RETURNING THE HONOR TO SERVE.

Thank you for expressing your interest in the *Spanish Peaks Veterans Community Living Center* (*SPVCLC*) - the Veterans Administration (VA) nursing home located in beautiful, southern Colorado. Although the COVID-19 pandemic has resulted in a current restriction of visitations and tours of our wonderful long-term and short-term care facility, I encourage you to read about our distinctiveness and what the *SPVCLC* has to offer not only to its highly respected Residents - but to their families and friends, as well. You may also want to visit our website at www.sprhc.org.

The *SPVCLC* and its staff not only have the extensive capability to fully handle a wide variety of needs, but also the sincere understanding that goes along hand-in-hand. Every Resident is treated as that same unique person they have spent their lifetime becoming.

Please take a moment to review the following information, the application, and the list of documents that are either required or requested to better serve the applicant. Our *SPVCLC* Admissions Committee will review the collected information and then offer its recommendation to the Medical Director who will make the final determination as to acceptance. Please know that this process can go very quickly as long as all the requested documentation is in place.

As the *SPVCLC* Admissions Coordinator, I can also help guide you regarding any possible Medicaid and Veterans Administration benefits to include obtaining a copy of a military discharge document. We can also discuss other possible choices for long-term and short-term care, other services, and health care options.

As a military Veteran myself and family member of an *SPVCLC* Resident, it is my sincere honor and privilege to help guide you through the admission application process. From my first-hand experience, I do understand what an emotional and stressful time this may be. But you've taken the first step by contacting the *SPVCLC* and requesting this application packet. This is where you begin.

Looking forward to assisting you,

Jan Novak
US Army Veteran
- *SPVCLC* Admissions Coordinator
Ph 719/738-5133 FAX 719/738-4522
Ph 800/645-VETS Email jnovak@sprhc.org

OVERVIEW

The *SPVCLC* is a 120-bed non-skilled nursing home facility offering a memory care unit for those Residents with Alzheimer's Disease and dementia special needs. It is easily accessible via Interstate 25 just a few miles west from the town of Walsenburg on US Hwy 160. Visitation is based on current COVID-19 restrictions.

Spanish Peaks Regional Health Center / Spanish Peaks Veterans Community Living Center & Specialty Clinic

★ ALL-INCLUSIVE DAILY RATE

- 24-hour Nursing Care
- Activities Department Offering Various Interests at Multiple Degrees of Capabilities
- Bathing Aide Services
- Computer Use with Internet Access
- Hospital Bed, Clothing Cabinet, Bed-Side Cabinet with Drawers, Hospital Bed-side Table
- Care Plan Meetings
- Diet Customization & Snacks
- DISH Basic Cable TV Access
- Various Types of Entertainment and Games
- Housekeeping & Laundry Services Provided
- Hydration Aides
- Library
- Mail Room Service In-House
- Meal Choices
- Medications, Oxygen, Adult Attends
- Memory Care Unit Alternative w/Fenced Garden
- Personal Care Items
- Restorative Therapy Programs
- SCANDENT - A Loss Prevention System
- Secure & Private Outdoor Areas
- Semi-Private or Private Room, as Applicable
- Shopping Trips
- Social Services Department
- VA Remote Tele-Health Counseling
- Transportation to Appointments with CNA's
- Veteran Service Officer for VA Benefit Assistance
- Volunteers to Assist with Various Activities
- Wi-Fi Access

Also available at the *SPVCLC* and on-campus are an in-house pharmacy, gift shop, barber/beauty salon, accessible physician and physician assistant services, complimentary Notary Public services, and the *Spanish Peaks Regional Health Center* (*SPRHC*) complex. The *SPRHC* is home to a Level IV Trauma Center and hospital with a surgical center, the Medicaid Swing Bed Unit, and a cafeteria offering a short-order grill.

Our *Specialty Clinic* houses the *Fresenius Kidney Care* dialysis center and visiting physicians who specialize in various medical fields for the convenience of the *SPVCLC* Residents and southern Colorado. The *Spanish Peaks Family Clinic* is open to the public for medical services. The *SPVCLC* overlooks the wonderful Lathrop State Park from its second-floor scenic advantage point. Residents may join in fishing outings and picnics at this very convenient picturesque spot during the summer months.

Should hospice care ever become necessary, please know that the *SPVCLC* is currently served by the outstanding *Sangre de Cristo Hospice* organization based in Trinidad.

★ ELIGIBILITY

- ✓ Veterans, spouses/widows/widowers of Veterans, and Gold Star parents may be accepted from all fifty U.S. states and territories
- ✓ Colorado residency is *not* a requirement
- ✓ Veterans must have a military discharge type other than dishonorable which meets criteria
- ✓ Spouses & widows/widowers of Veterans must have a Veteran marriage relationship with the same military discharge criteria as noted above. Divorcees of Veterans and widows/widowers of Veterans who later married a non-Veteran are not eligible to apply.
- ✓ Long-term care, short-term care (respite), and physical rehabilitation stays are available for qualified Veterans, spouses/widows/widowers of Veterans, and Gold Star parents

Spanish Peaks Mountain View from West-side Outdoor Area

★ PAYER SOURCES

The *SPVCLC* accepts the following payer sources for room and board services. Most of the *SPVCLC* rooms are semi-private (two people to a room). We only have a limited number of private rooms. I encourage you to call me to discuss payment options to include possible Medicaid eligibility. You won't know until you ask!

- **VETERANS**
  - Private Pay, Colorado Medicaid, and long-term care insurance are accepted
  - There is no charge for room and board if a Veteran has a VA service-connected disability rating of 70-100%

- **SPOUSES & WIDOWS/WIDOWERS OF VETERANS**
  - Private Pay, Colorado Medicaid, and long-term care insurance are accepted

- **GOLD STAR PARENTS**
  - Private Pay, Colorado Medicaid, and long-term care insurance are accepted

★ CURRENT DAILY RATES

The current daily rate includes oxygen, adult Attends/pull-up briefs, and prescription services:

> VETERANS

- PRIVATE PAY

Semi-Private Room	$262.01
- Less VA Per Diem	$112.36
= Final Daily Cost	$149.65
Private Room	$276.71
- Less VA Per Diem	$112.36
= Final Daily Cost	$164.35

- 70-100% DISABLED SERVICE-CONNECTED

No room and board charge

- **Colorado Medicaid & Long-Term Care Insurance Accepted**

Memory Care Unit	$269.91
- Less VA Per Diem	$112.36
= Final Daily Cost	$157.55

> SPOUSES & WIDOWS/WIDOWERS OF VETERANS

- PRIVATE PAY

Semi-Private Room	$262.01
Private Room	$276.71
Memory Care	$269.91

- Colorado Medicaid & Long-Term Care Insurance Accepted

> GOLD STAR PARENTS

- PRIVATE PAY

Semi-Private Room	$262.01
Private Room	$276.71
Memory Care	$269.91

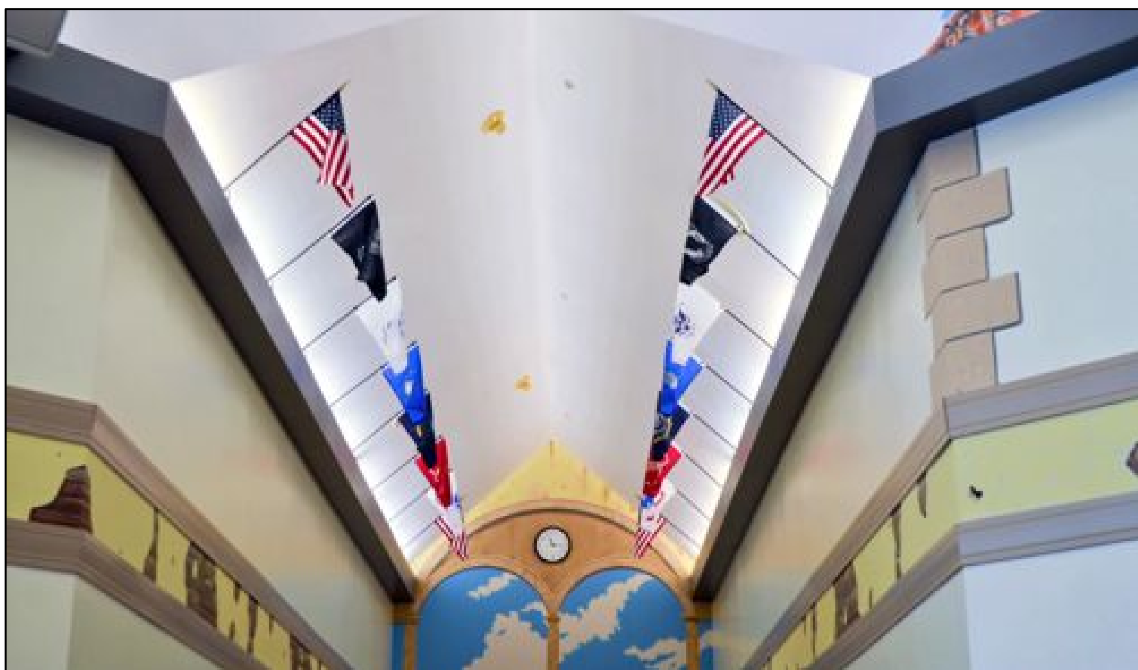
- Colorado Medicaid & Long-Term Care Insurance Accepted

Should you have any questions or concerns, please do not hesitate to contact me. Remember - I can help guide you regarding the payer sources, Colorado Medicaid, and the applicant's Veteran Service Officer in their county and state.

At first glance, I understand that this admission process might appear to be overwhelming - but I assure you that it is not. Please know that we at the *SPVCLC* only exist to serve our nation's Veterans, the spouses/widows/widowers of Veterans, and the Gold Star parents. It is our privilege to return the honor of service.

As part of the *Spanish Peaks Regional Health Care* complex in Walsenburg, the *SPVCLC* proudly shares the same motto:

"To Improve the Lives We Touch"



Main Hallway Honoring the U.S. Military Branches of Service

COLORADO
Department of Human Services

COLORADO
Department of Human Services
Veterans Community Living Centers

Admission Application

Veterans Community Living Centers

Fitzsimons	Florence	Homelake/Monte Vista	Rifle	**Walsenburg**
1919 Quentin Street	903 Moore Drive	P.O. Box 97	851 East 5th Street	**23500 US Hwy 160**
Aurora, CO 80045	Florence, CO 81226	Homelake, CO 81135	Rifle, CO 81650	**Walsenburg, CO 81089**
720-857-6406	719-784-6331	719-852-5118	970-625-0842	**719-738-5100**

Applicant's name: ____ Sex __________
Last First Full Middle

Address: ____
Street City County State Zip

Phone number(s): ___________________________ Religion: ___________________________________

Date of birth: _____________ Place of birth: ____
City County State Country

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

Applicant is a: Veteran _____ Veteran's spouse _____ Veteran's widow _____ Gold-Star Parent _____

Military Information

Branch of service: ___________________________ Service number: _____________________________
Date entered: _______________________________ Date discharged: ____________________________
Does the applicant have a service-connected disability rated by the VA? Yes _________ No _________
If yes, please list disability: ____________________ Percent disability: ___________________________

Medical and Health Insurance Information

Applicant's Social Security Number: ____________________ Medicare number: _________________
Does applicant have: Medicare Part A? Yes ______ No ______ Medicare Part B? Yes ______ No ______
Does an HMO manage the applicant's Medicare? Yes ______ No ______
Secondary/supplemental insurance: _________________________ Insurance ID number: _______________
Medicare Part D/other prescription coverage: _________________ Insurance ID number: _______________
Does applicant have Medicaid? Yes _____ No _____ If yes, provide Medicaid ID number: ______________
Has applicant received medical care from the VA? Yes ____ No ____ VA claim #: ____________________
If yes, where, when and for what did the applicant receive treatment? _______________________________
____
Does applicant have any of the following?:
Medical Power of Attorney (POA): ___ General POA: ___ Living Will: ___ Guardian/Conservator: ___

Spouse Information

Spouse's name: ___________________________________ Maiden name (if any): ___________________
Last First Middle
Date of Marriage: ______________________
Spouse's address: ____ Phone #: (_____)____________
Street City State Zip
Spouse's Social Security Number: _______________________ Spouse's Date of Birth: ________________

Emergency Notification:

1) Name: ______________________________________ Relationship: ____________________
Address: ____
Street City County State Zip
Phone number(s): ____

2) Name: ______________________________________ Relationship: ____________________
Address: ____
Street City County State Zip
Phone number(s): ____

3) Name: ______________________________________ Relationship: ____________________
Address: ____
Street City County State Zip
Phone number(s): ____

If admitted to the Veterans Community Living Center, who will handle your financial affairs? *(Provide name and phone):*____

Financial Information:

The following financial information is required to determine eligibility for benefits and ability to pay. Please state gross monthly amounts before any deductions.

Monthly Income	**Applicant**	**Spouse**
Social Security:	$ ______________	$ ______________
Civil Service:	$ ______________	$ ______________
Railroad retirement:	$ ______________	$ ______________
Military retirement (not VA):	$ ______________	$ ______________
VA service-connected disability compensation:	$ ______________	$ ______________
VA pension:	$ ______________	$ ______________
Other pensions (specify): ________________________________	$ ______________	$ ______________
Gross wages (employment):	$ ______________	$ ______________
Total Monthly Income:	**$ ______________**	**$ ______________**

Assets	**Applicant**	**Spouse**
Cash/checking account/savings:	$ ______________	$ ______________
Investments:	$ ______________	$ ______________
Trusts:	$ ______________	$ ______________
Real estate (other than your residence):	$ ______________	$ ______________
Other:	$ ______________	$ ______________

Please attach copies of the following:

- Military separation orders or discharge papers (DD214 or similar document)
- Service-Connected Disability Award Letter from the VA, if applicable
- Front and back of all insurance cards
- Medical POA, General POA, guardian/conservatorship documents and living will, if available

I understand that it may be necessary for me to provide copies of bank statements periodically to verify my financial position, and that I must keep my account current.

If I am admitted, I agree to abide by the rules and regulations of the Veterans Community Living Center. I realize that the facility is operated in full compliance with the Civil Rights Act of 1964, and the Americans with Disabilities Act of 1990, and that I am to cooperate with the nursing home in maintaining full compliance.

I authorize the Veterans Community Living Center to verify any and all information provided on this form. The information I have provided is true and complete to the best of my knowledge and belief.

Signature: ____ Date: ________________________
(Applicant or POA)

Spanish Peaks Veterans Community Living Center

FUNCTIONAL ASSESSMENT

APPLICANT NAME: ______________________________

LAST FIRST FULL MIDDLE NAME

GOALS

- IS DISCHARGE A GOAL? ☐ YES ☐ NO
- IF "YES", WHAT GOALS NEED TO BE ACCOMPLISHED BEFORE DISCHARGE CAN HAPPEN?: ______________________________
- WHAT ARE THE APPLICANT'S PERSONAL GOALS?: ______________________________
- WHAT ARE THE POWER OF ATTORNEY'S GOALS? ______________________________

GENERAL INFORMATION

- REASON FOR NURSING HOME PLACEMENT: ______________________________
- LENGTH OF STAY: ☐ Long-term Care ☐ Short-term Care ☐ Rehab Only
- CODE STATUS: ☐ Do Not Resuscitate ☐ Full Code
- HEIGHT: __________ WEIGHT: __________ WEIGHT LOSS IN LAST 30 DAYS? ☐ Yes ☐ No

CURRENT MEDICATIONS

- AT-HOME MEDICATION LIST - Prescription & Over-the-Counter....(Continue on Page 6, if necessary)

NAME	DOSAGE	DIAGNOSIS FOR MEDICATION
:		

MEDICATION ALLERGIES

MEDICATION NAME	REACTION	MEDICATION NAME	REACTION

IMMUNIZATIONS & VACINATIONS

IMMUNIZATION & VACINATION NAME	DATE	ADMINISTERING PHYSICIAN OR FACILITY
:		

LIST OF MEDICAL ENTITIES

- Please list the name and town of medical entities seen in the last six months (exp: primary physician, VA clinic, VA hospital, emergency room, hospital, specialist, rehab center, nursing home, assisted living facility, etc)

MEDICAL ENTITY NAME	MONTH/YEAR SEEN	CITY/STATE
:		

OXYGEN INFORMATION

- OXYGEN USE: ☐ Yes ☐ No OXYGEN SETTING: __________
- CPAP USE: ☐ Yes ☐ No CPAP SETTINGS: __________
- BPAP USE: ☐ Yes ☐ No BPAP SETTINGS: __________

WOUND INFORMATION

- OPEN WOUND PRESENT: ☐ Yes ☐ No WOUND MEASUREMENTS: __________
- WOUND LOCATION: __________
- WOUND TREATMENT REGIMEN: __________

ASSISTED DEVICES / SAFETY NEEDS

- WHEELCHAIR: ☐ Yes ☐ No
- CANE: ☐ Yes ☐ No
- SLIDE BOARD: ☐ Yes ☐ No
- WALKER: ☐ Yes ☐ No
- TRANSFER BAR: ☐ Yes ☐ No
- GERI CHAIR: ☐ Yes ☐ No
- RECLINER: ☐ Yes ☐ No
- LOW BED: ☐ Yes ☐ No
- REACHER: ☐ Yes ☐ No
- AIR MATTRESS: ☐ Yes ☐ No
- SAFETY HELMET: ☐ Yes ☐ No
- SPECIAL SHOES: ☐ Yes ☐ No
- MOTOR/POWER CHAIR* ☐ Yes ☐ No
- OTHER: __________

(*Note: Motor/power chairs must be approved by the *SPVCLC* PT Department for use in the nursing home)

FALLS

- WHEN WAS LAST FALL?: __________ REASON FOR FALL: __________
- NUMBER OF FALLS IN LAST 30 DAYS: _____ NUMBER OF FALLS IN LAST 31-60 DAYS: _____
- WHAT INTERVENTIONS HAVE BEEN HELPFUL TO REDUCE FALLS?: __________

SPLINTS & BRACES

- SPLINT: ☐ Yes ☐ No TYPE/LOCATION: __________
- BRACE: ☐ Yes ☐ No TYPE/LOCATION: __________

PACEMAKER

- PACEMAKER ☐ Yes ☐ No
- LAST TIME CHECKED: __________
- OFFICE THAT REMOTELY TESTS/CHANGES SETTINGS: __________

BEHAVIORAL INFORMATION

- BEHAVIORAL CONCERNS: ☐ Yes ☐ No
- DESCRIBE: __________
- TRIGGERS: __________
- HOW ARE THE BEHAVIORS HANDLED?: __________

ASSISTANCE REQUIRED

- EATING: ☐ Yes ☐ No
- GROOMING: ☐ Yes ☐ No
- DRESSING: ☐ Yes ☐ No
  ○ 1-person assist ○ 2-person assist
- BATHING: ☐ Yes ☐ No
  ○ 1-person assist ○ 2-person assist
- SHOWERING: ☐ Yes ☐ No
  ○ 1-person assist ○ 2-person assist
- HYGIENE: ☐ Yes ☐ No
- LOCOMOTION: ☐ Yes ☐ No
- SITTING: ☐ Yes ☐ No
  ○ 1-person assist ○ 2-person assist
- STANDING: ☐ Yes ☐ No
  ○ 1-person assist ○ 2-person assist
- TOILETING: ☐ Yes ☐ No
  ○ 1-person assist ○ 2-person assist
- WEIGHT BEARING: ☐ Full weight ☐ Partial Weight ☐ Non-weight bearing
- TRANSFER ASSIST: ☐ 1-person stand-by assist ☐ 1-person pivot/transfer assist ☐ 2-person pivot/transfer assist ☐ 1-person physical assist ☐ 2-person physical assist ☐ Stand-up lift ☐ Hoyer lift ☐ No assist
- DESCRIBE WHAT THE APPLICANT CAN DO FOR THEIR SELF: ______________________________

____

BOWEL & BLADDER INFORMATION

- BLADDER: ☐ Continent ☐ Incontinent
- DIAGNOSIS FOR CATHETER: ______________________________
- SELF-CATH: ☐ Yes ☐ No
- TYPE SIZE OF CATHETER: ______________________________
- SELF-CATH FREQUENCY: ______________________________
- INDWELLING CATHETER: ☐ Yes ☐ No
- ATTENDS: ☐ Yes ☐ No SIZE: ______________
- PULL-UPS: ☐ Yes ☐ No SIZE: ______________

- BOWEL: ☐ Continent ☐ Incontinent
- OSTOMY: ☐ Yes ☐ No OSTOMY SUPPLIES: ______________________________
- DIAGNOSIS FOR OSTOMY: ______________________________

VISION, HEARING, DENTAL

- VISUALLY IMPAIRED: ☐ Yes ☐ No
- EYEGLASSES: ☐ Yes ☐ No
- HARD OF HEARING: ☐ Yes ☐ No
- HEARING AIDS: ☐ None ☐ Left ☐ Right ☐ Both
- UPPER PARTIAL ONLY: ☐ Yes ☐ No
- LOWER PARTIAL ONLY: ☐ Yes ☐ No
- UPPER & LOWER PARTIALS: ☐ Yes ☐ No
- UPPER DENTURE ONLY: ☐ Yes ☐ No
- LOWER DENTURE ONLY: ☐ Yes ☐ No
- UPPER & LOWER DENTURES: ☐ Yes ☐ No
- DENTAL ISSUES: ☐ Yes ☐ No DESCRIBE: ______________________________

____

SLEEP PATTERN

- TROUBLE SLEEPING AT NIGHT: ☐ Yes ☐ No
- TIME PREFERENCE FOR RISING: ______________
- TIME PREFERENCE FOR BEDTIME: ______________
- PREFERENCE FOR SLEEPWEAR ATTIRE: ______________________________
- NAPS DURING THE DAY: ☐ Yes ☐ No
- NAP TIMES: ______________

COMMUNICATION

- COMMUNICATION NEEDS: ☐ Yes ☐ No
- COMMUNICATION BOARD: ☐ Yes ☐ No
- EXPLANATION: ____________

TOBACCO, ALCOHOL, & OTHER SUBSTANCES

- CHECK ALL THAT APPLY:
- CIGARETTES ☐ CIGARS ☐ ELECTRIC CIGARETTES ☐ MARIJUANA ☐
- HOOKAHS ☐ PIPES ☐ ALHOHOL ☐ Describe type/amt: ____________
- OTHER SUBSTANCES: ☐ EXPLAIN: ____________
- NONE ☐
- LAST DATE OF USE OF TOBACCO, ALCOHOL, OR SUBSTANCE ABUSE PRODUCTS: ____________

DIETARY/NUTRITION

- PEG TUBE: ☐ Yes ☐ No PEG TUBE SUPPLIES: ____________
- FOOD ALLERGIES: ☐ Yes ☐ No FOOD ALLERGY LIST: ____________
- FOOD PREFERENCES: ____________
- FOOD DISLIKES: ____________
- REGULAR DIET: ☐ Yes ☐ No
- MECHANICAL DIET: ☐ Yes ☐ No
- CCHO DIET: ☐ Yes ☐ No
- HEART HEALTHY DIET: ☐ Yes ☐ No
- LIQUID DIET: ☐ Yes ☐ No
- PLATE GUARD: ☐ Yes ☐ No
- CLEAR LIQUID DIET: ☐ Yes ☐ No
- FULL LIQUID DIET: ☐ Yes ☐ No
- RENAL DIET: ☐ Yes ☐ No
- DIABETIC DIET: ☐ Yes ☐ No
- PUREE DIET: ☐ Yes ☐ No
- ARTHRITIC TABLEWARE: ☐ Yes ☐ No

ACTIVITIES OF INTEREST

- BIBLE STUDY: ☐ Yes ☐ No
- COMMUNION: ☐ Yes ☐ No
- CHURCH SERVICES: ☐ Yes ☐ No
- GROUP ACTIVITIES: ☐ Yes ☐ No
- CARD GAMES: ☐ Yes ☐ No
- PUPPY POWER HOUR: ☐ Yes ☐ No
- EXERCISE GROUP: ☐ Yes ☐ No
- TRIVIA QUESTIONS: ☐ Yes ☐ No
- COUNTRY DRIVES: ☐ Yes ☐ No
- PET COMPANION PGRM: ☐ Yes ☐ No
- BINGO: ☐ Yes ☐ No
- ARTS & CRAFTS: ☐ Yes ☐ No
- TV/MOVIES: ☐ Yes ☐ No
- HOBBIES/SPECIAL INTERESTS: ____________

____

PAIN HISTORY

LOCATION OF PAIN	PAIN DIAGNOSIS	PAIN MEDICATION

SELF-ADMINISTERED MEDICATIONS

- IF THE APPLICANT CANNOT PASS A SELF-ADMINISTERED MEDICATION ASSESSMENT, PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS WILL NOT BE ALLOWED TO BE KEPT AT BEDSIDE (EXP: EYE DROPS, COUGH DROPS, PAIN RELIEVERS, ANTACIDS, ETC).

- IS THE APPLICANT INTERESTED IN SELF-ADMINISTERING THEIR OWN PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS?:

  ☐Yes ☐No

- IF "YES", DOES THE APPLICANT UNDERSTAND THAT A SELF-ADMINISTERED MEDICATION ASSESSMENT WILL BE COMPLETED UPON ADMISSION - AND - THE PHYSICIAN MUST APPROVE SELF-ADMINISTERED MEDICATIONS IF THE RESIDENT DOES PASS THE SELF-ADMINISTERED MEDICATION ASSESSMENT?:

  ☐Yes ☐No ☐ N/A

MORTUARY

IT IS IMPORTANT THAT THE FINAL WISHES OF THE APPLICANT BE HONORED. PLEASE PROVIDE THE MORTUARY NAME, LOCATION, AND CONTACT INFORMATION. PLEASE ALSO DESIGNATE WHETHER OR NOT THE PLAN IS PRE-PAID. THE ADMISSIONS COORDINATOR MAY BE ABLE TO PROVIDE YOU WITH A FEW OPTIONS IF YOU ARE UNDECIDED AT THIS TIME.

MORTUARY NAME	CITY/STATE	TELEPHONE NUMBER

IS THIS A PRE-PAID PLAN? ☐ Yes ☐ No

- Please submit a copy of the plan if there is one.

MISCELLEOUS

- ANYTHING ELSE YOU'D LIKE US TO KNOW?: ______________________

____

____

____

____

____

____

FORM COMPLETED BY: ______________________

NAME OF PERSON COMPLETING FORM DATE

FORM REVIEWED BY: ______________________

NAME OF ADMISSION COORDINATOR DATE

Please review selections/answers to ensure they are clearly marked and legible ~ Thank you!

AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION

Request for Release by:

Facility: ______________________

Address: ______________________

City/State/Zip: ______________________

Telephone/Fax: ______________________

Release to: Spanish Peaks Veterans Community Living Center
Attn: **Jan Novak**
23500 US Highway 160
Walsenburg, CO 81089
Telephone: 719-738-5133
Fax: 719-738-4522

____
Patient Name

____
Mailing Address

____
City State Zip

____
Phone Fax

Patient's Date of Birth: ______________________

Patient's Last 4 Digits of SSN: ______________________

Email Address: ______________________

Patient:	☐ Pick Up	☐ Fax	☐ Mail
Other Person:	☐ Pick Up	☐ Fax	☐ Mail
Facility:	☐ Secure Email	☐ Fax	☐ Mail

INFORMATION TO BE COPIED AND RELEASED (CHECK ALL THAT APPLY):

Date(s) of service: ______________________

☐ Emergency Room Report	☐ Nurses Notes	☐ Respiratory	☐ Immunization Records
☐ Discharge Summary	☐ Medication Records	☐ Rehab Services	☐ Billing Records
☐ History & Physical	☐ Physician Orders	☐ Patient Care Photos	☐ Other: ______________
☐ Consultation Reports	☐ Lab/Pathology Results	☐ Non-SPRHC Med Recs	☐ DHS/DSS: (Financial Records, Medical Info, Medicaid Application Progress, Medicaid Eligibility/Benefits, Form 5615)
☐ Operative Reports	☐ Radiology Report	☐ Behavioral Notes	
☐ Physician Progress Notes	☐ Radiology Images	☐ Social Services Notes	

I DO ☐ or **I DO NOT** ☐ consent to release of information relating to psychiatric or psychological testing or treatment, alcohol, and/or drug abuse diagnosis, prognosis and treatment, and /or HIV(AIDS) testing and/or results, genetic testing/results, sickle cell anemia testing/results. *****NOTE: If this section is not completed, then records of this type, if they exist for this patient, will not be released. *****

THE PURPOSE FOR THIS RELEASE:

☐ Continuity of Medical Care ☐ Damage/Claim Information ☐ Personal Use ☐ Legal

☐ Applicant to Veterans Nursing Home ☐ Other: ______________________

AUTHORIZATION: I hereby give the releasing facility permission to disclose my individually identifiable health information as listed above. I understand once this information is disclosed, it may no longer be protected. I understand this authorization is voluntary, that further treatment cannot be conditioned upon my signing this authorization. I acknowledge incomplete forms cannot be processed and there may be a cost to copy these records.

I understand **this consent expires one year from the date of my signature** unless otherwise specified as follows: ______________________.

I understand I can take back permission to release my medical records at any time, except to the extent that action has already been taken to comply with it. I understand I must provide notice in writing if I choose to revoke this authorization before the date/event of expiration, and the written revocation must be signed and dated with a date that is later than the date on this authorization. A copy, fax or scan of this form is to be considered as valid as the original. **Please retain a copy of your records for your personal use.**

~~~~~~PLEASE ALLOW 10 BUSINESS DAYS FOR YOUR RECORDS REQUEST TO BE PROCESSED.~~~~~~

______________________	__________	______________________	__________
Signature of Patient/Representative	**Date/Time**	**Signature of Witness**	**Date/Time**

Name of Staff person who released medical records: ______________________ **Date:** __________

OFFICE USE ONLY: Proof of Identification: ______________________

Number of pages released: __________ Completion date: __________ Delivery method: __________

Name of individual who received request: ______________________ Date received: __________

Patient Medical Record Number / Account Number: ______________________ REV/NOV 2019

APPLICATION CHECK-LIST

The following is a convenient check-list (for your use only) of documents necessary (or requested) to review an applicant for admission to the *Spanish Peaks Veterans Community Living Center*. Once you have these items available, the application package is ready for submission. Should you have any questions or concerns, please contact the *SPVCLC* Admissions Coordinator at 719/738-5133 (or 800/645-VETS).

❖ ALL APPLICANTS

- ☐ **ADMISSION APPLICATION FORM**
  NOTE: Only the applicant or MPOA, FPOA, Medical Proxy, Guardian, of Conservator may sign
- ☐ **MEDICAL POWER OF ATTORNEY, MEDICAL PROXY, or GUARDIANSHIP DOCUMENT** (for medical purposes)
- ☐ **CPR DIRECTIVE** (if applicable)
- ☐ **FINANCIAL POWER-OF-ATTORNEY or CONSERVATORSHIP DOCUMENT** (for financial purposes)
- ☐ **FUNCTIONAL ASSESSMENT FORM**
- ☐ **INSURANCE CARDS** (front/back copies of insurance cards such as Medicaid, Medicare, Tricare, RX, etc)
- ☐ **LIVING WILL** (if applicable)
- ☐ **LONG-TERM CARE INSURANCE POLICY** (if applicable)
- ☐ **MILITARY SEPARATION DOCUMENT** (commonly referred to as the Veteran's DD-214 document)
- ☐ **MOST FORM** (Medical Orders for Scope of Treatment, if applicable)
- ☐ **RELEASE OF INFORMATION FORM**

❖ ONLY APPLICANTS APPLYING WITH A PAYER SOURCE OF PRIVATE PAY OR MEDICAID:

- ☐ **Financial Statements** (for last two months such as checking, savings, stocks, bonds, etc)

❖ ONLY VETERANS WITH A 70%-100% VA-RATED SERVICE-CONNECTED DISABILITY:

- ☐ **VA Award Letter** of percentage rating (ONLY if applying as a 70-100% disabled Veteran)

❖ ONLY APPLICANTS APPLYING AS A VETERAN'S SPOUSE/WIDOW/WIDOWER :

- ☐ **Marriage Certificate Document**
- ☐ **Death Certificate Document**