



Dear Applicant and/or Family:

Thank you for your interest in South Carolina's State Veterans Home Program.

**To process a request for admission the following documents are required:**

1. Admission Application (3 pages)
2. Proof of Identity (Driver's license, ID card, etc.)
3. DD214 or equivalent of other than dishonorable discharge from the military  
*If you are unable to obtain a copy, please contact the Admissions Office immediately*
4. A completed VA Form 10-10EZ (Application for Health Benefits) whether already enrolled in VA Healthcare or not.
5. A release of protected health information form
6. A completed VA form 10-5345 (Request for and Authorization to Release Health Information)
7. A copy of insurance cards (front and back) including:
  - a. Medicare (A, B, D)
  - b. Supplemental Insurance Cards
  - c. Prescription Plan Card
8. Advance Directives/Legal
  - a. Power of Attorney
  - b. Living Will

**Suggested Medical Records to Include with Your Application**

To support a timely and thorough clinical review, applicants are encouraged to submit the following documentation, if available:

- Primary care notes from the three most recent office visits
- Specialty clinic notes from providers seen recently
- Current medication list
- Current wound care or skin treatment documentation
- Immunization records

Submission of these records at the time of application allows for a more complete assessment. Additional healthcare information may be requested from your providers if needed to support the review process.



Applying from: Home Hospital \_\_\_\_\_ Nursing Home/Assisted Living \_\_\_\_\_

Preference for admission: First Available Specific Locations (*Provide preferences in order below*)

Rank the homes in order of preference using numbers 1 - 6, with 1 indicating your highest preference.

\_\_\_ Anderson \_\_\_ Columbia \_\_\_ Florence \_\_\_ Gaffney \_\_\_ Sumter \_\_\_ Walterboro

**Demographic Information**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Current Address \_\_\_\_\_ County \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number \_\_\_\_\_ Birth Place \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_

Religion \_\_\_\_\_ Race \_\_\_\_\_

Marital Status Single Married Divorced Widowed Separated

Legal Date of Separation or Divorce \_\_\_\_\_

**Military Records Information**

Branch of Service \_\_\_\_\_ Service # \_\_\_\_\_

Entry Date \_\_\_\_\_ Separation Date \_\_\_\_\_ Discharge Type \_\_\_\_\_

War Era WWII (Europe) WWII (South Pacific) Korea  
Vietnam Gulf War Peace Time

Are you currently or were you previously a member of any Service Organization?

American Legion	Military Order of the Purple Heart	AMVETS
Masons	Knights of Columbus	Elks
29th Division	Lions Club	DAR
Veterans of Foreign Wars	Moose Lodge	DAV

Other Membership \_\_\_\_\_

Are you currently receiving any of the following VA Pensions?

Aid and Attendance Yes No Retirement Pension Yes No

Do you have a service connected disability? Yes No Percentage \_\_\_\_\_

Former POW? Yes No Retired Military? Yes No

Are you in enrolled with the VA Health System? Yes No

Have you used a VA Medical Center? Yes No Location \_\_\_\_\_

**Spouse Information (For VA Records)**

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

DOB \_\_\_\_\_ Date of Marriage \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Current Phone # \_\_\_\_\_

**Insurance Information**

Medicare: Part A Part B Member # \_\_\_\_\_  
Have you been receiving your medications from the VAMC or a base? Yes No  
Are you enrolled in a Medicare Part D Program? Yes No  
Company \_\_\_\_\_ Policy # \_\_\_\_\_  
Medicaid: Yes No Medicaid # \_\_\_\_\_  
Private Insurance: Company \_\_\_\_\_ ID # \_\_\_\_\_  
How is the premium paid? Deduction from pension Debit from bank account Check  
Long Term Care Insurance: Company \_\_\_\_\_

*Please provide a copy of all insurance cards (front and back) and any Long Term Care Insurance Policy (If Applicable)*

**Emergency Contact Information**

**Responsible Party:** Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone #: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
Email \_\_\_\_\_ Next of Kin Yes No  
**Second Contact:** Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone #: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
Email \_\_\_\_\_ Next of Kin Yes No

**Legal Documents**

Is there a Power of Attorney or Guardian for your affairs? Yes No  
If so, Name: Healthcare POA \_\_\_\_\_ Financial POA \_\_\_\_\_  
Is there an Advance Directive or Living Will? Yes No *If so, please provide a copy*  
Is there a living trust? Yes No *If so, please provide a copy*  
Do you have any pre-planned funeral arrangements? Yes No Funeral paid for? Yes No  
Funeral Home of Choice \_\_\_\_\_ City/State: \_\_\_\_\_

**Medical Service Utilization**

Have you utilized rehab, inpatient, or outpatient services? Yes No  
If yes, please provide the location(s) and date(s):  
Location: \_\_\_\_\_ Dates: \_\_\_\_\_  
Location: \_\_\_\_\_ Dates: \_\_\_\_\_  
Location: \_\_\_\_\_ Dates: \_\_\_\_\_  
Location: \_\_\_\_\_ Dates: \_\_\_\_\_

**Additional Information**

Are you currently assigned a social worker at the VA? Yes No  
If yes, Name: \_\_\_\_\_ Contact: \_\_\_\_\_

**Financial Information**

The State Veterans Home, in its financial planning, must have information about the financial ability of each applicant requesting admission. Please complete the following financial worksheet and provide as much detail as possible for each question. In a case where an applicant has a living spouse, information must be provided for both individuals. Should the Department of Admissions have any questions, you will be contacted by telephone at the number provided on this application.

**Income:** (Check where applicable and provide the monthly amount)

	<u>Veteran</u>	<u>Spouse</u>
Social Security	\$ _____	\$ _____
Employer Pensions	\$ _____	\$ _____
Union Pensions	\$ _____	\$ _____
Veteran Benefits	\$ _____	\$ _____
Trust	\$ _____	\$ _____
Annuity	\$ _____	\$ _____
IRA Distribution	\$ _____	\$ _____
Other _____	\$ _____	\$ _____

**Resources:** (Check where applicable and provide current balance)

Total Amount in Checking Accounts	\$ _____	\$ _____
Total Amount in Savings Accounts	\$ _____	\$ _____
Total Amount in Other Accounts	\$ _____	\$ _____
Total Amount in Stocks/Bonds/CDs	\$ _____	\$ _____
Total Amount in IRA/KEOGH/401K	\$ _____	\$ _____
Total Life Insurance/ (Face/Cash Value)	\$ _____ / _____	\$ _____ / _____
Total Amount in Trust	\$ _____	\$ _____
Other _____	\$ _____	\$ _____

Real Estate: Address \_\_\_\_\_

Do you have a mortgage payment? Yes No Amount: \$ \_\_\_\_\_

Do you have a reverse mortgage? Yes No Amount: \$ \_\_\_\_\_

Liabilities Do you currently have any deductions to income as a result of a debt owed (IRS, Alimony, etc)?

Yes No If yes please indicate: Type of Deduction \_\_\_\_\_ Amount \$ \_\_\_\_\_

Type of Deduction \_\_\_\_\_ Amount \$ \_\_\_\_\_

Has the applicant sold, gifted or transferred any cash, real estate or personal property within the past 60 months? Yes No If yes, please indicate: Asset Type \_\_\_\_\_ Value \$ \_\_\_\_\_

Asset Type \_\_\_\_\_ Value \$ \_\_\_\_\_

**I agree to furnish, upon request, verification of assets and all sources of income. My spouse and/or designated representative also agree to provide financial information as required to apply for Medicaid benefits. I agree to pay for my cost of care from my income and assets according to current rates set by the State of South Carolina as long as I am a resident. In the case that available funding cannot cover my cost of care, I agree to comply with the necessary steps in applying for South Carolina Medicaid assistance and benefits.**

X

Signature

Relationship to Applicant

Date

<b>Department of Veterans Affairs</b>				<b>VA DATE STAMP</b> <i>(For VHA Use Only)</i>			
<b>APPLICATION FOR HEALTH BENEFITS</b>							
<b>SECTION I - GENERAL INFORMATION</b>							
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:							
<input type="checkbox"/> <b>ENROLLMENT</b> - VA Medical Benefits Package (Veteran meets and agrees to the enrollment eligibility criteria specified at 38 CFR 17.36) <input type="checkbox"/> <b>REGISTRATION (Complete Sections I, II, and III)</b> - VA Health Services (Veterans meets the "Enrollment not required" eligibility criteria specified at 38 CFR 17.37)							
1A. VETERAN'S NAME <i>(Last, First, Middle Name)</i>			1B. PREFERRED NAME		2. MOTHER'S MAIDEN NAME		
3. SEX	4. WHAT IS YOUR RACE/ ETHNICITY? <i>(Check all that apply. Information is required for statistical purposes only.)</i>				5. SOCIAL SECURITY NO. <i>(999-99-9999)</i>		
<input type="checkbox"/> MALE  <input type="checkbox"/> FEMALE	<input type="checkbox"/> ASIAN  <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER  <input type="checkbox"/> MIDDLE EASTERN or NORTH AFRICAN	<input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE  <input type="checkbox"/> BLACK OR AFRICAN AMERICAN  <input type="checkbox"/> HISPANIC or LATINO  <input type="checkbox"/> CHOOSE NOT TO ANSWER	<input type="checkbox"/> WHITE				
6A. DATE OF BIRTH <i>(MM/DD/YYYY)</i>		6B. PLACE OF BIRTH <i>(City and State)</i>		7. PREFERRED LANGUAGE		8. RELIGION	
9A. MAILING ADDRESS <i>(Street)</i>			9B. CITY	9C. STATE	9D. ZIP CODE	9E. COUNTY	
9F. HOME TELEPHONE NO. <i>(optional)</i> <i>((999) 999-9999)</i>		9G. MOBILE TELEPHONE NO. <i>(optional)</i> <i>((999) 999-9999)</i>		9H. E-MAIL ADDRESS <i>(optional)</i>			
10A. HOME ADDRESS <i>(Street)</i>			10B. CITY		10C. STATE	10D. ZIP CODE	
10E. COUNTY							
11. CURRENT MARITAL STATUS							
<input type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED							
12A. NEXT OF KIN NAME			12B. NEXT OF KIN ADDRESS		12C. NEXT OF KIN RELATIONSHIP		
12D. NEXT OF KIN TELEPHONE NO. <i>(Include Area Code) ((999) 999-9999)</i>		13A. EMERGENCY CONTACT NAME			13B. EMERGENCY CONTACT TELEPHONE NO. <i>(Include Area Code) ((999) 999-9999)</i>		
14. DESIGNEE - INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH <i>(Note: This does not constitute a will or transfer of title)</i>							
15. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? <i>(for listing of facilities visit <a href="http://www.va.gov/find-locations">www.va.gov/find-locations</a>)</i>				16. WOULD YOU LIKE FOR VA TO CONTACT YOU TO SCHEDULE YOUR FIRST APPOINTMENT?			
				<input type="checkbox"/> YES <input type="checkbox"/> NO			
<b>SECTION II - MILITARY SERVICE INFORMATION</b>							
1A. LAST BRANCH OF SERVICE		1B. LAST ENTRY DATE <i>(MM/DD/YYYY)</i>		1C. FUTURE DISCHARGE DATE <i>(MM/DD/YYYY)</i>		1D. LAST DISCHARGE DATE <i>(MM/DD/YYYY)</i>	
1E. DISCHARGE TYPE					1F. MILITARY SERVICE NUMBER		
2. MILITARY HISTORY <i>(Check yes or no)</i>				YES	NO		
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?				<input type="checkbox"/>	<input type="checkbox"/>		
B. ARE YOU A FORMER PRISONER OF WAR?				<input type="checkbox"/>	<input type="checkbox"/>		
C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?				<input type="checkbox"/>	<input type="checkbox"/>		
D. WERE YOU DISCHARGED OR RETIRED FROM MILITARY FOR A DISABILITY INCURRED IN THE LINE OF DUTY?				<input type="checkbox"/>	<input type="checkbox"/>		
E. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998?				<input type="checkbox"/>	<input type="checkbox"/>		
F. DO YOU HAVE A VA SERVICE-CONNECTED RATING?				<input type="checkbox"/>	<input type="checkbox"/>		

<b>APPLICATION FOR HEALTH BENEFITS</b> <i>Continued</i>	VETERAN'S NAME <i>(Last, First, Middle)</i>	SOCIAL SECURITY NO. <i>(999-99-9999)</i>
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**SECTION II - MILITARY SERVICE INFORMATION (Continued)**

3. MILITARY EXPOSURE INFORMATION <i>(Check yes or no)</i>	YES	NO		YES	NO
<b>A. DID YOU SERVE IN AN IONIZING RADIATION LOCATION AND PARTICIPATE IN ANY NUCLEAR TESTING, TREATMENTS, OR CLEAN UP?</b> <i>(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.)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<b>D. DID YOU SERVE IN ANY OF THE FOLLOWING HERBICIDE</b> <i>(e.g. Agent Orange) LOCATIONS?</i> <i>(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.)</i>	<input type="checkbox"/>	<input type="checkbox"/>
<b>B. DID YOU SERVE IN ANY OF THE FOLLOWING GULF WAR HAZARD LOCATIONS?</b> <i>(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.)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<b>WHEN DID YOU SERVE IN THESE LOCATIONS?</b> <b>NOTE:</b> <i>Please provide an approximate time-frame (MM/YYYY)</i> FROM: _____ TO: _____		
<b>C. WERE YOU DEPLOYED IN SUPPORT OF ANY OF THE FOLLOWING OPERATIONS?</b> <i>(Enduring Freedom, Freedom's Sentinel, Iraqi Freedom, New Dawn, Inherent Resolve, and Resolute Support Mission)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<b>E. HAVE YOU BEEN EXPOSED TO ANY OF THE FOLLOWING?</b> <i>(Check all that apply)</i> Veterans can locate additional military exposure categories on VA's Public Health website at: <a href="https://www.publichealth.va.gov/exposures/">https://www.publichealth.va.gov/exposures/</a>		
			<input type="checkbox"/> AIR POLLUTANTS <i>(burn pits, sand, oil well/sulfur fires)</i> <input type="checkbox"/> CHEMICALS <i>(pesticides, herbicides, contaminated water)</i> <input type="checkbox"/> CONTAMINATED WATER AT CAMP LEJEUNE <input type="checkbox"/> RADIATION <input type="checkbox"/> SHAD <i>(Shipboard Hazard and Defense)</i> <input type="checkbox"/> OCCUPATIONAL HAZARDS <i>(jet fuel, industrial solvents, lead, firefighting foams)</i> <input type="checkbox"/> ASBESTOS <input type="checkbox"/> MUSTARD GAS <input type="checkbox"/> WARFARE AGENTS <i>(nerve agents, chemical and biological weapons)</i> <input type="checkbox"/> OTHER <i>(Specify):</i> _____ <b>WHEN WERE YOU EXPOSED?</b> <b>NOTE:</b> <i>Please provide an approximate time-frame (MM/YYYY)</i> FROM: _____ TO: _____		

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

1. ENTER YOUR HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER <i>(include coverage through spouse or other person)</i>			
2. NAME OF POLICY HOLDER		3. POLICY NUMBER	4. GROUP CODE
5. ARE YOU ELIGIBLE FOR MEDICAID? <i>(Federal health insurance for low income adults)</i>	6A. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A?	6B. EFFECTIVE DATE <i>(MM/DD/YYYY)</i>	6C. MEDICARE NUMBER
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		

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

1. SPOUSE'S NAME <i>(Last, First, Middle Name)</i>	2. CHILD'S NAME <i>(Last, First, Middle Name)</i>	
1A. SPOUSE'S SOCIAL SECURITY NUMBER	2A. CHILD'S DATE OF BIRTH <i>(MM/DD/YYYY)</i>	2B. CHILD'S SOCIAL SECURITY NO. <i>(999-99-9999)</i>
1B. SPOUSE'S DATE OF BIRTH <i>(MM/DD/YYYY)</i>	2C. DATE CHILD BECAME YOUR DEPENDENT <i>(MM/DD/YYYY)</i>	
1C. SPOUSE'S SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	2D. CHILD'S RELATIONSHIP TO YOU <i>(Check one)</i> <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> STEPSON <input type="checkbox"/> STEPDAUGHTER	
1D. DATE OF MARRIAGE <i>(MM/DD/YYYY)</i>	2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? <input type="checkbox"/> YES <input type="checkbox"/> NO	
1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER <i>(Street, City, State, ZIP if different from Veteran's)</i>	2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? <input type="checkbox"/> YES <input type="checkbox"/> NO	
3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT? <input type="checkbox"/> YES <input type="checkbox"/> NO	2G. EXPENSES PAID BY YOUR DEPENDENT CHILD WITH REPORTABLE INCOME FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING <i>(e.g., tuition, books, materials)</i>	

<b>APPLICATION FOR HEALTH BENEFITS</b> <i>Continued</i>	VETERAN'S NAME <i>(Last, First, Middle)</i>	SOCIAL SECURITY NO. <i>(999-99-9999)</i>
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**SECTION V - EMPLOYMENT INFORMATION**

1A. VETERAN'S EMPLOYMENT STATUS <i>(Check one)</i> . <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> NOT EMPLOYED <input type="checkbox"/> RETIRED		1B. DATE OF RETIREMENT <i>(MM/DD/YYYY)</i>
1C. COMPANY NAME. <i>(Complete if employed or retired)</i>	1D. COMPANY ADDRESS <i>(Complete if employed or retired - Street, City, State, ZIP)</i>	1E. COMPANY PHONE NUMBER <i>(Complete if employed or retired) (Include area code) (999) 999-9999</i>

**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)*

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

**SECTION VIII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES**

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE <i>(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home)</i> 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 <i>(Also enter spouse or child's information in Section VI.)</i>	\$ _____
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES <i>(e.g., tuition, books, fees, materials)</i> 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 <i>(Sign in ink)</i> _____	DATE <i>(MM/DD/YYYY)</i> _____
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**SOUTH CAROLINA STATE VETERANS HOMES**

**Authorization for Release of Protected Health Information**

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_  
(Veteran/Veteran's Representative) (Name of Facility)  
to release the entire record or portions thereof, on \_\_\_\_\_  
(Veteran's Name)  
to the Admissions Coordinator of:

- \_\_\_ E. Roy Stone Veteran's Pavilion - 2200 Harden Street, Columbia, SC 29203
- \_\_\_ Richard M. Campbell Veterans Home - 4605 Belton Highway, Anderson, SC 29621
- \_\_\_ Veterans Victory House Nursing Home - 2461 Sidneys Road, Walterboro, SC 29488
- \_\_\_ Palmetto Patriots Home - 120 Hampshire Drive, Gaffney, SC 29342
- \_\_\_ Veteran Village - 1200 E. National Cemetery Road, Florence, SC 29506
- Patriots Village - 915 North Wise Drive, Sumter, SC 29153

in order to assist us in evaluating this individual for potential admission to the facility.

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

Veteran's Date of Birth \_\_\_\_\_ Veteran's Social Security Number \_\_\_\_\_

The Authorization is valid for one year from the date of signing unless and earlier date, condition or event is specified here: \_\_\_\_\_

I understand that the information may include alcohol/drug abuse and/ or HIV/ARC and other infectious disease information. I do not want the following information disclosed:

\_\_\_\_\_

I understand that information disclosed may be subject to re-disclosure by the above named facility. I may cancel this authorization at any time by writing the local Privacy Officer where I received or am receiving treatment. I understand that if I cancel this Authorization it will not apply to information that has already been used or released to this authorization. I also understand that applicable law may permit or require the use, disclosure or re-disclosure of information about me without my authorization.

**VETERAN OR VETERAN REPRESENTATIVE:**

\_\_\_\_\_  
(Print Name: First, Middle, Last)

\_\_\_\_\_  
(Date of Signature)

\_\_\_\_\_  
(Signature of Veteran/Veteran Representative)

\_\_\_\_\_  
(Relationship to Veteran)



REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT STATEMENT: The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if information needed to locate records for release is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10A7 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS (Name and Location of the VA Health Care Facility)

LAST NAME- FIRST NAME- MIDDLE NAME

DATE OF BIRTH (MM/DD/YYYY)

PATIENT'S MAILING ADDRESS (including City, State and Zip Code)

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

- TREATMENT BENEFITS LEGAL EMPLOYMENT OTHER

(Please specify other):

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

- HEALTH SUMMARY (Prior 2 Years)
PATIENT MEDICAL RECORDS (Dates):
INPATIENT DISCHARGE SUMMARY (Dates):
PROGRESS NOTES:
SPECIFIC CLINICS (Name & Date Range):
SPECIFIC PROVIDERS (Name & Date Range):
DATE RANGE (Specify Date Range):
OPERATIVE/CLINICAL PROCEDURES (Name & Date):
LAB RESULTS:
SPECIFIC TESTS (Name & Date):
DATE RANGE (Specify Date Range):
RADIOLOGY REPORTS (Name & Date):
LIST OF ACTIVE MEDICATIONS (Specify Active Medications):
VACCINATION (Dose, Lot Number, Date & Location):
ADMINISTRATIVE RECORDS (Specify Administrative Records):
OTHER (Describe):

LAST NAME- FIRST NAME- MIDDLE NAME		DATE OF BIRTH (MM/DD/YYYY)
<b>SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE <u>OTHER THAN TREATMENT</u>.</b>		
<p>I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose (s) listed in this authorization.</p> <p> <input type="checkbox"/> DRUG ABUSE      <input type="checkbox"/> ALCOHOLISM OR ALCOHOL ABUSE      <input type="checkbox"/> SICKLE CELL ANEMIA  <input type="checkbox"/> HUMAN IMMUNODEFICIENCY VIRUS (HIV) </p> <p>I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked <u>unless</u> I indicate by checking the box below that I do not want this information released for this specific disclosure.</p> <p><input type="checkbox"/> <b>I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.</b></p>		
<p><b>AUTHORIZATION:</b> I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.</p> <p>I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.</p>		
<p><b>EXPIRATION:</b> Without my express revocation, the authorization will automatically expire (<i>select one of the following</i>):</p> <p> <input type="checkbox"/> AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED  <input type="checkbox"/> ON (Date) (MM/DD/YYYY) _____ (<i>enter a future date other than date signed by patient</i>)  <input type="checkbox"/> UNDER THE FOLLOWING CONDITION(S)  <i>(Specify Condition(s)):</i> _____ </p>		
PATIENT SIGNATURE ( <i>Sign in ink</i> )		DATE (MM/DD/YYYY)
LEGAL REPRESENTATIVE SIGNATURE ( <i>if applicable</i> ) ( <i>Sign in ink</i> )		DATE (MM/DD/YYYY)
PRINT NAME OF LEGAL REPRESENTATIVE		RELATIONSHIP TO PATIENT
<b>FOR VA USE ONLY</b>		
TYPE AND EXTENT OF MATERIAL RELEASED:		
DATE RELEASED (MM/DD/YYYY):		RELEASED BY: