Spanish Peaks
Regional Health Center
Veterans Community Living Center

# RETURNING THE HONOR TO SERVE.

Hello,

Thank you for expressing your interest in the Spanish Peaks Veterans Community Living Center (SPVCLC). Located in beautiful Southern Colorado, our facility is a Veterans Administration (VA) nursing home offering excellent long-term and short-term care. I invite you to learn more about what makes SPVCLC unique and the services we provide not only to our highly respected Veterans/ residents but also to their families and friends. You can visit our website at sprhc.org for additional information on the acute care hospital that we are share a location with.

The staff at SPVCLC possesses the extensive capability to meet a wide variety of needs, combined with a sincere understanding of the individual experiences of our Residents. Each Resident is treated as the unique person they have become over their lifetime. I encourage you to review the following information, including the application and the list of required or requested documents, to help us better serve the applicant. Our SPVCLC Admissions Committee will evaluate the submitted materials and make a recommendation to the Medical Director, who will make the final decision regarding acceptance. Please be assured that this process can proceed quickly if all requested documentation is provided.

As the Admissions Manager at SPVCLC, I can guide you through the various Medicaid and Veterans Administration benefits available, such as obtaining a copy of the military discharge document. We can also discuss other long-term and short-term care options and additional services. I understand that this can be an emotional and stressful time, but you have taken a significant step by reaching out to SPVCLC for this application packet. This is the beginning of the process. I look forward to assisting you.

Sincerely,

Lainie Tenorio
SPVCLC, Admissions Manager
Phone 719.738.4565 Fax 719.738.5147
Email: ltenorio@sprhc.org

Spanish Peaks
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# 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 admissions to discuss payment options.

- **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

Please contact the Admissions Manager for the most current daily rate which includes oxygen, adult Attends/ pull-up briefs, and prescription services. 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"

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?: Email address for POA_____
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): _____ Email: _____

2) Name: _____ Relationship: _____
Address: _____
Street City County State Zip
Phone number(s): _____ Email: _____

3) Name: _____ Relationship: _____
Address: _____
Street City County State Zip
Phone number(s): _____ Email: _____

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

**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)

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# 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 |
|---|---|---|
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## 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) Omitting any medical visits will delay the admissions process.

| MEDICAL ENTITY NAME | MONTH/YEAR SEEN | CITY/STATE |
|---|---|---|

Have you had an overnight stay or invasive medical or surgical procedure in a healthcare facility outside the U.S. in the previous year? Yes or No. If yes, where: _____

Have you had an overnight stay in a long-term acute care hospital or ventilator-capable skilled nursing facility anywhere in the U.S. in the previous year? Yes or No. If yes, where: _____

## 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
- HYGIENE: ☐ Yes ☐ No
- LOCOMOTION: ☐ Yes ☐ No
- DRESSING: ☐ Yes ☐ No
  ○ 1-person assist ○ 2-person assist
- SITTING: ☐ Yes ☐ No
  ○ 1-person assist ○ 2-person assist
- BATHING: ☐ Yes ☐ No
  ○ 1-person assist ○ 2-person assist
- STANDING: ☐ Yes ☐ No
  ○ 1-person assist ○ 2-person assist
- SHOWERING: ☐ 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
- INDWELLING CATHETER: ☐ Yes ☐ No
- DIAGNOSIS FOR CATHETER: _____
- SELF-CATH: ☐ Yes ☐ No
- ATTENDS: ☐ Yes ☐ No SIZE: _____
- TYPE SIZE OF CATHETER: _____
- PULL-UPS: ☐ Yes ☐ No SIZE: _____
- SELF-CATH FREQUENCY: _____
- 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 |
|---|---|---|
| | | |
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## 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.

## MISCELLANEOUS

- ANYTHING ELSE YOU WOULD 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!*

Spanish Peaks
Regional Health Center
Veterans Community Living Center

**AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION**

**Request for Release by:**

**Facility:** _____

**Address:** _____

**City/State/Zip:** _____

**Telephone/Fax:** _____

_____
Patient Name

_____
Mailing Address

_____
City State Zip

_____
Phone Fax

**Release to:** Spanish Peaks Veterans Community Living Center
Attn: Lainie Tenorio
23500 US Highway 160
Walsenburg, CO 81089
Telephone: 719-738-4565
Fax: 719-738-5147
Email: ltenorio@sprhc.org

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: ___FACESHEET_____ |
| ☐ Consultation Reports | ☐ Lab/Pathology Results | ☐ Non-SPRHC Med Recs | ☐ DHS/DSS: (Financial Records, Medical Info., |
| ☐ Operative Reports | ☐ Radiology Report | ☐ Behavioral Notes | Medicaid Application Progress, Medicaid |
| ☒ Physician Progress Notes | ☐ Radiology Images | ☐ Social Services Notes | Eligibility/Benefits, Form 5615) |

**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/MARCH 2025

Department of Veterans Affairs

# REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

**PRIVACY ACT AND PAPERWORK REDUCTION ACT INFORMATION:** The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out this form. 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, 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 information needed to locate records for release is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individuallyidentifiable health information for such research is required. 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 system of records notices identified as 24VA10A7 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Location of the VA Health Care Facility)*

| LAST NAME- FIRST NAME- MIDDLE NAME | DATE OF BIRTH *(mm/dd/yyyy)* |
|---|---|
| | |

PATIENT'S MAILING ADDRESS (*including City, State and Zip Code*)

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

**PURPOSE(S) OR NEED**: Information is to be used by the requestor for:

☐ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ EMPLOYMENT ☐ OTHER *(Please specify below):*

_____

**INFORMATION REQUESTED:** Check applicable box(es) and state the extent or nature of information to be provided:

☐ HEALTH SUMMARY *(Prior 2 Years)*

☐ PATIENT MEDICAL RECORDS *(Dates)*: _____

☐ INPATIENT DISCHARGE SUMMARY *(Dates)*: _____

☐ PROGRESS NOTES:

- ☐ SPECIFIC CLINICS *(Name & Date Range)*: _____
- ☐ SPECIFIC PROVIDERS *(Name & Date Range)*: _____
- ☐ DATE RANGE: _____

☐ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: _____

☐ LAB RESULTS:

- ☐ SPECIFIC TESTS *(Name & Date)*: _____
- ☐ DATE RANGE: _____

☐ RADIOLOGY REPORTS *(Name & Date)*: _____

☐ LIST OF ACTIVE MEDICATIONS: _____

☐ VACCINATION *(Dose, Lot Number, Date & Location)*: _____

_____

☐ ADMINISTRATIVE RECORDS: _____

☐ OTHER *(Describe)*:

_____

| LAST NAME- FIRST NAME- MIDDLE NAME | DATE OF BIRTH *(mm/dd/yyyy)* |
|---|---|
| | |

**SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.**

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

**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. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, 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 Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

**EXPIRATION:** Without my express revocation, the authorization will automatically expire *(select one of the following)*:

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed by patient)*

☐ UNDER THE FOLLOWING CONDITION(S): _____

_____

| PATIENT SIGNATURE *(Sign in ink)* | DATE *(mm/dd/yyyy)* |
|---|---|
| | |
| LEGAL REPRESENTATIVE SIGNATURE (*if applicable) (Sign in ink*) | DATE *(mm/dd/yyyy)* |
| | |

| PRINT NAME OF LEGAL REPRESENTATIVE | RELATIONSHIP TO PATIENT |
|---|---|
| | |

**FOR VA USE ONLY**

TYPE AND EXTENT OF MATERIAL RELEASED

| DATE RELEASED *(mm/dd/yyyy)* | RELEASED BY: |
|---|---|
| | |

# 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 Manager at 719-738-4565.

## ❖ 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)
- ☐ **COVID-19 VACCINATION CARD** (copy only)
- ☐ **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, COVID, 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** (For both the SPVCLC & the VA [if applicable])
- ☐ **MORTUARY AGREEMENT/POLICY/PRE-PAID PROOF** (if applicable)

## ❖ 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**