Welcome Heroes,

Indiana Veterans' *Home*

Proudly Serving Those Who Served

We accept VA Higher Per Diem, Medicare, Medicaid, Private Insurance and Private Pay.

On-Site Physician and Specialty Care

- Nephrologist
- Pulmonologist
- Endocrinology
- Psychiatrist
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Respiratory Therapy
- Podiatry
- Dentistry
- Social Services
- Music Therapy

The 70 % or greater service-connected Veteran is eligible for free nursing care at the Indiana Veterans' Home. This benefit at the Indiana State Veteran Home has no income limitation. (Reference 38 U.S.C. 1745)

Indiana Veterans' Home
3851 North River Road, West Lafayette, Indiana
P:765-463-1502 E: admissions&marketing@ivh.in.gov

STATE OF INDIANA

Eric J. Holcomb, Governor

INDIANA VETERANS' HOME
3851 N. River Road
West Lafayette, IN 47906
Telephone: (765) 463-1502

Enclosed is the application for admission to the Indiana Veterans' Home. The professional and compassionate team at the Indiana Veterans' Home appreciates your interest in the only state veterans' home in Indiana.

Here are some important items to keep in mind as you complete your application:

- **Please use the checklist for required documentation for applying to the Indiana Veterans' Home**. The Admissions Department is available to complete the application for you either over the phone or in person – (will need signature upon admission.)
- **We accept Medicare A, Medicaid, private insurance, and private payment**. **Special benefits are available for veterans with a service-connected disability rating of 70% or higher.** When applicable, veteran benefits may also help pay for a part of your stay. If your insurance and benefits do not cover the full cost of your care and you are unable to pay from your own funds, we will help you apply for Medicaid after your admission to the Indiana Veterans' Home.
    - ***Enclosed is the financial checklist. The Indiana Veterans' Home will gladly provide you with an estimated rate cost upon receiving requested documentation.***
- **Veterans with a VA Service-Connected Disability of 70% or greater or determined by the VA to meet the criteria for the Veterans' Administration VA Higher Per Diem Program participation, under 38 U.S.C. § 1745, qualify for free nursing care at the Indiana Veterans' Home.**
- **The current rate to reside at the Indiana Veterans' Home is $611.95* per day**. This is a comprehensive rate and includes nursing care, room, meals, housekeeping, laundry service, and recreation activities. We will work with you to determine your best options to pay for your stay with us.
- Effective April 1, 2016, the Indiana Veterans' Home Independent Living (Domiciliary) rate is $138.00* per day. The Indiana Veterans' Home did research and decided to reduce the domiciliary rate to the State Veterans' Home Domiciliary United States average daily rate.
- **If you currently live at home and plan to move into nursing care, please contact your local Area Agency on Aging to set up a Pre-Admission Screening (PAS).** The PAS must be completed before entering any nursing home in the state of Indiana. You can reach your Area Agency on Aging by calling (800) 986-3505. Please note: PAS is not required for applicants entering our independent living building.

The Indiana Veterans' Home encourages anyone that has financial questions regarding the daily cost of living charge, to contact our Trust Department at (765) 497-8590 to discuss the payment process.

Please contact Cheryl Coffman for any Medicaid questions. Cheryl can be reached directly by either phone, (765) 497-8693, or email, CCoffman1@ivh.in.gov.

If you have any questions about our application or the required documentation, please contact the Admissions Department at your convenience.

Best Regards,

Indiana Veterans' Home Admissions & Marketing Department
(765) 463-1502 // Admissions&Marketing@ivh.in.gov

*The Daily Rate is subject to change on an annual basis.

Indiana Veterans' *Home* Admissions Financial Checklist

Applicant's Name: _____

THE ADMISSIONS DEPARTMENT WILL ASSIST YOU WITH DOCUMENTATION THAT IS REQUIRED BASED OFF OF YOUR PAYER SOURCE.

***** PLEASE NOTE: IF LEGALLY MARRIED, WE WILL NEED A COPY OF ALL APPLICABLE DOCUMENTS BELOW FOR BOTH THE APPLICANT AND THE SPOUSE IF NEEDING TO APPLY FOR MEDICAID.***

	PERSONAL IDENTIFICATION & LEGAL
	IVH 2 Page Application
	Photo ID
	Social Security Card
	Birth Certificate / DD214
	All Medical Insurance Cards, including Medicare (front and back)
	Marriage Certificate, Death Certificate, Divorce Decree
	POA, Guardianship Paperwork
	INCOME AND ASSET INFORMATION
	Proof of all income (3 months), including, but not limited to, paycheck stubs, Social Security benefit letter, pension and other retirement income, unemployment benefits or veterans benefits
	Copies of statements for all bank accounts, including savings (3 months), checking (3 months), certificates of deposit (CDs), and retirement accounts [including IRAs and 401(k) accounts].
	Statements for all life insurance policies or annuities showing ownership, face value and current cash surrender value, and effective date of policy
	Copies of all stocks or United States savings bonds
	Copy of all vehicle titles or registration
	Copy of deeds for all homes and/or property
	Copy of cemetery lot deed or burial accounts
	Letter from the Auditor's office stating that applicant has not owned property in the last 5 years.
	Copy of Prepaid Irrevocable Funeral Arrangements (contract and listing of services)
	Documentation of any prior gifts from applicant in the past 5 years (e.g., gifts to another for expenses, transfer of property or assets to another, etc.)
	Long-term care insurance policy for applicant (and/or spouse)
	LIABILITY INFORMATION
	Health insurance premiums
	Prescription drug plans (premium and verification of coverage)
	Medical bills for the last 3 months (if any)
	SPOUSAL EXPENSES (if living in the community)
	Utility bills (e.g., electricity, gas, water, sewage)
	Phone bills
	Homeowner's insurance
	Mortgage payments or lot rental receipts, Condo fees
	Property taxes
	Copy of deed to home (if paid off)
	Automobile insurance
	Copy of title to car (if paid off)
	Health insurance premiums
	Other recurring spousal expenses

When completed, this form is CONFIDENTIAL.

APPLICATION FOR ADMISSION TO THE INDIANA VETERANS' HOME

State Form 37561 (R10 / 4-19)

FEDERAL REGULATION Public Law 22

* This State Agency is requesting your Social Security number only to expedite the processing of this form. You are not required to provide this information and cannot be penalized for declining to provide it.

INSTRUCTIONS:

1. *Every blank must be filled in. If the question does not apply, write "N/A".*
2. *Please provide all documentation specified on the Admissions Checklist.*
3. *When completed, please submit fully completed application Indiana Veterans' Home by one of the following ways:*
   E-mail: admissions&marketing@ivh.in.gov
   or Fax: (765) 497-8004
   or certified mail / FEDEX / UPS: Indiana Veterans' Home, ATTN: Admissions, 3851 North River Road, West Lafayette, IN 47906

Name *(first, middle, last)*		Age
Date of birth *(mm/dd/yyyy)*	Place of birth	
Present address in full *(number and street or Rural Route, city, state, and ZIP code)*		
Telephone number *(with area code)* ( )	Religion	Race
Previous occupation	Mother's maiden name	Do Not Resuscitate (DNR) // Full Code

Are you? *(Check one of the below.)*
☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Give record of all marriages below. *(If additional space is needed please attach separate list.)*

Name of Spouse	Date *(mm/dd/yyyy)* and Place of Marriage	Date *(mm/dd/yyyy)* and Place of Death / Divorce

Veteran's Military Service

Branch	Dates of Service *(mm/dd/yyyy)*	Place of Enlistment and Discharge	With which VA are you associated?

Where have you resided for the past five (5) years? *(If additional space is needed please attach separate list.)*

Street Address	City	State	From *(mm/dd/yyyy)*	To *(mm/dd/yyyy)*

Additional Military Information

American Legion? ☐ Yes ☐ No
Veterans of Foreign Wars? ☐ Yes ☐ No
Disabled American Veteran? ☐ Yes ☐ No

Is Veteran a former prisoner of war? ☐ Yes ☐ No
Was Veteran awarded the Purple Heart? ☐ Yes ☐ No

Give name, address, and telephone number in order of Emergency Contacts.

Name	Address *(number and street, city, state, and ZIP code)*	Relationship	Telephone Number

When completed, this form is CONFIDENTIAL.

Financial Evaluation

Social Security Number *	Medicare number
Name of other insurance provider	Type of insurance provider *(Check one.)* ☐ Advantage ☐ Supplemental ☐ Part D ☐ Other

Do you have any of the following income sources?

Pension or retirement income	Pension(s) or retirement(s) provider name	Monthly amount(s) $ // $
Social Security income	Do you have a Rep payee? ☐ Yes ☐ No	Monthly amount(s) $ // $
VA income	Aid and Attendance / compensation / retirement	Monthly amount(s) $ // $

VA service connected disability rating	VA service connected disability rating
Supporting documentation attached? ☐ Yes ☐ No	VA facility seen for disability?

Checking account	Name of bank	Current balance $
Savings account	Name of bank	Current balance $

Stocks, bonds, annuities, or certificates of deposit	Name of bank	Type *(stock, bond, etc.)*	Current balance $

Have you owned any real property within the last three (3) years? ☐ Yes ☐ No	If Yes, total real property estimated value $

Do you have a will? ☐ Yes ☐ No	Do you have one of the following? ☐ Power of Attorney (POA) ☐ Health Care Representative (HCR) ☐ Guardian
Do you have a prepaid funeral? ☐ Yes ☐ No	If Yes, with whom?

Do you have life insurance? ☐ Yes ☐ No	If Yes, with whom?	Face value	Policy(ies) number(s)
Do you have life insurance? ☐ Yes ☐ No	If Yes, with whom?	Face value	Policy(ies) number(s)

Are you currently a resident of a residential or care facility? ☐ Yes ☐ No	Do you agree to abide by all the laws and regulations governing the Home? ☐ Yes ☐ No

Residency Verification

This verification can be made by an elected township, city or county official, or by an individual not related to the applicant.

Printed or typed name	*Please check one:* ☐ Neighbor ☐ Elected or Appointed Official
Signature	
Address *(number and street, city, state, and ZIP code)*	

Dated this _____ day of _____, 20_____.

Do you, in consideration of being admitted and maintained in the Indiana Veterans' Home, understand that you or your estate are obligated to pay full cost of care and maintenance? (Depending on the amount of your current assets and income from any source this rate may be reduced.) ☐ Yes ☐ No

I acknowledge by signing this form the information provided on this application is accurate to the best of my knowledge and understanding.

Signature of applicant	Date signed *(mm/dd/yyyy)*

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of my protected health information as described below. I understand signing this authorization is voluntary and I do not need to sign this form to assure treatment, payment or eligibility of benefits. I understand that the information disclosed may be subject to re-disclosure by the recipient and the privacy of the information may no longer be protected by the law.

The specific organization that is authorized to disclose my protected health information is:

_____

(Name and Address of Facility/individual to Release the Protected Health Information)

The specific organization or individual to which the information is to be released:

Indiana Veterans' Home (IVH) 3851 N. River Road

(Name and Address of Facility/individual to Receive the Protected Health Information)

The specific protected health information that is authorized to be disclosed is:

- ☑ Physician order
- ☑ Physician progress notes
- ☑ History and physical
- ☑ Immunization record & TB Screening
- ☑ Nurses' notes
- ☑ Discipline specific progress notes. Specify: Neurology visit notes & Pysch Notes
- ☑ Medication record
- ☑ Treatment record
- ☑ Laboratory results
- ☑ X-ray and imaging reports
- ☑ Consultation reports

Other: Current Chest X-Ray within last 6 months

The purpose of the disclosure of my protected health information is:

Application for Admissions to the Indiana Veterans' Home

I understand this authorization is automatically void on the following date, event or condition _____, but in any case, is only in effect sixty (60) days from the date of signature below under Indiana Law.

I understand that I may revoke this authorization at any time by notifying the organization in writing, but if I do it won't have any effect on any actions taken before the revocation was received.

By signing this authorization, I acknowledge that I have read and understand this authorization. I understand that my protected health information will be disclosed in accordance with this authorization.

_____ _____

Signature of resident or authorized representative Date

_____ _____

Printed name of resident or authorized representative

_____ _____

Description of authority, if signed by representative Address of resident or authorized representative

Indiana Veterans' Home
Grievance Concerns and Assistance Contact Information

Each resident has the right to voice concerns or complaints regarding care and services, any infringement upon resident rights, and to make suggestions for the improvement of services provided by the Indiana Veterans' Home at any time. If a resident has a problem or concern regarding his or her care, or if a family member is concerned about the care of a loved one living at the Indiana Veterans' Home, these concerns should be conveyed to management as soon as possible.

Although it is recommended that residents report problems internally first, residents may also report a concern or voice a suggestion externally, at any time. If desired, residents may contact:

Indiana State Department of Health
Division of Long-Term Care
2 North Meridian Street
Indianapolis, IN 46204
(317) 233-7442
Toll-Free Complaint Division Number:
(800) 246-8909

Roudebush VA Medical Center
Patient Advocate
1481 West 10th Street
Indianapolis, IN 46202
(317) 554-0000

Adult Protective Services
301 Main Street
Lafayette, IN 47901-1376
(877) 749-9111 or (765) 423-9305

Protection and Advocacy Services
4701 North Keystone Avenue, Suite 222
Indianapolis, IN 46205
(317) 722-5555 or (800) 622-4845

Tippecanoe County Office, Division of Family and Children
111 N. 4th Street
Lafayette, IN 47901
(765) 742-0400

Indiana Legal Services
Local Long-Term Care Ombudsman
Andrea Smothers
639 Columbia Street
Lafayette, IN
(765) 423-5327 or (800) 382-7581

State Long-Term Care Ombudsman Program
P.O. Box 7083
Indianapolis, IN 46207-7083
(800) 622-4484 or (317) 232-7134

Additional Contacts	**Phone**
Superintendent	(765) 497-8501
Assistant Superintendent	(765) 497-8620
Long-term Care Ombudsman	(765) 423-5327
Adult Protective Services	(765) 420-1587
Health Department Hotline	(800) 246-8909
State Police (Lafayette, IN)	(765) 567-2125
VA Medical Center – Roudebush	(317) 554-0000
Medicare Fraud Reporting	(800) 447-8477
Medicaid Fraud Reporting	(800) 382-1039