



# STATE OF CONNECTICUT

DEPARTMENT OF VETERANS AFFAIRS

287 West Street  
Rocky Hill, Connecticut 06067



Dear Veteran,

Thank you for your interest in seeking admission to the Connecticut Department of Veterans' Affairs. Enclosed is an admission application for the Health Care Center (HCC) and the Residential Facility (RF).

## **Guidelines for Submitting an Application**

In order to process the application, each of the following requirements must be met:

1. Enclose a copy(s) of your DD FORM 214 – Certificate of Release or Discharge from Active Duty, which lists your place of entry and place of discharge, date of entry and discharge, record of service, time lost, and character of service. **If you served more than one period please submit a copy of each DD214 you have received.** A DD214 must be furnished to us even if you have been here in the past. If you do not have a DD Form 214 – follow instructions on the enclosed Standard Form 180 (SF180) and mail it to the designated area listed.
2. Proof of Connecticut (CT) Residency – General Statutes of Connecticut Revised January 1, 2009, Volume 9, Section 27– Armed Forces and Veterans, General Provisions Section 27-103(b) states “veteran” means any veteran who served in time of war, as defined in subsection (a) of this section, and who is a resident of this state, provided, if he was not a resident or resident alien of this state at the time of enlistment or induction into the armed forces, he shall have resided continuously in this state for at least two years.
3. Enclose a copy of your Health Insurance Card(s) – VA CT Healthcare System card (Newington or West Haven Campus), Medicare, Medicaid Title XIX card and/or other health insurance cards you have.
4. Physician to complete the enclosed Medical Certificate on Pg. 11 & 12.
5. Complete and sign the application along with the following forms:
  - Release of Information Form
  - Billing Information Form
  - Income Assets Questionnaire

Omissions, false information, or lack of sufficient detail, will result in the delay or denial of the processing of your application.

6. Your application will be delayed until this information is received. Please make an appointment with your Primary Care Provider at VA CT Healthcare System (Newington or West Haven Campus) to obtain the following information:
  - a. Name of Primary Care Provider at VA CT Healthcare System
  - b. A current PPD or chest x-ray, and lab report
  - c. A current psychiatric and substance abuse assessment
  - d. A current medical assessment and list of medications

EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

## **Guidelines for Submitting an Application (continued)**

7. Enclose a copy of the Probate Court document – if a Conservator and/or Power of Attorney has been appointed for you.
8. Enclose a copy of a Living Will if you have one, enclose a copy of your assigned Health Care Agent and/or a Durable Power of Attorney document(s) if applicable.
9. Enclose a copy of any Legal Dispositions - Recent court cases or current terms/conditions of Probation/Parole.
10. Meet criteria for admission outlined on page 3.

Please be advised that a date for admission will not be considered until all documents are submitted and the application is reviewed and approved.

### **For Health Care Center**

Questions concerning the application or application process for Long Term or Respite Care in the Health Care Center, contact the HCC Admissions Office (860) 616-3705

Fax application to:  
(860) 616-3545

Mail application to:  
HCC Admissions Coordinator  
Department of Veterans' Affairs  
287 West Street  
Rocky Hill, CT 06067

### **For Residential Facility**

Questions concerning the application or application process for the Domicile in the Residential Facility, contact the RF Admissions Office (860) 616-3802

Fax application to:  
(860) 616-3556

Mail application to:  
RF Admissions Coordinator  
Department of Veterans' Affairs  
287 West Street  
Bldg. 3, Rm. 104  
Rocky Hill, CT 06067

## **ADMISSIONS CRITERIA**

### THE FOLLOWING GENERAL STATEMENTS APPLY:

1. Submit completed application.
2. A veteran must have received an honorable discharge or general under honorable discharge from the Armed Forces of the United States. Veterans with a dishonorable discharge are not eligible for admission.
3. A veteran must meet all other legal requirements as outlined in the Connecticut statutes.
4. (For Residential Facility - RF) – the veteran must be able to ambulate without assistance; require no nursing or attendant care, must be able to take own medication; dress without assistance; make own bed and participate in an assigned therapeutic activity.  
(For Health Care Center - HCC) – the veteran must require 24 hour medical nursing care.
5. For admission to the RF or HCC – A medical certificate is enclosed for the veteran’s Primary Care Provider to complete.
6. In addition to the completed application, a veteran may be required to complete a medical, psychiatric, or substance abuse prescreen by our clinicians before a final determination for admission can be made.
7. Each veteran will be charged for care provided. Ability to pay for care is determined by the Department of Veterans’ Affairs Regulations. See page 19.
8. Any applicant who meets the above eligibility criteria, but has been denied admission has the right to appeal in writing to the Commissioner within 10 days of notification.

### SOME IMPORTANT FACTS IF ADMITTED TO THE RESIDENTIAL FACILITY (RF)

- All applicants will be subject to a Police Background Check;
- If admitted to the RF, motor vehicles are not allowed on grounds for ninety (90) days; Motor Vehicles are not allowed if admitted to HCC.
- A monthly billing fee will be determined upon admission; and
- In general once admitted to the RF, no authorization to leave the grounds will be permitted until the entire check in procedure is completed. (Minimum of one (1) week).



Name \_\_\_\_\_ Last 4 Digits of Social Security # \_\_\_\_\_

### Section 3 – MILITARY SERVICE

Date Entered Active Duty _____	Place of Entry _____
Date of Separation _____	Place of Separation _____
Branch of Service _____	Military Service Number _____
Rank _____	Pay Grade _____
Character of Service <input type="checkbox"/> Honorable <input type="checkbox"/> Under Honorable Conditions <input type="checkbox"/> Medical <input type="checkbox"/> Other (Explain) _____	

Did you re-enlist and were issued more than one DD214?  Yes  No **If yes, provide copies.**  
Name you served under if different from your current name \_\_\_\_\_  
Check yes or no for each of the following questions:  
Are you a Purple Heart recipient?  Yes  No  
Are you a former prisoner of war?  Yes  No  
Do you have a VA service connected rating?  Yes  No If yes, what % \_\_\_\_\_  
For what condition(s) \_\_\_\_\_  
VA Claim # \_\_\_\_\_ Did you serve in combat after 11/11/1998?  Yes  No  
Was your discharge from the military for a disability incurred or aggravated in the line of duty?  Yes  No  
Are you receiving disability retirement pay instead of VA compensation?  Yes  No  
Do you need care of conditions potentially related to service in SW Asia during the Gulf War?  Yes  No  
Were you exposed to Agent Orange while serving in Vietnam?  Yes  No  
Were you exposed to radiation while in the military?  Yes  No  
Do you have a spinal cord injury?  Yes  No  
Do you receive a VA pension?  Yes  No If yes, provide VA Claim # \_\_\_\_\_  
Name of Service Officer \_\_\_\_\_ Phone # \_\_\_\_\_  
Have you been seen at a VA Health Care Center?  Yes  No If yes, provide VA # \_\_\_\_\_

### Section 4 – CONSERVATORSHIP/POWER OF ATTORNEY

Has a Probate Court appointed someone as your conservator  Yes  No (complete information below and enclose a copy of decree)

If Yes, in which Probate Court was the Appointment made \_\_\_\_\_

Is this Appointment for  Person  Estate  Both Effective date \_\_\_\_\_

Does anyone hold Power of Attorney for you:  Yes  No

CONSERVATOR		POWER OF ATTORNEY	
Name	_____	Name	_____
Relationship	_____	Relationship	_____
Street	_____	Street	_____
Apartment #	_____	Apartment #	_____
City	_____	City	_____
State	_____ Zip _____	State	_____ Zip _____
Home Phone	_____	Home Phone	_____
Work Phone	_____	Work Phone	_____
Cell Phone	_____	Cell Phone	_____
Fax #	_____	Fax #	_____
Email Address	_____	Email Address	_____

Name \_\_\_\_\_ Last 4 Digits of Social Security # \_\_\_\_\_

**Section 5 – ADVANCE DIRECTIVES AND SURROGATE DECISION MAKER**

Advance Medical Directives are NOT a condition of admission. However, if you have already executed an Advance Medical Directive, a copy will be needed upon admission.

Have you appointed a Durable Power of Attorney for Healthcare (DPOA)?  Yes  No **(Please enclose copy)**

(The DPOA for Health Care Decisions is appointed only to make medical decisions other than withholding or withdrawal of life support systems on behalf of the patient. If there is more than one DPOA, please note if they serve jointly or separately. Note: Not all Power of Attorney appointments include Health Care.)

Have you appointed a Health Care Agent?  Yes  No **(please enclose copy)**

(The Health Care Agent is appointed only to convey the patient’s wishes concerning the withholding or withdrawal of life supports if the patient is unable to understand and communicate informed consent regarding treatment.)

Have you appointed a Health Care Representative?  Yes  No **(please enclose copy)**

**Organ/Tissue/Body Donor** -  Yes  No

Next of Kin _____	Relationship _____
Street Address _____	Home Phone _____
City _____ Zip _____	Cell Phone _____
Email Address _____	Work Phone _____
Fax # _____	Pager _____

Emergency Contact _____	Relationship _____
Street Address _____	Home Phone _____
City _____ Zip _____	Cell Phone _____
Email Address _____	Work Phone _____
Fax# _____	Pager _____

**Section 6 – EDUCATION AND EMPLOYMENT**

Education (Highest Grade Completed) \_\_\_\_\_ Occupation \_\_\_\_\_

Employment: Are you currently employed?  Yes  No

Full Time  Part Time  Retired Date of Retirement (mm/dd/yyyy)

Name of Employer \_\_\_\_\_  
Address \_\_\_\_\_  
Phone # \_\_\_\_\_

Name \_\_\_\_\_ Last 4 Digits of Social Security # \_\_\_\_\_

**Section 7- FAMILY AND SPOUSAL INFORMATION**

Mother's Maiden Name \_\_\_\_\_ Father's Name \_\_\_\_\_  
Mother's Place of Birth \_\_\_\_\_ Father's Place of Birth \_\_\_\_\_  
\_\_\_\_\_ Living \_\_\_\_\_ Deceased \_\_\_\_\_ Living \_\_\_\_\_ Deceased  
Marital Status \_\_\_\_\_ Never Married \_\_\_\_\_ Married (1,2,3,4) \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widowed  
Spouse's Name (Last, First, Middle Name) \_\_\_\_\_  
Spouse's Maiden Name \_\_\_\_\_  
Address (Street, City, State, Zip) \_\_\_\_\_  
Phone # (\_\_\_\_\_) \_\_\_\_\_ Spouse's Date of Birth (mm/dd/yyyy) \_\_\_\_\_  
Spouse's Social Security \_\_\_\_\_ Date of Marriage # (mm/dd/yyyy) \_\_\_\_\_  
Spousal Employment Status \_\_\_\_\_ full time \_\_\_\_\_ part time \_\_\_\_\_ not employed \_\_\_\_\_ retired  
If employed, provide company name, address, and telephone # \_\_\_\_\_

How many children do you have? \_\_\_\_\_ # Adults \_\_\_\_\_ # Minors \_\_\_\_\_  
For minor dependent children, please provide Name (Last, First, Middle Name), Relationship to you, Social Security #,  
Date of birth (mm/dd/yyyy), and Address (Street, City, State, Zip)

If your spouse or dependent child did not live with you in the past year, amount you contributed to support  
\_\_\_\_\_

Name \_\_\_\_\_ Last 4 Digits of Social Security # \_\_\_\_\_

**Section 8 – MEDICAL INFORMATION**

Please answer all questions below.	Yes	No
Are you able to climb stairs without help? If not, please explain.		
Are you able to shower/bathe without help? If not, please explain.		
Are you able to feed yourself without help? If not, please explain.		
Are you able to dress without help? If not, please explain.		
Do you sometimes lose control of your urine or bowels? If yes, please explain.		
Do you use a cane? If yes, please explain.		
Do you use a walker? If yes, please explain.		
Do you use crutches? If yes, please explain.		
Do you use a scooter? If yes, please explain.		
Do you have difficulty remembering to do things? If yes, please explain.		
Have you ever been told that you have trouble with your heart or blood pressure? If yes, please explain.		
Have you ever been told that you have problems with your kidneys? If yes, please explain.		
Do you have trouble breathing? If yes, please explain.		
Do you use a BI-PAP machine?		

Name \_\_\_\_\_ Last 4 Digits of Social Security # \_\_\_\_\_

**Section 8 – MEDICAL INFORMATION (continued)**

Please answer all questions below.	Yes	No
Do you use a CPAP machine?		
Are you on Oxygen Therapy?		
Have you ever had a seizure? If yes, please explain.		
Do you have night sweats, cough or weight loss? If yes, please explain.		
Have you ever had Tuberculosis (TB)? If yes, please explain.		
Have you ever been told that you have PTSD? If yes, please explain.		
Do you have trouble controlling your anger? If yes, please explain.		
Have you had any problems with depression? If yes, please explain.		
Have you ever been told you have a Psychiatric illness? If yes, please explain.		
Have you ever felt like harming yourself? If yes, please explain.		
Where do you go now for your medical care?		
Have you been hospitalized in the past 5 years? If yes, when, where, and for what reason.		

Name \_\_\_\_\_ Last 4 Digits of Social Security # \_\_\_\_\_

**Section 8 – MEDICAL INFORMATION (continued)**

**MEDICATIONS**

What medications do you take or should you be taking?	Dose	How often do you take this medication?

**Section 9 – RECOVERY SUPPORT**

Please answer all questions below.	Yes	No
Have you ever taken drugs or alcohol or been told that you have a substance abuse problem? If yes, please explain.		
Have you ever attended a program for drug or alcohol abuse? If yes, when and where?		
Are you attending a substance abuse program now?  When did you start? When will you complete it? Where is it located?		
Are you interested in participating in our Recovery Support Services to assist you with your ongoing substance abuse recovery?		

**If you receive your care from the VA Connecticut Healthcare System, the name and signature of your Primary Care Physician is required.**

**“This person will continue to be eligible for care within the VA Connecticut Healthcare System”**

<hr/> <b>Printed Name of Primary Care Provider</b>	<hr/> <b>Signature of Primary Care Provider</b>	<hr/> <b>Date</b>
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**MEDICAL CERTIFICATE**

**Veteran's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**Last 4 Digits of Social Security #** \_\_\_\_\_

**1. History of Present Illness / Chief Complaints:**

\_\_\_\_\_

**2. Past Medical History (including any surgery w/ dates)**

\_\_\_\_\_

**3. Review of Systems (circle and/ or explain)**

Cough \_\_\_\_\_ Abdominal Pain \_\_\_\_\_ Extremities \_\_\_\_\_ Mental Status \_\_\_\_\_  
 Dyspnea \_\_\_\_\_ Vomiting \_\_\_\_\_ Skin \_\_\_\_\_ Vision \_\_\_\_\_  
 Chest Pain \_\_\_\_\_ UTI/ frequency \_\_\_\_\_ Dentures \_\_\_\_\_ Hearing \_\_\_\_\_  
 Substance Abuse \_\_\_\_\_ Other \_\_\_\_\_ Other \_\_\_\_\_

**4. Allergies :** \_\_\_\_\_

**5. Physical Exam: P** \_\_\_\_\_ **R** \_\_\_\_\_ **B/P** \_\_\_\_\_ / \_\_\_\_\_ **T** \_\_\_\_\_ **Wgt** \_\_\_\_\_ **Ht** \_\_\_\_\_

Check	Normal	Abnormal	Positive Findings
General			
Head - Eyes/Ears/Mouth			
Chest/ Breast			
Lungs			
Heart/ Vascular			
Abdomen/ Rectum			
Genitalia/ Pelvic			
Extremities/ Back			
Neurologic			
Skin/ Other			

**6. Laboratory Studies:**

X-Ray \_\_\_\_\_ EKG: \_\_\_\_\_

Blood Tests: WBC \_\_\_\_\_ HBG \_\_\_\_\_ HCT \_\_\_\_\_ PLT \_\_\_\_\_ FBS \_\_\_\_\_ K \_\_\_\_\_  
 CRT \_\_\_\_\_ BUN \_\_\_\_\_ Other: \_\_\_\_\_ (ie. PSA, TSH, Electrolytes etc)

**7. PPD & Influenza and Pneumococcal Vaccinations**

**Annual PPD is required**

Date of PPD: \_\_\_\_\_ Date read: \_\_\_\_\_ Test Result: \_\_\_\_\_

If positive, Treatment: \_\_\_\_\_

If positive/ no treatment, please explain: \_\_\_\_\_

**Date of Influenza vaccination** \_\_\_\_\_ **Date of Pneumococcal vaccination** \_\_\_\_\_

Name \_\_\_\_\_ Last 4 Digits of Social Security # \_\_\_\_\_

**8. Diagnoses**

Diagnosis/Problem	Plan of Care

**9. Medications: (should reasonably reflect diagnoses)**

Medication Name & Dosage	Directions:

**10. History of Infectious Diseases**      **Has the patient had any of the following:**

TB		HEPATITIS		CHICKEN POX		OTHER: _____		OTHER: _____	
Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

If any of the above are checked, please explain: \_\_\_\_\_

**11. Other Problems: (ex. MRSA colonization or Vancomycin Resistive Enterococcus) Please specify:**

**12. Mental Status:** \_\_\_Alert \_\_\_Slightly Confused \_\_\_Moderately Confused \_\_\_Very Confused  
 \_\_\_Euphoric \_\_\_Depressed \_\_\_Hallucinations \_\_\_Paranoia \_\_\_Forgetful \_\_\_

Mentally competent? \_\_\_yes \_\_\_no

**13. Activity Status:** \_\_\_bed rest \_\_\_bed to chair \_\_\_limited \_\_\_as desired \_\_\_as tolerated

**14. Transfer:** \_\_\_Independent \_\_\_Supervise \_\_\_Assist \_\_\_Unable

**15. Ambulation:** \_\_\_Independent \_\_\_Supervise \_\_\_Assist \_\_\_Unable Can climb stairs? \_\_\_Yes \_\_\_No  
 \_\_\_Wheelchair \_\_\_Cane \_\_\_Walker

**16. Nutritional Status:** \_\_\_Overweight \_\_\_Underweight \_\_\_Malnourished \_\_\_Adequate \_\_\_Tube  
 Diet: \_\_\_\_\_

**17. Devices:** \_\_\_eyeglasses \_\_\_contact lenses \_\_\_dentures \_\_\_hearing aide/s

**18. Fall risk:** \_\_\_low \_\_\_moderate \_\_\_high \_\_\_non-applicable

**19. Special Instructions/Concerns:** \_\_\_\_\_

<b>Examined by</b> _____ <b>MD</b> <b>Date:</b> _____ Address: _____ _____ Phone # _____
--

Name \_\_\_\_\_ Last 4 Digits of Social Security # \_\_\_\_\_

**Section 10-INSURANCE INFORMATION**

Are you covered by health insurance? (including coverage through a spouse or another person)  Yes  No

Name of Policy Holder \_\_\_\_\_ Policy Number \_\_\_\_\_

Group Code \_\_\_\_\_

Health Insurance Company's Name, Address (Street, City, State, Zip), and Telephone Number  
\_\_\_\_\_  
\_\_\_\_\_

Are you eligible for Medicaid?  Yes  No Medicaid # \_\_\_\_\_

Have you applied for Medicaid?  Yes  No Date Applied: \_\_\_\_\_

Are you receiving Medicaid?  Yes  No

Case Worker's Name \_\_\_\_\_ Case No. \_\_\_\_\_

Are you enrolled in Medicare Hospital Insurance Part A?  Yes  No

Effective Date (mm/dd/yyyy) \_\_\_\_\_

Are you enrolled in Medicare Hospital Insurance Part B?  Yes  No

Effective Date (mm/dd/yyyy) \_\_\_\_\_

Medicare Claim Number \_\_\_\_\_

Name exactly as it appears on your Medicare Card \_\_\_\_\_

Is need for care due to an accident? (Check one)  Yes  No

Is need for care due to on the job injury? (Check one)  Yes  No

**Section 11 –LEGAL HISTORY**

**OMISSIONS OR FALSIFICATIONS MAY AFFECT ADMISSION**

1. Have you ever been convicted of a felony:  Yes  No If Yes, complete the remainder of this question listing all convictions and index the Degree (1<sup>st</sup>, 2<sup>nd</sup>, etc) and the date of the conviction and the office of jurisdiction.

Felony Charge	Date of Conviction	Place of Conviction	Court of Jurisdiction
1. _____			
2. _____			
3. _____			
4. _____			

Use a separate sheet of paper to list any additional felonies.

Describe the circumstances of each felony charge and provide a copy of the police report and court documents.

2. Are you currently on probation?  Yes  No If yes, when does your probation end? \_\_\_\_\_,  
Legal charge(s) that your on probation for? \_\_\_\_\_

3. Are you currently on parole?  Yes  No If Yes, when does your parole end? \_\_\_\_\_.  
Legal charge(s) that your on parole for? \_\_\_\_\_

4. Please list the name of your probation/parole officer and the telephone number where they can be reached. \_\_\_\_\_

**\*\*\*ENCLOSE A COPY OF YOUR CURRENT TERMS/CONDITIONS OF PROBATION/PAROLE –**  
**YOUR APPLICATION WILL NOT BE PROCESSED WITHOUT ONE.\*\*\***

Name \_\_\_\_\_ Last 4 Digits of Social Security # \_\_\_\_\_

**Section 11 - Legal History (continued)**

4. Are there any outstanding warrants for your arrest?  Yes  No If yes, please explain.

5. Have you ever been convicted of any other legal charges (misdemeanor, etc.)?  Yes  No If yes, please explain.

6. Have you been arrested for any offenses that have not yet been resolved in Court?  Yes  No  
If "Yes", please explain.

7. Have you ever been incarcerated?  Yes  No If "Yes", please explain.

Where:

When:

Length of Time:

**RELEASE OF INFORMATION**

Veteran's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ VA Claim Number \_\_\_\_\_

**I HEREBY AUTHORIZE THE STATE OF CONNECTICUT, DEPARTMENT OF VETERANS' AFFAIRS, TO OBTAIN INFORMATION FROM:**

1. VA Connecticut Medical Centers, Newington and West Haven, CT
2. US VA Regional Office, Newington, CT
3. Other Treatment Facilities (List)

\_\_\_\_\_

**INFORMATION TO BE DISCLOSED:** (Initial each item that applies):

- \_\_\_\_\_ Copy of complete health records including outpatient, E.R., hospitalization
- \_\_\_\_\_ Alcohol Abuse
- \_\_\_\_\_ Drug Abuse
- \_\_\_\_\_ Psychiatric
- \_\_\_\_\_ Sickle Cell
- \_\_\_\_\_ On-going communication (telephonic/written/faxed)
- \_\_\_\_\_ Military Service

I authorize the Connecticut Department of Veterans' Affairs to release/obtain all pertinent information regarding my treatment which may include information relating to medical, psychiatric, alcohol, and drug abuse, HIV/AIDS, and Sickle Cell to/from such facilities as necessary for the admissions process and any treatment and care.

For release of information, this authorization will automatically expire ninety (90) days from the date below.

This facility, its employees, officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized therein.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2 and 38CFR) and/or state law. The Federal rules and/or state law prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42CFR Part 2 and/or state law. A general authorization for the release of medical or other information is NOT sufficient information to criminally investigate or prosecute any alcohol or drug abuse patient.

X \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Veteran or Conservator of Person

Name \_\_\_\_\_

Last 4 Digits of Social Security # \_\_\_\_\_

**PLEASE READ CAREFULLY BEFORE SIGNING**

1. I agree that upon admission I will obey the rules and regulations of the Connecticut Department of Veterans' Affairs. A copy will be provided to you upon admission.
2. For Admissions to the Residential Facility, I understand there is a 90-day Probationary period. I am expected to comply with all rules and regulations. Any violation may result in discharge.
3. I understand and agree that I shall pay for care provided to me and that I will comply with medical care as determined by the medical staff at this facility. Read below the Fiduciary Responsibilities according to Regulations CT State Agencies Section 27-102/d: (Amended October 11, 2007).  
***Sec. 27-102/(d)-253 Fiduciary duties***
  - (2) If a veteran is or may be eligible for a third party payment, including federal veterans' benefits, Medicaid and Medicare, based on a means test or other qualifying criteria, the department shall take actions designed to ensure initial and continued eligibility for such benefits and programs.***Sec. 27-102/(d)-254 Liability for services rendered***
  - (a) Each veteran or his legally liable relative shall be liable for the cost of services rendered, except as otherwise provided in the Regulations of Connecticut State Agencies and state or federal law(s). A presumption shall exist that a veteran can pay in full for all services rendered. The burden is at all times on the veteran to demonstrate that he is without ability to pay.***Sec. 27-102/(d)-259 Third Party benefits***
  - (a) The Department may execute and maintain agreements with other public agencies and private entities to participate in reimbursement programs, including but not limited to Title XVIII (Medicare) and XIX (Medicaid) of the Social Security Act and the United States Department of Veterans' Affairs.
  - (b) Each veteran who the Commissioner determines may be eligible for reimbursements from a third party insurer of governmental program is obligated to provide necessary information and fully cooperate with the Department in the application for and maintenance of such income reimbursement or benefit. Failure to comply with this subsection shall be grounds for involuntary assignment of income and assets or involuntary discharge.
  - (c) For any program administered by the Department of Veterans' Affairs for which the Department is a Medicaid provider and for the purposes of determining order of liability, the state Department of social services through the Medicaid program shall be "payor of last resort" and all other payment sources shall be exhausted before any bill is presented to the Department of Social Services.
  - (d) For any program administered by the Department of Veterans' Affairs for which the Department is a Medicaid provider and in the event that a portion of the regulations of Connecticut state agencies is in conflict with the Department of Social Services' Uniform Policy Manual as amended from time to time, the Department of Social Services regulation shall prevail.
  - (e) The veteran shall, or shall cause his representative to, promptly file and claim income, assets, and reimbursement due and owed, or available to the veteran for payment of or reimbursement of expenditures made on his behalf or which may be claimed for services rendered to him. Sources covered by this subsection include, but are not limited to private insurance, a trust or any other arrangement under which the veteran is or could be a beneficiary, whether specifically named or not.
  - (f) The veteran shall cooperate in any action, including making application, or proceeding that can or may be brought for the purpose of making the veteran's income, asset or reimbursement available to meet the costs of his care. In the event that the veteran refuses or fails to cooperate in such efforts, the Commissioner may:
    - (1) Apply for a conservatorship to accomplish these tasks;
    - (2) Consider the failure to comply with the regulations of Connecticut state agencies as a ground for involuntary assignment of the same; or
    - (3) Initiate proceeding for involuntary discharge.

Name \_\_\_\_\_ Last 4 Digits of Social Security # \_\_\_\_\_

**PLEASE READ CAREFULLY BEFORE SIGNING (Continued)**

4. I understand and agree that in the event of my death, the Commissioner may make a claim against my estate for the cost of care provided to me.
5. I understand and agree that I am solely responsible for any money, clothing, jewelry, or other valuables retained by me while a resident of this facility.
6. **RELEASE OF INFORMATION** - I consent that any physician, primary care provider, surgeon, dentist or hospital that has treated or examined me for any purpose, or that I have consulted professionally, may furnish to this facility, any information about myself, and I waive any privilege which renders such information confidential. I consent to a check of my history, if any, by the Department of Public Safety, Division of State Police.

**I HAVE READ THIS FORM AND I CERTIFY THAT THE INFORMATION GIVEN IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.**

X \_\_\_\_\_  
Signature of Veteran or Conservator of Person

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

cc: Veteran

Name \_\_\_\_\_ Last 4 Digits of Social Security # \_\_\_\_\_

**Billing/DVA Cost of Care Information**

Cost of care is determined by the facility/level of care program the veteran is admitted to:  
Residential Facility or Health Care Center.

**Residential Facility):**

The cost of care is determined by the length of stay. However, in extreme financial hardship, the Department of Veterans’ Affairs will waive the cost of care for veterans in need with proper documentation/ verification of assets and service connectivity.

<b>LEVEL:</b>	<b>Length of Stay</b>	<b>Monthly Billing Rate</b>
<b>1</b>	<b>0 to 3 months</b>	<b>\$0.00</b>
<b>2</b>	<b>4 to 36 months (3 years)</b>	<b>\$200.00</b>
<b>3</b>	<b>37 to 60 months (3 to 5 years)</b>	<b>\$300.00</b>
<b>4</b>	<b>61 months + (5 years or more)</b>	<b>\$500.00*</b>

\*(Not to exceed 1/3 income)

**Health Care Center:**

The cost of care is determined by the *current* allowable Medicaid rate.

- According to Connecticut General Statute (CGS) 27-108: If unable to pay healthcare costs, the veteran is required to have a completed and filed “pending” Medicaid (a/k/a Title XIX) application. The financially responsible party is required to pay charges assessed by DVA until such time the veteran is eligible for Medicaid. Once Medicaid eligibility is determined, Medicaid assumes the primary responsibility for paying the veteran’s cost of care; however, the veteran remains responsible for contributing their “applied income” towards the cost of care as computed by Department of Social Services.
- Or if the veteran has a 70% or more Service Connected Disability; provided eligibility criteria is met; the veteran may opt to have the Federal Department of Veterans’ Affairs assume the primary responsibility for paying the veteran’s cost of care to the State DVA.

**Respite Care:**

Respite care is a program to give a primary care giver a temporary break (“respite”).

There is no fee for this program; however the care is limited to a minimum of five (5) days to a maximum of twenty-eight (28) days in any twelve (12) month period. As per CGS 27-102l(d)108 (J): Should the care giver be unable or unwilling to *resume* the role of primary care giver, then a discharge placement plan must be presented, other than admission to a DVA departmental program.

To find out the *current* Medicaid rate and if you have any questions related to the billing process or any billing policies, please contact one of the Billing Office Staff listed below:

- Elizabeth Syska - Fiscal Administrative Supervisor - (860) 616-3644
- Linda Turgeon - Fiscal Administrative Officer - (860) 616-3645
- Susan Amenta - Fiscal Administrative Officer - (860) 616-3646



Name \_\_\_\_\_ Last 4 Digits of Social Security # \_\_\_\_\_

**State of Connecticut  
Department of Veterans' Affairs  
Residential Facility**

**NINETY-DAY AGREEMENT**

The State of Connecticut, Department of Veterans' Affairs, Rocky Hill Veterans' Home, requires that all individuals who are admitted to the Residential Facility sign and comply with the following Agreement.

**During the ninety-day probationary period, I agree to the following:**

- I will follow the rules and regulations of the CTDVA.
- Any violation of the rules and regulations related to substance use will result in involuntary discharge, unless I comply with the recommended treatment offered to me.

**ADDITIONAL REQUIREMENTS ARE AS FOLLOWS:**

- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_  
**Resident's Printed Name**

\_\_\_\_\_  
**Staff Representative's Printed Name**

\_\_\_\_\_  
**Resident's Signature**

\_\_\_\_\_  
**Staff Representative's Signature**

\_\_\_\_\_  
**Date**

**FAILURE TO SIGN THIS AGREEMENT WILL RESULT IN DENIAL OF ADMISSION TO CTDVA.**



**STATE OF CONNECTICUT/DEPARTMENT OF VETERANS' AFFAIRS**  
**INCOME/ASSETS QUESTIONNAIRE (IA)/DVA CASE#: \_\_\_\_\_**

Form: DVA-BO-IAQ (Rev. 01/07) Page 1 of 2

Instructions: **Please complete form in its entirety.** If no Income or Assets are indicated, please fill in each area with a zero. In addition, **please initial each section; sign and date at the end of this form.** According to Connecticut General Statue 27-108 such veterans who are able to pay in whole or in part for services are required to pay their cost of care based on their ability to pay. If unable to pay, those entering the hospital are required to have a completed and filed "pending" Medicaid (Title XIX) application. The veteran and/or responsible party are required to provide full disclosure of all financial information in accordance with CGS 27-117. If there is a pending Medicaid application, the veteran and/or responsible party are required to continue paying the charges assessed by the DVA pursuant to CGS 27-108 until such time as The Department of Social Services (DSS) determines that the veteran is eligible for assistance. Once Medicaid eligibility is determined, Medicaid assumes the primary responsibility for paying the veteran's care at the hospital; however, the veteran remains responsible for contributing his/her "applied income" towards the cost of care as computed by DSS pursuant to its administration of the Medicaid program.

Veteran's Name:		Spouse's Name:	
Street Address:		Street Address:	
City, State, Zip:		City, State, Zip:	
Home Phone:		Home Phone:	
<b>Type of Income/ Acct # (if applicable)</b>	<b>Source of Income Address (if applicable)</b>	<b>Veteran Amount</b>	<b>Spouse Amount</b>
Social Security	Social Security Administration		Monthly
VA Pension.Comp.	U.S. Department of Veterans' Affairs		Monthly
Retirement/Pension			
Retirement/Pension			
Dividends/Interest Account #:			
Rental Property Income			
Other (describe)			
<b>Type of Asset ID # (if applicable)</b>	<b>Location of Asset Name/Address/Phone (if applicable)</b>	<b>Veteran Amount</b>	<b>Spouse Amount</b>
Savings Account Account #:			
Savings Account Account #:			
Checking Account Account #:			
Checking Account Account #:			
Certificate of Deposit Account #:			
Stock Certificate Number(s):			
Bonds Certificate Number(s):			
Prepaid Funeral Contract #:			
Life Insurance Policy Policy #:			
Motor Vehicle VIN Number #:			
Real Estate Address:			
Other Asset Account ID #:			

**IA/DVA QUESTIONNAIRE (Continued)**

Name \_\_\_\_\_ Last 4 Digits of Social Security # \_\_\_\_\_

Case # \_\_\_\_\_

Form: DVA-BO-IAQ (Rev. 01/07) Page 2 of 2

**COURT- ORDERED OBLIGATION INFORMATION** (Note: Court Documentation is required)

TYPE OF OBLIGATION	Paid to (Name/Address)	Veteran Amount	Spouse Amount	Frequency
Alimony				
Child Support				
Other:				

**COURT- ORDERED OBLIGATION INFORMATION**

TYPE OF HOUSEHOLD COST	Paid to (Name/Address)	Veteran Amount	Spouse Amount	Frequency
Rent				
Mortgage				
Rental/Mortgage Insurance				
Real Estate Tax				
Other (identify)				

**FINANCIAL RELATIONSHIP TO VETERAN:** (Please check one)

Self     Power of Attorney     Conservator of Estate    Probate Court: \_\_\_\_\_ Appointment Date: \_\_\_\_\_  
 (Jurisdiction)

I certify that the information provided on this form is complete and accurate to the best of my knowledge. I understand that I am required to provide this information completely and accurately according to the Connecticut General Statutes (CGS) 27-117. I also understand that I am responsible for paying for the cost of my care at the Department of Veterans' Affairs (DVA), and that I will be assessed monthly charges based on my ability to pay as per CGS 27-108 and DVA regulations. I understand that paying the assessed charges may result in the depletion of my resources. If I reside in the Health Care Center, I understand that I am required to apply for the Title XIX Medicaid benefits upon request, and to take all steps reasonably necessary to obtain Medicaid eligibility. If I apply for Title XIX benefits, I understand that I am responsible to continue paying for my portion of the cost of care as assessed by the Department of Veterans' Affairs pursuant to CGS 27-108 until such time as Title XIX is granted. If Medicaid eligibility is determined by the Department of Social Services, I understand that I am then responsible for contributing my "applied income" towards the cost of care, as computed by the Department of Social Services.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_