GEORGIA WAR VETERANS HOME
2249 Vinson Highway
Milledgeville, GA 31061

October 2026

Dear Veteran and Family,

Applying to Georgia War Veterans Home

Thank you for considering Georgia War Veterans Home. Applying for long-term care can be a difficult step for a Veteran and family. You may still be deciding what care is needed or wondering what life here would be like. We welcome those questions and the opportunity to talk with you.

This application begins our work together. It helps the Georgia Department of Veterans Service confirm eligibility and gives our care team the information needed to understand how we can help. As we learn about your health and daily life, we also want to hear what matters to you and how you would like your family involved in your care.

We know this packet asks for a great deal of information. We will begin our review and assessments as information arrives. Sending available records promptly and answering the questions as fully as possible helps us work with you and your family toward an admission decision. Our Admissions team will help you complete the application and coordinate with your current care providers when records are needed.

The guide on the next page explains each section and who should complete it. You can work through the packet over several sittings. Please call us at (478) 445-4295 if a question is unclear or you have difficulty finding a document. Let us know what you have available so we can begin working with you.

Georgia War Veterans Home is owned by the Georgia Department of Veterans Service and managed by HMR Veterans Services. We provide skilled nursing care around the clock. At HMR, we believe every Veteran deserves to continue their story. The partnership in care that makes this possible begins with Admissions, and we look forward to getting to know you.

Sincerely,

Trylene Case
Administrator
Georgia War Veterans Home

Your guide to applying

Georgia War Veterans Home • Milledgeville

Use this guide to work through the application and gather the records we need. A family member or another helper may write the answers with you. Admissions is available at (478) 445-4295 if you need assistance.

Pages	Section	What you will find	Estimated time
1–3	Getting started	Instructions and a checklist to prepare and return the packet.	10–15 minutes
4–8	Application	Veteran information and contacts, coverage, Georgia eligibility requirements and signatures.	20–25 minutes
9–12	Care information	Care assessment, provider information and a checklist of medical records for review.	15–20 minutes
13–17	Costs and payment	The daily and monthly fee, payment instructions and the State payment agreement.	15–20 minutes
18–21	Before admission	Transportation planning, personal items and funeral home information for arrival.	10–15 minutes
22–41	VA forms	Instructions and VA forms for benefits and records, plus an optional advance directive.	30–40 minutes*
42–45	Visitor information	The Georgia Department of Veterans Service visitor access requirements.	5 minutes

*Estimates cover the applicant and family portions with records available. Clinical work and agency review take additional time. Allow extra time if you choose to complete a new advance directive.

Completing the packet

Allow about two hours to complete your sections, taking breaks as needed. Please leave the certification on page 6 for GDVS to complete.

Admissions will work with you and your current care providers to gather the information needed for review. You or your representative will need to help obtain records, sign any required releases and arrange appointments if requested. Admissions will explain what is needed and help with questions along the way.

- Write clearly in black or blue ink, or use the PDF fields. Write “N/A” when a question does not apply. If an answer is unknown, say so and ask Admissions what is needed.
- Use the Veteran’s legal name throughout and include area codes with phone numbers. Identify the Veteran and the question on any added sheet. Follow the VA instructions when adding information to a VA form.

> Before you sign, please read each signature section and follow the form’s signature and witness instructions. If you are signing for the Veteran, include the document that gives you that authority.

If admission is approved, we will review the separate Georgia Admissions Packet with you. That packet explains resident rights and the terms of living at the Home, including care consents and admission acknowledgments.

Gather your records and return the packet

Check your packet before returning it

- ☐ Application and residency evidence, with the declaration signed (pages 4–8)
- ☐ Care assessment and history (pages 9–11)
- ☐ Available clinical records listed on page 12
- ☐ State payment agreement, reviewed with staff before signing (pages 15–17)
- ☐ Transportation acknowledgment (page 19)
- ☐ Funeral home designation (page 21)
- ☐ VA 10-10EZ (pages 24–29)
- ☐ VA 21-22, as directed on page 22
- ☐ VA 10-5345, as directed on page 23
- ☐ Existing advance directive, if any, or optional VA 10-0137 (pages 36–41)

Attach clear copies

1. Military records

- ☐ DD Form 214 or equivalent
- ☐ For WWII service, service/separation record
- ☐ For WWII service, honorable discharge certificate
- ☐ Military award letters
- ☐ Proof of military retired pay, if received

2. Residency and income

- ☐ Residency evidence selected on page 6
- ☐ Proof of household income for benefits and fee-waiver review

3. Identification and coverage

- ☐ Insurance cards
- ☐ Medicare card
- ☐ Driver license
- ☐ Voter registration
- ☐ Social Security card
- ☐ VA identification

4. Legal documents

- ☐ Relevant power of attorney or guardianship order
- ☐ Advance directive or living will
- ☐ Any trust document establishing authority for this application

For identification and coverage, provide legible color copies of both sides of each card or document, as available.

> If you need help finding military records, contact a GDVS Veterans Field Service Office or visit archives.gov/veterans/military-service-records. A certification of service may be available if the original records were lost.

Return to Admissions

Georgia War Veterans Home
Attention: Admissions
2249 Vinson Highway
Milledgeville, GA 31061
(478) 445-4295

Catherine Dean, Admissions Director
catherine.dean@hmrvsi.com

Before sending personal records, please call Admissions to confirm secure fax or electronic delivery. You may use email to arrange delivery, then follow the instructions Admissions provides.

Application | About the Veteran (Part I)

Please complete pages 4–8, leaving the certification on page 6 for GDVS. The Veteran or an authorized representative should sign the declaration on page 8.

Legal last name	First name	Middle name / initial

Maiden or former name, if applicable	Preferred name

Date of birth	Age	Social Security number

Legal residence address, city, state and ZIP

Present address, if different; include facility name when applicable

Telephone where we can reach you	Email, if used

Applying from: ☐ Home ☐ Hospital ☐ Nursing home ☐ Assisted living ☐ Other

Current facility admission date, if applicable	Preferred language / communication assistance

Marital status: ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Never married

Spouse's name and telephone, if applicable

Military service and VA benefits

Branch of service	Dates of active service	Discharge character

VA claim or file number	VA service-connected rating, if known

Military retired pay: ☐ Yes ☐ No ☐ Unknown Attach proof if yes.

VA enrollment: ☐ Yes ☐ No ☐ Unknown VA pension / Aid and Attendance: ☐ Yes ☐ No ☐ Unknown

Current VA medical center / clinic	VA social worker or benefits contact

> Please include available military service and benefit records with your application. GDVS verifies military eligibility, and the VA confirms which benefits apply.

Application | Contacts, authority and coverage

Primary emergency contact

Full name	Relationship

Address, city, state and ZIP

Home telephone	Work / mobile

Email

Additional contact

Full name	Relationship

Address, city, state and ZIP

Home telephone	Work / mobile

Email

Who has authority to act for the Veteran?

- ☐ Healthcare power of attorney
- ☐ Financial power of attorney
- ☐ Guardianship order
- ☐ Advance directive / living will
- ☐ Trust
- ☐ Other authority
- ☐ None known

Representative's name and telephone; specify healthcare or financial authority

Document date and limits of authority; attach copies of relevant documents

Health coverage

- ☐ Medicare A
- ☐ Medicare B
- ☐ Medicare Advantage
- ☐ Medicaid
- ☐ VA health benefits
- ☐ Private insurance
- ☐ Long-term care insurance
- ☐ None / unknown

Primary plan / Medicare number	Other plan name and member number

Prescription / Part D plan and member number	Current pharmacy / VA medication contact

Current medication source

☐ VA ☐ Military facility ☐ Community pharmacy ☐ Other

> Naming a contact gives them no decision-making authority or payment obligation. For staff review, please include authority documents, coverage cards and any long-term care policy.

Application | Georgia residency (Part II)

The following information may be used in lieu of VS Form 27-173 Aug 2025

Do you currently live in Georgia? ☐ Yes ☐ No

The applicant must be domiciled in Georgia. Select the residency period met immediately before this application.

☐ At least two years in Georgia
☐ At least five of the preceding 15 years in Georgia
☐ Neither period is met
☐ Help needed to document residency

Georgia residence dates and addresses relevant to the requirement

Evidence attached

☐ Georgia income tax returns	☐ Georgia driver license plus supporting records
☐ Dated voter registration card	☐ School attendance records
☐ Employer statement on letterhead	☐ Homestead exemption
☐ Deed and tax statements with homestead code	☐ Record on file in a GDVS office

Other residency evidence	**Additional residency evidence**

Person who can certify residency under oath

Full name	**Relationship to Veteran**

Address, city, state and ZIP

Home telephone	**Work telephone**

For GDVS use only | Verification (Part V)

Military service verified by: ☐ DD Form 214 ☐ VA ☐ Other

If other, identify evidence and explain

Under penalty of law, the undersigned hereby certifies and declares that the applicant provided the documentary evidence listed in Part II, as required by the Georgia Department of Veterans Service, to support fulfillment of the residency requirement identified in Parts II & III of this application.

Printed Name & Signature of GDVS Representative	**Date**

VFSO office location	**Telephone, including area code**

Application | Eligibility terms (Part III)

Read these terms and the responsibilities on the next page before signing the declaration.

1. To be eligible for admission, applicants must meet the requirements listed below in accordance with 38 CFR Part 51, of the U.S. Department of Veterans Affairs (VA), January 6, 2000, as amended; Georgia State Laws; and Georgia Department of Veterans Service policies as outlined in Georgia Department of Veterans Service Department Directive 27.119, State Veterans Home Program, as amended:

a. Applicant must be domiciled in Georgia and have actually resided in Georgia for at least two years or five out of the preceding 15 years immediately preceding the date of application.

b. The applicant must be a "war veteran." The term war veteran (see DD 27.119 for complete definition) means any veteran who was discharged under other than dishonorable conditions and who served on active duty in the Armed Forces of the United States or on active duty in a Reserve Component of the Armed Forces of the United States during wartime or during the period beginning January 31, 1955 and ending on August 1, 1990 or during the period beginning January 1, 1947, and ending on June 26, 1950.

c. Since September 1980, an individual who enlists in the military for the first time must have completed a minimum period of service to be eligible for certain VA benefits. With some exceptions, the minimum period of service is either twenty-four months of continuous active duty or the entire period for which the individual was called or ordered to active duty.

d. Applicant must be approved as "eligible for care and treatment" by the VA.

e. An applicant with contagious diseases, behavioral, psychiatric problems or other diagnoses the care and treatment for which may exceed the capability of the homes to provide will be reviewed before a decision will be made on accepting the veteran for admission to the homes. However, the facilities are unable to care for some cases of the diseases. When the contagious, infectious disease, behavioral, psychiatric problems or other diagnoses the care and treatment for which may exceed the capability of the homes to provide are resolved, under control, or it is determined the home has the capability to provide the care and treatment required, the applicant may be considered for admission based on facility resources.

f. Applicant must not need to be sustained by line-operated mechanical means (e.g., electrical respirator, external pace makers, dialysis machines, or other life support apparatuses).

g. Applicant must not be in need of hospital level of services (e.g., surgery, transfusions, intravenous infusion of drugs or fluids).

h. Applicant must not be participating in medical research programs that have special medical, treatment or transportation requirements.

i. The Veteran applicant must not have civil or criminal charges pending nor be under a detainer from any court of law or law enforcement agency. A waiver to this restriction for nonviolent offenders may be granted by the Commissioner of Veterans Service or their designated representative.

Additional care screening

The Home's admission criteria also exclude the following.

- Ventilators
- External pacemakers
- Dialysis machines
- PICC lines
- Ports
- A-V fistulas
- Unhealed tracheotomy
- Active chemotherapy, radiation or other cancer treatment

Tell Admissions about these needs and any planned treatment before admission is arranged.

GDVS and the Home will review eligibility and care needs. Please include the clinical records listed on page 12. Admission depends on approval, available funding and an appropriate bed. A waiting list may apply.

Application | Responsibilities and declaration

Read the eligibility terms on page 7 and the responsibilities below before signing.

2. Residents will be required to:
   a. Pay some expenses incurred by regulation (e.g., Medicare or health insurance co-pays and deductibles).
   b. Pay all costs of transportation to and from the home (e.g., medical or other appointments, special outings, and etc.), unless specifically provided by the VA or the Georgia Department of Veterans Service.
   c. Abide by the rules and regulations established for resident conduct in the resident handbook and other individual policies, rules and regulations that may from time to time be published by the home, the Georgia Department of Veterans Service, or the VA with the understanding that violations will result in discharge from the home. Operation of a motor vehicle on the premises of the homes is not permitted for residents.
   d. Accept transfer to other medical facilities (including those operated by the VA), if the medical considerations indicate and pay all costs of transportation, unless provided by the VA or the Georgia Department of Veterans Service.
   e. Accept discharge from the home when medical or administrative review determines such action to be appropriate and in accordance with the medical needs of the patient.
   f. Recognize that each of the homes will be operated in full compliance with the Civil Rights Act without discrimination on the basis of a person's race, color, religion, national origin, sex, handicap or age.

> **Your rights.** Transfer and discharge decisions remain subject to applicable notice, review and resident-rights requirements. Signing this application does not waive those protections.

Applicant declaration (Part IV)

Under penalty of law, the undersigned hereby certifies and declares that all answers to questions in this application and the attached documents are correct to the best of my knowledge and belief, that all questions are fully understood and that all questions and answers have been read by me or read and explained to me and that I understand and accept the terms and conditions required in Part III of this application. FURTHER, I understand misleading statements on this application and any attached forms or documents will be grounds for non-admission to the home or discharge from the home.

Veteran or designated representative signature	**Date**

Printed name	**Representative's authority, if applicable**

Witness 1 signature, if signing with an X	**Witness 2 signature, if signing with an X**

Witness 1 Printed Name	**Witness 2 Printed Name**

Care assessment | Everyday activities

The following information may be used in lieu of VS Form 27-106, Apr 2015

Please have someone familiar with the Veteran's daily care complete and sign pages 9–11, marking Yes (Y), No (N), or Unknown (?). Use page 11 to explain assistance or changes in care. Incomplete or unsigned forms may delay review.

Veteran's name	Assessment date

Walking and mobility

Ability / condition	Y	N	?
Walks without assistance	☐	☐	☐
Uses cane or walker	☐	☐	☐
Uses a wheelchair	☐	☐	☐
Stays in bed or chair	☐	☐	☐
Falls frequently	☐	☐	☐

Arms, legs and therapy

Ability / condition	Y	N	?
Moves arms without help	☐	☐	☐
Moves legs without help	☐	☐	☐
Receives physical therapy	☐	☐	☐

Dressing

Ability / condition	Y	N	?
Dresses upper body without help	☐	☐	☐
Dresses lower body without help	☐	☐	☐
Puts on socks / shoes without help	☐	☐	☐
Receives occupational therapy	☐	☐	☐

Grooming

Ability / condition	Y	N	?
Shaves without help	☐	☐	☐
Brushes teeth / cleans dentures	☐	☐	☐
Trims nails without help	☐	☐	☐

Bathing

Ability / condition	Y	N	?
Needs a bed bath	☐	☐	☐
Takes a tub bath without help	☐	☐	☐
Showers without help	☐	☐	☐
Resists bathing	☐	☐	☐

Transfers and position

Ability / condition	Y	N	?
Transfers without help (bed/chair/toilet)	☐	☐	☐
Must be carried or helped to transfer	☐	☐	☐
Shifts weight in chair without help	☐	☐	☐
Turns self in bed	☐	☐	☐
Uses nurse call system	☐	☐	☐

Eating

Ability / condition	Y	N	?
Feeds self	☐	☐	☐
Has a feeding tube	☐	☐	☐
Completes meals	☐	☐	☐

Diet type, texture, restrictions and feeding assistance

Mobility equipment and assistance needed for safe transfers

> Please describe what the Veteran can safely do now with the help normally provided. Admissions will review your answers along with the clinical records to understand the Veteran's care needs.

Care assessment | Health and support needs

The following information may be used in lieu of VS Form 27-106, Apr 2015

Please mark Yes (Y), No (N), or Unknown (?) and describe any care or safety concerns on page 11.

Veteran's name

Awareness and behavior

Ability / condition	Y	N	?
Alert and aware	☐	☐	☐
Physically fights / hostile behavior	☐	☐	☐
Yells	☐	☐	☐
Wanders	☐	☐	☐
Comatose / unconscious	☐	☐	☐
Cooperative with care	☐	☐	☐

Vision, hearing and communication

Ability / condition	Y	N	?
Has poor vision	☐	☐	☐
Is blind	☐	☐	☐
Wears glasses / contact lenses	☐	☐	☐
Is deaf	☐	☐	☐
Uses a hearing aid	☐	☐	☐
Can communicate needs	☐	☐	☐

Toileting

Ability / condition	Y	N	?
Controls bowels	☐	☐	☐
Controls bladder	☐	☐	☐
Has a urinary catheter	☐	☐	☐
Has a colostomy	☐	☐	☐
Has an ileostomy	☐	☐	☐

Skin

Ability / condition	Y	N	?
Dry skin	☐	☐	☐
Bruises easily	☐	☐	☐
Skin tears	☐	☐	☐
Rash	☐	☐	☐
Pressure injuries / bedsores	☐	☐	☐

Breathing

Ability / condition	Y	N	?
Uses oxygen	☐	☐	☐
Has a tracheostomy	☐	☐	☐
Needs suctioning	☐	☐	☐
Can cough	☐	☐	☐
Smokes or chews tobacco	☐	☐	☐

Equipment and legal documents

Ability / condition	Y	N	?
Needs safety devices	☐	☐	☐
Has dentures	☐	☐	☐
Uses artificial limbs / braces	☐	☐	☐
Has a guardian	☐	☐	☐
Has a power of attorney	☐	☐	☐
Has a living will	☐	☐	☐
Has durable healthcare POA	☐	☐	☐
Has Georgia advance directive	☐	☐	☐

Pressure injuries / bedsores: number and locations, if present

Other skin concerns, equipment details or support needs

> Please use page 11 to describe behavior, tobacco use and equipment needs. If a concern is new or worsening, notify the current care team while the application is under review.

Care assessment | History and daily routine

The following information may be used in lieu of VS Form 27-106, Apr 2015

Please answer all five questions, explaining any Yes answers or writing "Unknown" if you need help finding the information. You may attach additional pages as needed.

Veteran's name

1. Current or past alcohol problem? ☐ Yes ☐ No ☐ Unknown

Details for question 1

2. Hospitalized for alcoholism or an alcohol-related problem? ☐ Yes ☐ No ☐ Unknown

Details for question 2

3. Current or past problem with illicit drugs? ☐ Yes ☐ No ☐ Unknown

Details for question 3

4. Treatment for a psychiatric (mental) illness? Include diagnosis, where and when. ☐ Yes ☐ No ☐ Unknown

Details for question 4

5. Currently participating in an experimental research therapy program? ☐ Yes ☐ No ☐ Unknown

Details for question 5

Daily routine, personality, habits, likes and dislikes; explain assistance or other concerns

Person completing this assessment	**Relationship / role**

Signature	**Date**

> Before signing, please check that your answers accurately describe the Veteran's needs. Falsification may result in denial of admission or discharge, subject to applicable resident rights and required review.

Clinical records and care coordination

Please share this page with the Veteran's current care providers and call Admissions at (478) 445-4295 to confirm how to send records securely.

Primary care clinician / practice and telephone	Other clinicians / specialists and telephone

Recent hospital, nursing home or rehabilitation stays and dates

Upcoming appointments

For each appointment, include the date, provider, purpose and location.

Medical records for review

Please send the records you have and let Admissions know what is still being gathered. We may need your help obtaining records from current providers or signing releases. We will begin reviewing information as it arrives and contact you about missing records or any additional assessment needed.

1. Records to gather for each applicant

- ☐ Primary care notes from the three most recent visits, including the latest medical summary
- ☐ Most recent history and physical
- ☐ Current medication list, including allergies
- ☐ Current treatment orders
- ☐ Available laboratory results from the last three months
- ☐ Available immunization records

2. Additional records when applicable

- ☐ Recent specialist visit notes
- ☐ Wound and skin treatment records
- ☐ Psychiatric history and behavioral notes
- ☐ Current behavioral treatment plan
- ☐ Equipment and assistance needs
- ☐ Records from hospitalizations in the last three months, including discharge summaries

Records based on the Veteran's current setting

If currently in a hospital, ask the care team to send the following.

- ☐ Admission history and physical
- ☐ Nursing notes
- ☐ Current orders

If currently in a nursing home, ask for the past 30 days of nursing notes and orders. Otherwise, include primary care notes explaining the need for skilled nursing care.

> Our clinical team needs current information to determine whether the Home can meet the Veteran's care needs and may request an in-person evaluation. Please tell Admissions about any changes during review or while waiting for admission. Staff will confirm care needs before admission.

Daily fee and monthly schedule | 2026

Standard daily resident fee: $31.92

Care at the Home is supported by State funding and VA payments, with a resident fee when applicable.

The daily resident fee is $0.00 when VA pays in full for covered nursing home care, including qualifying Veterans with a service-connected rating of 70% or higher. An approved hardship waiver may reduce or waive the resident fee. Staff will verify the applicable category; a benefit or waiver application alone does not establish approval.

Month	Amount	Month	Amount
January	$989.52	July	$989.52
February	$893.76	August	$989.52
March	$989.52	September	$957.60
April	$957.60	October	$989.52
May	$989.52	November	$957.60
June	$957.60	December	$989.52

> The Business Office can answer questions about the Veteran's fee and will confirm the amount that applies. Any rate change requires written notice.

How to make payment

Make checks or money orders payable to:
GA DEPT OF VETERANS SERVICE

Cash is not accepted for fee payments. Cash may be deposited into a resident trust account if one has been established. Credit cards and electronic transfers are not accepted. A returned check requires future payments by cashier's check or money order.

Drop-off and mailing

Black payment drop boxes are located at the MSU nurses station and on the first floor of the Wood and Vinson buildings beside the information desk. Use the box labeled "GA Dept of Veteran Services Payment Drop Box." Lift the top and deposit checks or money orders only.

Mail payments to:
Georgia War Veterans Home
P.O. Box 1412
Milledgeville, GA 31059-1412

Questions about payment

Kenyada Braddy, Financial Counselor
(478) 445-5749 • Wheeler Building, Suite D-109

Understanding costs and the State agreement

Please review this page along with the State Veterans Home Payment Agreement on pages 15–17. The Business Office can explain any terms you are unsure about before you sign.

Services supplied by the Home

Services provided by the Home include the following.

- Healthcare provider and nursing services
- Routine nursing supplies
- Lodging
- Routine linens and their laundry
- Meals and snacks
- Routine therapies and care equipment
- Social Services
- Activities

The admissions contract provides the complete services and fee disclosure.

At GWVH, personal laundry, in-house beautician services including haircuts, and routine personal items supplied by the Home are provided at no additional charge. Residents pay for optional personal purchases or separately elected services beyond those supplied by the Home only after the applicable charge is disclosed.

> Although the State agreement excludes personal laundry, haircuts and certain personal items from its general fee coverage, GWVH provides the services described above at no additional charge. Please ask the Business Office about any personal service you plan to arrange separately.

Billing, leave and additional costs

- The State agreement sets out monthly advance billing, payment due within 10 days of the invoice date, collection terms, refunds and notice of rate changes. Review the original agreement for the complete terms.
- The applicable daily fee continues throughout an elected bed hold, including hospitalization and other leave. VA payment-in-full exemptions and approved waivers apply. The admission contract includes the Bed Hold Notice and election.
- Outside provider copayments, deductibles, uncovered services and transportation may be the Veteran's responsibility, depending on benefits and coverage. The Home's pharmacy arrangement and any separate charge are explained in the admission contract.

Who should sign the State agreement?

The State agreement includes a section where a responsible party may voluntarily agree to pay. Being named as a contact or representative on this application does not create that obligation. Before signing, ask the Business Office to explain who should sign and what each signature means.

Benefits assistance

Please work with a Veterans Field Service Officer before or at admission on the GDVS benefits review, including Aid and Attendance when applicable. The review is required within the first two weeks for new residents. Eligibility must be determined for benefits and hardship waivers.

> If you have already applied for Aid and Attendance, please provide a copy of the filing information so staff can follow up. The Business Office can help you obtain income records or apply for a fee waiver.

State Veterans' Home Payment Agreement

This information can be used in lieu of VS Form 27-303 January 2013.

Name of Veteran Patient	Date

First Initial of Last Name and Last Four of Social Security Number

Mailing Addresses for Georgia's State Veterans' Homes

Check the block for the appropriate State Veterans' Home.

☐ Georgia War Veterans Nursing Home
1101 15th Street
Augusta, Georgia 30901-3196
ATTN: Executive Director

☐ Georgia War Veterans Home
2249 Carl Vinson Highway
Milledgeville, Georgia 31061
ATTN: Executive Director

Introduction

This is a Georgia State Veterans Home Payment Agreement (Agreement) by and between the Georgia Department of Veterans Service, the Georgia War Veterans Nursing Home in Augusta, Georgia, or the Georgia War Veterans Home in Milledgeville, Georgia and the undersigned veteran patient and/or responsible party(s). This is a legal document creating rights and obligations for each person, or party signing the Agreement. Please read the Agreement carefully before you sign it. This agreement is required by Chapter 690-1-1-.03(7), Fee for Residency in a Facility of the Georgia State War Veterans' Home, Georgia's Administrative Rules and Regulations, November 1, 2012.

Period of the Agreement

This agreement shall be effective on the date first indicated above, or the date of admission to the indicated State Veterans' Home, whichever occurs later. In accordance with Chapter 690-1-1-.03(7) it shall remain in effect for the period of time the veteran patient named above remains a resident of the State Veterans' Home indicated above.

References to the Parties

We believe this Agreement will be more easily understood if we use, where practical, personal pronouns in referring to the parties to this Agreement. References to "we", "our", "home", the "Facility", and to "our Facility" are references to the Georgia Department of Veterans Service, the Georgia War Veterans Nursing Home, or the Georgia War Veterans Home. References to "you" and "your" are references to any person signing this Agreement.

State Veterans' Home Payment Agreement (continued)

Agreement as Veteran Patient or Responsible Party.

A Veteran Patient is an individual who meets the eligibility requirements for residency in a State Veterans' Home as stated in Georgia law and is the actual patient who resides in or will reside in the facility.

A Responsible Party is an individual who voluntarily agrees to honor certain specified obligations of financial liability of the Veteran Patient. If you sign this Agreement as the Responsible Party you are accepting responsibility for the Veteran Patient and any debts that may be incurred by the Veteran Patient at the facility related to payment of the Daily Fee and the monthly invoice.

Billing and Changes in Rates

Our current Daily Fee on the date of this agreement is $

We shall provide you with at least 30 days written notice of any increase in the Daily Fee. You agree to pay us our Daily Fee for each day of nursing facility care and services we provide to the Veteran Patient. Such payment shall be made one month at a time. We shall provide you with monthly invoices itemizing total charges incurred by you of the Daily Fee times the number of days the veteran patient was a resident in the home during the month. Invoices will be issued at the beginning of the month of residency in the home and each subsequent month. Payments will be due and payable no later than 10 days following the date of invoice. In the event of death or permanent discharge, fees paid for days not used will be refunded to the Veteran Patients' responsible party; however, any and all outstanding amounts owed will be due and payable within 10 days after the beginning of the month following the death or permanent discharge of the veteran patient. Payments for partial months will be calculated from the first day of the month through the day prior to death or permanent discharge of the Veteran Patient. Our current Daily Fee is expected for bed holds, including but not limited to, hospitalizations and therapeutic leaves. We neither extend credit nor accept payment in installment. (Chapter 690-1-1, Georgia's Administrative Rules)

Advance Payment upon Admission

New admissions to the facility will make payments to the home for the amount of the Daily Fee from the day/date of admission through the last day of the month of admission. Subsequent monthly invoices will be submitted to the Veteran Patients and/or Responsible Parties in accordance with standard invoicing and business procedures.

Collection Costs and Attorneys' Fees

We require you or your Responsible Party to agree, as a condition of admission and continued stay in our Facility, to pay attorney's fees or any other costs incurred in collecting payment for the nursing facility care and services we provide to you.

State Veterans' Home Payment Agreement (continued)

Services

The basic Daily Fee includes payment for healthcare providers (physicians, nurse practitioners, physician's assistants), nursing services and lodging, linens (routine laundry service of them), routine nursing supplies, regular meals and snacks, routine therapies, routine equipment, social services, activities, and routine items which are required to meet your needs. It does not include personal services (such as personal laundry service), haircuts or personal items.

Acknowledgements

By signing below, I/we acknowledge my/our understanding and agreement to the stipulations and requirements outlined in this payment agreement.

Veteran Patient / If able to sign

Signature	Date

Print Name

Responsible Party / Spouse

Signature	Date

Print Name

State Veterans' Home Representative

Signature	Date

Print Name

Abbreviated Home Name

Appointments and transportation | What to expect

Coordinating VA care

For Veterans receiving VA healthcare, the Home coordinates the transfer of care to the Carl Vinson VA Medical Center, 1826 Veterans Boulevard, Dublin, Georgia, and its associated clinics. Associated clinics include Albany, Brunswick, Kathleen, Macon, Milledgeville and Tifton. Staff will confirm the appropriate location for each appointment.

When needed services are not available within the Dublin jurisdiction, VA may arrange a referral to community care or to another VA facility, including Augusta or Atlanta. Community-care referrals depend on VA eligibility, available services and the individual Veteran's needs.

Transportation arrangements and cost

The Home assists with transportation arrangements but does not guarantee transportation or payment for every appointment. Unless the VA, HMR, insurance or another confirmed source provides payment, the Veteran is responsible for the transportation cost. Discuss the arrangement and available funds with staff before travel is scheduled.

Depending on the Veteran's medical needs, arrangements may involve non-emergency transportation, a taxi or a non-emergency ambulance. A stretcher may be necessary. Insurance payment for stretcher transportation generally requires review and prior authorization; eligibility depends on the plan, medical need and service. Dialysis or debridement does not by itself guarantee coverage.

When a Home vehicle may be available

- Available Home vehicles may support appointments in the Dublin VA jurisdiction and appointments outside that jurisdiction made or referred by the Dublin VAMC.
- Subject to vehicle availability, the Home may assist with non-VA medical, dental and psychological appointments within Baldwin County and adjacent counties.
- The Home does not provide stretcher transportation in its vehicles. Staff will help coordinate an appropriate outside service when needed.

Scheduling and changes

When Home assistance is requested, an appointment may need to be rescheduled based on medical necessity and transportation availability. Transportation cannot be scheduled solely around family convenience. Tell Nursing or Social Services promptly if VA or another provider gives the family an appointment change or cancellation.

> You may arrange appointments and transportation independently. Please coordinate with Nursing or Social Services so staff can prepare the Veteran and communicate care or equipment needs. Social Services can answer questions about these arrangements.

Appointments and transportation | Planning and acknowledgment

Please review the transportation information on page 18 before completing and signing this page. Naming someone as a contact here does not make that person responsible for payment.

Veteran's name	**Date**

Help us plan

Expected travel needs: ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Not yet known

Mobility equipment, oxygen or other assistance needed during travel

Family / other transportation contact and telephone

Known outside transportation provider and telephone, if any

Upcoming appointments or transport concerns to review with staff

Acknowledgment

I have reviewed the transportation information on page 18 and had an opportunity to ask questions. I understand that Home assistance depends on care needs and availability, and that the Veteran pays transportation costs unless another source confirms payment. I will notify Nursing or Social Services of appointments, changes and independently arranged travel.

Initials acknowledging the transportation cost information: _____

Veteran's signature, if able	**Date**

Representative's printed name and relationship / authority

Representative's signature, if applicable	**Date**

GWVH representative's printed name and title

GWVH representative's signature	**Date**

Preparing for the Home | Personal items and safety

Veteran's name

Weapons, alcohol and medications

Do not bring weapons, alcohol or illicit drugs into the Home. Prohibited items include knives, saws, tools and razor blades. Discuss personal grooming tools or other necessary items with staff before bringing them to the Home.

Prescription and over-the-counter medications must be given to Nursing for review and secure medication storage. They are not to be kept in a resident's room, on the resident's person or elsewhere on the grounds outside the Home's authorized medication process.

Health and wellness checks

The Home conducts routine health and wellness checks. Prohibited items found during a check are secured, labeled and held for family pickup or appropriate disposal, consistent with applicable requirements. Staff will discuss the item and next steps with the Veteran or representative. Do not attempt to dispose of medications or weapons independently on the campus.

Responding to a concern

Tell staff if an item, medication or safety concern needs attention. The Home will address risks and review the situation. Any transfer or discharge decision must follow applicable resident-rights, notice and review requirements. Staff will review the Home's Violence and Weapons information with you during admission.

> Smoking is permitted in designated areas. Staff can show you where these are and discuss any assistance or safety arrangements you may need.

Before arrival

☐ Discuss personal grooming tools or other items that need a staff review.

☐ Plan to give all medications to Nursing on arrival.

☐ Arrange for family to keep items that cannot be brought to the Home.

Items, medication arrangements or questions to discuss with staff

> Please check with Admissions before bringing furniture or large personal items. Staff can help you plan around the available space and the Veteran's care needs.

Funeral home designation

Please identify a funeral home before admission. If arrangements are incomplete, Social Services can help you work through the information needed.

Veteran's full name	
Date of birth	**Last four digits of Social Security number**

Designated funeral home

Funeral home name		
Street address		
City	**State**	**ZIP code**

Telephone	**Contact person, if known**

Prearrangement: ☐ Completed ☐ In progress ☐ Assistance requested

Prepaid arrangement, if known: ☐ Yes ☐ No ☐ Unknown

Person to contact about these arrangements	**Telephone**
Additional instructions or information for Social Services	

Designation

I identify the funeral home above for the Home's records. I will notify Social Services if the designation or contact information changes. If arrangements are incomplete, I will work with the admissions team to complete the required plan before admission.

Veteran or authorized representative signature	**Date**
Printed name and representative's authority, if applicable	

> Your signature records your choice of funeral home. Any purchases or assignment of funds must be arranged separately with the funeral provider, and existing legal instructions remain in effect.

VA forms | Completion guide

Please review these directions before starting the VA forms, keeping each form's instructions with it and following its signature requirements.

VA Form 10-10EZ | Health benefits • pages 24–29

The Veteran or authorized signer completes the personal, insurance and financial information requested by the form. The State application requires this form even if the Veteran already receives VA care. If a current electronic application or update is on file with VA, ask Admissions whether it can be used.

> Please complete the certification and signature/date fields for your method of submission. If someone signs for the Veteran, include their legal authority. When signing with a mark, follow the VA witness instructions.

VA Form 21-22 | Benefits representative • pages 30–33

This form appoints a recognized Veterans Service Organization to assist with VA benefits claims. Review it with a Veterans Field Service Officer (VFSO). Tell the VFSO if you already have a representative so they can determine whether a new appointment is needed. This form does not authorize healthcare decisions.

Please complete the applicable Veteran and claimant information, with VFSO help for the service-organization details. Before signing, read the authorizations and disclosure choices.

> The appointment requires both signatures. The Veteran or claimant must sign and date items 22A–22B on form page 2 (packet page 31), and the authorized VSO representative must sign and date items 23A–23B. Notarization is not required.

VA forms | Records and care wishes

VA Form 10-5345 | Health records release • pages 34–35

This form authorizes VA to release specified health information to the Home. The recipient and requested records are already entered. Read both pages, including the selected categories and expiration choices, to confirm that the release reflects your wishes.

> After completing the patient information and required consent choices, please sign and date form page 2 (packet page 35). A representative must identify their relationship and provide the authority the form requests. Please ask Admissions about any unclear entry before signing.

VA Form 10-0137 | Advance directive • pages 36–41

An advance directive records healthcare choices and may name someone to make healthcare decisions when you cannot. You may provide an existing directive or use this form. Completing a new directive is voluntary and is not a condition of admission or care. You may ask for help, decide later or decline.

Discuss your wishes with your chosen healthcare agent and clinician, then complete the parts you intend to use. Please read and follow the instructions, including signing rules and who may serve as a witness.

> Please sign only when the required witnesses are present. An advance directive does not by itself create a do-not-resuscitate order. Staff will review the Home's advance-directive information with you during admission.

Where to ask for help

If you need help, call Admissions at (478) 445-4295. We can connect you with the VFSO for benefits representation or with a clinician or Social Services to discuss healthcare wishes.

Visitor information | pages 42–45

The GDVS visitor directive follows the VA forms. It explains requirements for non-family visitors, organizations and delegations, with exceptions for immediate family and expressly invited individuals. Read the directive for the full requirements. No applicant signature is needed.

Department of Veterans Affairs

INSTRUCTIONS FOR COMPLETING ENROLLMENT APPLICATION FOR HEALTH BENEFITS

Please Read Before You Start . . . What is VA Form 10-10EZ used for?

For Veterans to apply for enrollment in the VA health care system. The information provided on this form will be used by VA to determine your eligibility for medical benefits and on average will take 30 minutes to complete. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Where can I get help filling out the form and if I have questions?

You may use ANY of the following to request assistance:

- Ask VA to help you fill out the form by calling us at 1-877-222-VETS (8387).
- Go to www.va.gov/health-care for information about VA health benefits.
- Contact the Enrollment Coordinator at your local VA health care facility.
- Contact a National or State Veterans Service Organization.

Definitions of terms used on this form:

- SERVICE-CONNECTED (SC): A VA determination that an illness or injury was incurred or aggravated in the line of duty, in the active military, naval or air service.
- COMPENSABLE: A VA determination that a service-connected disability is severe enough to warrant monetary compensation.
- NONCOMPENSABLE: A VA determination that a service-connected disability is not severe enough to warrant monetary compensation.
- TOXIC EXPOSURE RISK ACTIVITY (TERA): Veterans who were exposed to one or more of the following hazards or conditions during active duty, active duty for training, or inactive duty training (this is not an all-inclusive list): air pollutants, chemicals, occupational hazards, radiation, and warfare agents. For more information visit https://www.publichealth.va.gov/exposures/.
- NONSERVICE-CONNECTED (NSC): A Veteran who does not have a VA determined service-related condition.
- REPORTABLE INCOME: The minimum amount of gross income required to file a Federal income tax return according to the Internal Revenue Code of 1954 Section 6012(a).

Getting Started: ALL VETERANS MUST COMPLETE SECTIONS I - III.

Directions for Sections I - III:

Section I - General Information: Answer all questions.

Type of Benefit Applying For:

- **Enrollment -** Veterans applying for enrollment for the Full Medical Benefits Package provide in 38 C.F.R. 17.38 must meet the eligibility requirements of 38 C.F.R. 17.36.
- **Registration** - For Registrations, only complete Sections I, II, and III. Enrollment not required - Veterans requesting an eligibility assessment, clinical evaluation, care or treatment pursuant to a special treatment authority provided in 38 C.F.R. 17.37:
  - Care for a Veteran with a VA service connected disability rating of 50% or greater
  - Care for a VA rated service connected disability
  - Care for psychosis or other mental illness
  - Care for Military Sexual Trauma treatment (MST)
  - Catastrophically Disabled Examination
  - A veteran who was discharged or released from active military service for a disability incurred or aggravated in the line of duty can receive VA care for the 12-month period following discharge or release
  - Care for a Veteran participating in VA's vocational rehabilitation program under 38 U.S.C. 31

Section II - Military Service Information: If you are not currently receiving benefits from VA, you may attach a copy of your discharge or separation papers from the military (such as DD-214 or, for WWII Veterans, a "WD" Form), with your signed application to expedite processing of your application. If claiming a Military Exposure, you may provide us a written statement, or statements from people who witnessed your claimed exposure(s). If you are currently receiving benefits from VA, we will cross-reference your information with VA data.

Section III - Insurance Information: Include information for all health insurance companies that cover you, this includes coverage provided through a spouse or significant other. Bring your insurance cards, Medicare and/or Medicaid card with you to each health care appointment.

Directions for Sections IV-IX:

Section IV - Dependent Information: Include the following:

- Your spouse even if you did not live together, as long as you contributed support last calendar year.
- Your biological children, adopted children, and stepchildren who are unmarried and under the age of 18, or at least 18 but under 23 and attending high school, college or vocational school (full or part-time), or became permanently unable to support themselves before age 18.
- Child support contributions. Contributions can include tuition or clothing payments or payments of medical bills.

Section V - Employment Information:

- Veterans Employment Status
- Date of Retirement
- Company Name
- Company Address
- Company Phone Number

Section VI - Financial Disclosure: ONLY NSC AND 0% NONCOMPENSABLE SC VETERANS MUST COMPLETE THIS SECTION TO DETERMINE ELIGIBILITY FOR VA HEALTH CARE ENROLLMENT AND/OR CARE OR SERVICES.

Financial Disclosure Requirements Do Not Apply To:

- a former Prisoner of War; or
- those in receipt of a Purple Heart; or
- a recently discharged Combat Veteran; or
- those who served in a toxic exposure risk activity (TERA); or
- those discharged for a disability incurred or aggravated in the line of duty; or
- those receiving VA SC disability compensation; or
- those receiving VA pension; or
- those in receipt of Medicaid benefits; or
- those who served in an Agent Orange exposure location; or
- those who served in SW Asia during the Gulf War between August 2, 1990 and November 11, 1998; or
- those who served at least 30 days at Camp Lejeune between August 1, 1953 and December 31, 1987.

You are not required to disclose your financial information; however, VA is not currently enrolling new applicants who decline to provide their financial information unless they have other qualifying eligibility factors. If a financial assessment is not used to determine your priority for enrollment you may choose not to disclose your information. However, if a financial assessment is used to determine your eligibility for cost-free medication, travel assistance or waiver of the travel deductible, and you do not disclose your financial information, you will not be eligible for these benefits.

Section VII - Previous Calendar Year Gross Annual Income of Veteran, Spouse and Dependent Children
Report:

- Gross annual income from employment, except for income from your farm, ranch, property or business. Include your wages, bonuses, tips, severance pay and other accrued benefits and your child's income information if it could have been used to pay your household expenses.
- Net income from your farm, ranch, property, or business.
- Other income amounts, including retirement and pension income, Social Security Retirement and Social Security Disability income, compensation benefits such as VA disability, unemployment, Workers and black lung, cash gifts, interest and dividends, including tax exempt earnings and distributions from Individual Retirement Accounts (IRAs) or annuities.

Do Not Report:

Donations from public or private relief, welfare or charitable organizations; Supplemental Security Income (SSI) and need-based payments from a government agency; profit from the occasional sale of property; income tax refunds, reinvested interest on Individual Retirement Accounts (IRAs); scholarships and grants for school attendance; disaster relief payments; reimbursement for casualty loss; loans; Radiation Compensation Exposure Act payments; Agent Orange settlement payments; Alaska Native Claims Settlement Acts Income, payments to foster parent; amounts in joint accounts in banks and similar institutions acquired by reason of death of the other joint owner; Japanese ancestry restitution under Public Law 100-383; cash surrender value of life insurance; lump-sum proceeds of life insurance policy on a Veteran; and payments received under the Medicare transitional assistance program.

Section VIII - Previous Calendar Year Deductible Expenses

Report non-reimbursed medical expenses paid by you or your spouse. Include expenses for medical and dental care, drugs, eyeglasses, Medicare, medical insurance premiums and other health care expenses paid by you for dependents and persons for whom you have a legal or moral obligation to support. Do not list expenses if you expect to receive reimbursement from insurance or other sources. Report last illness and burial expenses, e.g., prepaid burial, paid by the Veteran for spouse or dependent(s).

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.

Submitting Your Application

1. You or an individual to whom you have delegated your Power of Attorney must sign and date the form. If you sign with an "X", 2 people you know must witness you as you sign. They must sign the form and print their names. If the form is not signed and dated appropriately, VA will return it for you to complete.
2. Attach any continuation sheets, a copy of supporting materials and your Power of Attorney documents to your application.

Where do I send my application?

Mail the original application and supporting materials to the Health Eligibility Center, PO Box 5207, Janesville, WI 53547-5207.

PAPERWORK REDUCTION ACT AND PRIVACY ACT INFORMATION

VA Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-0091, and it expires 07/31/2027. Public reporting burden for this collection of information is estimated to average 35 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing this burden, to VA Reports Clearance Officer at vapra@va.gov. Please refer to OMB Control No. 2900-0091 in any correspondence. Do not send your completed VA Form 10-10EZ to this email address.

Privacy Act Information: VA is asking you to provide the information on this form under 38 U.S.C. Sections 1705,1710, 1712, and 1722 in order for VA to determine your eligibility for medical benefits. Information you supply may be verified from initial submission forward through a computer-matching program. 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 systems of records notices and in accordance with the VHA Notice of Privacy Practices. Providing the requested information is voluntary, but if any or all of the requested information is not provided, it may delay or result in denial of your request for health care benefits. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify Veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

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

3. SEX	4. WHAT IS YOUR RACE/ ETHNICITY? *(Check all that apply. Information is required for statistical purposes only.)*	5. SOCIAL SECURITY NO. *(999-99-9999)*
☐ FEMALE ☐ MALE	☐ AMERICAN INDIAN or ALASKA NATIVE ☐ ASIAN ☐ MIDDLE EASTERN or NORTH AFRICAN ☐ BLACK or AFRICAN AMERICAN ☐ NATIVE HAWAIIAN or OTHER PACIFIC ISLANDER ☐ HISPANIC or LATINO ☐ WHITE ☐ CHOOSE NOT TO ANSWER	

6A. DATE OF BIRTH *(MM/DD/YYYY)*	6B. PLACE OF BIRTH *(City and State)*	7. PREFERRED LANGUAGE	8. RELIGION

9A. MAILING ADDRESS *(Street)*	9B. CITY	9C. STATE	9D. ZIP CODE	9E.COUNTY

9F. HOME TELEPHONE NO. *(optional) ((999) 999-9999)*	9G. MOBILE TELEPHONE NO. *(optional) ((999) 999-9999)*	9H. E-MAIL ADDRESS *(optional)*

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

11. CURRENT MARITAL STATUS

☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED

12A. NEXT OF KIN NAME	12B. NEXT OF KIN ADDRESS	12C. NEXT OF KIN RELATIONSHIP

12D. NEXT OF KIN TELEPHONE NO. *(Include Area Code) ((999) 999-9999)*	13A. EMERGENCY CONTACT NAME	13B. EMERGENCY CONTACT TELEPHONE NO. *(Include Area Code) ((999) 999-9999)*

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 (*Note: This does not constitute a will or transfer of title*)

15. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? *(for listing of facilities visit www.va.gov/find-locations)*	16. 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 NO. *(999-99-9999)*

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)*

1A. SPOUSE'S SOCIAL SECURITY NUMBER

1B. SPOUSE'S DATE OF BIRTH *(MM/DD/YYYY)*

1C. SPOUSE'S SEX
☐ MALE ☐ FEMALE

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

2. CHILD'S NAME *(Last, First, Middle Name)*

2A. CHILD'S DATE OF BIRTH *(MM/DD/YYYY)*	2B. CHILD'S SOCIAL SECURITY NO. *(999-99-9999)*

2C. DATE CHILD BECAME YOUR DEPENDENT *(MM/DD/YYYY)*

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 NO. *(999-99-9999)*

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) ((999) 999-9999)*

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. 2900-0321
Respondent Burden: 5 minutes
Expiration Date: 07/31/2026

Department of Veterans Affairs

APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

INSTRUCTIONS: Before completing the form, read the Privacy Act and Respondent Burden on Page 3. The VA Office of General Counsel maintains a list of all attorneys, claims agents, and Veterans Service Organization (VSO) representatives accredited by VA to assist in preparing, presenting, and prosecuting claims for VA benefits at: https://www.va.gov/ogc/apps/accreditation/index.asp. You can search this list by name, state, or zip code. We recommend you use the list to confirm and validate VA accreditation before signing any contract or appointing someone to represent you on your VA benefits claim. If you prefer to have an individual assist you with your claim instead of a VSO, complete VA Form 21-22a, *Appointment of Individual as Claimant's Representative*. For more information, you can contact us through Ask VA: https://ask.va.gov/, or call us toll-free at 1-800-827-1000 (TTY:711). VA forms are available at www.va.gov/vaforms. After completing the form, use the mailing addresses provided on Page 4.

SECTION I: VETERAN'S INFORMATION

NOTE: You can *either* complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly to expedite processing of the form.

1. VETERAN'S NAME *(First, Middle Initial, Last)*

2. VETERAN'S SOCIAL SECURITY NUMBER *(SSN) (999-99-9999)* – –

3. VA FILE NUMBER *(If applicable)*

4. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)* Month – Day – Year

5. VETERAN'S SERVICE NUMBER *(If applicable)*

6. INSURANCE NUMBER(S) *(If applicable) (Include letter prefix)*

7. MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

8. TELEPHONE NUMBER *(Include Area Code) ((999) 999-9999)*

9. EMAIL ADDRESS *(Optional)*

SECTION II: CLAIMANT'S INFORMATION *(If other than veteran)*

10. CLAIMANT'S NAME *(First, Middle Initial, Last)*

11A. CLAIMANT'S DATE OF BIRTH *(MM/DD/YYYY)* Month – Day – Year

11B. RELATIONSHIP TO VETERAN

12. MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

13. TELEPHONE NUMBER *(Include Area Code) ((999) 999-9999)*

14. EMAIL ADDRESS *(Optional)*

SECTION III: SERVICE ORGANIZATION INFORMATION

15. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS *(See list on Page 3 before selecting organization)*

16A. NAME OF OFFICIAL REPRESENTATIVE ACTING ON BEHALF OF THE ORGANIZATION NAMED IN ITEM 15 *(This is an appointment of the entire organization and does not indicate the designation of only this specific individual to act on behalf of the organization)*

16B. JOB TITLE OF PERSON NAMED IN ITEM 16A

17. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 15

18. DATE OF THIS APPOINTMENT *(MM/DD/YYYY)*

VETERAN'S SOCIAL SECURITY NUMBER ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION IV: AUTHORIZATION INFORMATION

19. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C. - By checking the box below I authorize VA to disclose to the service organization named on this appointment form any records that may be in my file relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia.

☐ I **authorize** the VA facility having custody of my VA claimant records to disclose to the service organization named in Item 15 all treatment records relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. Redisclosure of these records by my service organization representative, other than to VA or the Court of Appeals for Veterans Claims, is not authorized without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the service organization named in Item 15, either by explicit revocation or the appointment of another representative.

20. LIMITATION OF CONSENT- I authorize disclosure of records related to treatment for all conditions listed in Item 19 except:

☐ DRUG ABUSE ☐ INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)

☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

21. AUTHORIZATION TO CHANGE CLAIMANT'S ADDRESS - By checking the box below, I authorize the organization named in Item 15 to act on my behalf to change my address in my VA records.

☐ I **authorize** any official representative of the organization named in Item 15 to act on my behalf to change my address in my VA records. This authorization does not extend to any other organization without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I file a written revocation with VA; or (2) I appoint another representative, or (3) I have been determined unable to manage my financial affairs and the individual or organization named in Item 16A is not my appointed fiduciary.

I, the claimant named in Items 1 ***or*** 10, hereby **appoint** the service organization named in Item 15 as my representative to prepare, present and prosecute my claim(s) for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 1. I authorize VA to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 19 and 20), to my appointed service organization. I understand that my appointed representative will not charge any fee or compensation for service rendered pursuant to this appointment. I understand that the service organization I have appointed as my representative may revoke this appointment at any time, subject to 38 CFR 20.6. *Additionally, in some cases a veteran's income is developed because a match with the Internal Revenue Service necessitated income verification. In such cases, the assignment of the service organization as the veteran's representative is valid for only five years from the date the claimant signs this form for purposes restricted to the verification match.* Signed and accepted subject to the foregoing conditions.

SECTION V: SIGNATURES

NOTE: THIS POWER OF ATTORNEY DOES NOT REQUIRE EXECUTION BEFORE A NOTARY PUBLIC

22A. SIGNATURE OF VETERAN OR CLAIMANT *(Do Not Print)*	22B. DATE SIGNED *(MM/DD/YYYY)*
23A. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 16A *(Do Not Print)*	23B. DATE SIGNED *(MM/DD/YYYY)*

NOTE: As long as this appointment is in effect, the organization named herein will be recognized as the sole representative for preparation, presentation and prosecution of your claim before the Department of Veterans Affairs in connection with your claim or any portion thereof.

VA USE ONLY	COPY OF VA FORM 21-22 SENT TO: ☐ VR&E FILE ☐ EDU FILE ☐ LG FILE ☐ INSURANCE FILE	DATE SENT *(MM/DD/YYYY)*	ACKNOWLEDGED *(Date) (MM/DD/YYYY)*	REVOKED *(Reason)* DATE *(MM/DD/YYYY)*

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement of a material fact, knowing it to be false or for the fraudulent acceptance of any payment to which you are not entitled.

RECOGNIZED SERVICE ORGANIZATIONS

Membership in an organization is not a prerequisite to appointment of the organization as claimant's representative.

The following is a listing of national, regional, or local organizations recognized by the Secretary of Veterans Affairs in the preparation, presentation, and prosecution of claims under laws administered by the Department of Veterans Affairs.

African American PTSD Association
American Legion
American Red Cross
American Veterans (AMVETS)
Armed Forces Services Corporation
Army and Navy Union, USA
Blinded Veterans Association
Catholic War Veterans of the U.S.A.
Dale K. Graham Veterans Foundation
Disabled American Veterans
Fleet Reserve Association
Gold Star Wives of America, Inc.
Green Beret Foundation
Italian American War Veterans of the United States, Inc.
Jewish War Veterans of the United States
Legion of Valor of the United States of America, Inc.
Marine Corps League
Military Officers Association of America (MOAA)
National Association for Black Veterans, Inc.
National Association of County Veterans Service Officers, Inc,
National Law School Veterans Clinic Consortium
National Montford Point Marine Association, Inc.
National Veterans Legal Services Program
National Veterans Organization of America
Navajo Nation Veterans Administration
Navy Mutual Aid Association
Paralyzed Veterans of America, Inc.
Polish Legion of American Veterans, U.S.A.
Swords to Plowshares, Veterans Rights Organization, Inc.
The Retired Enlisted Association
United Spanish War Veterans of the United States
United Spinal Association, Inc.
Veterans of Foreign Wars
Veterans of the Vietnam War, Inc. & The Veterans Coalition
Veterans of World War I of the U.S.A., Inc.
Veterans' Voice of America
Vietnam Veterans of America
Wounded Warrior Project

Although agency titles vary, the following States and possessions maintain veterans service agencies which are recognized to present claims:

Alabama	Hawaii	Minnesota	North Dakota	Tennessee
American Samoa	Idaho	Mississippi	Northern Mariana Islands	Texas
Arizona	Illinois	Missouri	Ohio	Utah
Arkansas	Iowa	Montana	Oklahoma	Vermont
California	Kansas	Nebraska	Oregon	Virginia
Colorado	Kentucky	Nevada	Pennsylvania	Virgin Islands
Connecticut	Louisiana	New Hampshire	Puerto Rico	Washington
Delaware	Maine	New Jersey	Rhode Island	West Virginia
Florida	Maryland	New Mexico	South Carolina	Wisconsin
Georgia	Massachusetts	New York	South Dakota	Wyoming
Guam	Michigan	North Carolina		

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. However, the requested information is considered relevant and necessary to recognize a service organization as your representative and/or identify disclosable records. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to recognize the service organization you name to act on your behalf in the preparation, presentation, and prosecution of claims for VA benefits (38 U.S.C. 5902). We will also use the information to identify any VA records that we may disclose to the service organization (38 U.S.C. 5701(b)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

WHERE TO SEND YOUR WRITTEN CORRESPONDENCE

Documents may be submitted by mail, in person at a VA regional office or electronically. However, VA recommends submitting correspondence electronically as this is the fastest method of receipt.

VA provides several tools to assist in electronic submission. To learn more about how to submit documents and claims electronically, visit www.va.gov/disability/upload-supporting-evidence. You can also go directly to access.va.gov to digitally upload any correspondence using Direct Upload.

By visiting www.va.gov you can also check your claims status and learn about other VA benefits.

If you need assistance, you can find a local, accredited representative at https://www.benefits.va.gov/vso/.

If you prefer to mail your correspondence, please use the related mailing address below.

COMPENSATION CLAIMS	PENSION & SURVIVORS BENEFIT CLAIMS
Department of Veterans Affairs **Evidence Intake Center** **PO Box 4444** **Janesville, WI 53547-4444**	**Department of Veterans Affairs** **Pension Intake Center** **PO Box 5365** **Janesville, WI 53547-5365**
FIDUCIARY	**BOARD OF VETERANS' APPEALS**
Department of Veterans Affairs **Fiduciary Intake** **PO Box 95211** **Lakeland, FL 33804-5211**	**Department of Veterans Affairs** **Board of Veterans' Appeals** **PO Box 27063** **Washington, DC 20038**

These addresses serve **all United States** and **foreign locations**.

Department of Veterans Affairs

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)*
All VAMCs

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
Georgia War Veterans Home 2249 Vinson Highway, Milledgeville, GA 31061

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

☒ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ EMPLOYMENT ☐ OTHER *(Please specify below):*

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)*: H&P, Mental Health, and Social Work for last three months

☒ INPATIENT DISCHARGE SUMMARY *(Dates)*: Last 12 Months

☒ PROGRESS NOTES:

- ☐ SPECIFIC CLINICS *(Name & Date Range)*:
- ☐ SPECIFIC PROVIDERS *(Name & Date Range)*:
- ☒ DATE RANGE: All clinic and providers: last 2 outpatient progress notes

☐ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*:

☒ LAB RESULTS:

- ☐ SPECIFIC TESTS *(Name & Date)*:
- ☒ DATE RANGE: Within the last 3 months

☐ RADIOLOGY REPORTS *(Name & Date)*:

☒ LIST OF ACTIVE MEDICATIONS:

☒ VACCINATION *(Dose, Lot Number, Date & Location)*: Complete immunization history

☒ ADMINISTRATIVE RECORDS:

☐ OTHER *(Describe)*:

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

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.

☒ DRUG ABUSE ☒ ALCOHOLISM OR ALCOHOL ABUSE ☒ SICKLE CELL ANEMIA

☒ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

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 unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **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.**

AUTHORIZATION: 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.

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.

EXPIRATION: Without my express revocation, the authorization will automatically expire *(select one of the following)*:

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed by patient)*

☐ UNDER THE FOLLOWING CONDITION(S): _____

_____

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
LEGAL REPRESENTATIVE SIGNATURE *(if applicable) (Sign in ink)*	DATE *(mm/dd/yyyy)*
PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

Description of information requested (continued from above):

I/We authorize Georgia War Veterans Home to request information from all non-VA providers in order to process the application.

I/We authorize Georgia War Veterans Home to release the application for admission including all VA forms, medical information, and required documents to the Carl Vinson Medical Center in Dublin, GA, for consideration for admission to a state home.

I/We authorize the Carl Vinson Medical Center in Dublin, GA, to release to Georgia War Veterans Home any and all documents associated with pre-approval and final approval that may contain protected health information and/or personally identifiable information including VA form 1010 SH and any correspondence. //

DATE RELEASED *(mm/dd/yyyy)*	RELEASED BY:

OMB Approval Number 2900-0556
Estimated Burden Avg: 30 minutes
Expiration Date: 04/30/2027

Department of Veterans Affairs

VA ADVANCE DIRECTIVE
DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND LIVING WILL

INSTRUCTIONS

This advance directive form is an official document where you can write down your preferences for your health care. If someday you can't make health care decisions for yourself anymore, this advance directive can help guide the people who will make decisions for you.

You can use this form to:

- Name specific people to make health care decisions for you
- Describe your preferences for how you want to be treated
- Describe your preferences for medical care, mental health care, long-term care, or other types of health care

You may complete some, none, or all sections of this form. If you need more space for any part of the form, you may attach extra pages. Be sure to initial and date every page that you attach. You also must initial the sections you complete and sign the form. If you are unable to initial or sign the form because of a physical impairment, you can place an "X", thumbprint, or stamp on the form instead of your initials and signature. If a physical impairment prevents you from doing any of these things, you can ask someone else who is with you to sign, place an "X", thumbprint, or stamp on the form.

When you complete this form, it's important that you also talk to a member of your health care team, family, and other loved ones to explain what you meant when you filled out the form. A member of your health care team can help you with this form and can answer any questions that you have.

PART I: PERSONAL INFORMATION

NAME *(Last, First, Middle)*:	DATE OF BIRTH *(mm/dd/yyyy)*:

STREET ADDRESS:

CITY, STATE, ZIP:

HOME PHONE WITH AREA CODE:	WORK PHONE WITH AREA CODE:	MOBILE PHONE WITH AREA CODE:

PUBLIC BURDEN STATEMENT: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-0556, and it expires 04/30/2027. Public reporting burden for this collection of information is estimated to average 30 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing the burden, to VA Reports Clearance Officer at VACOPaperworkReduAct@va.gov. Please refer to OMB Control No. 2900-0556 in any correspondence. Do not send your completed VA Form 10-0137 to this email address.

PRIVACY ACT STATEMENT: The information requested on this form is solicited under the authority of 38 C.F.R. §17.32. It is being collected to document your preferences for your health care in the event that you cannot speak for yourself anymore. The information you provide may be disclosed outside the VA as permitted by law. Possible disclosures include those that are described in the "routine uses" identified in the VA system of records 24VA10P2, Patient Medical Records-VA, published in the Federal Register in accordance with the Privacy Act of 1974. This is also available in the Compilation of Privacy Act Issuances. You may choose to fill out this form or not, but without this information, VA health care providers may not clearly understand your preferences. If you do not fill out this form, there will be no effect on any benefits you are entitled to receive.

NAME *(Last, First, Middle)*:	DATE OF BIRTH *(mm/dd/yyyy)*:

PART II: DURABLE POWER OF ATTORNEY FOR HEALTH CARE

This section of the advance directive form is called a Durable Power of Attorney for Health Care. It lets you appoint a specific person to make health care decisions for you in case you can't make decisions for yourself anymore. This person will be called your Health Care Agent.

Your Health Care Agent should be someone:

- You trust
- Who knows you well
- Who is familiar with your values and beliefs

If you get too sick to make decisions for yourself, your Health Care Agent will have the authority to make all health care decisions for you. This includes decisions to admit and discharge you from any hospital or other health care institution. Your Health Care Agent can also decide to start or stop any type of health care treatment. He or she can access your personal health information, and medical records, including information about whether you have been tested for HIV or treated for AIDS, sickle cell anemia, substance abuse or alcoholism.

NOTE: If you wish to give general permission for VA to share your medical records or health information with others, you can complete VA Form 10-5345 (Request for and Authorization to Release Medical Records or Health Information). You can get VA Form 10-5345 from your VA health care provider or you can get it using a computer from this website https://www.va.gov/vaforms/medical/pdf/VA_Form_10-5345_Fillable.pdf.

A - HEALTH CARE AGENT

Place your initials in the box next to your choice. Choose only one.

Initials	
Initials	I don't wish to appoint a Health Care Agent right now. (Skip this section and go to Part III, Living Will.)
Initials	I appoint the person named below to make decisions about my health care if I can't decide for myself anymore.

Name *(Last, First, Middle):*	Relationship to Me:
Street Address:	
City, State, Zip:	

Home Phone with Area Code:	Work Phone with Area Code:	Mobile Phone with Area Code:

B - ALTERNATE HEALTH CARE AGENT

Fill out this section if you want to appoint a second person to make health care decisions for you, in case the first person isn't available.

Initials	
Initials	If the person named above can't or doesn't want to make decisions for me, I appoint the person named below to act as my Health Care Agent.

Name *(Last, First, Middle):*	Relationship to Me:
Street Address:	
City, State, Zip:	

Home Phone with Area Code:	Work Phone with Area Code:	Mobile Phone with Area Code:

NAME *(Last, First, Middle)*:	DATE OF BIRTH *(mm/dd/yyyy)*:

PART III: LIVING WILL

This section of the advance directive form is called a Living Will. This section of it lets you write down how you want to be treated in case you aren't able to decide for yourself anymore. Its purpose is to help others decide about your care.

A - SPECIFIC PREFERENCES ABOUT LIFE-SUSTAINING TREATMENTS

In this section, you can indicate your preferences for life-sustaining treatments in certain situations. Some examples of life-sustaining treatments are:

- CPR (cardiopulmonary resuscitation)
- a breathing machine (mechanical ventilation)
- kidney dialysis
- a feeding tube (artificial nutrition and hydration)

Think about each situation described on the left and ask yourself, “In that situation, would I want to have life-sustaining treatments?” Place your initials in the box that best describes your treatment preference. You may complete some, all, or none of this section. Choose only one box for each statement.

	Yes. I would want life-sustaining treatments.	I'm not sure. It would depend on the circumstances.	**No.** I would not want life-sustaining treatments.
If I am unconscious, in a coma, or in a vegetative state and there is little or no chance of recovery.	Initials	Initials	Initials
If I have permanent, severe brain damage that makes me unable to recognize my family or friends (for example, severe dementia).	Initials	Initials	Initials
If I have a permanent condition where other people must help me with my daily needs (for example, eating, bathing, toileting).	Initials	Initials	Initials
If I need to use a breathing machine and be in bed for the rest of my life.	Initials	Initials	Initials
If I have pain or other severe symptoms that cause suffering and can't be relieved.	Initials	Initials	Initials
If I have a condition that will make me die very soon, even with life-sustaining treatments.	Initials	Initials	Initials
Other:	Initials	Initials	Initials

NAME *(Last, First, Middle)*:	DATE OF BIRTH *(mm/dd/yyyy)*:

B - MENTAL HEALTH PREFERENCES

This section is optional. You may skip this section if you do not have a serious mental health problem or if you do not want to write down your preferences for mental health care. If you have a serious mental health condition, you might want to write down medications that have worked for you in the past and that you would want again, or you might want to write down the mental health facilities or hospitals that you like and those that you don't like. If you need more space, you may attach extra pages and use this space to refer to attached pages. Be sure to initial and date every page that you attach.

C - ADDITIONAL PREFERENCES

This section is optional. In this space, you can write other important preferences for your health care that aren't described somewhere else in this document. For example, these might be social, cultural, or faith-based preferences for care, or preferences about treatments such as feeding tubes, blood transfusions, or pain medications. If you need more space, you may attach extra pages and use this space to refer to attached pages. Be sure to initial and date every page that you attach.

NAME *(Last, First, Middle)*:	DATE OF BIRTH *(mm/dd/yyyy)*:

D - HOW STRICTLY YOU WANT YOUR PREFERENCES FOLLOWED

Place your initials in the box next to the statement that reflects how strictly you want others to follow your preferences. Choose only one.

Initials	I want my preferences, as expressed in this Living Will, to serve as a general guide. I understand that in some situations, the person making decisions for me may decide something different from the preferences I express above, if they think it's in my best interests.
Initials	I want my preferences, as expressed in this Living Will, to be followed strictly, even if the person making decisions for me thinks that this isn't in my best interests.

PART IV: SIGNATURES

A - YOUR SIGNATURE

By my signature below, I certify that this form accurately describes my preferences.

SIGNATURE *(Sign in ink)*:	DATE *(mm/dd/yyyy)*:

B - WITNESSES' SIGNATURES

Two people must witness your signature. Witnesses to the patient's signing of an advance directive are attesting by their signatures only to the fact that they saw the patient or designated third party sign the VA Advance Directive form. Neither witness may, to the witness' knowledge, be named as a beneficiary in the patient's estate, appointed as health care agent in the advance directive, or financially responsible for the patient's care. Nor may a witness be the designated third party who has signed the VA Advance Directive form at the direction of the patient and in the patient's presence.

Witness #1

I personally witnessed the signing of this advance directive. I am not the designated third party who signed this VA Advance Directive form at the direction of the patient and in the patient's presence. I am not appointed as Health Care Agent in this advance directive. I am not financially responsible for the care of the patient making this advance directive. To the best of my knowledge, I am not named as a beneficiary in the patient's estate.

SIGNATURE *(Sign in ink)*:	DATE *(mm/dd/yyyy)*:

Name *(Printed or Typed):*

Street Address:

City, State, Zip:

Witness #2

I personally witnessed the signing of this advance directive. I am not the designated third party who signed this VA Advance Directive form at the direction of the patient and in the patient's presence. I am not appointed as Health Care Agent in this advance directive. I am not financially responsible for the care of the patient making this advance directive. To the best of my knowledge, I am not named as a beneficiary in the patient's estate.

SIGNATURE *(Sign in ink)*:	DATE *(mm/dd/yyyy)*:

Name *(Printed or Typed):*

Street Address:

City, State, Zip:

NAME *(Last, First, Middle)*:	DATE OF BIRTH *(mm/dd/yyyy)*:

PART V: SIGNATURE AND SEAL OF NOTARY PUBLIC *(Optional)*

This VA Advance Directive form is valid in VA facilities without being notarized. However, you may need to have it notarized to be legally binding outside the VA health care setting. Space for a Notary's signature and seal is included below.

On this _____ day of _____ , in the year of _____ , personally appeared before me

_____,

known by me to be the person who completed this document and acknowledged it as their free act and deed.

IN WITNESS WHEREOF, I have set my hand and affixed my official seal in the County of _____,

State of _____ , on the date written above.

Notary Public: _____ Commission Expires: _____

[SEAL]

Patricia M. Ross
Commissioner

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January 5, 2026

Administration

Department Directive 21.200

SUBJECT: Access Control Procedures for Visitors to the Georgia Veterans War Homes

OFFICE OF PRIMARY RESPONSIBILITY: Commissioner of Veterans Service

PURPOSE:

1. To establish a uniform, legally compliant process governing access to the Georgia War Veterans Home (GWVH) by non-family visitors, organizations, and delegations, while safeguarding resident rights, privacy, safety, and uninterrupted clinical operations, consistent with applicable federal and state law and accepted skilled nursing facility standards.

AUTHORITY AND REGULATORY REFERENCES:

2. This policy is issued under the authority of the Georgia Department of Veterans Service (GDVS) and is governed by, and shall be interpreted in a manner consistent with, the following:
   - Centers for Medicare & Medicaid Services
     - 42 C.F.R. Part 483 – Requirements for Long-Term Care Facilities
       - §483.10 – Resident Rights
       - §483.12 – Freedom from Abuse, Neglect, and Exploitation
       - §483.15 – Quality of Life
       - §483.70 – Administration
   - U.S. Department of Veterans Affairs
     - 38 U.S. C. Part 17 - Medical
       - §17.33 – Patient's Rights (c)
   - Applicable state licensure and privacy laws, including resident confidentiality and facility security requirements.

SCOPE:

3. This policy does not apply to immediate family members or individuals expressly invited by a resident with decision-making capacity, or their a duly authorized representative, subject to applicable health, safety, and operational limitations.

POLICY STATEMENT:

4. GWVH recognizes and respects residents' rights to visitation as required by Centers for Medicare & Medicaid Services and the U.S. Department of Veterans Affairs standards. At the same time, the facility has a legal and operational obligation to regulate non-family and organizational access to ensure resident privacy, safety, infection control, and continuity of care. Accordingly, non-family visitation is subject to prior administrative approval.

DEFINITIONS:

5. **Immediate Family:** Individuals recognized as family members under Centers for Medicare & Medicaid Services and the U.S. Department of Veterans Affairs resident rights guidance.

6. **Non-Family Visitor:** Any individual, organization, or group not qualifying as immediate family or not expressly invited by a resident with capacity, or their a duly authorized representative.

7. **Office of the Commissioner:** The Office of the Commissioner, Georgia Department of Veterans Service, or designee.

POLICY REQUIREMENTS:

8. **Prior Approval.**

   Any visitor, organization, or delegation that is not an immediate family member or expressly approved by a current resident with decision-making capacity, or their a duly authorized representative, must obtain prior written approval from the Office of the Commissioner or their designee before arriving on the GWVH campus. This requirement is consistent with CMS-authorized facility administration and does not restrict resident rights under 42 C.F.R. §483.10.

9. **Request Process.**

   - Requests for non-family visitation must be submitted no fewer than five (5) business days in advance, unless otherwise authorized by the Office of the Commissioner due to operational necessity or exigent circumstances.
   - Requests must include:
     - Full names of all proposed visitors
     - Organizational affiliation, if applicable
     - Purpose and scope of the visit
     - Requested date, time, and anticipated duration
     - Any requested accommodation or special access

   Requests that are incomplete or inconsistent with regulatory requirements may be denied or returned for clarification.

10. Review and Vetting.

All requests are subject to administrative review to ensure compliance with:

- Resident privacy and confidentiality protections
- Infection prevention and control standards
- Facility security requirements
- VA oversight obligations
- Operational capacity and clinical care priorities

Approval may be granted, denied, modified, or conditioned, including but not limited to restrictions on time, location, group size, escort requirements, or access to resident care areas.

11. Unscheduled or Unauthorized Visitors.

Individuals or groups arriving on site without prior approval may be:

- Denied entry, or
- Directed to submit a formal request for future consideration

This provision applies uniformly and is necessary to maintain compliance with CMS and VA standards.

12. Staff Responsibilities.

- All staff receiving inquiries or requests for non-family visitation shall refer such requests to the Office of the Commissioner.
- No staff member is authorized to independently approve non-family visits, regardless of position or tenure.
- Staff are responsible for enforcing this policy consistently, professionally, and without discrimination.

RESIDENT RIGHTS:

13. Nothing in this policy shall be construed to limit or infringe upon a resident's right to receive visitors of their choosing, provided:

- The resident has decision-making capacity or appropriate authorization exists; and
- The visit does not compromise the health, safety, or rights of other residents or facility operations.

NEUTRAL APPLICATION

14. This policy shall be applied uniformly and without regard to viewpoint, advocacy position, organizational affiliation, or political status. Decisions are based solely on regulatory compliance, resident welfare, and operational considerations.

ENFORCEMENT:

15. Failure to comply with this policy may result in denial of access, removal from the premises, or other administrative action as permitted by law.

COMMISSIONER



PATRICIA M. ROSS