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 by mail or email 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:

Bill Nichols State Veterans Home
1784 Elkahatchee Road
Alexander city, AL 35010
(256) 329-3311
Nicholssvh.application@va.alabama.gov

William F. Green State Veterans Home
300 Faulkner Drive
Bay Minette, AL 36507
(251) 937-8049
Greensvh.application@va.alabama.gov

Floyd E. "Tut" Fann State Veterans Home
2701 Meridian Street
Huntsville, AL 35811
(256) 851-2807
Fannsvh.application@va.alabama.gov

Col R. L. Howard State Veterans Home
7054 Veterans Parkway
Pell City, AL 35125
(205) 338-6487
Howardsvh.application@va.alabama.gov

CSM Bennie G. Adkins State Veterans Home
552 Veterans Parkway
Enterprise, AL 36330
(334) 470-2443
Adkinssvh.application@va.alabama.gov

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
- 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)
- 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. Bedhold charges apply to all Residents residing in the 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. The Veterans Home must be fully recognized by the Federal VA before Federal per diem is paid
   If applicable, per diem will be paid for certain veterans based on service-connected disabilities and who reside in a skilled care nursing bed. 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.

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.

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 bed hold charged to residents. The facility must be at 90% occupancy before this applies. **The veteran is responsible for bed hold 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.

Description	To be completed by
☐ Personal Admission Information	Veteran or Sponsor
☐ Information on Legal Residency	Veteran or Sponsor
☐ VA Form 10-10EZ Application for Medical Benefits	Veteran or Sponsor
☐ VA Form 10-10SH Medical Certification	Medical Physician
☐ Mental Health Evaluation	Medical Physician, RN, or Social Worker
☐ Medical Statement for Domiciliary Care (If applicable)	Medical Physician
☐ ADVA Declaration of Citizenship or Alien Status	Veteran or Sponsor
☐ 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: Driver's 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.

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

CSM Bennie G. Adkins 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 ☐ NURSINGHOME ☐ OTHER FACILITY ☐

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

   _____

   _____
6. NAME OF SPOUSE/RESPONSIBLE PARTY: _____

   IF OTHERTHAN SPOUSE, RELATION TO VETERAN: _____

   ADDRESS: _____

   HOMEPHONE: _____ CELLPHONE: _____ WORK PHONE: _____

   EMAIL Address: _____
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) preceeding 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 criminial 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 continous 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.

OMB Control No. 2900-0091
Estimated Burden Avg. 35 min.
Expiration Date: 07/31/2027

Department of Veterans Affairs

APPLICATION FOR HEALTH BENEFITS

VA DATE STAMP
(For VHA Use Only)

SECTION I - GENERAL INFORMATION

Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)

TYPE OF BENEFIT(S) APPLYING FOR:

- ☐ **ENROLLMENT** - VA Medical Benefits Package (Veteran meets and agrees to the enrollment eligibility criteria specified at 38 CFR 17.36)
- ☐ **REGISTRATION** ***(Complete Sections I, II, and III)*** - VA Health Services (Veterans meets the "Enrollment not required" eligibility criteria specified at 38 CFR 17.37)

1A. VETERAN'S NAME *(Last, First, Middle Name)*	1B. PREFERRED NAME	2. MOTHER'S MAIDEN NAME

3A. BIRTH SEX	3B. SELF-IDENTIFIED GENDER IDENTITY	4. ARE YOU HISPANIC OR LATINO?
☐ MALE ☐ FEMALE	☐ MAN ☐ WOMAN ☐ TRANSGENDER MAN ☐ TRANSGENDER WOMAN ☐ NON-BINARY ☐ PREFER NOT TO ANSWER ☐ A GENDER NOT LISTED HERE	☐ YES ☐ NO

5. WHAT IS YOUR RACE? *(You may check more than one. Information is required for statistical purposes only.)*	6. SOCIAL SECURITY NO.
☐ ASIAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ WHITE ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ CHOOSE NOT TO ANSWER	

7A. DATE OF BIRTH *(mm/dd/yyyy)*	7B. PLACE OF BIRTH *(City and State)*	8. PREFERRED LANGUAGE	9. RELIGION

10A. MAILING ADDRESS *(Street)*	10B. CITY	10C. STATE	10D. ZIP CODE	10E.COUNTY

10F. HOME TELEPHONE NO. *(optional)* *(Include Area Code)*	10G. MOBILE TELEPHONE NO. *(optional)* *(Include Area Code)*	10H. E-MAIL ADDRESS *(optional)*

11A. HOME ADDRESS *(Street)*	11B. CITY	11C. STATE	11D. ZIP CODE	11E.COUNTY

12. CURRENT MARITAL STATUS

☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED

13A. NEXT OF KIN NAME	13B. NEXT OF KIN ADDRESS	13C. NEXT OF KIN RELATIONSHIP

13D. NEXT OF KIN TELEPHONE NO. *(Include Area Code)*	14A. EMERGENCY CONTACT NAME	14B. EMERGENCY CONTACT TELEPHONE NO. *(Include Area Code)*

15. DESIGNEE - INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH (*Note: This does not constitute a will or transfer of title*)

16. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? *(for listing of facilities visit www.va.gov/find-locations)*	17. WOULD YOU LIKE FOR VA TO CONTACT YOU TO SCHEDULE YOUR FIRST APPOINTMENT? ☐ YES ☐ NO

SECTION II - MILITARY SERVICE INFORMATION

1A. LAST BRANCH OF SERVICE	1B. LAST ENTRY DATE *(mm/dd/yyyy)*	1C. FUTURE DISCHARGE DATE *(mm/dd/yyyy)*	1D. LAST DISCHARGE DATE *(mm/dd/yyyy)*

1E. DISCHARGE TYPE	1F. MILITARY SERVICE NUMBER

2. MILITARY HISTORY *(Check yes or no)*	YES	NO		YES	NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?	☐	☐	D. WERE YOU DISCHARGED OR RETIRED FROM MILITARY FOR A DISABILITY INCURRED IN THE LINE OF DUTY?	☐	☐
B. ARE YOU A FORMER PRISONER OF WAR?	☐	☐	E. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998?	☐	☐
C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?	☐	☐	F. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	☐	☐

APPLICATION FOR HEALTH BENEFITS *Continued*	VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

SECTION II - MILITARY SERVICE INFORMATION *(Continued)*

3. MILITARY EXPOSURE INFORMATION *(Check yes or no)*	YES	NO
A. DID YOU SERVE IN AN IONIZING RADIATION LOCATION AND PARTICIPATE IN ANY NUCLEAR TESTING, TREATMENTS, OR CLEAN UP? (*Hiroshima and Nagasaki cleanup or Enewetak Atoll, cleanup of Air Force B-52 bomber carrying nuclear weapons off the coast of Palomares, Spain, response to the fire onboard an Air Force B-52 bomber carrying nuclear weapons near Thule Air Force Base in Greenland.)*	☐	☐
B. DID YOU SERVE IN ANY OF THE FOLLOWING GULF WAR HAZARD LOCATIONS? *(Iraq, Kuwait, Saudi Arabia, the neutral zone between Iraq and Saudi Arabia, Bahrain, Qatar, the United Arab Emirates, Oman, Yemen, Lebanon, Somalia, Afghanistan, Israel, Egypt, Turkey, Syria, Jordan, Djibouti, Uzbekistan, the Gulf of Aden, the Gulf of Oman, the Persian Gulf, the Arabian Sea, and the Red Sea.)* WHEN DID YOU SERVE IN THESE LOCATIONS? ***NOTE:*** *Please provide an approximate time-frame (mm/yyyy)* FROM: _____ TO: _____	☐	☐
C. WERE YOU DEPLOYED IN SUPPORT OF ANY OF THE FOLLOWING OPERATIONS? *(Enduring Freedom, Freedom's Sentinel, Iraqi Freedom, New Dawn, Inherent Resolve, and Resolute Support Mission)*	☐	☐

	YES	NO
D. DID YOU SERVE IN ANY OF THE FOLLOWING HERBICIDE *(e.g. Agent Orange)* LOCATIONS? *(Republic of Vietnam to include 12 nautical mile territorial waters; Thailand at any United States or Royal Thai base; Laos; Cambodia at Mimot or Krek; Kampong Cham Province; Guam or American Samoa; or in the territorial waters thereof; Johnston Atoll or a ship that called at Johnston Atoll; Korean demilitarized zone; aboard (to include repeated operations and maintenance with) a c-123 aircraft known to have been used to spray an herbicide agent (during service in the Air Force and Air Force Reserves.)* WHEN DID YOU SERVE IN THESE LOCATIONS? ***NOTE:*** *Please provide an approximate time-frame (mm/yyyy)* FROM: TO:	☐	☐

E. HAVE YOU BEEN EXPOSED TO ANY OF THE FOLLOWING? *(Check all that apply)*
Veterans can locate additional military exposure categories on VA's Public Health website at: https://www.publichealth.va.gov/exposures/

- ☐ AIR POLLUTANTS *(burn pits, sand, oil well/sulfur fires)*
- ☐ CHEMICALS *(pesticides, herbicides, contaminated water)*
- ☐ CONTAMINATED WATER AT CAMP LEJEUNE
- ☐ RADIATION ☐ SHAD *(Shipboard Hazard and Defense)*
- ☐ OCCUPATIONAL HAZARDS *(jet fuel, industrial solvents, lead, firefighting foams)*
- ☐ ASBESTOS ☐ MUSTARD GAS
- ☐ WARFARE AGENTS *(nerve agents, chemical and biological weapons)*
- ☐ OTHER *(Specify)*:

WHEN WERE YOU EXPOSED?
NOTE: *Please provide an approximate time-frame (mm/yyyy)*
FROM: TO:

SECTION III - INSURANCE INFORMATION *(Use a separate sheet for additional information)*

1. ENTER YOUR HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER *(include coverage through spouse or other person)*

2. NAME OF POLICY HOLDER	3. POLICY NUMBER	4. GROUP CODE

5. ARE YOU ELIGIBLE FOR MEDICAID? *(Federal health insurance for low income adults)*	6A. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A?	6B. EFFECTIVE DATE *(mm/dd/yyyy)*	6C. MEDICARE NUMBER:
☐ YES ☐ NO	☐ YES ☐ NO		

SECTION IV - DEPENDENT INFORMATION *(Use a separate sheet for additional dependents)*

1. SPOUSE'S NAME *(Last, First, Middle Name)*	2. CHILD'S NAME *(Last, First, Middle Name)*
1A. SPOUSE'S SOCIAL SECURITY NUMBER	2A. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)* / 2B. CHILD'S SOCIAL SECURITY NO.
1B. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)*	2C. DATE CHILD BECAME YOUR DEPENDENT *(mm/dd/yyyy)*

1C. SPOUSE'S SELF-IDENTIFIED GENDER IDENTITY
- ☐ MAN ☐ WOMAN ☐ TRANSGENDER MAN
- ☐ TRANSGENDER WOMAN ☐ NON-BINARY
- ☐ PREFER NOT TO ANSWER ☐ A GENDER NOT LISTED HERE

1D. DATE OF MARRIAGE *(mm/dd/yyyy)*

1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP if different from Veteran's)*

3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT?
☐ YES ☐ NO

2D. CHILD'S RELATIONSHIP TO YOU *(Check one)*
☐ SON ☐ DAUGHTER ☐ STEPSON ☐ STEPDAUGHTER

2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18?
☐ YES ☐ NO

2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR?
☐ YES ☐ NO

2G. EXPENSES PAID BY YOUR DEPENDENT CHILD WITH REPORTABLE INCOME FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(e.g., tuition, books, materials)*

APPLICATION FOR HEALTH BENEFITS *Continued*	VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

SECTION V - EMPLOYMENT INFORMATION

1A. VETERAN'S EMPLOYMENT STATUS *(Check one)*.

☐ FULL TIME ☐ PART TIME ☐ NOT EMPLOYED ☐ RETIRED

1B. DATE OF RETIREMENT *(mm/dd/yyyy)*

1C. COMPANY NAME. *(Complete if employed or retired)*	1D. COMPANY ADDRESS *(Complete if employed or retired - Street, City, State, ZIP)*	1E. COMPANY PHONE NUMBER *(Complete if employed or retired) (Include area code)*

SECTION VI - FINANCIAL DISCLOSURE

Disclosure allows VA to accurately determine whether certain Veterans will be charged copays for care and medications, their eligibility for other services and enrollment priority. Veterans are not required to disclose their financial information. Veterans who choose not to disclose financial information may not be eligible for enrollment or may be responsible for any applicable VA copayments, if they are enrolled. **Recent Combat Veterans (e.g., OEF/OIF/OND)** may answer YES in Section VI and complete Sections VII and VIII to have their priority for enrollment and financial eligibility for travel assistance, cost-free medications and/or medical care for services unrelated to military experience.

☐ **No, I do not wish to provide financial information in Sections VII through VIII.** If I am enrolled, I agree to pay applicable VA copayments. Sign and date the form in the Assignment of Benefits section.

☐ **Yes, I will provide my household financial information for last calendar year.** Complete applicable Sections VII and VIII. Sign and date the form in the Assignment of Benefits section.

SECTION VII - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN

(Use a separate sheet for additional dependents)

	VETERAN	SPOUSE	CHILD 1
1. GROSS ANNUAL INCOME FROM EMPLOYMENT *(wages, bonuses, tips, etc.)* EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
3. LIST OTHER INCOME AMOUNTS *(e.g., Social Security, compensation, pension, interest, dividends)* EXCLUDING WELFARE.	$	$	$

SECTION VIII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE *(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home) VA will calculate a deductible and the net medical expenses you may claim.*	$
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES (INCLUDING PREPAID BURIAL EXPENSES) FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD *(Also enter spouse or child's information in Section VI.)*	$
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES *(e.g., tuition, books, fees, materials) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.*	$

SECTION IX - CONSENT TO COPAYS AND TO RECEIVE COMMUNICATIONS

By submitting this application, you are agreeing to pay the applicable VA copayments for care or services (including urgent care) as required by law. You also agree to receive communications from VA to your supplied email, home phone number, or mobile number. However, providing your email, home phone number, or mobile number is voluntary.

ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section 1729 and 42 U.S.C. 2651, the Department of Veterans Affairs (VA) is authorized to recover or collect from my health plan (HP) or any other legally responsible third party for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse. Furthermore, I hereby assign to the VA any claim I may have against any person or entity who is or may be legally responsible for the payment of the cost of medical services provided to me by the VA. I understand that this assignment shall not limit or prejudice my right to recover for my own benefit any amount in excess of the cost of medical services provided to me by the VA or any other amount to which I may be entitled. I hereby appoint the Attorney General of the United States and the Secretary of Veterans' Affairs and their designees as my Attorneys-in-fact to take all necessary and appropriate actions in order to recover and receive all or part of the amount herein assigned. I hereby authorize the VA to disclose, to my attorney and to any third party or administrative agency who may be responsible for payment of the cost of medical services provided to me, information from my medical records as necessary to verify my claim. Further, I hereby authorize any such third party or administrative agency to disclose to the VA any information regarding my claim.

ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS WHICH DEFINE WHO CAN SIGN ON BEHALF OF THE VETERAN.

SIGNATURE OF APPLICANT *(Sign in ink)* _____

DATE *(mm/dd/yyyy)* _____

OMB Control No: 2900-0160
Estimated Burden: 20 minutes
Expiration Date: 10-31-2026

Department of Veterans Affairs

STATE HOME PROGRAM APPLICATION FOR VETERAN CARE MEDICAL CERTIFICATION

PART I - ADMINISTRATIVE

1. STATE HOME FACILITY	2. DATE ADMITTED *(MM/DD/YYYY)*

3. STATE HOME FACILITY ADDRESS *(Street, City, State and Zip Code)*

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

5. SOCIAL SECURITY NUMBER	6. GENDER	7. AGE	8. DATE OF BIRTH *(MM/DD/YYYY)*	9. ADVANCED MEDICAL DIRECTIVE
	☐ M ☐ F			☐ NO ☐ YES

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

18. NECK	19. CARDIOPULMONARY
20. ABDOMEN	21. GENITOURINARY
22. RECTAL	23. EXTREMITIES
24. NEUROLOGICAL	25. ALLERGY/DRUG SENSITIVITY

26. X-RAY/ LAB								
	CHEST X-RAY	DATE *(MM/DD/YYYY)*	RESULT	☐ N/A	CBC	DATE *(MM/DD/YYYY)*	RESULT	☐ N/A
	SEROLOGY							☐ N/A
	URINALYSIS	DATE *(MM/DD/YYYY)*	ALBUMIN		ACETONE		SUGAR	☐ N/A

CHECK ALL BOXES THAT APPLY OR CHECK N/A

27. IS DEMENTIA THE PRIMARY DIAGNOSIS	28. IS THERE A DIAGNOSIS OF MENTAL ILLNESS	29. HAS RESIDENT RECEIVED MENTAL HEALTH SERVICES WITHIN THE PAST 2 YEARS	30. IS CLIENT A DANGER TO SELF OR OTHERS
☐ YES ☐ NO ☐ N/A	☐ YES ☐ NO ☐ N/A	☐ YES ☐ NO ☐ N/A	☐ YES ☐ NO ☐ N/A

31. IS THERE ANY PRESSING EVIDENCE OF MENTAL ILLNESS SUCH AS:

☐ SCHIZOPHRENIA ☐ PARANOIA ☐ OTHER PSYCHOTIC OR MENTAL DISORDERS LEADING TO CHRONIC DISABILITY
☐ MOOD SWINGS ☐ SOMATOFORM DISORDER ☐ PANIC OR SEVERE ANXIETY DISORDER ☐ PERSONALITY DISORDER ☐ N/A

32. OXYGEN	33. FEEDING	34. WOUND	35. FOLEY CATHETER
☐ MASK ☐ PRN ☐ CONTINUOUS ☐ NASAL CANNULA ☐ N/A	☐ TUBE FEEDING ☐ OSTOMY ☐ TRACHEOSTOMY ☐ N/A	☐ DECUBITUS ULCERS ☐ DRAINING WOUND ☐ WOUND CULTURED ☐ N/A	☐ TEMPORARY ☐ PERMANENT ☐ N/A

36. REFERRING PHYSICIAN	37. PRIMARY DIAGNOSIS
38. SECONDARY DIAGNOSIS	39. TERTIARY DIAGNOSIS

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.

Department of Veterans Affairs

STATE HOME PROGRAM APPLICATION FOR VETERAN CARE MEDICAL CERTIFICATION

PART III - EVALUATION *(Select an appropriate number in each category)*

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

46. SOCIAL SECURITY NUMBER

COMMUNICATION	☐ 1. Transmits messages/receives information ☐ 2. Limited ability ☐ 3. Nearly or totally unable	**SPEECH**	☐ 1. Speaks clearly with others of same language ☐ 2. Limited ability ☐ 3. Unable to speak clearly or not at all
HEARING	☐ 1. Good ☐ 2. Hearing slightly impaired ☐ 3. Nearly or totally unable ☐ 4. Virtually/completely deaf	**SIGHT**	☐ 1. Good ☐ 2. Vision adequate - Unable to read/see details ☐ 3. Vision limited - Gross object differentiation ☐ 4. Blind
TRANSFER	☐ 1. No assistance ☐ 2. Equipment only ☐ 3. Supervision only ☐ 4. Requires human transfer w/wo equipment ☐ 5. Bedfast	**AMBULATION**	☐ 1. Independence w/wo assistive device ☐ 2. Walks with supervision ☐ 3. Walks with continuous human support ☐ 4. Bed to chair (total help) ☐ 5. Bedfast
ENDURANCE	☐ 1. Tolerates distances (250 feet sustained activity) ☐ 2. Needs intermittent rest ☐ 3. Rarely tolerates short activities ☐ 4. No tolerance	**MENTAL AND BEHAVIOR STATUS**	☐ 1. Alert ☐ A. Agreeable ☐ 2. Confused ☐ B. Disruptive ☐ 3. Disoriented ☐ C. Apathetic ☐ 4. Comatose ☐ D. Well motivated
TOILETING	☐ 1. No assistance ☐ 2. Assistance to and from transfer ☐ A. Bathroom ☐ 3. Total assistance including personal hygiene, help with clothes ☐ B. Bedside commode ☐ C. Bedpan	**BATHING**	☐ 1. No assistance ☐ A. Tub ☐ 2. Supervision Only ☐ B. Shower ☐ 3. Assistance ☐ C. Sponge bath ☐ 4. Is bathed
DRESSING	☐ 1. Dresses self ☐ 2. Minor assistance ☐ 3. Needs help to complete dressing ☐ 4. Has to be dressed	**FEEDING**	☐ 1. No assistance ☐ 2. Minor assistance, needs tray set up only ☐ 3. Help feeding/encouraging ☐ 4. Is fed
BLADDER CONTROL	☐ 1. Continent ☐ 2. Rarely incontinent ☐ 3. Occasional - once/week or less ☐ 4. Frequent - up to once a day ☐ 5. Total incontinence ☐ 6. Catheter, indwelling	**BOWEL CONTROL**	☐ 1. Continent ☐ 2. Rarely incontinent ☐ 3. Occasional - once/week or less ☐ 4. Frequent - up to once a day ☐ 5. Total incontinence ☐ 6. Ostomy
SKIN CONDITION	☐ 1. Intact ☐ 2. Dry/Fragile ☐ 3. Irritations (Rash) ☐ 4. Open wound ☐ 5. Decubitus Number _____ Stage _____ **NOTE:** Number & Stage fields will become available only when #2 through 5 are selected.	**WHEEL CHAIR USE**	☐ 1. Independence ☐ 2. Assistance in difficult maneuvering ☐ 3. Wheels a few feet ☐ 4. Unable to use ☐ 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	51. RESTRICT ACTIVITY	52. PRECAUTIONS	53. FREQUENCY OF TREATMENT
☐ YES ☐ NO	☐ YES ☐ NO	☐ CARDIAC ☐ OTHER *(Type other, specify)*	

54. TREATMENT GOALS:

☐ ACTIVE	☐ COORDINATING ACTIVITIES	☐ FULL WEIGHT BEARING	☐ WHEELCHAIR INDEPENDENT
☐ STRETCHING	☐ ACTIVE ASSISTIVE	☐ NON-WEIGHT BEARING	☐ PROGRESS BED TO WHEELCHAIR	☐ COMPLETE AMBULATION
☐ PASSIVE ROM	☐ PROGRESSIVE RESISTIVE	☐ PARTIAL WEIGHT BEARING	☐ RECOVERY TO FULL FUNCTION	

55. ADDITIONAL THERAPIES ☐ O.T. ☐ SPEECH ☐ 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.

63. DATE *(MM/DD/YYYY)*

64. REMARKS *(Attach additional sheets if necessary)*

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

☐ CSM Bennie G. Adkins
552 Veterans Parkway
Enterprise, AL 36330

_____ _____
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

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)* Date

(*) Tracking purposes only.

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) (50", 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