Virginia Department of Veterans Services

Jones & Cabacoy Veterans Care Center

2641 Nimmo Parkway, Virginia Beach, VA 23456

Jones & Cabacoy Veterans Care Center (JCVCC)

The Jones & Cabacoy Veterans Care Center (JCVCC) was named after two war heroes, Lieutenant Colonel William A. Jones and Staff Sergeant Christopher F. Cabacoy. Both were local to the Hampton Roads area and were awarded many medals for their bravery and heroism.

JCVCC is a 128-bed center that offers skilled nursing care for those needing short term rehab, memory care, and long-term care. It is nestled in a wooded area with walking trails and ponds surrounding the building. We have 2 "communities" that are broken up into 8 individual, 16 bed "households". Each household includes a dining room, kitchenette, dayroom and access to an adjoined courtyard. The center offers each resident their own spacious private room with restroom and walk in shower.

Rehabilitation services will be available for our long-term residents to continue maximal function and short-term residents prior to going home. We offer a broad range of intensive therapy services including physical, occupational, and speech services that is tailored to each resident's needs. We have a state of that art equipment that will ensure the resident is at their highest level of function as possible.

Our memory care section provides specialty trained staff and programming for residents with Alzheimer's or related memory disorders. They will be able to move freely in a safe and secure environment including an enclosed courtyard.

Our nursing staff will offer a wide scope of care for all our long-term care, memory and skilled care Veteran residents. We have an in-house pharmacy, which is a unique benefit and service offered at all our State Veteran Homes in Virginia.

JONES & CABOCOY VETERANS CARE CENTER

Eligibility and Admissions

Eligible applicants are veterans who must be:

1. A resident of Virginia at the time of admission
2. Honorably Discharged from active-duty service
3. Needing a skilled nursing level of care

Upon meeting the eligibility requirements, the applicant will be provided an application packet and if necessary, the applicants name will be placed on our potential admissions waiting list. Included in the application package is form 10-10EZ. Please complete even if you have recently completed one for the VA. The 10-10EZ must be signed by the veteran or the veteran's POA. The service members DD214 and any POA documents will need to be submitted as well.

The rate for JCVCC is currently $325.00 per day. Once the VA Survey is completed this rate may be reduced depending on eligibility status. JCVCC will notify those of the new rate once it is determined.

Jones & Cabacoy Veterans Care Center is a NON-SMOKING center

For more information about JCVCC please contact:

Bianca Freeman — Admissions Director — (757) 263-3100

Stephanie Lukis — Admissions Coordinator — (757) 263-3108

(757) 526-8845

JCVCCadmissions@dvs.virginia.gov

MEDICAL REVIEW SHEET

DO NOT gather the medical documents listed below unless requested by the Admissions Department at Jones & Cabacoy.

To aid in the placement of our future residents we will need the following documents:

Admissions from Hospital/SNF

- Current Physician orders
- Current MAR/TAR
- Current Nurse's Notes x 2 weeks
- Chest X-ray/PPD (done within 30 days prior to placement)
- Recent Labs within 30 days
- Skin Assesment
- Current Physician Notes and Rehab progress notes
- History & Physical (current)
- Completed DMAS-96, DMAS-95 and UAI
- Immunization Record
- Psych Eval/Progress Notes
- Operative Reports (if applicable)
- Weight Summary
- Psych Notes (if applicable)
- Consultations
- DNR (if applicable)
- Discharge Summary/Physicians Discharge Orders

Admissions from Home

- Current History and Physical w/medications
- Current Physician Referral
- Chest X-ray or PPD completed within the past 30 days
- Office visits progress notes if available (current)
- Completed UAI (if Medicaid is in place)

At time of admission, all new residents are required to give copies of the following documents:

- Copy of Medicare card
- Copy of Medicare Part D Insurance Card
- Copy of Secondary Insurance Card (if applicable)
- Copy of Medicaid (if applicable)
- Copy of Power of Attorney or Guardian Documentation
- Copy of Advanced Directive
- Copy of Living Will
- DNR (if applicable)

Important Note:

Please do not bring powered wheelchair/scooter at time of admission. The resident must be screened by the Rehabilitation Department before the use of these in the center to make sure it is operated safely.

SERVICE LIMITATIONS OF JCVCC

WE CANNOT ACCOMODATE THE FOLLOWING

- Anyone who is an active smoker or who has smoked in the last 6 months
- Anyone who has current drug/alcohol abuse requiring treatment
- Anyone with acute psychosis or behaviors
- Anyone who is a danger to self or others
- Anyone requiring a ventilator
- Anyone with active TB
- Anyone requiring in house or peritoneal dialysis
- Pregnancy
- Anyone who has Huntington's Disease
- Anyone requiring external defibrillators
- Anyone requiring frequent deep suctioning
- Anyone requiring a trach
- Anyone requiring a trilogy machine
- Anyone requiring Infusion chemo & some oral chemo medications
- Anyone requiring IV cardiogenic drugs
- Anyone with a Dobhoff feeding tube
- Anyone requiring a NG tube
- Anyone requiring parenteral nutrition, such as TPN or hyperalimentation
- Anyone who weighs over 450lbs

After reviewing medical records, there may be other instances of clinical situations we are unable to care for.

*Please complete *ONLY* the highlighted portions of the "AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION RECORDS" form. Leave everything else blank on this form, as we will fill in anything pertinent that we need in order to request medical records for you or your family member.

Please complete *ALL OF THE REMAINING* forms in this application package.

Return *ALL* completed forms to:

Jones & Cabacoy Veterans Care Center (Admissions Dept)

2641 Nimmo Parkway

Virginia Beach, VA 23456

JONES & CABACOY VETERANS CARE CENTER

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION RECORDS

I hereby authorize JONES & CABACOY VETERANS CARE CENTER (Providers Name) to disclose my individual identifiable health information as described below.

_____	_____	_____
Patients Name	Social Security Number	Date of Birth

Name and address of person(s) or organization(s) requesting the records, if different from the patient:

_____
_____
_____
_____

Name and address of person(s) or organization(s) to receive the records:

_____
_____
_____
_____

- ❑ I will review the records at the provider's location.
- ❑ I wish to have the following records copied, and I will pick them up at the provider's location.
- ❑ I am requesting that the provider copy the records and send the records to the above address.

Information Requested (please initial)

I am requesting the following records from the patients' medical records that were created **between ___/___/___ and ___/___/___.**

___ Dietary Notes	___ Activity Notes	___ Nursing Notes
___ Physician Notes	___ Physician Progress Notes	___ Care Plans
___ Discharge Summary	___ X-Ray Reports	___ Lab Results
___ Social Service Notes	___ Therapy Notes	

___Other:

_____

___ Other:

_____

Purpose in which records will be used:

_____

JONES & CABACOY VETERANS CARE CENTER
2641 Nimmo Parkway, Virginia Beach, VA, 23456

JONES AND CABACOY VETERANS CARE CENTER

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION RECORDS (CONTINUED)

___ I am the patient noted above.

___ I am the patient's legal decision maker under state law, and I am entitled to receive medical records under state law.

___ I am the patient attorney-in-fact, and I have attached to this authorization a valid Power of Attorney or Durable Power of Attorney for Health Care (DPAHC) that grants me the power to request the patient's medical record.

___ I am the patient's legal Guardian, and I have attached to this authorization a valid appointment of guardianship from a probate court.

___ If the patient is deceased: I am the executor/administrator of the patient's estate, and I have attached to this authorization a valid appointment of such from a probate court.

___ The patient has executed a legally binding instrument granting me the authority to obtain his/her medical records, and I have attached a copy of this instrument to this authorization.

___ The patient's legally authorized representative has executed a legally binding instrument granting me the authority to obtain the patient's medical record. I have attached a copy of the instrument granting me such authority to do so (example power of attorney or probate court order).

UNDERSTANDINGS AND AGREEMENTS OF REQUESTOR

1. This authorization is voluntary
2. This authorization will expire two months from the date of my signature below
3. I understand that I may revoke this authorization at any time by notifying the provider in writing, but if I do, it will have no effect on any actions taken prior to receiving the revocation.
4. I agree to waive all claims against the providers for the release of the requested information
5. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protection, afforded by the provider if the recipient of the information is not a health plan. Health care provider, healthcare clearing house, or a business associate that has the contract with the provider.

6. The provider may not place conditions on treatment, payment, enrollment, or eligibility for benefits on whether I sign an authorization when the prohibition on conditioning of authorizations applies.

7. I understand that I must provide the Provider with at least twenty-four (24) hour notice before coming to the provider
8. I understand that after I have reviewed the records, I must provide the Provider with two (2) working days advance notice of any copies of the record that I would like to pick up at the providers location.
9. I understand that if I requested that record to be copied and sent to me that the provider would make a good faith effort to send those records to me in a reasonable amount of time.
10. I understand that if I wish to have copies of records made, then the Provider will access a fee for copying the records.
11. The provider will notify me of the total amount due for copying and shipping of the requested records: I agree that the Provider will only send me the requested information once it has received payment in full for those costs.

_____ _____ _____

SIGNATURE OF REQUESTOR PRINT NAME DATE