Applying from: Home Hospital ____________ Nursing Home/Assisted Living ____________

Preference for admission: First Available Specific Locations *(Provide preferences in order below)*

Rank the homes in order of preference using numbers 1 - 5, with 1 indicating your highest preference.

___ Anderson ___ Columbia ___ Florence ___ Gaffney ___ Sumter ___ Walterboro

Demographic Information

Last Name ____________ First Name ____________ MI ____

Current Address ____________ County ____________

City ____________ State ____________ Zip ____________

Telephone Number ____________ Birth Place ____________

Birth Date ____________ Age ____ Social Security # ____________

Religion ____________ Race ____________

Marital Status Single Married Divorced Widowed Separated

Legal Date of Separation or Divorce ____________

Military Records Information

Branch of Service ____________ Service # ____________

Entry Date ____________ Separation Date ____________ Discharge Type ____________

War Era WWII (Europe) WWII (South Pacific) Korea
Vietnam Gulf War Peace Time

Are you currently or were you previously a member of any Service Organization?

American Legion Military Order of the Purple Heart AMVETS
Masons Knights of Columbus Elks
29th Division Lions Club DAR
Veterans of Foreign Wars Moose Lodge DAV

Other Membership ____________

Are you currently receiving any of the following VA Pensions?

Aid and Attendance Yes No Retirement Pension Yes No

Do you have a service connected disability? Yes No Percentage ____________

Former POW? Yes No Retired Military? Yes No

Are you in enrolled with the VA Health System? Yes No

Have you used a VA Medical Center? Yes No Location ____________

Spouse Information (For VA Records)

Name ____________ Social Security # ____________

DOB ____________ Date of Marriage ____________

Street Address ____________

City ____________ State ____________ Zip ____________

Current Phone # ____________

Insurance Information

Medicare: Part A Part B Member # ______

Have you been receiving your medications from the VAMC or a base? Yes No

Are you enrolled in a Medicare Part D Program? Yes No

Company ______ Policy # ______

Medicaid: Yes No Medicaid # ______

Private Insurance: Company ______ ID # ______

How is the premium paid? Deduction from pension Debit from bank account Check

Long Term Care Insurance: Company ______

Please provide a copy of all insurance cards (front and back) and any Long Term Care Insurance Policy (If Applicable)

Emergency Contact Information

Responsible Party: Name ______ ______

Street Address ______

City ______ State ______ Zip ______

Phone #: Home ______ Work ______ Cell ______

Email ______ Next of Kin Yes No

Second Contact: Name ______ Relationship ______

Street Address ______

City ______ State ______ Zip ______

Phone #: Home ______ Work ______ Cell ______

Email ______ Next of Kin Yes No

Legal Documents

Is there a Power of Attorney or Guardian for your affairs? Yes No

If so, Name: Healthcare POA ______ Financial POA ______

Is there an Advance Directive or Living Will? Yes Is No ***If so, please provide a copy***

Is there a living trust? Yes No ***If so, please provide a copy***

Do you have any pre-planned funeral arrangements? Yes No Funeral paid for? Yes No

Funeral Home of Choice ______ City/State: ______

Medical Service Utilization

Have you utilized rehab, inpatient, or outpatient services? Yes No

If yes, please provide the location(s) and date(s):

Location: ______ Dates: ______

Location: ______ Dates: ______

Location: ______ Dates: ______

Location: ______ Dates: ______

Additional Information

Are you currently assigned a social worker at the VA? Yes No

If yes, Name: ______ Contact: ______

Financial Information

The State Veterans Home, in its financial planning, must have information about the financial ability of each applicant requesting admission. Please complete the following financial worksheet and provide as much detail as possible for each question. In a case where an applicant has a living spouse, information must be provided for both individuals. Should the Department of Admissions have any questions, you will be contacted by telephone at the number provided on this application.

Income: (Check where applicable and provide the monthly amount)

	Veteran	Spouse
Social Security	$ ______	$ ______
Employer Pensions	$ ______	$ ______
Union Pensions	$ ______	$ ______
Veteran Benefits	$ ______	$ ______
Trust	$ ______	$ ______
Annuity	$ ______	$ ______
IRA Distribution	$ ______	$ ______
Other ______	$ ______	$ ______

Resources: (Check where applicable and provide current balance)

	Veteran	Spouse
Total Amount in Checking Accounts	$ ______	$ ______
Total Amount in Savings Accounts	$ ______	$ ______
Total Amount in Other Accounts	$ ______	$ ______
Total Amount in Stocks/Bonds/CDs	$ ______	$ ______
Total Amount in IRA/KEOGH/401K	$ ______	$ ______
Total Life Insurance/ (Face/Cash Value)	$ ___ / ___	$ ___ / ___
Total Amount in Trust	$ ______	$ ______
Other ______	$ ______	$ ______

Real Estate: Address ______________________________________

____

Do you have a mortgage payment? Yes No Amount: $ ______

Do you have a reverse mortgage? Yes No Amount: $ ______

Liabilities Do you currently have any deductions to income as a result of a debt owed (IRS, Alimony, etc)?

Yes No If yes please indicate: Type of Deduction ______ Amount $______

Type of Deduction ______ Amount $______

Has the applicant sold, gifted or transferred any cash, real estate or personal property within the past 60 months? Yes No If yes, please indicate: Asset Type ______ Value $______

Asset Type ______ Value $______

I agree to furnish, upon request, verification of assets and all sources of income. My spouse and/or designated representative also agree to provide financial information as required to apply for Medicaid benefits. I agree to pay for my cost of care from my income and assets according to current rates set by the State of South Carolina as long as I am a resident. In the case that available funding cannot cover my cost of care, I agree to comply with the necessary steps in applying for South Carolina Medicaid assistance and benefits.

X ______________________________________

Signature Relationship to Applicant Date

OMB Control No. 2900-0091
Estimated Burden Avg. 35 min.
Expiration Date: 07/31/2027

Department of Veterans Affairs

VA DATE STAMP
(For VHA Use Only)

APPLICATION FOR HEALTH BENEFITS

SECTION I - GENERAL INFORMATION

Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)

TYPE OF BENEFIT(S) APPLYING FOR:

- ☐ **ENROLLMENT** - VA Medical Benefits Package (Veteran meets and agrees to the enrollment eligibility criteria specified at 38 CFR 17.36)
- ☐ **REGISTRATION** ***(Complete Sections I, II, and III)*** - VA Health Services (Veterans meets the "Enrollment not required" eligibility criteria specified at 38 CFR 17.37)

1A. VETERAN'S NAME *(Last, First, Middle Name)*	1B. PREFERRED NAME	2. MOTHER'S MAIDEN NAME

3. SEX
- ☐ MALE
- ☐ FEMALE

4. WHAT IS YOUR RACE/ ETHNICITY? *(Check all that apply. Information is required for statistical purposes only.)*
- ☐ ASIAN
- ☐ AMERICAN INDIAN OR ALASKA NATIVE
- ☐ BLACK OR AFRICAN AMERICAN
- ☐ WHITE
- ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
- ☐ HISPANIC or LATINO
- ☐ MIDDLE EASTERN or NORTH AFRICAN
- ☐ CHOOSE NOT TO ANSWER

5. SOCIAL SECURITY NO. *(999-99-9999)*

6A. DATE OF BIRTH *(MM/DD/YYYY)*	6B. PLACE OF BIRTH *(City and State)*	7. PREFERRED LANGUAGE	8. RELIGION

9A. MAILING ADDRESS *(Street)*	9B. CITY	9C. STATE	9D. ZIP CODE	9E.COUNTY

9F. HOME TELEPHONE NO. *(optional)* *((999) 999-9999)*	9G. MOBILE TELEPHONE NO. *(optional) ((999) 999-9999)*	9H. E-MAIL ADDRESS *(optional)*

10A. HOME ADDRESS *(Street)*	10B. CITY	10C. STATE	10D. ZIP CODE	10E.COUNTY

11. CURRENT MARITAL STATUS
☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED

12A. NEXT OF KIN NAME	12B. NEXT OF KIN ADDRESS	12C. NEXT OF KIN RELATIONSHIP

12D. NEXT OF KIN TELEPHONE NO. *(Include Area Code) ((999) 999-9999)*	13A. EMERGENCY CONTACT NAME	13B. EMERGENCY CONTACT TELEPHONE NO. *(Include Area Code) ((999) 999-9999)*

14. DESIGNEE - INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH (*Note: This does not constitute a will or transfer of title*)

15. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? *(for listing of facilities visit* www.va.gov/find-locations*)*

16. WOULD YOU LIKE FOR VA TO CONTACT YOU TO SCHEDULE YOUR FIRST APPOINTMENT?
☐ YES ☐ NO

SECTION II - MILITARY SERVICE INFORMATION

1A. LAST BRANCH OF SERVICE	1B. LAST ENTRY DATE *(MM/DD/YYYY)*	1C. FUTURE DISCHARGE DATE *(MM/DD/YYYY)*	1D. LAST DISCHARGE DATE *(MM/DD/YYYY)*

1E. DISCHARGE TYPE	1F. MILITARY SERVICE NUMBER

2. MILITARY HISTORY *(Check yes or no)*	YES	NO		YES	NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?	☐	☐	D. WERE YOU DISCHARGED OR RETIRED FROM MILITARY FOR A DISABILITY INCURRED IN THE LINE OF DUTY?	☐	☐
B. ARE YOU A FORMER PRISONER OF WAR?	☐	☐	E. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998?	☐	☐
C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?	☐	☐	F. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	☐	☐

APPLICATION FOR HEALTH BENEFITS *Continued*

VETERAN'S NAME *(Last, First, Middle)*

SOCIAL SECURITY NO. *(999-99-9999)*

SECTION II - MILITARY SERVICE INFORMATION *(Continued)*

3. MILITARY EXPOSURE INFORMATION *(Check yes or no)*

	YES	NO
A. DID YOU SERVE IN AN IONIZING RADIATION LOCATION AND PARTICIPATE IN ANY NUCLEAR TESTING, TREATMENTS, OR CLEAN UP? *(Hiroshima and Nagasaki cleanup or Enewetak Atoll, cleanup of Air Force B-52 bomber carrying nuclear weapons off the coast of Palomares, Spain, response to the fire onboard an Air Force B-52 bomber carrying nuclear weapons near Thule Air Force Base in Greenland.)*	☐	☐
B. DID YOU SERVE IN ANY OF THE FOLLOWING GULF WAR HAZARD LOCATIONS? *(Iraq, Kuwait, Saudi Arabia, the neutral zone between Iraq and Saudi Arabia, Bahrain, Qatar, the United Arab Emirates, Oman, Yemen, Lebanon, Somalia, Afghanistan, Israel, Egypt, Turkey, Syria, Jordan, Djibouti, Uzbekistan, the Gulf of Aden, the Gulf of Oman, the Persian Gulf, the Arabian Sea, and the Red Sea.)* WHEN DID YOU SERVE IN THESE LOCATIONS? ***NOTE:*** *Please provide an approximate time-frame (MM/YYYY)* FROM: TO:	☐	☐
C. WERE YOU DEPLOYED IN SUPPORT OF ANY OF THE FOLLOWING OPERATIONS? *(Enduring Freedom, Freedom's Sentinel, Iraqi Freedom, New Dawn, Inherent Resolve, and Resolute Support Mission)*	☐	☐
D. DID YOU SERVE IN ANY OF THE FOLLOWING HERBICIDE *(e.g. Agent Orange)* LOCATIONS? *(Republic of Vietnam to include 12 nautical mile territorial waters; Thailand at any United States or Royal Thai base; Laos; Cambodia at Mimot or Krek; Kampong Cham Province; Guam or American Samoa; or in the territorial waters thereof; Johnston Atoll or a ship that called at Johnston Atoll; Korean demilitarized zone; aboard (to include repeated operations and maintenance with) a c-123 aircraft known to have been used to spray an herbicide agent (during service in the Air Force and Air Force Reserves.)* WHEN DID YOU SERVE IN THESE LOCATIONS? ***NOTE:*** *Please provide an approximate time-frame (MM/YYYY)* FROM: TO:	☐	☐

E. HAVE YOU BEEN EXPOSED TO ANY OF THE FOLLOWING? *(Check all that apply)*
Veterans can locate additional military exposure categories on VA's Public Health website at: https://www.publichealth.va.gov/exposures/

- ☐ AIR POLLUTANTS *(burn pits, sand, oil well/sulfur fires)*
- ☐ CHEMICALS *(pesticides, herbicides, contaminated water)*
- ☐ CONTAMINATED WATER AT CAMP LEJEUNE
- ☐ RADIATION ☐ SHAD *(Shipboard Hazard and Defense)*
- ☐ OCCUPATIONAL HAZARDS *(jet fuel, industrial solvents, lead, firefighting foams)*
- ☐ ASBESTOS ☐ MUSTARD GAS
- ☐ WARFARE AGENTS *(nerve agents, chemical and biological weapons)*
- ☐ OTHER *(Specify)*:

WHEN WERE YOU EXPOSED?
NOTE: *Please provide an approximate time-frame (MM/YYYY)*
FROM: TO:

SECTION III - INSURANCE INFORMATION *(Use a separate sheet for additional information)*

1. ENTER YOUR HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER *(include coverage through spouse or other person)*

2. NAME OF POLICY HOLDER	3. POLICY NUMBER	4. GROUP CODE

5. ARE YOU ELIGIBLE FOR MEDICAID? *(Federal health insurance for low income adults)* ☐ YES ☐ NO	6A. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A? ☐ YES ☐ NO	6B. EFFECTIVE DATE *(MM/DD/YYYY)*	6C. MEDICARE NUMBER

SECTION IV - DEPENDENT INFORMATION *(Use a separate sheet for additional dependents)*

1. SPOUSE'S NAME *(Last, First, Middle Name)*

1A. SPOUSE'S SOCIAL SECURITY NUMBER

1B. SPOUSE'S DATE OF BIRTH *(MM/DD/YYYY)*

1C. SPOUSE'S SEX
☐ MALE ☐ FEMALE

1D. DATE OF MARRIAGE *(MM/DD/YYYY)*

1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP if different from Veteran's)*

3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT?
☐ YES ☐ NO

2. CHILD'S NAME *(Last, First, Middle Name)*

2A. CHILD'S DATE OF BIRTH *(MM/DD/YYYY)*

2B. CHILD'S SOCIAL SECURITY NO. *(999-99-9999)*

2C. DATE CHILD BECAME YOUR DEPENDENT *(MM/DD/YYYY)*

2D. CHILD'S RELATIONSHIP TO YOU *(Check one)*
☐ SON ☐ DAUGHTER ☐ STEPSON ☐ STEPDAUGHTER

2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18?
☐ YES ☐ NO

2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR?
☐ YES ☐ NO

2G. EXPENSES PAID BY YOUR DEPENDENT CHILD WITH REPORTABLE INCOME FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(e.g., tuition, books, materials)*

APPLICATION FOR HEALTH BENEFITS *Continued*	VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NO. *(999-99-9999)*

SECTION V - EMPLOYMENT INFORMATION

1A. VETERAN'S EMPLOYMENT STATUS *(Check one)*. ☐ FULL TIME ☐ PART TIME ☐ NOT EMPLOYED ☐ RETIRED	1B. DATE OF RETIREMENT *(MM/DD/YYYY)*	
1C. COMPANY NAME. *(Complete if employed or retired)*	1D. COMPANY ADDRESS *(Complete if employed or retired - Street, City, State, ZIP)*	1E. COMPANY PHONE NUMBER *(Complete if employed or retired) (Include area code) ((999) 999-9999)*

SECTION VI - FINANCIAL DISCLOSURE

Disclosure allows VA to accurately determine whether certain Veterans will be charged copays for care and medications, their eligibility for other services and enrollment priority. Veterans are not required to disclose their financial information. Veterans who choose not to disclose financial information may not be eligible for enrollment or may be responsible for any applicable VA copayments, if they are enrolled. **Recent Combat Veterans (e.g., OEF/OIF/OND)** may answer YES in Section VI and complete Sections VII and VIII to have their priority for enrollment and financial eligibility for travel assistance, cost-free medications and/or medical care for services unrelated to military experience.

☐ **No, I do not wish to provide financial information in Sections VII through VIII.** If I am enrolled, I agree to pay applicable VA copayments. Sign and date the form in the Assignment of Benefits section.

☐ **Yes, I will provide my household financial information for last calendar year.** Complete applicable Sections VII and VIII. Sign and date the form in the Assignment of Benefits section.

SECTION VII - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN

(Use a separate sheet for additional dependents)

INCOME CATEGORIES	VETERAN	SPOUSE	CHILD 1
1. GROSS ANNUAL INCOME FROM EMPLOYMENT *(wages, bonuses, tips, etc.)* EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS			
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS			
3. LIST OTHER INCOME AMOUNTS *(e.g., Social Security, compensation, pension, interest, dividends)* EXCLUDING WELFARE.			

SECTION VIII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE *(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home) VA will calculate a deductible and the net medical expenses you may claim.*	$
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES (INCLUDING PREPAID BURIAL EXPENSES) FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD *(Also enter spouse or child's information in Section VI.)*	$
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES *(e.g., tuition, books, fees, materials) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.*	$

SECTION IX - CONSENT TO COPAYS AND TO RECEIVE COMMUNICATIONS

By submitting this application, you are agreeing to pay the applicable VA copayments for care or services (including urgent care) as required by law. You also agree to receive communications from VA to your supplied email, home phone number, or mobile number. However, providing your email, home phone number, or mobile number is voluntary.

ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section 1729 and 42 U.S.C. 2651, the Department of Veterans Affairs (VA) is authorized to recover or collect from my health plan (HP) or any other legally responsible third party for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse. Furthermore, I hereby assign to the VA any claim I may have against any person or entity who is or may be legally responsible for the payment of the cost of medical services provided to me by the VA. I understand that this assignment shall not limit or prejudice my right to recover for my own benefit any amount in excess of the cost of medical services provided to me by the VA or any other amount to which I may be entitled. I hereby appoint the Attorney General of the United States and the Secretary of Veterans' Affairs and their designees as my Attorneys-in-fact to take all necessary and appropriate actions in order to recover and receive all or part of the amount herein assigned. I hereby authorize the VA to disclose, to my attorney and to any third party or administrative agency who may be responsible for payment of the cost of medical services provided to me, information from my medical records as necessary to verify my claim. Further, I hereby authorize any such third party or administrative agency to disclose to the VA any information regarding my claim.

ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS WHICH DEFINE WHO CAN SIGN ON BEHALF OF THE VETERAN.

SIGNATURE OF APPLICANT *(Sign in ink)* ______________________ **DATE** *(MM/DD/YYYY)* ______________