F. Green State Veterans Home  
300 Faulkner Drive  
Bay Minette, Alabama 36507  
(251) 937-8049
- 3) Floyd E. "Tut" Fann State Veterans Home  
2701 Meridian Street  
Huntsville, Alabama 35811  
(256) 851-2807
- 4) Colonel Robert L. Howard State Veterans Home  
7054 Veterans Parkway  
Pell City, Alabama 35125  
(205) 338-6487

If you have any questions, contact the State Home Director at the above number or you may contact me at:

Alabama State Department of Veterans Affairs  
P.O. Box 1509  
Montgomery, Alabama 36102-1509  
(334) 242-5077

Sincerely,

Kimberly B. Justice  
Executive Director  
Alabama State Veterans Homes

## **Eligibility Requirements:**

Code of Alabama, Section 31-5A-8 states, “admission to and discharge from any Alabama state veterans’ home shall be in accordance with the policies and procedures as established by the State Board of Veterans Affairs at the time application for admission or for discharge is presented; provided, that the State Board of Veterans Affairs may admit and discharge veterans to any Alabama veterans’ home who qualify for care and treatment under 8 CFR, Section 51.50, and may adopt appropriate rules consistent with accepted medical considerations to carry out this function.” To be eligible for care from any Alabama State Veterans Home the veteran must meet the following eligibility requirements:

- Must be honorably discharged from military service with a minimum of 90 continuous days of Active Duty service. Veterans who enlisted after September 7, 1980, and those commissioned after October 16, 1981, must have served a minimum of 24 continuous months or the full period (minimum of 90 continuous days of Active Duty) for which the person was called and be honorably discharged. Active duty service means full-time service other than Active Duty for Training. A DD-214 or equivalent must be included in the application package.
- Must meet the qualifications as set forth by the U.S. Department of Veterans Affairs criteria for skilled nursing care or domiciliary/assisted living.
- Must have been a resident of the State of Alabama during the immediate past 12 months. (Proof of residency will be required).
- Must have had a medical examination by a physician to show that he/she does not:
  - Need medical care for which the Homes are not equipped or staffed to provide.
  - Have behavioral traits which may prove to be dangerous to the well-being of the resident, other residents, staff, or visitors.
  - Have a diagnosis or confirmed history of mental illness which outweighs their medical condition.
- Must meet the requirements of Alabama's immigration laws.

**Note:** *Applicants for the State Veterans Home will be checked against the Sex Offender Registry and a background check for active felony status. Anyone found to be on the Sex Offender Registry or in a felony fugitive status shall not be considered for admission.*

### **What the Facility Will Provide:**

- Quality food service with individual diet counseling by a certified dietician.
- Skilled nursing care and assisted living care by licensed professionals with around the clock supervision by Registered Nurses.
- Medical supervision by a Veterans Home Medical Director, a licensed physician knowledgeable in long term care.
- Initial dental examination and an annual exam thereafter.
- Social Services programs tailored to meet the individual needs of the resident.
- Activity program designed to appeal to the interests of the individual resident.
- Appropriate resident education programs.
- In-house pharmacy and licensed pharmacist to dispense medications as dictated by physicians' orders.
- Basic supplies for personal care.
- Transportation to local activities and routine medical appointments, including transportation to VA Medical Centers during normal business hours.
- Laundry and linen services to include personal laundry.
- Around the clock security staff.
- Maintain licensure and certification standards established by the U.S. Department of Veterans Affairs (USDVA), and the Alabama Department of Public Health (ADPH).
- Appropriate support groups for families and responsible parties.
- T.V. and cable provided.
- Barber/Beauty Shops

### **What the Facility Will Not Provide:**

- Free nursing home care.
- Acute or sub-acute care.
- One-on-one care.
- Dispense medications not prescribed by a physician.
- Restraints requested by family members, responsible parties, or friends.
- Special adaptive appliances/devices (NOTE: we do assist in securing these items through the Federal Department of Veterans Affairs for those eligible.)
- Replacement for loss, damage, or destruction of personal items.
- Free ambulance service.

### **Resident/Sponsor Responsibilities:**

The below listed items are examples of non-covered charges and are the responsibility of the Resident/Sponsor. This list is not all inclusive:

- Services not covered by insurance. (Third party provider charges that are billable include but are not limited to physician services, therapy services, labs, and x-rays).
- Charges/co-pays for pharmaceuticals.
- Private telephone services.
- Physician specialist consultation fees.
- Durable Medical Equipment (including oxygen), not furnished by the Veterans Administration.
- Private duty nurses and sitters.
- Definitive dental treatment and repairs.
- Maintenance and repair of personal property.
- Non-covered transportation charges.
- Bed Hold charges.

***Submission of this application is acceptance by all parties of the services and applicable charges.***

# Alabama State Veterans Home

## General Information

1. The term Resident is used synonymously with the term sponsor/guardian when the resident is deemed incapable of making rational decisions. Such sponsor/guardian shall be legally appointed and documentation of proof provided to the Homes at the time of application.
2. The Resident shall consent to abide by all rules and/or regulations governing the Homes and to follow the course of treatment prescribed by the Home's medical staff or outside medical consultant(s) before admission to the Home.
3. All Alabama State Veterans Homes are tobacco free campuses. Smoking/tobacco cessation must begin before admission to a Veterans home.
4. The Homes shall charge the residents for comprehensive care. Every resident shall be responsible for the full payment of the comprehensive care rate payable one month in advance, and not later than the 10th of each month thereafter. Bedhold charges apply to all Residents residing in the home. Exception: Per diem will be paid for certain veterans based on service-connected disabilities. Veterans who qualify under Title 38, Part 51, Subpart C will not be billed for room and board or routine services if the resident meets one of the following criteria: (1) Is in need of nursing home care for a VA adjudicated service-connected disability, or (2) has a service connected rating of 70 percent or more based on one or more service-connected disabilities or a rating of total disability based on individual unemployability and is in need of nursing home care. Title 38 will only apply once USDVA has fully recognized the State Veterans Home. It is the authority of the Department of Veterans Affairs to give final approval for per diem and to determine the amount of payment. This process may take up to two weeks after admission. The veteran is responsible for the full daily rate to include federal/state per diem if the veteran is not approved. Discharge may result in some cases.
5. Transportation to local appointments and activities is provided. Other transportation is the responsibility of the veteran.
6. Residents shall furnish their own items of personal clothing. Resident furniture is provided.
7. Residents shall accept transfer and/or discharge to other medical facilities or home care if medical condition mandates, as determined by the State Veterans Homes Medical Staff/Director.
8. Residents shall recognize that the Home will be operated in full compliance with the Civil Rights Act without discrimination as to race, color, creed, religion or gender.
9. Residents may apply for all U. S. Department of Veterans Affairs benefits for which he/she may be entitled. He/she may be counseled about benefit entitlements by a representative of the Department of Veterans Affairs, (normally this will be our Veterans Service Officer in your county).
10. Residents shall also bring with them any orthopedic appliances, braces, wheelchairs, walkers, etc., issued to them by the U. S. Department of Veterans Affairs.
11. Residents are allowed 10 days per occurrence for hospitalization and 12 days annually for therapeutic leave in which the USDVA will pay per diem and no bedhold charged to residents. The facility must be at 90% occupancy before this applies. The veteran is responsible for bedhold charges on any day occupancy rate is below 90%.
12. Failure to pay for comprehensive care will result in discharge from the Homes. The Contractor is authorized to use all applicable laws to recoup monies due the Homes for comprehensive care.

***Submission of this application is acceptance by all parties of the aforementioned rules and regulations.***

# Application and Information Sheet and Checklist

You are encouraged to contact your local Veterans Service Officer for assistance.

<u>Description</u>	<u>To be completed by</u>
<input type="checkbox"/> Personal Admission Information	Veteran or Sponsor
<input type="checkbox"/> Information on Legal Residency	Veteran or Sponsor
<input type="checkbox"/> VA Form 10-10EZ Application for Medical Benefits	Veteran or Sponsor
<input type="checkbox"/> VA Form 10-10SH Medical Certification	Medical Physician
<input type="checkbox"/> Mental Health Evaluation	Medical Physician, RN, or Social Worker
<input type="checkbox"/> Medical Statement for Domiciliary Care	Medical Physician
<input type="checkbox"/> ADVA Declaration of Citizenship or Alien Status	Veteran or Sponsor
<input type="checkbox"/> Authorization for Release of Medical Information	Veteran or Sponsor

## CHECKLIST FOR INFORMATION TO BE RETURNED WITH APPLICATION

- DD Form 214 or equivalent (mandatory)
- Copy of legal Power of Attorney (if available)
- Copy of Living Will / Advanced Directive (if available)
- Copy of insurance cards (front and back)
- Proof of Residence (Include proof of residency and completion of page 3). Examples to support residency requirement: Drivers license with an issue date covering last 12 months, property tax payment records for prior year, state income tax records for prior year, utility bills for last continuous 12 months, etc. Other documents may be accepted. Contact the veterans home director at the facility of choice should you have questions regarding appropriate documentation.

If applicant is in a long term care facility, please include the following items when returning admission packet:

- History & Physical
- Nurse's Notes (last 3 months)
- Physician Notes (last 3 months)
- Social Services Notes
- MDS & Care Plan

If applicant is in the hospital during the application process, please include the following when returning the admission packet:

- History & Physical
- Interim Summary or Discharge Summary

**Notice to Applicant:** The following forms: VA Form 10-10SH, 10-10EZ, Mental Health Evaluation, are very detailed and require concise and accurate information to ensure your application is processed in the most efficient manner. Failure to provide the requested information could adversely affect your prospects for entering an Alabama State Veterans Home. Each form serves a specific purpose, whether it be for the Admissions Committee to determine your medical eligibility for admission or the category of care you will require or for the expediting of the processing for payment of the VA Per Diem to the Home. In any case, these documents are of the utmost importance and merit your closest attention. Acceptance for admission or placement on the waiting list **will not occur until all information is received.**

# Alabama State Veterans Home



Please check facility of choice: (May select more than one)

Bill Nichols State Veterans Home  
 Skilled Care

Col. Robert L. Howard State Veterans Home  
 Skilled Care     Domiciliary/Assisted Living

Floyd E. "Tut" Fann State Veterans Home  
 Skilled Care

William F. Green State Veterans Home  
 Skilled Care

## Personal Information

1. APPLICANT NAME: \_\_\_\_\_ (Nickname/Alias) \_\_\_\_\_  
Last, First, Middle

2. VA CLAIM #: \_\_\_\_\_ SSN: \_\_\_\_\_

3. HOME ADDRESS: \_\_\_\_\_  
Street Apt #

City State Zip Phone No.

4. LEGAL ADDRESS (IF DIFFERENT FROM HOME ADDRESS)  
\_\_\_\_\_

5. PRESENT LOCATION OF APPLICANT:

HOME  HOSPITAL  NURSING HOME  OTHER FACILITY

IF OTHER THAN HOME, PROVIDE NAME, ADDRESS & PHONE NO. OF FACILITY.

\_\_\_\_\_

6. NAME OF SPOUSE/RESPONSIBLE PARTY: \_\_\_\_\_

IF OTHER THAN SPOUSE, RELATION TO VETERAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

7. PERSONAL PHYSICIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NO. \_\_\_\_\_

8. HAS APPLICANT EVER BEEN CONVICTED OF A FELONY?     YES     NO    IF YES, PLEASE DESCRIBE BELOW:

\_\_\_\_\_

9. INSURANCE: CHECK ALL THAT APPLY AND PROVIDE A COPY WITH APPLICATION.

MEDICARE: PART A \_\_\_\_\_ PART B \_\_\_\_\_ PART D \_\_\_\_\_

PRIVATE INSURANCE: \_\_\_\_\_

CARRIER NAME

ANY OTHER INSURANCE: \_\_\_\_\_

CARRIER NAME

**NOTE:** ONCE ADMITTED TO THE STATE VETERANS HOME, PRIMARY CARE SERVICES ARE PROVIDED AT THE STATE VETERANS HOME. YOU MAY NO LONGER RECEIVE PRIMARY CARE SERVICES BY THE FEDERAL VA MEDICAL CENTER.

VA MEDICATIONS ARE ONLY PROVIDED TO THOSE IN RECEIPT OF NSC PENSION WITH AID AND ATTENDANCE OR FOR SOME SERVICE CONNECTED DISABLED VETERANS.

ALL OTHER CHARGES ARE BILLABLE.

10. HIGHEST LEVEL OF EDUCATION ACHIEVED: \_\_\_\_\_

11. USUAL OCCUPATION BEFORE RETIREMENT: \_\_\_\_\_ DATE LAST EMPLOYED: \_\_\_\_\_

12. DATE OF BIRTH: \_\_\_\_\_ COUNTY OF BIRTH: \_\_\_\_\_

STATE/COUNTRY OF BIRTH: \_\_\_\_\_ CURRENT AGE: \_\_\_\_\_

13. DATE ENTERED SERVICE: \_\_\_\_\_ DATE RELEASED FROM SERVICE: \_\_\_\_\_

BRANCH OF SERVICE: \_\_\_\_\_ PERIOD OF SERVICE: \_\_\_\_\_ WAR \_\_\_\_\_ PEACE

\_\_\_\_\_ WWII (12/7/41 – 12/31/46) \_\_\_\_\_ KOREAN (6/27/50 – 1/31/55)

\_\_\_\_\_ VIETNAM (8/5/64 – 5/7/75)\* \_\_\_\_\_ GULF WAR (8/20/90 – Date to be set) \_\_\_\_\_ OEF/OIF

(\*VIETNAM – Start date of 11/1/55 “in country” before 8/5/64)

14. DID A VETERANS SERVICE OFFICER ASSIST YOU: YES \_\_\_\_\_ NO \_\_\_\_\_

IF SO, WHAT COUNTY: \_\_\_\_\_

IS THE VETERAN CURRENTLY IN RECEIPT OF VA SERVICE CONNECTED DISABILITY COMPENSATION OR NON-SERVICE CONNECTED PENSION: YES \_\_\_\_\_ NO \_\_\_\_\_

IF SO, HOW MUCH? PENSION \$ \_\_\_\_\_ COMPENSATION \$ \_\_\_\_\_

SC DISABILITY PERCENTAGE: \_\_\_\_\_

HAS VETERAN APPLIED FOR NSC PENSION W/AID AND ATTENDANCE OR SERVICE CONNECTED DISABILITY COMPENSATION? YES \_\_\_\_\_ NO \_\_\_\_\_

IF SO, WHO ASSISTED WITH APPLICATION: \_\_\_\_\_

I HAVE READ AND UNDERSTOOD THE TERMS AND CONDITIONS OF ADMISSIONS/DISCHARGE TO THE STATE VETERANS HOMES. I CONSENT TO ABIDE BY ALL THE RULES AND/OR REGULATIONS GOVERNING THE HOMES

SIGNATURE OF RESIDENT/SPONSOR: \_\_\_\_\_

DATE COMPLETED: \_\_\_\_\_



# Alabama State Veterans Home



TO BE COMPLETED BY: Veteran or Sponsor

## Information on Legal Residency

1. Have you been a resident of Alabama for the last twelve (12) preceding months?

Yes       No

2. List the address(es) where you have resided during the past one (1) year.

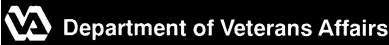
Number	Street	County	City
Number	Street	County	City
Number	Street	County	City

I hereby certify, under penalty of perjury, that all statements on or attached to this application are true, correct, and complete. I understand that providing false information or documents, to include failing to disclose a relevant fact or failing to report changes to a relevant fact, may result in a denial of benefits, required repayment, and legal action up to and including criminal prosecution.

\_\_\_\_\_  
Signature of Veteran, His/Her Spouse or other Authorized Individual

### **Proof of Residence Documentation:**

Examples to support residency requirement: Drivers license with an issue date covering last 12 months, property tax payment records for prior year, state income tax records for prior year, utility bills for last continuous 12 months, etc. Other documents may be accepted. Contact the veterans home director at the facility of choice should you have questions regarding appropriate documentation.



## STATE HOME PROGRAM APPLICATION FOR VETERAN CARE MEDICAL CERTIFICATION

### PART I - ADMINISTRATIVE

1. STATE HOME FACILITY	2. DATE ADMITTED (MM/DD/YYYY)
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3. STATE HOME FACILITY ADDRESS (Street, City, State and Zip Code)

4. RESIDENT'S NAME (Last, First, Middle)

5. SOCIAL SECURITY NUMBER	6. GENDER <input type="checkbox"/> M <input type="checkbox"/> F	7. AGE	8. DATE OF BIRTH (MM/DD/YYYY)	9. ADVANCED MEDICAL DIRECTIVE <input type="checkbox"/> NO <input type="checkbox"/> YES
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10. HAS THE VETERAN PROVIDED FINANCIAL DISCLOSURE FOR PURPOSES OF DETERMINING ELIGIBILITY FOR DOMICILIARY PER DIEM PAYMENTS?  
 YES  NO  N/A **10-10EZ or 10-10EZR IS REQUIRED TO BE SUBMITTED EITHER IN PAPER FORM OR ELECTRONICALLY WITH THE 10-10SH**

### PART II - HISTORY AND PHYSICAL (Use separate sheet if necessary)

11. HISTORY

12. HEIGHT	13. WEIGHT	14. TEMP	15. PULSE	16. BP	17. HEAD/EYES/EAR/NOSE AND THROAT
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18. NECK	19. CARDIOPULMONARY
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20. ABDOMEN	21. GENITOURINARY
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22. RECTAL	23. EXTREMITIES
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24. NEUROLOGICAL	25. ALLERGY/DRUG SENSITIVITY
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26. X-RAY/ LAB	CHEST X-RAY	DATE (MM/DD/YYYY)	RESULT	<input type="checkbox"/> N/A	CBC	DATE (MM/DD/YYYY)	RESULT	<input type="checkbox"/> N/A	
	SEROLOGY <span style="float: right;"><input type="checkbox"/> N/A</span>								
	URINALYSIS	DATE (MM/DD/YYYY)	ALBUMIN	ACETONE	SUGAR	<input type="checkbox"/> N/A			

CHECK ALL BOXES THAT APPLY OR CHECK N/A

27. IS DEMENTIA THE PRIMARY DIAGNOSIS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	28. IS THERE A DIAGNOSIS OF MENTAL ILLNESS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	29. HAS RESIDENT RECEIVED MENTAL HEALTH SERVICES WITHIN THE PAST 2 YEARS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	30. IS CLIENT A DANGER TO SELF OR OTHERS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
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31. IS THERE ANY PRESSING EVIDENCE OF MENTAL ILLNESS SUCH AS:

<input type="checkbox"/> SCHIZOPHRENIA	<input type="checkbox"/> PARANOIA	<input type="checkbox"/> OTHER PSYCHOTIC OR MENTAL DISORDERS LEADING TO CHRONIC DISABILITY
<input type="checkbox"/> MOOD SWINGS	<input type="checkbox"/> SOMATOFORM DISORDER	<input type="checkbox"/> PANIC OR SEVERE ANXIETY DISORDER <input type="checkbox"/> PERSONALITY DISORDER <input type="checkbox"/> N/A

32. OXYGEN <input type="checkbox"/> MASK <input type="checkbox"/> PRN <input type="checkbox"/> CONTINUOUS <input type="checkbox"/> NASAL CANNULA <input type="checkbox"/> N/A	33. FEEDING <input type="checkbox"/> TUBE FEEDING <input type="checkbox"/> OSTOMY <input type="checkbox"/> TRACHEOSTOMY <input type="checkbox"/> N/A	34. WOUND <input type="checkbox"/> DECUBITUS ULCERS <input type="checkbox"/> DRAINING WOUND <input type="checkbox"/> WOUND CULTURED <input type="checkbox"/> N/A	35. FOLEY CATHETER <input type="checkbox"/> TEMPORARY <input type="checkbox"/> PERMANENT <input type="checkbox"/> N/A
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36. REFERRING PHYSICIAN	37. PRIMARY DIAGNOSIS
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38. SECONDARY DIAGNOSIS	39. TERTIARY DIAGNOSIS
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40. ARE THE ADMITTING DIAGNOSIS RELATED TO A SERVICE CONNECTED CONDITION?  YES  NO  UNKNOWN

41. TYPE OF CARE RECOMMENDED:  SKILLED NURSING HOME CARE  DOMICILIARY CARE  ADULT DAY HEALTH CARE

42. MEDICATION AND TREATMENT ORDERS ON ADMISSION, CONTINUE ON SEPARATE SHEET IF NECESSARY

43. PRINTED OR TYPED NAME OF SVH PHYSICIAN/APRN/PA	44. SIGNATURE OF SVH PHYSICIAN/APRN/PA	Note: This field cannot be signed without first filling out item numbers 36 through 43. After signing, all fields in Part 2 will become locked and read only.
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**PART III - EVALUATION** (Select an appropriate number in each category)

45. RESIDENT'S NAME (Last, First, Middle)

46. SOCIAL SECURITY NUMBER

<b>COMMUNICATION</b>	<input type="checkbox"/> 1. Transmits messages/receives information <input type="checkbox"/> 2. Limited ability <input type="checkbox"/> 3. Nearly or totally unable	<b>SPEECH</b>	<input type="checkbox"/> 1. Speaks clearly with others of same language <input type="checkbox"/> 2. Limited ability <input type="checkbox"/> 3. Unable to speak clearly or not at all
<b>HEARING</b>	<input type="checkbox"/> 1. Good <input type="checkbox"/> 2. Hearing slightly impaired <input type="checkbox"/> 3. Nearly or totally unable <input type="checkbox"/> 4. Virtually/completely deaf	<b>SIGHT</b>	<input type="checkbox"/> 1. Good <input type="checkbox"/> 2. Vision adequate - Unable to read/see details <input type="checkbox"/> 3. Vision limited - Gross object differentiation <input type="checkbox"/> 4. Blind
<b>TRANSFER</b>	<input type="checkbox"/> 1. No assistance <input type="checkbox"/> 2. Equipment only <input type="checkbox"/> 3. Supervision only <input type="checkbox"/> 4. Requires human transfer w/wo equipment <input type="checkbox"/> 5. Bedfast	<b>AMBULATION</b>	<input type="checkbox"/> 1. Independence w/wo assistive device <input type="checkbox"/> 2. Walks with supervision <input type="checkbox"/> 3. Walks with continuous human support <input type="checkbox"/> 4. Bed to chair (total help) <input type="checkbox"/> 5. Bedfast
<b>ENDURANCE</b>	<input type="checkbox"/> 1. Tolerates distances (250 feet sustained activity) <input type="checkbox"/> 2. Needs intermittent rest <input type="checkbox"/> 3. Rarely tolerates short activities <input type="checkbox"/> 4. No tolerance	<b>MENTAL AND BEHAVIOR STATUS</b>	<input type="checkbox"/> 1. Alert <input type="checkbox"/> A. Agreeable <input type="checkbox"/> 2. Confused <input type="checkbox"/> B. Disruptive <input type="checkbox"/> 3. Disoriented <input type="checkbox"/> C. Apathetic <input type="checkbox"/> 4. Comatose <input type="checkbox"/> D. Well motivated
<b>TOILETING</b>	<input type="checkbox"/> 1. No assistance <input type="checkbox"/> 2. Assistance to and from transfer <input type="checkbox"/> A. Bathroom <input type="checkbox"/> 3. Total assistance including personal hygiene, help with clothes <input type="checkbox"/> B. Bedside commode <input type="checkbox"/> <input type="checkbox"/> C. Bedpan	<b>BATHING</b>	<input type="checkbox"/> 1. No assistance <input type="checkbox"/> A. Tub <input type="checkbox"/> 2. Supervision Only <input type="checkbox"/> B. Shower <input type="checkbox"/> 3. Assistance <input type="checkbox"/> C. Sponge bath <input type="checkbox"/> 4. Is bathed
<b>DRESSING</b>	<input type="checkbox"/> 1. Dresses self <input type="checkbox"/> 2. Minor assistance <input type="checkbox"/> 3. Needs help to complete dressing <input type="checkbox"/> 4. Has to be dressed	<b>FEEDING</b>	<input type="checkbox"/> 1. No assistance <input type="checkbox"/> 2. Minor assistance, needs tray set up only <input type="checkbox"/> 3. Help feeding/encouraging <input type="checkbox"/> 4. Is fed
<b>BLADDER CONTROL</b>	<input type="checkbox"/> 1. Continent <input type="checkbox"/> 2. Rarely incontinent <input type="checkbox"/> 3. Occasional - once/week or less <input type="checkbox"/> 4. Frequent - up to once a day <input type="checkbox"/> 5. Total incontinence <input type="checkbox"/> 6. Catheter, indwelling	<b>BOWEL CONTROL</b>	<input type="checkbox"/> 1. Continent <input type="checkbox"/> 2. Rarely incontinent <input type="checkbox"/> 3. Occasional - once/week or less <input type="checkbox"/> 4. Frequent - up to once a day <input type="checkbox"/> 5. Total incontinence <input type="checkbox"/> 6. Ostomy
<b>SKIN CONDITION</b>	<input type="checkbox"/> 1. Intact <input type="checkbox"/> 5. Decubitus <input type="checkbox"/> 2. Dry/Fragile Number _____ <input type="checkbox"/> 3. Irritations (Rash) Stage _____ <input type="checkbox"/> 4. Open wound	<b>WHEEL CHAIR USE</b>	<input type="checkbox"/> 1. Independence <input type="checkbox"/> 2. Assistance in difficult maneuvering <input type="checkbox"/> 3. Wheels a few feet <input type="checkbox"/> 4. Unable to use <input type="checkbox"/> N/A

47. SIGNATURE OF REGISTERED NURSE OR PHYSICIAN/APRN/PA

Note: After signing, all fields in Part 3 will become locked and read only.

48. DATE (MM/DD/YYYY)

**PHYSICAL THERAPY** (To be completed by Physical Therapist or Physician/APRN/PA) 49. Check if  NEW REFERRAL  CONTINUATION OF THERAPY  N/A

50. SENSATION IMPAIRED <input type="checkbox"/> YES <input type="checkbox"/> NO	51. RESTRICT ACTIVITY <input type="checkbox"/> YES <input type="checkbox"/> NO	52. PRECAUTIONS <input type="checkbox"/> CARDIAC <input type="checkbox"/> OTHER (Type other, specify)	53. FREQUENCY OF TREATMENT
54. TREATMENT GOALS: <input type="checkbox"/> ACTIVE <input type="checkbox"/> COORDINATING ACTIVITIES <input type="checkbox"/> FULL WEIGHT BEARING <input type="checkbox"/> WHEELCHAIR INDEPENDENT <input type="checkbox"/> STRETCHING <input type="checkbox"/> ACTIVE ASSISTIVE <input type="checkbox"/> NON-WEIGHT BEARING <input type="checkbox"/> PROGRESS BED TO WHEELCHAIR <input type="checkbox"/> COMPLETE AMBULATION <input type="checkbox"/> PASSIVE ROM <input type="checkbox"/> PROGRESSIVE RESISTIVE <input type="checkbox"/> PARTIAL WEIGHT BEARING <input type="checkbox"/> RECOVERY TO FULL FUNCTION			
55. ADDITIONAL THERAPIES <input type="checkbox"/> O.T. <input type="checkbox"/> SPEECH <input type="checkbox"/> DIETARY	56. SIGNATURE OF AND TITLE OF THERAPIST OR PHYSICIAN/APRN/PA	Note: After signing, all fields under Physical Therapy will become locked and read only.	57. DATE (MM/DD/YYYY)

**PART IV - SOCIAL WORK ASSESSMENT** (To be completed by SVH Social Worker (SW) or Physician/APRN/PA)

58. PRIOR LIVING ARRANGEMENTS	59. LONG RANGE PLAN
60. ADJUSTMENT TO ILLNESS OR DISABILITY, LIVING ENVIRONMENT AND MAKE COMPETENT DECISIONS	61. PRINT NAME OF SW OR PHYSICIAN/APRN/PA
62. SIGNATURE OF SW OR PHYSICIAN/APRN/PA	Note: After signing, all fields in Part 4 will become locked and read only.
64. REMARKS (Attach additional sheets if necessary)	63. DATE (MM/DD/YYYY)

**MENTAL HEALTH EVALUATION**

*Completed by: Medical Physician, RN,  
or Social Worker*

**NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

1. DIAGNOSIS

\_\_\_\_\_

2. SENSORY/COMMUNICATION

\_\_\_\_\_ Hearing Impaired      \_\_\_\_\_ Cannot Communicate, Describe: \_\_\_\_\_  
\_\_\_\_\_ Vision Impaired      \_\_\_\_\_ Requires Assistance to Communicate, Describe: \_\_\_\_\_  
\_\_\_\_\_ Mute      \_\_\_\_\_ No Communication Issues

3. BEHAVIOR ADJUSTMENT (Check all that Apply)

\_\_\_\_\_ Anxious      \_\_\_\_\_ Disoriented (Person, Time, Situation)  
\_\_\_\_\_ Confused      \_\_\_\_\_ Combative, Describe: \_\_\_\_\_  
\_\_\_\_\_ Delusional      \_\_\_\_\_ Agitated, Describe: \_\_\_\_\_  
\_\_\_\_\_ Hallucinates      \_\_\_\_\_ Self-Abusive, Describe: \_\_\_\_\_  
\_\_\_\_\_ Wanders      \_\_\_\_\_ Seizures  
\_\_\_\_\_ Depressed      \_\_\_\_\_ None of the Above

4. PSYCHOTROPIC, ANTI-DEPRESSANT & ANTI-ANXIETY MEDICATIONS (Identify medication name and the corresponding diagnosis for the medication):

\_\_\_\_\_

5. SUSPECTED MENTAL ILLNESS (Please check all that apply):

\_\_\_\_\_ Schizophrenia      \_\_\_\_\_ Somatoform Disorder      \_\_\_\_\_ Mood Disorder  
\_\_\_\_\_ Personality Disorder      \_\_\_\_\_ Paranoid Disorder      \_\_\_\_\_ Other Psychotic Disorder  
\_\_\_\_\_ Panic Disorder      \_\_\_\_\_ Other Severe Anxiety Disorder      \_\_\_\_\_ Unspecified Mental Disorder that may lead to Chronic disability

A. LEVEL OF IMPAIRMENT DUE TO THE ABOVE SUSPECTED MENTAL ILLNESS

Does the above noted disorder result in functional limitations in major life activities within the past 3-6 months with:

- 1. Difficulty in interpersonal functioning? Yes \_\_\_\_\_ No \_\_\_\_\_
- 2. Serious difficulty in concentration, persistence, and pace? Yes \_\_\_\_\_ No \_\_\_\_\_
- 3. Serious adaptation to change? Yes \_\_\_\_\_ No \_\_\_\_\_

B. DURATION OF ABOVE NOTED ILLNESS:

Has the individual had:

- 1. Psychiatric treatment more intensive than outpatient care to include Senior Care Unit? Yes \_\_\_\_\_ No \_\_\_\_\_

If "Yes," Give name of the facility \_\_\_\_\_

- 2. Within the last 5 years, due to the mental disorder, experienced an episode of significant disruption to the normal living situation? Yes \_\_\_\_\_ No \_\_\_\_\_ If "Yes," please describe: \_\_\_\_\_

\_\_\_\_\_

6. DANGEROUSNESS

Is the individual combative? Yes \_\_\_\_\_ No \_\_\_\_\_ If "Yes," describe \_\_\_\_\_

Is the individual suicidal? Yes \_\_\_\_\_ No \_\_\_\_\_ If "Yes," describe \_\_\_\_\_

7. CERTIFICATION

I certify that the above information is correct to the best of my knowledge.

\_\_\_\_\_  
Physician, RN, or Social Worker's Signature

\_\_\_\_\_  
Date

Phone: \_\_\_\_\_

# Alabama State Veterans Home



Complete **ONLY** if Applying for Domiciliary Care at  
Colonel Robert L. Howard State Veterans Home,  
Pell City, Alabama

To Be Completed by Physician

## Medical Statement for Domiciliary Care

\_\_\_\_\_  
Veteran's Name

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date of Birth

Veteran is found to be able to make rational and competent decisions as to his/her desire to remain or leave the facility.

Additionally, the Veteran is found to be unemployable due to a disability, disease, or defect of such a degree that incapacitates the Veteran from earning a living.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

# Alabama State Veterans Home



**TO BE COMPLETED BY: Veteran or Sponsor**

## Authorization for Release of Medical Information

(Applicant/Sponsor complete Part A only)

A. I hereby authorize the \_\_\_\_\_

to release medical records or other information regarding my treatment, hospitalization, and/or outpatient care to Alabama Department of Veterans Affairs for the purpose of assessing medical needs related to potential admission. I understand that this authorization may be revoked at any time at my request.

Please check the Veterans Home requesting information:

Bill Nichols  
1784 Elkahatchee Road  
Alexander City, AL 35010

William F. Green  
300 Faulkner Drive  
Bay Minette, AL 36507

Floyd E. "Tut" Fann  
2701 Meridian Street  
Huntsville, AL 35811

Col. Robert L. Howard  
7054 Veterans Parkway  
Pell City, AL 35125

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Patient/Sponsor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

B. FOR FACILITY USE ONLY

RE:

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
VA Claim Number

Dear Correspondence Secretary:

The above named patient is currently being treated or has made application for admission to one of the Alabama State Veterans Home and gives a history of having been a patient at your facility. In order to provide optimal care, the patient or applicant authorizes that his/her medical records be released to our office. Please forward a copy of:

Complete Medical Records: \_\_\_\_\_ Medical X-Rays: \_\_\_\_\_

Discharge Summary: \_\_\_\_\_ Dates: \_\_\_\_\_

**ALABAMA DEPARTMENT OF VETERANS AFFAIRS  
DECLARATION OF CITIZENSHIP  
OR ALIEN STATUS FOR ADMISSION TO THE  
ALABAMA STATE VETERANS HOMES PROGRAM**

Alabama Act No. 2011-535, as amended by Alabama Act No. 2012-491, requires government agencies to verify the lawful presence in the United States of all applicants for a state or local public benefit before issuing any benefits. Any applicant applying for admission to any Alabama veterans' home, a state public benefit codified in Ala. Code §§ 31- 5A-1 *et seq.*, must complete this form before the Alabama Department of Veterans' Affairs can issue any benefits. If an applicant is unable to complete the form, his/her sponsor may complete and sign this form on behalf of the applicant.

**Directions: This form must be completed by ALL applicants for admission to any Alabama state veterans' home. All applicants must complete Sections I, II, and IV of this form. Applicants who indicate that they are not United States citizens or nationals must also complete Section III. Submit this completed form with any required documentation with your application for admission to the Alabama state veterans' home.**

**SECTION I - APPLICANT INFORMATION**

Name (Print or type):

\_\_\_\_\_  
(Last) (First) (M.I.)

Current Address: \_\_\_\_\_  
\_\_\_\_\_

County of Current Residence: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ (MM/DD/YYYY)

**SECTION II - CITIZENSHIP OR NATIONAL STATUS DECLARATION**

Are you a citizen or national of the United States? (check one) Yes No

If you checked **YES**, complete Section IV (No additional documentation required.)

If you checked **NO**, complete Sections III and IV.

**SECTION III - ALIEN STATUS**

Are you an alien lawfully present in the United States? (check one) Yes No

If you checked **YES**, attach a legible copy of a document from the attached list or other document as evidence of your status. Name of document attached: \_\_\_\_\_  
Complete Section IV.

If you checked **NO**, complete Section IV.

**SECTION IV - DECLARATION**

I declare under penalty of perjury under the laws of the State of Alabama that the answers and evidence I provided are true and correct to the best of my knowledge. I understand that this public benefit is granted pending verification of my lawful presence in the United States. I further understand that if at any time it is determined that I am not lawfully present in the United States, the ADVA will deny this benefit or will terminate this benefit, will remove me from the veterans' home, and will seek repayment of any benefit awarded on my behalf.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Sponsor's Signature (only if applicant is unable to sign)

\_\_\_\_\_  
Date

\_\_\_\_\_  
ADVA Employee Receiving Form (Print)\*  
(\* Tracking purposes only.

\_\_\_\_\_  
Date



## DOCUMENTS INDICATING QUALIFIED ALIEN STATUS

Evidence of "Qualified Alien" status includes the following:

### Alien Lawfully Admitted for Permanent Residence

- Form I-551 (Alien Registration Receipt Card, commonly known as a "green card"); or
- Unexpired Temporary I-551 stamp in foreign passport or on \* I Form-94

### Asylee

- Form I-94 annotated with stamp showing grant of asylum under section 208 of the INA;
- Form I-688B (Employment Authorization Card) annotated "274a. 12(a) (5)", or
- Form I-766 (Employment Authorization Document) annotated "A5";
- Grant letter from the Asylum Office of the U.S. Citizenship and Immigration Service; or
- Order of an immigration judge granting asylum.

### Refugee

- Form I-94 annotated with stamp showing admission under §207 of the INA;
- Form I-688B (Employment Authorization Card) annotated "274a. 12(a) (3)"; or
- Form I-766 (Employment Authorization Document) annotated "A3"

### Alien Paroled Into the U.S. for at Least One Year

- Form I-94 with stamp showing admission for at least one year under section 212 (d) (5) of the INA. (Applicant cannot aggregate periods of admission for less than one year to meet the one year requirement.)

### Alien Whose Deportation or Removal Was Withheld

- Form I-688B (Employment Authorization Card) annotated "274a. 12(a) (10);
- Form I-766 (Employment Authorization Document) annotated "A10"; or
- Order from an immigration judge showing deportation withheld under §243(h) of the INA as in effect prior to April 1, 1997, or removal withheld under §241 (b) (3) of the INA.

### Alien Granted Conditional Entry

- Form I-94 with stamp showing admission under §203(a)(7) of the INA;
- Form I-688B (Employment Authorization Card) annotated "274a. 12(a) (3)"; or
- Form I-766 Form I-766 (Employment Authorization Document) annotated "A3"

### Cuban/Haitian Entrant

- Form I-551 (Alien Registration Receipt Card, commonly known as a "green card") with the code CU6, CU7, or CH6;
- Unexpired temporary I-551 stamp in foreign passport or on \* Form I-94 with the code CU6 or CU7; or
- Form I-94 with stamp showing parole as "Cuba/Haitian Entrant "under Section 212(d) (5) of the INA.

### Alien Who Has Been Declared a Battered Alien Subjected to Extreme Cruelty

- U.S. Citizenship and Immigration Service petition and supporting documentation