

ELIGIBILITY REQUIREMENTS

A prospective resident must meet the following requirements in order to be eligible for admission to the **George E. Wahlen Ogden Veterans Home**:

- I. Be recognized as a veteran who has a greater than dishonorable discharge from active service, or a spouse, surviving spouse, or Gold Star Parent of an eligible veteran.
- II. Must require skilled or long-term nursing home care as certified by a physician.
- III. Must be able to pay the resident's portion of the cost of care (if not covered by other payer sources)
- IV. Be enrolled in the VA Health Care System

APPLICATION PROCESS (Check List)

In order for us to evaluate the eligibility requirements, the following items must be completed and returned to the Admissions Director to be considered for admission. Items 1 through 5 are included in this packet, and items 6 through 14 must be provided by the person making application.

1. _____ **Application for Admission** (included in this packet)
2. _____ **Application for Health Benefits/Form 10-10EZ** (included in this packet)
3. _____ **Health Questionnaire** (included in this packet; must be signed by a physician)
4. _____ **cHIE Patient Consent Form** (included in this packet)
5. _____ **Virtual Lifetime Electronic Record (VLER) Form** (included in this packet)
6. _____ **Copy of the veteran's Honorable Discharge/Form DD-214** (if unable to locate Honorable Discharge, please refer to the instructions provided in this packet on how-to request a new DD-214)
7. _____ **Most Recent History and Physical**
8. _____ **Current List of Medications**
9. _____ **Copies of both sides of Health and Rx Insurance Cards**
10. _____ **Copy of Marriage License** (for a Spouse Application)
11. _____ **Advanced Health Care Directive or Living Will** (if one exists)
12. _____ **Power of Attorney, Guardianship, or Fiduciary** (if one exists)
13. _____ **Copy of Aid and Attendance Pension Award Letter** (if applicable)
14. _____ **Copy of Service Connected Disability Rating Letter** (if applicable)

DAILY RATE INFORMATION*

Room/Resident	Resident	VA Per Diem
Private Room w/Shared Bath (Veteran)	\$68.50	\$100.37
Private Room w/Private Bath (Veteran)	\$84.60	\$100.37
Private Room w/Shared Bath (Spouse)	\$160.00	
Private Room w/Private Bath (Spouse)	\$170.00	

*Mandatory Veterans defined as veterans who have been awarded a **Service-Connected Disability Rating between 70 and 100%** have their entire cost of care paid for by the Veterans Administration.

A spouse or surviving spouse of a veteran will be considered eligible for admission based on the veteran's eligibility. Spouses must have been married to the veteran for at least one year prior to the date of application for admission. Reasonable accommodations will be made to admit married couples into the same room, or rooms close to one another whenever possible.

Complete applications with all required documentation may be submitted by mail, e-mail, or fax to:

George E. Wahlen Ogden Veterans Home
Attn: Admissions Director
1102 North 1200 West
Ogden, UT 84404

Email: kdinsdale@avalonhci.com

Fax: 801-334-4301
Attn: Kelsie Dinsdale, Admissions Director

After a complete application is reviewed, you will be contacted by the Admissions Director regarding whether the application was approved or denied. You will also be notified on which waiting list (if applicable) the applicant has been placed. Since admission is based on the order complete and approved applications are received, it is advisable to submit the application and required documentation as soon as possible.

If you have any questions regarding the above information or need assistance with the required application materials, please feel free to contact our Admission Department at 801-334-4315.

14. Applicant's Branch of Military Service:

Date of Enlistment: _____

Date of Discharge: _____

Was Discharge Honorable?

Yes: _____ No: _____

***Provide copy of Form DD-214 or Honorable Discharge Certificate**

15. In which of the following did the Veteran serve: (Place a check mark)

World War II: _____	Cold War: _____	Afghanistan: _____	Granada: _____
Korean War: _____	Desert Storm: _____	Panama: _____	
Viet Nam: _____	Iraqi Freedom: _____	Kosovo: _____	

16. Did the Veteran serve in the respective foreign country (i.e., served in Korea during the Korean War) during the defined war period :

Yes: _____ No: _____

17. Does Applicant receive Compensation from the VA:

Yes: _____ No: _____

Does Applicant have a Service-Connected Disability:

Yes: _____ No: _____

If Yes, What percentage rating is the Service Connected Disability: _____

If Yes, Please provide confirmation letter from VA showing percentage rating.

18. Does the Applicant receive a Pension from the VA:

Yes: _____ No: _____

If Yes, is it the Aid and Attendance Pension* (A&A):

Yes: _____ No: _____

If No, has the Applicant applied for A&A:

Yes: _____ No: _____

If Yes, Please provide award letter from VA showing pension amount.

**Medications CAN NOT be provided by VA Pharmacy until A&A award letter is submitted. If A&A application has been submitted but not yet approved, please note that it is your responsibility to bring a copy of the award letter to the veterans home upon approval.*

19. Has the Applicant executed the following? (Check all that apply and provide a copy)

_____ Advanced Directive	_____ Court-appointed Guardian
_____ Living Will	_____ Power of Attorney (Medical)
_____ Fiduciary	_____ Power of Attorney (Financial)

20. List 3 contact persons that may be contacted regarding this applicant's status:

Primary: _____ Relation: _____ Phone: () _____

Address: _____ Cell: () _____

(Street) (City) (State) (Zip)

Email: _____ Power of Attorney: Yes: _____ No: _____

Health Questionnaire

George E. Wahlen Ogden Veterans Home

APPLICATIONS WILL NOT BE REVIEWED UNLESS THIS FORM IS COMPLETED BY A LICENSED PHYSICIAN. A COPY OF THE *MOST RECENT HISTORY AND PHYSICAL AND CURRENT LIST OF MEDICATIONS MUST ALSO BE ATTACHED.*

1. APPLICANT NAME: _____ MALE _____ FEMALE _____

2. PRIMARY CARE PHYSICIAN: _____

3. PRIMARY CARE CLINIC: _____ PHONE: _____

4. CURRENT RESIDENCE: Hospital _____ Nursing Home _____ Assisted Living _____ Home _____

If at Hospital, Nursing Home, or Assisted Living please list Name, Address, and Phone Number:

If at Home list number of inhabitants: _____

5. IS APPLICANT CURRENTLY RECEIVING HOME HEALTH SERVICES? YES _____ NO _____

If yes, please indicate the Name and Phone Number of agency: _____

6. IS APPLICANT CURRENTLY RECEIVING HOSPICE SERVICES? YES _____ NO _____

If yes, please indicate the name and phone number of agency: _____

7. CURRENT DIAGNOSIS(ES):

8. ALLERGIES AND ALLERGIC REACTIONS:

l. Physically Combative.....			
m. Verbally Combative.....			
n. Wandering Without Regard for Safety.....			
o. Exit-Seeking.....			
12. Does applicant require:			
a. 1:1 Supervision.....			
b. A Secured Unit.....			
c. Another Person to Anticipate Needs.....			
d. Special Diet, if yes, please Specify: _____			
e. Tube Feed, if yes, Specify: _____			
f. Colostomy/ Urostomy Care.....			
g. Foley Catheter Care.....			
h. Tracheostomy Suctioning, if yes, Specify how often: _____			
i. Prosthetic Device, if yes, Specify: _____			
j. Sensory Aid, if yes, Specify: _____			

13. DOES APPLICANT HAVE ANY INFECTION PRESENT? YES _____ NO _____

If yes, please describe: _____

14. DOES THE APPLICANT HAVE ANY WOUNDS OR SORES? YES _____ NO _____

If yes, please describe: _____

15. IS APPLICANT UNDERGOING CANCER OR DIALYSIS TREATMENT? YES _____ NO _____

If yes, please describe: _____

Based on the applicant's current medical status, my professional recommendation is that 24hr in-patient Skilled Nursing Home Care is appropriate:

YES _____ NO _____

Signed: _____
 Examining Physician
 Date: _____
 Name: _____
 Print Full Name

Address: _____
 City, State, Zip Code: _____
 Phone: () _____
 Zip Phone Number

ADDITIONAL COMMENTS
(Please attached additional sheets if necessary)



Knowledge can save lives.

By choosing to participate in the cHIE any healthcare professional can instantly know what prescriptions you are on, whether you have a chronic illness, if you have allergies to a medication, what immunizations you have had, and more. Additionally, you are allowing healthcare professionals to disclose, or share, your medical information with other participating organizations for treatment purposes. Being part of the cHIE is very important to ensuring higher quality care for you and your family.

Sources of medical information.

Medical information securely accessed through the cHIE comes from a variety of sources. These sources may include participating hospitals, provider offices, clinics, health insurers, pharmacies, the Utah Department of Health and health or medical laboratories. Medical information will become available as health care professionals participate with the cHIE and once you have filled out the consent form and it is processed.

The power of sharing.

All of your medical information can easily be shared. Important information - such as prescriptions, allergies, medical conditions, immunizations, illness histories, surgeries, chronic condition information, test results, lab reports, transcription records, x-ray reports, discharge summaries, prior office visits, and other aspects of your medical history - can be accounted for instantly. The cHIE is here to make your life simpler and safer.

The cHIE may also contain medical information related to sensitive health conditions such as alcohol or drug use problems, mental health conditions, HIV/AIDS, birth control or abortion, or sexually transmitted diseases. Remember, only authorized healthcare professionals can access this information and only for treatment purposes.

From a medical perspective, it is vitally important that your

healthcare professionals have access to all your medical information. If you are concerned about sharing sensitive medical information, then you might consider choosing LIMITED or NOT PARTICIPATING on the consent form.

How Your Medical Information is Protected.

Federal law protects your medical information. HIPAA, the Healthcare Insurance Portability and Accountability Act of 1996, is the federal law that protects your medical information and limits who can look at and receive your medical information. HIPAA's protections were further strengthened by another federal law, the HITECH Act, which may impose severe financial fines on anyone who violates your medical-privacy rights.

All data on the cHIE – including your medical information – is encrypted to federal standards - and is accessible only as allowed by law. In addition, your healthcare professional can provide you with a Notice of Privacy Practices, which describes how your healthcare professional uses and protects your medical information.

Only authorized healthcare professionals who have a treatment relationship with you may access your medical information. All access to your cHIE medical information is logged and you can request an audit of access to your cHIE records at participating cHIE organizations.

The Utah Department of Health allows healthcare professionals to use the cHIE for public health reporting.

Questions About Improper Access.

If you ever suspect that someone has improperly accessed your medical information on the cHIE, please contact your healthcare professional, the Utah Health Information Network at 877-693-3071, or file a complaint with the Federal Office for Civil Rights at <http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html>, or the Utah Office of the Attorney General at uag@utah.gov.

Changing Consent.

You may change your consent status at any time through any participating cHIE healthcare professional. Simply complete the attached consent form, give it to a participating healthcare professional, and they will make the change(s) for you.

Until you fill out the consent form and indicate that you give consent to share and access your data, no healthcare professional can access your medical information through the cHIE. This consent only applies to information shared through the cHIE. Healthcare professionals can still share your medical information through the methods they use currently.

Please note that changes made to your consent will be processed in a reasonable amount of time, and may not be immediate. Your current consent status will remain until your request can be updated.

If PARTICIPATING is selected, this option will remain in effect for 5 years for most patients and at age 18 for minors, unless changed prior to that time. After 5 years, PARTICIPATING will automatically change to LIMITED, at which time you may want to resubmit your selection.

As a patient, you may decide the risks outweigh the benefits and decide to not participate in the cHIE. It is important to understand that if you change your consent to "NOT-PARTICIPATE" the cHIE will not have your current or past medical information.

If you have opted out and later decide to have your information included again, you will need to complete a new consent form, and your medical information in the cHIE will only contain health information created after you decide to participate back into the cHIE.

For more information go to www.mychie.org, or call UHIN at 877-693-3071



Privacy Act Information: The execution of this form does not authorize the release of information other than that specifically described below. 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, (HIPAA) 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 the information containing last four of the Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Nationwide Health Information Network will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. 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 identified as 24VA19 "Patient Medical Record - VA" and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you do not the Nationwide Health Information Network exchange will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. VA may also use this information on this form to identify Veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

Patient Full Name Last: (print) First: Middle:

Last four digits of SSN:

Requestor Name: VA Approved Nationwide Health Information Network Participants

Information Requested: Pertinent health information from electronic health record.

I request and authorize my VA health care facility to release my protected health information (PHI) for treatment purposes only to the communities that are participating in the Nationwide Health Information Network (NwHIN). This information may consist of the diagnosis of Sickle Cell Anemia, the treatment of or referral for Drug Abuse, treatment of or referral for Alcohol Abuse or the treatment of or testing for infection with Human Immunodeficiency Virus. This authorization covers the diagnoses and related health information that I may have upon signing of the authorization and the diagnoses and the related health information that I may acquire in the future, including those protected by 38 U.S.C. 7332.

This authorization will remain in effect for the period of five years. I may revoke this authorization through the eBenefits portal, or in writing at my Release of Information (ROI) unit at the VA health care facility housing my records, 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 (ROI). Re-disclosure of my electronic health records by those receiving the information may be accomplished without my further authorization and may no longer be protected.

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.

Signature of Patient

Date

THE AID AND ATTENDANCE PENSION

The Aid and Attendance (A&A) Pension provides benefits for eligible veterans and surviving spouses who require the regular attendance of another person to assist in eating, bathing, dressing and undressing, and taking care of the needs of nature. It also includes individuals who are blind or are in a nursing home because of mental or physical incapacity.

The A&A benefit is paid in addition to monthly pension, and is not paid without eligibility to Pension. Since A&A allowances increase the pension amount, people who are not eligible for a basic pension due to excessive income may be eligible for pension at these increased rates.

ELIGIBILITY FOR THE AID AND ATTENDANCE PROGRAM

Any War-Time Veteran having served 90 days of active duty, with 1 day beginning or ending during a VA defined period of War is eligible to apply for the A&A pension. A surviving spouse (marriage must have ended due to the death of veteran) of a War-Time Veteran may also apply. The individual must qualify both medically and financially.

HOW TO APPLY

It is recommended to contact a VA Service Officer to assist with completing and submitting the A&A application. The following organizations have Service Officers available to assist you:

American Legion: 801-326-2380 550 Foothill Drive, Suite 203 Salt Lake City, UT 84158	Veterans of Foreign Wars (VFW): 801-326-2385 550 Foothill Drive, Suite 203 Salt Lake City, UT 84158
*Disabled American Veterans (DAV): 801-326-2375 550 Foothill Drive, Suite 203 Salt Lake City, UT 84188	Purple Heart: 801-326-2471 550 Foothill Drive, Suite 203 Salt Lake City, UT 84158

*A Service Officer from the DAV meets with Veterans and Family members by appointment **every Thursday** at the George E. Wahlen Ogden Veterans Home (1102 North 1200 West, Ogden, UT 84404). To schedule an appointment, please contact the DAV at 801-326-2375.

HOW TO REQUEST MILITARY RECORDS

If you are unable to locate the veteran's Honorable Discharge Certificate (Form DD-214), you will need to request a new one. This can be done by calling the VA Record Management Center at **1-800-827-1000**. Or you can electronically request a copy at: <http://vetrecs.archives.gov>