



## VERMONT VETERANS' HOME

To our Veterans and their Family Members,

For more than 130 years, the Vermont Veterans' Home has been providing the highest quality of care to our Veterans, their spouses, and Gold Star Parents. Our commitment is evidenced by our nationally accredited dementia care program, Freedom Village, and our internationally recognized Namaste Program. In addition, we offer short term rehabilitation, long term and respite care as well as offering outpatient rehabilitation.

At the Vermont Veterans' Home, we recognize the sacrifices our Veterans have made for our Country. I understand these sacrifices first hand having members of my family serving in the military since World War II and being a Navy wife for 20 years.

Our motto, "Fulfilling the Promise," is accomplished through our mission "to provide a healthcare community for Veterans, their spouses and Gold Star Parents in an environment that allows residents to achieve their self-determined quality of life."

On behalf of the Veterans and staff at the Vermont Veterans' Home, I invite you to experience the fulfillment of this promise.

Sincerely,

Melissa A. Jackson, BSW, LNHA  
CEO / Administrator

# INFORMATION AND FORMS FOR APPLYING TO THE VERMONT VETERANS' HOME



## **Vermont Veterans' Home**

325 North Street

Bennington, Vermont 05201

802.442.6353

[vvh.vermont.gov](http://vvh.vermont.gov)

# THANK YOU FOR CONSIDERING THE VERMONT VETERANS' HOME

**We are here to help. Please give us a call if you have questions.**

This package contains information and directions for preparing an application to the Veterans' Home. The process will take some time and you will need to collect copies of other documents and forms to include. If you have any questions at all, please feel free to pick up the phone and call.

General information and questions

Admissions Department

802.447.6539

[vvh-admissions@vermont.gov](mailto:vvh-admissions@vermont.gov)

## **Checklist of documents to include with application**

- ☐ Application for Admission
- ☐ Authorization for Release of Medical Record Information
- ☐ VA Form 10-10EZ
- ☐ Immunization and Infectious Disease Record
- ☐ Mental Health Screening
- ☐ Military Service Discharge Papers
- ☐ Documentation of Criminal Offenses (if any)
- ☐ Power of Attorney and other Authorizations for Legal Oversight
- ☐ DNR, Durable Power of Attorney or other Medical Instructions
- ☐ Long-Term Care Insurance Policy
- ☐ Photocopies of Health Insurance and Prescription Coverage Cards

**APPLICATION FOR ADMISSION**☐ Short Term ☐ Long Term

Thank you for your interest in the Vermont Veterans' Home. In order to properly process an individual's application, we must have the information requested below. Please answer all questions carefully. The information contained herein is confidential and is the basis for patient admission.

**If you need help filling out the paperwork, call the Admissions Department at 802.447.6539. We are here to help.**

Where did you hear about the Vermont Veterans' Home? \_\_\_\_\_

**APPLICANT INFORMATION**

_____ Last Name	_____ First Name	_____ Middle Name	_____ Date
_____ Street Address		_____ City	_____ State / Zip Code
_____ Phone	_____ Email	_____ Soc. Security No	_____ Age
_____ Date of Birth	_____ Place of Birth	_____ Religion	_____ Sex

**APPLICANT'S CURRENT LOCATION** (if different from home address)

_____ Facility / Residence	_____ Phone Number
_____ Street Address	_____ City
_____ State / Zip Code	

**MILITARY SERVICE**

☐ Air Force ☐ Army ☐ Coast Guard ☐ Marine Corps ☐ Merchant Marine ☐ Navy

_____ Service Serial Number	_____ VA Claim Number	_____ Date of Entry into Active Duty	_____ Date of Discharge
_____ Type of Discharge			

**You must attach a copy of the discharge papers.**

Does applicant have a service-related disability? ☐ Yes ☐ No Percent Disabled \_\_\_\_\_ %

**SIGNATURE AND RELEASE**

*I hereby give the Vermont Veterans' Home permission to verify the financial and insurance information supplied on this application for admission. I also give the Vermont Veterans' Home permission to contact the emergency contact person regarding the applicant's medical condition.*

_____ Applicant Signature	_____ Date	_____ Responsible Party Signature	_____ Date
------------------------------	---------------	--------------------------------------	---------------

*Federal and state law prohibit discrimination based on race, creed, color, national origin, sex, sponsor, disability, handicap, blindness, reimbursement source, sexual preference or marital status.*

**ADDITIONAL INFORMATION**

Attending Physician \_\_\_\_\_ Hospital of Choice \_\_\_\_\_

Most recent hospital stay \_\_\_\_\_

Applicant's Highest Education Level \_\_\_\_\_ Prior Occupation \_\_\_\_\_

Does applicant have any criminal convictions? ☐ Yes ☐ No **If yes, please list the date and type of conviction**\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Type of Conviction **Include documentation / contact information****PERSON TO BE NOTIFIED IN CASE OF EMERGENCY**

Last Name First Name Relationship to Applicant

Street Address City State / Zip Code

Home Phone Cell Phone Email

**LEGAL AGENT OF THE APPLICANT**

Last Name First Name Relationship to Applicant

Street Address City State / Zip Code

Home Phone Cell Phone Email Signature

Agent's Status / Check all that apply:

☐ Power of Attorney ☐ Conservator ☐ Person Responsible for Financial Transactions ☐ Guardianship

Other Authorizations:

☐ DNR ☐ Health Care Proxy ☐ Living Will ☐ Durable Power of Attorney for Medical Decisions☐ Other \_\_\_\_\_ **Please include copies of paperwork****FINANCIAL DISCLOSURE**

Income Source	Monthly Income	Income Source	Monthly Income
Social Security	_____	Annuities	_____
Retirement Pension	_____	Rental Income	_____
Veteran's Pension	_____	U.S. Civil Service	_____
Railroad Pension	_____	Other _____	_____
Supplementary Security Income	_____	Total Monthly Income	_____

**FINANCIAL DISCLOSURE** – Continued

Bank Savings / Stocks / Bonds	Type of Account	Joint?	Account No.	Balance
				\$
				\$
				\$

Does the applicant own a car, truck, ATV, trailer, boat, RV or Snow vehicle? ☐ Yes ☐ No ☐ Jointly owned

If owned jointly, with whom? \_\_\_\_\_

Is there a loan on the vehicle? ☐ Yes ☐ No Loan holder and amount \_\_\_\_\_

Does the applicant own a home? ☐ Yes ☐ No If yes, is it jointly owned? ☐ Yes ☐ No

What is the estimated market value? \_\_\_\_\_

Is there a mortgage, reverse mortgage, home equity loan or any lien on the property? ☐ Yes ☐ No

If yes, in what amount? \_\_\_\_\_

Does the applicant have "life use" of the property? ☐ Yes ☐ No

Does the applicant own any other property? ☐ Yes ☐ No If yes, is it jointly owned? ☐ Yes ☐ No

What is the estimated market value? \_\_\_\_\_

What other assets does the applicant own?

Description _____	Value \$ _____
Description _____	Value \$ _____
Description _____	Value \$ _____

Have any assets been transferred within the last 60 months? ☐ Yes ☐ No

If yes, list assets transferred, fair market value, date of transfer and value

**MEDICAL POLICIES** – Please attach photocopies of the front and back of all insurance / enrollment cards.

If applicant is enrolled in Medicare, what type of plan? ☐ Traditional ☐ HMO (Advantage)

Please specify Medicare / Managed Care No. \_\_\_\_\_ Please specify VA number \_\_\_\_\_

Is applicant enrolled in Medicare Type B program? ☐ Yes ☐ No Medicare D program? ☐ Yes ☐ No

If yes, list plan information \_\_\_\_\_  
Carrier ID No. Group No.

Is applicant enrolled in the Medicaid program? ☐ Yes ☐ No

If yes, list Medicaid No. \_\_\_\_\_ County Responsible \_\_\_\_\_



### MEDICAL POLICIES - Continued

If not enrolled in Medicaid, is there an application pending? ☐ Yes ☐ No Date submitted \_\_\_\_\_

Name of Case Worker \_\_\_\_\_ County where applied \_\_\_\_\_

Is an attorney handling the application? ☐ Yes ☐ No If yes, Attorney's name \_\_\_\_\_

Attorney's phone \_\_\_\_\_

Does the applicant have long-term care insurance? ☐ Yes ☐ No **If yes, Please attach a copy of the policy**

Does the applicant have any other insurance for Healthcare, HMO or Prescription Plan coverage? If yes, list policy data.

Carrier \_\_\_\_\_ ID No. \_\_\_\_\_ Group No. \_\_\_\_\_

### FUNERAL HOME INFORMATION

Has the applicant made funeral arrangements? ☐ Yes ☐ No If yes, please provide contact information

Name of Funeral Home \_\_\_\_\_ Director / Contact Name \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State / Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_ Cemetery / Location \_\_\_\_\_

**ADDITIONAL COMMENTS** – Include additional background information that is relevant. Attach separate page if necessary.



## AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

This authorizes Vermont Veterans' Home, 325 North Street, Bennington VT, 05201

to provide access to all medical records requested for the review, examination and/or release of the following patient:

Name of Resident

Social Security Number

Date of Birth

Email

Phone Number

Please list the names and contact information of third parties (i.e. hospital, nursing home, care facilities):

---

---

---

**Information to be released:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Data Sheet               | <input type="checkbox"/> MD Progress Notes       | <input type="checkbox"/> HIV/Test   |
| <input type="checkbox"/> History/Physical         | <input type="checkbox"/> Nurses Notes            | <input type="checkbox"/> Radiology Report   |
| <input type="checkbox"/> Laboratory Tests         | <input type="checkbox"/> Social Service Notes    | <input type="checkbox"/> Pharmacy Script  |
| <input type="checkbox"/> Treatment Plan           | <input type="checkbox"/> Physical Progress Notes | <input type="checkbox"/> Other: <u>EKG</u>  |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Operative Report        | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Alcohol/Drug Treatment   | <input type="checkbox"/> Path Report             | <input type="checkbox"/> <b>Any information we feel is necessary to continue medical treatment from patient's chart</b> |
| <input type="checkbox"/> Sickle Anemia/Test       | <input type="checkbox"/> Consults                |   |
| <input type="checkbox"/> Discharge Summary        | <input type="checkbox"/> P.T. Report             |   |

The above information is released for the following purposes and these purposes only. Any other use is forbidden.

**Continuing medical treatment with physician/medical facility other than primary physician**

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it (eg. probation, parole, etc.) and that in the event this authorization expires automatically as described below.

**This authorization will stay in effect as long as a resident is residing at the Vermont Veterans' Home and expires upon the date of discharge from this facility.**

Signature of Resident or Representative

Date

Witness

Relationship to resident

**This form may be sent by facsimile. Any disclosure of medical record information by the recipient(s) is prohibited except when implicit in the purpose of this disclosure.**

(INFO-REL-AUTHOR MD COMMUNITY FRM-CY 01.22.2016) (FILE ORIGINAL IN CHART UNDER — COPY GOES WITH RESIDENT FIRST TIME — LIST ON CENSUS)





## COST AND FINANCIAL OPTIONS

### RESIDENTIAL FACILITY RATES

---

#### Rates per day for room and board / Private Pay

Level of Care	Non-Veteran Resident *	Qualifying Veteran's Portion	70% or Higher Disabled Veteran	VA Per Diem Contribution
Skilled Nursing Private	\$335.00	\$225.27	\$0.00 †	Varies
Skilled Nursing Semi-private	\$315.00	\$205.27	\$0.00 †	Varies
Domiciliary Assisted Living		\$57.64	\$0.00 †	Varies

\* Qualifying spouses and Gold Star parents

† VA surcharges may apply for some Veterans

### INSURANCE AND MEDICARE/MEDICAID COVERAGE

---

Medicare pays 100% for days 1-20 if the person has had a qualifying hospital stay and requires skilled care.

Daily co-pay for Medicare days 21-100 for those who continue to require skilled care is **\$170.50**.

Check with your insurance as Medigap or similar insurances may cover the co-pay.

Not all medications are covered by Medicaid and we highly recommend obtaining Medicaid Part B for Veterans and residents.

If applying for Medicaid for the co-pay and/or long-term care, the application should be filed at the time of admission. If you need assistance with New York or Vermont applications, you may contact your local Medicaid office or our business office at 802.447.6518.

Medications are included in the rate for residents covered by both Medicare or Medicaid Part B. Medications are not included for other forms of payment. Check with your insurance to see if your policy covers medications.

Rates are effective March 1, 2016.

Note: Rates and co-pay charges are subject to change at any time with 30 day notice.



## NEWS YOU CAN USE ABOUT THE VERMONT VETERANS' HOME

### NEWS AND COMMUNICATIONS

---

#### Buzz Word Newsletter

The *Buzz Word* is a monthly publication which features activities, events, and meetings at the Vermont Veterans' Home. It's filled with articles and pictures and is a great way for residents and families to learn what's going on. You can obtain copies by these methods:

WEBSITE: Go to [www.vvh.vermont.gov](http://www.vvh.vermont.gov) and find Newsletter under the site map menu at the top.

MAIL / EMAIL: You can receive *Buzz Word* by mail or email. Call the editor of Buzz Word at 802-447-6510 or email [vvh-admissions@vermont.gov](mailto:vvh-admissions@vermont.gov) to subscribe.

#### Facebook

Like us on Facebook! You will find up-to-date information on events, activities and news that happens at the Home and other organizations in the Veteran community. Go to Facebook and search for "The Vermont Veterans' Home."

### CONTACT INFORMATION

---

#### Contacting the Veterans Home Staff

You can reach the Home 24 hours a day by dialing 802.442.6353. (I recommend you add any relevant emergency contacts etc.)

#### Contacting Residents

Mail should be sent to residents as follows:

Resident's Name  
Room Number  
325 North Street  
Bennington VT 05201

We also have Skype carts available for face to face conversations. These can be arranged at any time.

### VISITS FROM FAMILY AND FRIENDS

---

#### Guest Visits and Holiday Meals

Did you know that you can join your loved one for breakfast, lunch or dinner?

Families are welcome to dine with our Veterans and enjoy a meal together. A 24-hour notice is very much appreciated as space is limited, especially for the holidays.

Guest meals are reasonable priced at:

Breakfast	\$7.00
Lunch	\$10.00
Dinner	\$7.00



## **VISITS FROM FAMILY AND FRIENDS**

On the following special occasions, the Veteran or Member is able to sponsor one guest for free:

Resident's Birthday

Easter Sunday

Thanksgiving

Christmas Day

New Year's Day

To purchase meal tickets, contact the Receptionist by email at [vvh-admissions@vermont.gov](mailto:vvh-admissions@vermont.gov) or by phone at 802-447-6510.

### **Accommodations for Visiting Guests**

To accommodate those who travel long distances, the Vermont Veterans' Home offers a Guest Room that can be reserved for short stays while visiting with a loved one.

No fee is charged for the use of the room located on the second floor of the main building. The room is furnished with two twin beds, a private bath and other amenities.

To make a reservation, please call 802-447-6510 or email [vvh-admissions@vermont.gov](mailto:vvh-admissions@vermont.gov).

## **POLICIES AND RESTRICTIONS**

### **Pet Policy**

Pets are welcome to visit their family members at the VVH under the following circumstances:

Up-to-date vaccinations must be on file with the Receptionist. The record may be sent prior to, or at the time of the visit.

Pets cannot roam freely or be left unattended; they must be on leashes or in appropriate animal carriers. Handlers must be in control of pets at all times.

Animals are not allowed in food preparation areas, dining rooms or in the treatment rooms.

Owners are responsible to cleanup their pet's waste; feces are not to be left in the grass or anywhere on the grounds.

Barking or other disruptive behaviors may be grounds to have the pet removed from the facility.

### **Smoking Policy**

The Home's smoking policy allows smoking for Veterans only in designated areas.

Smoking is not permitted on the front porch, under the canopy or by any of the entrances. Guests may smoke at the shelter off American Way, or in the courtyard across from Activities, off Brandon Boulevard.