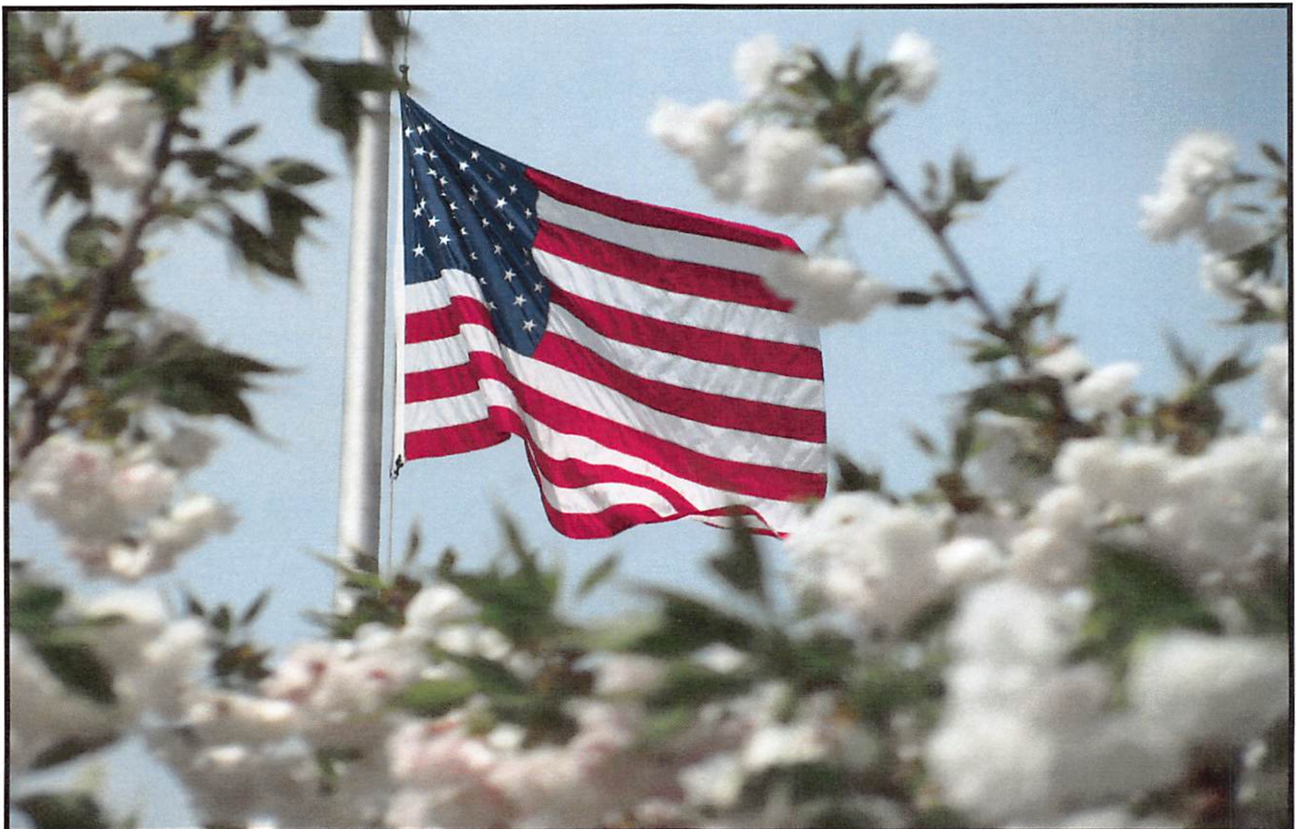
Admission Application



COMMONWEALTH of VIRGINIA

Virginia Veterans Care Center
Department of Veterans Services

Heather Whiteheart
Director of Admissions and Marketing
4550 Shenandoah Avenue N.W.
Roanoke, Virginia 24017

Phone: (540) 982-2860
Fax: (540) 982-1907

Dear Veteran:

Thank you for your interest in Virginia Veterans Care Center. We take great pride in caring for those who have cared for us!

Attached you will find the information and forms you will need to begin the administration process.

Please fill out the following and return to us, either by mail, email, or fax.

1. **The Application.** Please answer all the questions you can. Be sure to sign the last page.
2. **A copy of your Honorable Discharge or a DD 214.** Do not send originals.
3. **A copy of your Medicare card, Medicaid card, or any additional insurance cards you have in effect.** Our Business Office will contact your insurance company(s) to investigate what benefits you may have.
4. **A copy of your Power of Attorney Papers and your Advance Directive, if you have them.** If you do not have a power of attorney, please arrange for someone to assist you in financial and medical decisions.
5. **Medical History.** Contact your present Physician and request that he/she fax your medical information for the previous 6 months to (540) 982-1907. This is not necessary if coming from a hospital or nursing home.
6. **Physical Form.** There is also a Physical Form enclosed, but this physical must be done within 30 days of your admission to Virginia Veterans Care Center. Please wait until we know you are going to be living here before you have a physical done.

Please feel free to call me at 540-982-2860 or email at heather.whiteheart@dvs.virginia.gov if I can answer any questions. I will be happy to assist anyway I can.

Sincerely,

Heather Whiteheart

Heather Whiteheart

The Virginia Veterans Care Center opened on Veterans Day, 1992. We are proud to care for Virginia's Veterans. Our staff is dedicated to providing the best quality of life to the Veterans who served us. Whether it is a short stay for rehab or for long-term care, the Virginia Veterans Care Center offers individualized services in a safe, caring, and professional environment. Virginia Veterans Care Center is a smoke free facility.

Care Levels

- Skilled Nursing
- Intermediate Nursing
- Alzheimer's/ Dementia
- Hospice

Nursing Staff

Registered Nurses, Licensed Practical Nurse and Certified Nursing Assistants provide 24-hour care to our residents

Amenities

- Library
- Barber Shop
- Chapel
- Paved wheelchair paths
- 20 acres of park-like grounds and nature trails

Features

- In– house physical, occupational, and speech therapy
- Special Veteran and patriotic programs throughout the year
- Events by local Veteran Services
- Therapeutic activities such as pet therapy, bingo, fishing trips, outings, and weekly shopping trips
- Transportation to community and sporting events, and medical appointments

Eligibility

Eligibility requirements for admission include an honorable discharge form the U.S. Armed Forces and Virginia residency at the time of admission, or entry into the Armed Forces from Virginia. VVCC accepts payment from private insurers, Medicare and Medicaid. Most Veterans also qualify for the VA per diem facility credit.

The staff is fantastic and provides excellent care for my dad. They communicate well with my family about my dad's care.—Susie H.

I cannot emphasize enough as to how welcoming everyone was. We were met with smiling faces and compassion. VVCC is extremely clean, organized, and friendly. My dad was treated with the utmost of dignity. The VVCC is located on an absolutely beautiful setting. Dad loved to be taken outside and watch the deer and squirrels. I never once worried about the care my dad was receiving at the VVCC. I could lay my head down at night knowing he was being well taken care of.—Terri H.

I like everything here! I have made a lot of friends and the food is delicious. I especially like the bacon, eggs, and sausage gravy.
The staff take excellent care of me. I took a golf cart ride around the property the other day and it was beautiful. I thoroughly enjoy living here! — Marvin P.

Virginia Veterans Care Center
Virginia Department of Veterans Services

Application for Admission

PERSONAL INFORMATION

Applicant's full name: ____________________

First Middle Last

Phone Number (____) ____________ Mothers Maiden Name: ____________

Home Address ____________ City ____________ State ___ Zip ________

Virginia resident? ☐ Yes ☐ No How long? ________ ☐ Months ☐ Years

Where did you enter the service? ____________ (City) ____________ (State) Do you smoke? ☐ Yes ☐ No

Date of Birth ____/____/____ Age____ Sex_____ Social Security # ______-______-______

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Never Married

Mother's Maiden Name ____________ Your Place of Birth: ____________

Applicant coming to VVCC from ____________ Do you smoke? ☐ Yes ☐ No

Desired arrival date ____/____/____ Expected Level of Care: ☐ Assisted Living ☐ Nursing Home ☐ Dementia Care

MILITARY INFORMATION

Military Service: ☐ Coast Guard ☐ Army ☐ Navy ☐ Marine Corps ☐ Air Force

Service Number ____________ Type of Discharge: ____________

Date entered into service ____________ (Month Day Year) Date separated from service ____________ (Month Day Year)

Do you have a copy of your DD-214 ? ☐ Yes ☐ No

Have you received treatment at a VA Hospital? ☐ Yes ☐ No Where: ____________

Are you Service Connected? ☐ Yes ☐ No What percentage? ____________

HEALTH INFORMATION

Have you ever been treated for mental illness (es)? ☐ Yes ☐ No If yes, dates of treatment and name facility

____

Have you ever been treated for drug or alcohol problems? ☐ Yes ☐ No If yes, dates of treatment and name facility

____

Hospital stays during last 6 months? ☐ Yes ☐ No If yes, dates of treatement and name facility

____

Resident of healthcare center in the last year? ☐ Yes ☐ No If yes, dates of treatment and name facility

____

Financial Resources

APPLICANT'S PAYMENT SOURCE

- ☐ Private funds I have adequate personal funds available to cover at least ________ months of care.
- ☐ Medicare (number) ________
- ☐ Medicare Supplemental insurance (name of carrier) ________
- ☐ Medicaid (number) ________
- ☐ We have applied for Medicaid? ☐ Yes ☐ No What County did you apply in: ________

APPLICANT'S SOURCE OF MONTHLY INCOME

- ☐ Retirement/Pension $ ________
- ☐ Social Security Income (SSA) $ ________
- ☐ Veterans benefits $ ________
- ☐ Supplemental Security Income (SSI) $ ________
- ☐ Other (identify) ________ $ ________

APPLICANT'S ASSETS

- ☐ Real Estate (type/location/value) ________

  ____
- ☐ Bank accounts (checking, savings, CDs, IRAs, other) (value) ________

  ____
- ☐ Life Insurance policies

  Type/carrier ________ Cash value $ ________

  Type/carrier ________ Cash value $ ________
- ☐ Burial and/or Irrevocable Trust ☐ Yes ☐ No

Has applicant transferred ownership of any type of assets in the past 5 years? ☐ Yes ☐ No

If yes, asset and date of transfer ________

Social Security check is made payable to the applicant? ☐ Yes ☐ No

If no, name of representative payee ________ Relationship ________

Representative's address: ________

City ________ State ________ Zip ________

Responsible Party

A Responsible Party is held responsible for paying for the Veteran's stay with the Residents Funds.

Responsible Party ____
First Middle Last

Relationship to Applicant: ____

Address ______________________ City ______________ State ______ Zip ________

Telephone (home) ______________ (cell) ______________ (work) ______________

Power of Attorney (POA)? ☐ Yes ☐ No (If yes, include copy with application packet)
Are you a Court Appointed Guardian? ☐ Yes ☐ No (If yes, include copy with application packet)

POA Name ____

POA Address ______________________ City ______________ State ______ Zip ________

POA Telephone (home) ______________ (cell) ______________ (work) ______________

I/We hereby confirm that all information stated herein is current and correct to the best of my/our knowledge, and no requested information has been withheld or misrepresented. I/We authorize Virginia Veterans Care Center to verify any of the information herein. I/We understand that falsification of the stated information may jeopardize admission into the VVCC. I/We understand that all information will be kept confidential by Virginia Veterans Care Center and will not be released without my/our written permission.

____ ______________________
Applicant's or Authorized Representative's Signature Date

Required Admission Supplements

To start the application process, the following documents are also required:

1. The **last 6 months** of the applicant's medical history, faxed from all the applicant's health providers. Ask Dr's office or VA to fax information to (540) 982-1907.
2. A copy of both the front and back the applicant's insurance cards, e.g., Medicare, Medicaid and Blue Cross/Blue Shield.
3. A copy of Veteran's DD-214 or Honorable Discharge.
4. A copy of any legal guardianship papers or Power of Attorney documentation.

Please mail Application and Additional Supplements to:
Virginia Veterans Care Center
Admissions Director
4550 Shenandoah Ave.
Roanoke, VA 24017

Have questions or need assistance?
Call 540-982-2860
Ask For
The Admissions Department

REPORT OF PHYSICAL EXAMINATION FOR PLACEMENT

Must be completed by physician within 30 days prior to admission.
If admission is delayed beyond 30 days, addendum will be requested.

NAME ______________________ PHONE __________ DATE OF EXAM _________
ADDRESS ____
____

Resident's Height _________ Weight ___________ BP _________

Current Diagnoses/Problems

____
____
____
____
____
____
____

Significant Medical History

____
____
____
____

General physical condition/systems review:

____
____
____
____
____
____
____
____

Is this person:

_____ Ambulatory (physically and mentally capable of self-preservation by evacuating in response to an emergency to a refuge area as defined by the Uniform Statewide Building code without the assistance of another person, or from the structure itself without the assistance of another person if there is no such refuge area within the structure, even if such a resident may require the assistance of a wheelchair, walker, cane, prosthetic device or a single verbal command to evacuate).

_____ Nonambulatory (by reason of physical or mental impairment is not capable of self-preservation without the assistance of another person).

REPORT OF PHYSICAL EXAMINATION FOR PLACEMENT

Name ______________________________

Diet Education Needed: ______________________________

Current Activity ______________________________

Current Treatment Orders ______________________________

ALLERGIES (medication, food, other): ______________________________

____

Current Scheduled Medications (including OTC products):

List PRN medications on page 3 or 4.

Name	Dose	Route	Frequency	Reason for prescribing

Unless VVCC is notified of changes, these orders will be used for admission orders.

Signature of MD ______________________________ Date ____________

REPORT OF PHYSICAL EXAMINATION FOR PLACEMENT
PRN MEDICATIONS

Name ______________________________

PRN medications must include symptoms/indication for use, exact timeframes the medication is to be given in a 24-hour period, and directions for what to do if symptoms persist. All PRN medications must be available individually for each resident.

VVCC has adopted the following **over the counter medications** to alleviate symptoms of temporary conditions. If symptoms are not relieved or worsen, the PCP or VAMC ER physician will be notified. Please check approved orders or write in others.

1. For mild pain or temp. of 101° or higher:
   - ☐ Tylenol 650 mg. PO every four hours PRN. Maximum of 6 doses per 24 hours.
   - ☐ ______________________________
2. For constipation:
   - ☐ Milk of Magnesia 30 ml. PO daily PRN
   - ☐ ______________________________
   - ☐ Fleet's enema x 1 PRN
3. For diarrhea:
   - ☐ Licensed nurse to check for fecal impaction.
   - ☐ If none present, may give Imodium AD 2 caplets PO. May repeat 1 caplet after each loose stool up to a maximum dose of 16 mg. (8 caplets) within a 24 hour period.
   - ☐ ______________________________
4. For nausea, vomiting, acid indigestion, or upset stomach:
   - ☐ Mylanta 15 ml. PO every 2 hours PRN for acid indigestion.
   - ☐ ______________________________
   - ☐ Emetrol 15 ml. every 15 minutes PRN for nausea and vomiting up to a maximum of 5 doses in 24 hours.
   - ☐ ______________________________
5. For cough/cold symptoms:
   - ☐ Guaifenesin-DM Sugar-Free 10ml. PO every 4 hours PRN. Maximum of 4 doses in 24 hour period.
   - ☐ ______________________________
6. For difficulty sleeping:
   - ☐ Benadryl 25mg. PO at bedtime PRN
   - ☐ ______________________________
7. For minor skin tears and abrasions:
   - ☐ Clean area with Normal Saline daily until healed. Apply Bacitracin Ointment and clean dry dressing daily.
   - ☐ ______________________________
8. For shortness of breath:
   - ☐ Check vital signs and pulse ox, start O2 at 2 LPM, and notify MD.
   - ☐ ______________________________

Unless VVCC is notified of changes, these orders will be used for admission orders.

Signature of MD ______________________________ Date ____________

REPORT OF PHYSICAL EXAMINATION FOR PLACEMENT
OTHER SCHEDULED OR PRN MEDICATIONS

Name ____

Name	Dose	Route	Frequency/Max per 24 hour period
Specific indication for use		If symptoms persist	

Name	Dose	Route	Frequency/Max per 24 hour period
Specific indication for use		If symptoms persist	

Name	Dose	Route	Frequency/Max per 24 hour period
Specific indication for use		If symptoms persist	

Name	Dose	Route	Frequency/Max per 24 hour period
Specific indication for use		If symptoms persist	

Name	Dose	Route	Frequency/Max per 24 hour period
Specific indication for use		If symptoms persist	

Name	Dose	Route	Frequency/Max per 24 hour period
Specific indication for use		If symptoms persist	

Name	Dose	Route	Frequency/Max per 24 hour period
Specific indication for use		If symptoms persist	

Name	Dose	Route	Frequency/Max per 24 hour period
Specific indication for use		If symptoms persist	

Name	Dose	Route	Frequency/Max per 24 hour period
Specific indication for use		If symptoms persist	

Unless VVCC is notified of changes, these orders will be used for admission orders.

Signature of MD ____________________________________ Date ____________

REPORT OF PHYSICAL EXAMINATION FOR PLACEMENT

Name ____

Does this individual have any of the following conditions or care needs?

Condition/Care Need	Yes	No	Comment
Ventilator dependency			
Pressure Ulcer, Stage III or IV			If stage III ulcer, is it healing?
IV therapy or IV injections			If intermittent IV therapy , check yes and indicate expected time period
Airborne infectious disease that requires isolation or special precautions			
Psychotropic medications without appropriate diagnosis and treatment plans			
Nasogastric tubes			
Gastric tubes			If yes, is the person capable of independently feeding himself and caring for the tube and site?
Presents imminent physical threat or danger to self or others			In need of immediate assessment by a qualified mental health professional.
Requires continuous licensed nursing care			Licensed nurse must provide specific needed care each shift.

Does applicant have a history of mental health problems requiring intervention in the past year?

____

Has the applicant exhibited any of these behavior(s) in the past year requiring assessment, treatment, or monitoring? Yes _____ No_____ If yes, check behaviors identified:

- ☐ Physically assaulting others
- ☐ Gesturing a threat of assault
- ☐ Verbalizing a threat of harm to self or others
- ☐ Suicidal ideation or attempts
- ☐ Verbalizing an unrealistic fear of being harmed by others
- ☐ Destroying property that exposes self or others to harm
- ☐ Wandering inside or outside current residence
- ☐ Being intrusive in the personal space of others
- ☐ Putting objects or liquids in the mouth that are mistaken as food or consumable fluids
- ☐ Increased physical activity such as floor pacing that might indicate anxiety or stress
- ☐ Increased or confusing speech pattern or communications that might indicate a disorder of thought process
- ☐ Decreased physical activity such as staying in bed, not eating, or not communicating that might indicate depression
- ☐ Self-neglect – bathing, grooming, clean clothing, clean environment
- ☐ Pattern of alcohol abuse
- ☐ Pattern of drug abuse or misuse
- ☐ Compulsive behavior patterns
- ☐ Other ____

Is applicant capable of making financial decisions? _____, Medical decisions? _______

Signature of MD ____________________________________ Date ____________

REPORT OF PHYSICAL EXAMINATION FOR PLACEMENT
TUBERCULOSIS SCREENING EVALUATION

Name ___________________________________

Date of most recent Mantoux tuberculin skin test _______________

Result: mm of induration _______________

- ☐ Applicant previously tested positive
- ☐ Previously treated ____

Is person exhibiting any TB-like symptoms? Yes _____ No _____

If TB skin test is 10mm or greater (5mm in HIV infected), previously positive, or if TB-like symptoms exist, respond to the following:

Date of last chest x-ray _________________ (Attach report)

Was chest x-ray suggestive of active TB? Yes_____ No _____

If yes, were sputum smears collected for AFB? Yes ____ No ____

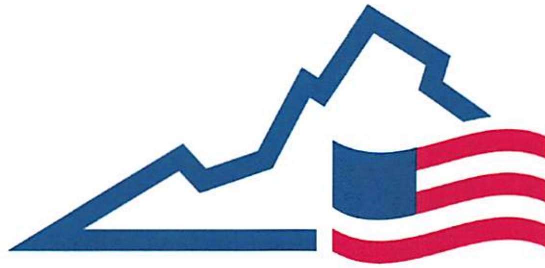
Were three consecutive smears negative for AFB? Yes ___ No ___

Based on the above, is this individual free of communicable TB? Yes ___ No ____

Name of licensed MD, nurse practitioner, or local health department official completing evaluation.

Print Name __________________________ Phone _____________________

Signature _____________________________________ Date ____________



Daily Room Rates

Effective 02-01-2020

Level of Care	Semi-Private Room Rate	Private Room Rate	VA Per Diem Facility Credit	Resident Cost for Semi-Private Room After	Resident Cost for Private Room After Credit
Nursing Facility	$252.36	$288.36	$112.36	$140.00*	$176.00*
Alzheimer Special Care Unit	$252.36	$288.36	$112.36	$140.00*	$176.00*

* A facility credit may be applied to the accounts of eligible residents