STATE OF CONNECTICUT

DEPARTMENT OF VETERANS AFFAIRS
ADMISSIONS OFFICE
287 West Street
Rocky Hill, Connecticut 06067

Ronald P. Welch
Commissioner
Brigadier General U.S. Army (Ret)

Dear Veteran:

Thank you for your interest in the **Connecticut Department of Veterans Affairs (DVA) Residential Programs and Services.** To be eligible for consideration for admission to the DVA Residential Program, Veteran must:

1. Have received an honorable discharge or general discharge under honorable conditions from the Armed Forces of the United States on Veteran's most recent DD 214.

2. Be a resident of Connecticut at time of application or was a resident of Connecticut at time of induction or enlistment into the Armed Forces.

3. Have served at least ninety (90) days of active duty in the Armed Forces not including active duty for initial entry training (e.g. basic training).

Applicants to the DVA Residential Facility must be able to perform regular activities of daily living without assistance such as bathing, eating, dressing and cleaning.

For an application to be considered for review the following must be provided:

- Completed and signed Application for Admission with most recent DD 214.
- Proof of Connecticut residency
- Current Federal VA Benefit Verification Letter
- All Disability Federal VA Rating Decision Letters
- DVA Release of Information (*Application Attachment A*)
- Acknowledgement of DVA Rules and Veteran Responsibilities (*Application Attachment B*).
- Medical Certificate completed by Primary Care Provider at VA CT Healthcare System or other Physician (*Application Attachment C*)
- U.S. Dept. of Veterans Affairs Health Benefits Application (10-10EZ) (*Application Attachment D)*
- U.S. Dept. of Veterans Affairs Medical Information Release (10-5345) (*Application Attachment E)*

Copies of the following must be provided as applicable:

- Veterans who are conserved must provide Probate Court Order of Conservatorship.
- (Veterans conserved of person are not eligible for admission to the Residential Program)
- Living Will, Healthcare Representative/Proxy and any Power of Attorney document(s).
- Court orders with terms and conditions of Probation or Parole.
- Medical/Health Insurance cards (VA CT Health System Card, Medicare, Medicaid and Private)
- Marriage certificate, if currently married.

For questions regarding admission to the Residential Program call: 860-616-3802. Residential Facility applications may be submitted via facsimile: 860-616-3556, email: Residential.DVA@ct.gov, or via US mail to:

Residential Admissions Coordinator
Department of Veterans Affairs
287 West Street
Rocky Hill, CT 06067

Admission denials may be appealed in writing to the Commissioner within ten days of notification of a denial.

Sincerely,
The Connecticut Department of Veterans Affairs
Residential Programs and Services

Rev. June 29, 2023

Connecticut Department of Veterans Affairs
Application for Residential or Healthcare Center Admission

SECTION 1. PERSONAL INFORMATION (Must be completed by all applicants and proof of Connecticut residency provided such as copy of driver's license or other photo identification)

FIRST NAME	MIDDLE NAME	LAST NAME	SOCIAL SECURITY #
OTHER NAME/S USED	MAIDEN NAME (if applicable)	Gender: ☐ Male ☐ Female ☐ Nonbinary	DATE OF BIRTH
PLACE OF BIRTH		RELIGION	MARITAL STATUS
HOME ADDRESS		CITY STATE ZIP CODE	
HOME PHONE	CELL PHONE	WORK PHONE	EMAIL ADDRESS

Resident of Connecticut: From To

Current or most recent occupation:

Select one option:
Are you seeking admission to the Department's Residential Facility (independent living domiciliary)? ☐

Are you seeking admission to the Department's Healthcare Center (skilled nursing facility)? ☐

If you are not currently residing in your home listed, indicate where are you currently staying:

☐ Shelter ☐ Substance Abuse Facility ☐ Hospital ☐ Rest/Nursing Home ☐ With Family/Friends ☐ Other

If other, explain _____

Name of Facility_____Time at Facility: _____

Contact Person:_____Title:_____Phone:_____

Address: _____

RACE, ETHNICITY AND LANGUAGE: Race and ethnicity information is optional for statistical purposes only. You may indicate more than one or decline. ☐ Decline to provide.

Race:

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other_____

Ethnicity:

☐ Hispanic, Latino, Spanish Origin

☐ Not of Hispanic, Latino, Spanish Origin

Primary Language:

☐ English ☐ Spanish

☐ Other_____

SECTION 2. MILITARY SERVICE (All applicants must submit a copy of most recent DD 214

BRANCH OF SERVICE

☐ Army ☐ Marine Corps ☐ Navy

☐ Air Force ☐ Space Force ☐ Coast Guard

NAME SERVED UNDER (If different from your current name)

DISCHARGE TYPE:

☐ Honorable ☐ Under Honorable Conditions ☐ Other (explain): _____

WARS/CONFLICT SERVED IN? ☐ WWII ☐ KOREA ☐ VIETNAM ☐ GULF ☐ OTHER: _____

If you have a service connected disability rating, state percentage:_____%

For what condition(s):_____

You must provide a copy of all current Federal VA Benefit Verification Letters and all Disability Federal VA Rating Decision Letters.

FAILURE TO SUBMIT DD-214 WILL RESULT IN TECHNICAL DENIAL OF APPLICATION

SECTION 3. HEALTH INSURANCE INFORMATION (Must be completed by all applicants)

Are you covered by private Health Insurance? ☐ Yes ☐ No

If you responded yes to above, provide:

Name of Policy Holder Policy # Group Code

Health Insurance Company's Name, Address (Street, City, State, Zip) and Telephone #

Are you enrolled in VA CT Healthcare System? ☐ Yes ☐ No ☐ Not Sure

Do you have Medicare 'A'? ☐ Yes ☐ No Medicare 'B'? ☐ Yes ☐ No

Medicare # _____ Date Issued _____

Do you have Medicaid? ☐ Yes ☐ No

Medicaid Claim # _____

If not, have you applied for Medicaid? ☐ Yes ☐ No

Date applied: _____

Medicaid Case Worker's Name: Case Worker's Phone Number and/or Email:

SECTION 4. EMERGENCY CONTACTS (Must be completed by all applicants)

A. Primary Emergency Contact

FIRST	MIDDLE	LAST	RELATIONSHIP

HOME ADDRESS	CITY/STATE	ZIP	COUNTY

CONTACT PHONE NUMBERS

CELL PHONE _____ HOME PHONE _____ WORK PHONE _____

EMAIL ADDRESS

POWER OF ATTORNEY? ☐ YES ☐ NO HEALTHCARE REPRESENTATIVE? ☐ YES ☐ NO

CONSERVATOR OF PERSON? ☐ YES ☐ NO CONSERVATOR OF ESTATE? ☐ YES ☐ NO

B. Secondary Emergency Contact (If any)

FIRST	MIDDLE	LAST	RELATIONSHIP

HOME ADDRESS	CITY/STATE	ZIP	COUNTY

CONTACT PHONE NUMBERS

CELL PHONE _____ HOME PHONE _____ WORK PHONE _____

EMAIL ADDRESS

POWER OF ATTORNEY? ☐ YES ☐ NO HEALTHCARE REPRESENTATIVE? ☐ YES ☐ NO

CONSERVATOR OF PERSON? ☐ YES ☐ NO CONSERVATOR OF ESTATE? ☐ YES ☐ NO

SECTION 5. CONSERVATOR CONTACT (Complete if different from emergency contact)

A. Conservator of Person? ☐ YES ☐ NO

FIRST	MIDDLE	LAST	RELATIONSHIP

ADDRESS	CITY/STATE	ZIP	COUNTY

CONTACT PHONE NUMBERS

CELL PHONE _____ HOME PHONE _____ WORK PHONE _____

EMAIL ADDRESS

B. Conservator of Estate? ☐ YES ☐ NO

FIRST	MIDDLE	LAST	RELATIONSHIP

ADDRESS	CITY/STATE	ZIP	COUNTY

CONTACT PHONE NUMBERS

CELL PHONE _____ HOME PHONE _____ WORK PHONE _____

EMAIL ADDRESS

ALSO POWER OF ATTORNEY? ☐ YES ☐ NO ALSO HEALTHCARE REPRESENTATIVE? ☐ YES ☐ NO

SECTION 6. CRIMINAL HISTORY (Must be completed by all applicants)

Have you been convicted of a violent crime or felony? ☐ Yes ☐ No

If yes, date(s): _____

Type of conviction(s): _____

State of conviction(s): _____

Are you registered as a sex offender? ☐ Yes ☐ No

Are you currently on probation or on parole? ☐ Yes ☐ No

Probation: ☐ Yes ☐ No Parole: ☐ Yes ☐ No

If yes, for what charges? _____

Probation/Parole officer name: _____

Phone number and/or Email: _____

YOU MUST PROVIDE A COPY OF YOUR CURRENT TERMS/CONDITIONS OF PROBATION/PAROLE

Do you have any outstanding criminal proceedings against you? ☐ Yes ☐ No

If yes, please explain: _____

SECTION 7. SUBSTANCE USE DISORDER & RECOVERY INFORMATION (Must be completed by all applicants)

Have you ever attended a program for drug and/or alcohol use disorder? ☐ Yes ☐ No

If yes, state when and where:

Are you currently attending a program for Substance Use Disorder now? ☐ Yes ☐ No

When did you start? _____

When will you complete it? _____

Where is it located? _____

SECTION 8. MEDICAL INFORMATION (Check and complete all items that apply)
Residential applicants complete Boxes A, B, C, D, J & K. Healthcare *center* applicants complete ALL BOXES

A. Ambulation

- ☐ Independent
- ☐ With assist
- ☐ Walker
- ☐ Cane
- ☐ Wheelchair manual
- ☐ Wheelchair electric
- ☐ Bedbound
- ☐ Transfers
  - ☐ Independent
  - ☐ Assist of
    - ☐ 1 ☐ 2
- ☐ Hoyer lift ☐ Sara

B. Continence

- ☐ Continent
- ☐ Incontinent
  - ☐ Bowel
  - ☐ Bladder
- ☐ Foley catheter
- ☐ Texas catheter
- ☐ Ostomy (type)

_____

☐ Commode utilized

C. Miscellaneous

Weight_____

Height_____

- ☐ Hearing impaired
- ☐ Speech impaired
- ☐ Vision impaired
- ☐ Oxygen ☐ CPAP
- ☐ Allergies_____

☐ Skin:

- ☐ Reddened
- ☐ Intact
- ☐ Open area

Size

_____

Location

_____

D. Devices & Incidents

Dentures:

☐ Upper ☐ Lower

Glasses: ☐ Yes ☐ No

Hearing Aid:

☐ Right ☐ Left

Falls in past 6 months:

_____

_____

_____

Therapies:

☐ PT ☐ OT ☐ Speech

Prosthetics:

_____

_____

E. Feeding

- ☐ Independent
- ☐ With assist
  - ☐ Total assist
  - ☐ Feeding tube
    - ☐ NG
    - ☐ Peg
    - ☐ Gastric
    - ☐ J-tube
      - ☐ Rate
      - ☐ Solution
- ☐ Special Diet:

☐ Food Allergies:

F. Behavioral

- ☐ Cooperative
- ☐ Depressed
- ☐ Withdrawn
- ☐ Belligerent
- ☐ Noisy
- ☐ Needs restraints
- ☐ Wanders
- ☐ Combative
- ☐ Other (Please explain)

G. Mental Status

- ☐ Alert
- ☐ Understands
- ☐ Forgetful
- ☐ Confused
- ☐ Non responsive
- ☐ Oriented

H. Bathing

- ☐ Independent
- ☐ With assist
- ☐ Total care

I. Dressing

- ☐ Independent
- ☐ With assist
- ☐ Total care

SECTION 8 CONTINUED. MEDICAL INFORMATION CONTINUED

J. MEDICATIONS (list all medications, and if necessary attach additional sheet of paper)

Name of Medication	Dose	Frequency

K. Additional information you feel important for us to know regarding your medical care:

_____

_____

_____

SECTION 9. INCOME & ASSET INFORMATION (Healthcare Center applicants with a seventy percent (70%) or greater service connected disability rating do not complete this section. All other applicants must complete this form as instructed below.)

A. Income Statement (must be completed by all Residential and Healthcare Center applicants except those with a seventy percent service connected disability rating.)

Type of Income	Veteran Amount	Spouse Amount	Frequency
Social Security			
VA Pension Comp			
Retirement/Pension (first)			
Retirement/Pension (second)			
Dividends/Interest			
Rental Property Income			
Employment Income			
Other (annuity, alimony, etc.)			

SECTION 9 CONTINUED. INCOME & ASSET INFORMATION CONTINUED

B. Asset Statement (must be completed by all Healthcare Center applicants except those with a seventy percent service connected disability rating.)

Type of Asset (ID # if applicable)	Veteran Amount	Spouse Amount
Savings Acct #:		
Checking Acct #:		
Cert of Deposit Acct #:		
Stock Cert Acct #:		
Bonds Cert Acct #:		
Funeral Contract #:		
Life Insurance Policy #:		
Motor Vehicle Vin #:		
Real Estate Address:		
Other Asset Acct #:		

APPLICATION SIGNATURE AND CERTIFICATION

Relationship to Veteran of person signing below: ☐ Self ☐ Power of Attorney ☐ Conservator of Person or Estate*

If Conservator of Person or Estate signing, below provide name of issuing Probate Court: _____ Date of Court Order (copy must be provided):_____

I certify that all personal, medical and financial information provided in this application for Admission and attachments hereto is complete and accurate to the best of my knowledge and belief and understand that knowingly making a false statement intended to mislead a state official in the processing of this application is a Class A misdemeanor pursuant to Conn. Gen. Stat. §53a-157b and is punishable by up to one year imprisonment.

Veteran Applicant or Conservator of Person or of Estate:

_____ _____

Signature Date

_____ _____

Printed Name Phone Number

NOTICE OF PRIVACY RIGHTS

A summary of your HIPAA rights is included in this application as the last two pages, Attachment F. Please make a selection and sign below.

☐ Acknowledge Receipt of the Notice ☐ Refuse to Sign Acknowledgement of Receipt of the Notice

_____ _____

Signature Date

**Veterans Conserved of Person are not eligible for Residential Program*

APPLICATION ATTACHMENT A

DVA RELEASE OF INFORMATION

Veteran's Name: _____ Date of Birth:_____

Social Security Number: _____ VA Claim Number: _____

I HEREBY AUTHORIZE THE STATE OF CONNECTICUT, DEPARTMENT OF VETERANS AFFAIRS, TO OBTAIN INFORMATION FROM:

1. US VA Medical Centers
2. Other Treatment Facilities: List_____
3. CT Department of Public Safety, Division of State Police (criminal background check)

This release applies to relevant information for the admissions process regarding the Veteran's military service and medical treatment which may include information relating to medical, psychiatric, alcohol, and drug abuse, HIV/AIDS, and Sickle Cell to/from such facilities as necessary for the admissions process.

The Department of Veterans Affairs, its employees, officers and attending physicians are required to comply with all privacy laws and rules including but not limited to the protection of medical and health related information pursuant to HIPPA. The Department of Veterans Affairs, its employees, officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. This release will automatically ***expire ninety (90) days*** from the date below.

Veteran or Conservator of Person[1]

Signature:_____ Date:_____

Printed Name: _____

[1] Veterans Conserved of Person are not eligible for admission to the Residential Program.

APPLICATION ATTACHMENT B
READ CAREFULLY BEFORE SIGNING

ACKNOWLEDGEMENT OF DEPARTMENT OF VETERANS AFFAIRS ADMISSION REQUIREMENTS AND VETERAN RESIDENT AND PATIENT RESPONSIBILITIES

All Applicants: I understand and agree that upon admission Veteran Residents and Patients must follow all policies, rules and regulations of the Connecticut Department of Veterans Affairs (DVA) copies of which will be provided upon admission. Copies are available prior to admission upon request.

All Applicants: I understand and agree that Veteran Patients in the Healthcare Center are not permitted to maintain or operate a vehicle on the DVA Campus and that any Veteran Resident in the Residential Program with an authorized vehicle on the DVA Campus who are transferred to the Healthcare Center will not be allowed to maintain or operate a vehicle on the DVA Campus.

All Applicants: I understand and agree that Veteran Residents and Veteran Patients are required to register to receive medical care through the VA Connecticut Healthcare system if eligible and that Veteran Residents and Patients are to be active participants in managing their medical care to the fullest extent possible including following all Physician, primary care and Interdisciplinary provider treatment plans and complete an annual physical and PPD test.

All Applicants: I understand and agree that Veteran Residents and Patients will be provided with an assigned room or living space along with state issued furniture that is not to be removed at any time from the DVA Campus.

All Applicants: I understand and agree that Veteran Residents and Patients are responsible for the safe keeping of their medication, personal property and valuables including money, clothing, and jewelry retained by them while a resident of this facility unless such items are in the possession of the DVA pursuant to DVA policy.

All Applicants: I understand and agree that Veteran Residents and Patients who are discharged from the Residential Program Facility or the Healthcare Center are required to have all personal property removed within 60 days and that after that time the DVA has the authority to dispose of said property.

All Applicants: I understand and agree that in the event of the death of a Veteran Resident or Patient, the Commissioner may make a claim against the Veteran's estate for the cost of care provided to the Veteran.

All Applicants: I understand and agree as part of my plan of care to apply for all state and federal medical, insurance and other benefits that I am eligible to receive.

All Applicants: I understand and agree that all firearms, ammunition, and other weapons (including but not limited to knives that present a danger to Staff or other Veterans) are prohibited on campus as all times.

All Applicants: I understand and agree that all alcoholic beverages, alcoholic beverage containers, pornographic materials, marijuana in any form (including medical marijuana), illegal drugs, (including unauthorized prescription medication) and drug paraphernalia are prohibited on campus at all times.

Healthcare Center Applicants or Transferees from Residential Program Facility: I understand and agree that Veteran Patients in the Healthcare Center are required to pay for care provided by the DVA and if unable to pay healthcare costs the Veteran Patient must have a completed and filed "pending" Medicaid (Title XIX) application. I understand Veteran Patients in the Healthcare Center are required to apply for Title XIX Medicaid benefits upon request by the DVA, and take all steps reasonably necessary to obtain Medicaid eligibility including cooperating with DVA staff for the purpose of obtaining Title XIX. While a Title XIX application is pending, I understand that Veteran Patients are responsible for paying their portion of the cost of care as assessed by the DVA pursuant to C.G.S. §27-108 until such time as Title XIX is granted. If Medicaid eligibility is determined by the Department of Social Services (DSS), I understand that Veterans are responsible for contributing their "applied income" towards the cost of care, as computed by the Department of Social Services. Once eligibility is determined, the Veteran Patient agrees to cooperate and take necessary steps to renew and continue eligibility as required by DSS.

Residential Program Applicants: I understand and agree that Veteran Residents in the DVA Residential Program Facility are required to pay a monthly Program Fee, the amount of which is set by the DVA and its Board of Trustees.

Residential Program Applicants: I understand and agree that Veteran Residents who have demonstrated a current abuse of alcohol or prescription medication or the use of illegal drugs will be referred to a treatment program. Urine testing is done on an individual basis when working with Recovery Support Team.

Residential Program Applicants: I understand and agree that Veterans seeking admission to the Residential Program Facility are required to provide verification of their ability to physically perform and manage all Activities of Daily Living (ADL) without assistance and to self-manage their medical and psychiatric care and appointments. Self-reporting, medical records documentation and scheduled interviews with DVA clinicians are utilized to assess admission eligibility. Veterans using adaptive equipment such as a cane, walker or motorized scooter are required to successfully complete a self-evacuation assessment conducted by DVA staff. Veterans appointed a Conservator of Person by a Court are not eligible for admission to the Residential Program Facility.

Residential Program Applicants: I understand and agree as part of my plan of care to meet with an assigned DVA Social Worker and/or Case Manager at least on a monthly basis, if not more frequently to establish and work on identified goals and objectives.

Residential Program Applicants: I understand and agree that Veteran Residents admitted to the Residential Facility will be responsible for the upkeep and cleaning of their assigned living spaces.

Residential Program Applicants: I understand and agree that Veteran Residents are to participate in some type of work activity either non-compensated or compensated. Non-compensated work activity may include assignments that support the daily upkeep and maintenance of the facility. Those Veteran Residents approved for participation in the Veteran Vocation Therapeutic Program (VVTP) will receive compensation for the hours of participation in the VVTP Program and compensation will be based on the established minimum wage.

I understand and agree that this work activity plan will be jointly developed between the Veteran Resident and Staff within 30 days of admission and will be reviewed every 90 days and documented in the medical record. Any updates or changes that need to be made to the plan will be made jointly and also documented in the medical record. The work activity plan will be part of the ITP process and will be reviewed and assessed on an ongoing basis. I hereby consent to the work activity and the work activity plan described herein and further understand and agree that I must approve and consent to the work activity plan as part of the admissions process.

Residential Program Applicants: I understand that I am subject to arrest for any crime committed on the DVA Campus, which may also result in my involuntary discharge from the Residential Facility.

I have read, understand, and acknowledge the requirements and responsibilities set forth above and agree to comply with all requirements and responsibilities as a condition of my admission. *Residential Program Applicants*: I further understand and acknowledge that for continued participation in the Residential Program, I must comply with all requirements and responsibilities set forth above and should I violate any of these requirements and responsibilities or any DVA rules, regulations, or policies, I may be subject to disciplinary action up to and including discharge from the DVA Residential Facility.

Check Applicable box: ☐ Veteran ☐ Conservator of Person[1]

_____
Signature of Veteran or Conservator

_____
Printed Name

Date: _____

[1] Veterans Conserved of Person are not eligible for admission to the Residential Program.

APPLICATION ATTACHMENT C

MEDICAL CERTIFICATE

To be completed by Primary Care Provider at VA CT Healthcare System or by personal physician for Applicants to the Sgt. John L. Levitow Healthcare Center & Residential Program Facility

Veteran Name:_____ Date of Birth:_____
Code Status:_____ Date of Flu Vaccination:_____
Immunization dates: 1.) Influenza _____ 2.) TD/Tdap _____ 3.) Pneumonia _____
4.) Zoster _____ 5.) COVID-19 _____
Colonoscopy Date: _____
Date of PPD:_____ Test results: _____Must have PPD placed within the last year:_____
Dates of tetanus/diphtheria: _____ Date of Pneumovac Vaccination:
Allergies:_____
Organ/tissue donor? ☐ Yes ☐ No

Medical and Surgical History

1.	**5.**	**9.**
2.	**6.**	**10.**
3.	**7.**	**11.**
4.	**8.**	**12.**

Review of Systems

Cough_____ Abdominal Pain_____ Extremities_____ Mental Status_____
Dyspnea_____ Vomiting_____ Skin_____ Vision_____
Chest Pain_____ UTI/frequency_____ Dentures_____ Hearing_____
Substance Abuse_____ Other_____

Physical Exam: P _____ R _____ B/P _____/_____ T _____ Wgt _____Ht_____

Check	Normal	Abnormal	Positive Findings
General			
Head - Eyes/Ears/Mouth			
Chest/ Breast			
Lungs			
Heart/ Vascular			
Abdomen/ Rectum			
Genitalia/ Pelvic			
Extremities/ Back			
Neurologic			
Mental Status			
Skin/ Other			

Laboratory Studies:
X-Ray_____ EKG:_____

Blood Tests: WBC_____ HBG_____ HCT_____ PLT_____ FBS_____ K_____
Cr_____ BUN_____ Other:_____(i.e. PSA, TSH, Electrolytes etc.)

Name of PCP _____ Signature of PCP: _____ Date:_____

Address: _____ Telephone #: _____
_____

Department of Veterans Affairs

INSTRUCTIONS FOR COMPLETING ENROLLMENT APPLICATION FOR HEALTH BENEFITS

Please Read Before You Start . . . What is VA Form 10-10EZ used for?

For Veterans to apply for enrollment in the VA health care system. The information provided on this form will be used by VA to determine your eligibility for medical benefits and on average will take 30 minutes to complete. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Where can I get help filling out the form and if I have questions?

You may use ANY of the following to request assistance:

- Ask VA to help you fill out the form by calling us at 1-877-222-VETS (8387).
- Go to www.va.gov/health-care for information about VA health benefits.
- Contact the Enrollment Coordinator at your local VA health care facility.
- Contact a National or State Veterans Service Organization.

Definitions of terms used on this form:

- SERVICE-CONNECTED (SC): A VA determination that an illness or injury was incurred or aggravated in the line of duty, in the active military, naval or air service.
- COMPENSABLE: A VA determination that a service-connected disability is severe enough to warrant monetary compensation.
- NONCOMPENSABLE: A VA determination that a service-connected disability is not severe enough to warrant monetary compensation.
- NONSERVICE-CONNECTED (NSC): A Veteran who does not have a VA determined service-related condition.

Getting Started: **ALL VETERANS MUST COMPLETE SECTIONS I - III.**

Directions for Sections I - III:

Section I - General Information: Answer all questions.

Type of Benefit Applying For:

- **Enrollment -** Veterans applying for enrollment for the Full Medical Benefits Package provide in 38 C.F.R. 17.38 must meet the eligibility requirements of 38 C.F.R. 17.36.
- **Registration** - For Registrations, only complete Sections I, II, and III. Enrollment not required - Veterans requesting an eligibility assessment, clinical evaluation, care or treatment pursuant to a special treatment authority provided in 38 C.F.R. 17.37:
  - Care for a Veteran with a VA service connected disability rating of 50% or greater
  - Care for a VA rated service connected disability
  - Care for psychosis or other mental illness
  - Care for Military Sexual Trauma treatment (MST)
  - Catastrophically Disabled Examination
  - A veteran who was discharged or released from active military service for a disability incurred or aggravated in the line of duty can receive VA care for the 12-month period following discharge or release
  - Care for a Veteran participating in VA's vocational rehabilitation program under 38 U.S.C. 31

Section II - Military Service Information: If you are not currently receiving benefits from VA, you may attach a copy of your discharge or separation papers from the military (such as DD-214 or, for WWII Veterans, a "WD" Form), with your signed application to expedite processing of your application. If you are currently receiving benefits from VA, we will cross-reference your information with VA data.

Section III - Insurance Information: Include information for all health insurance companies that cover you, this includes coverage provided through a spouse or significant other. Bring your insurance cards, Medicare and/or Medicaid card with you to each health care appointment.

Directions for Sections IV-IX:

Section IV - Dependent Information: Include the following:

- Your spouse even if you did not live together, as long as you contributed support last calendar year.
- Your biological children, adopted children, and stepchildren who are unmarried and under the age of 18, or at least 18 but under 23 and attending high school, college or vocational school (full or part-time), or became permanently unable to support themselves before age 18.
- Child support contributions. Contributions can include tuition or clothing payments or payments of medical bills.

Section V - Employment Information:

- Veterans Employment Status
- Date of Retirement
- Company Name
- Company Address
- Company Phone Number

Section VI - Financial Disclosure: ONLY NSC AND 0% NONCOMPENSABLE SC VETERANS MUST COMPLETE THIS SECTION TO DETERMINE ELIGIBILITY FOR VA HEALTH CARE ENROLLMENT AND/OR CARE OR SERVICES.

Financial Disclosure Requirements Do Not Apply To:

- a former Prisoner of War; or
- those in receipt of a Purple Heart; or
- a recently discharged Combat Veteran; or
- those discharged for a disability incurred or aggravated in the line of duty; or
- those receiving VA SC disability compensation; or
- those receiving VA pension; or
- those in receipt of Medicaid benefits; or
- those who served in an Agent Orange exposure location; or
- those who served in SW Asia during the Gulf War between August 2, 1990 and November 11, 1998; or
- those who served at least 30 days at Camp Lejeune between August 1, 1953 and December 31, 1987.

You are not required to disclose your financial information; however, VA is not currently enrolling new applicants who decline to provide their financial information unless they have other qualifying eligibility factors. If a financial assessment is not used to determine your priority for enrollment you may choose not to disclose your information. However, if a financial assessment is used to determine your eligibility for cost-free medication, travel assistance or waiver of the travel deductible, and you do not disclose your financial information, you will not be eligible for these benefits.

Section VII - Previous Calendar Year Gross Annual Income of Veteran, Spouse and Dependent Children

Report:

- Gross annual income from employment, except for income from your farm, ranch, property or business. Include your wages, bonuses, tips, severance pay and other accrued benefits and your child's income information if it could have been used to pay your household expenses.
- Net income from your farm, ranch, property, or business.
- Other income amounts, including retirement and pension income, Social Security Retirement and Social Security Disability income, compensation benefits such as VA disability, unemployment, Workers and black lung, cash gifts, interest and dividends, including tax exempt earnings and distributions from Individual Retirement Accounts (IRAs) or annuities.

Do Not Report:

Donations from public or private relief, welfare or charitable organizations; Supplemental Security Income (SSI) and need-based payments from a government agency; profit from the occasional sale of property; income tax refunds, reinvested interest on Individual Retirement Accounts (IRAs); scholarships and grants for school attendance; disaster relief payments; reimbursement for casualty loss; loans; Radiation Compensation Exposure Act payments; Agent Orange settlement payments; Alaska Native Claims Settlement Acts Income, payments to foster parent; amounts in joint accounts in banks and similar institutions acquired by reason of death of the other joint owner; Japanese ancestry restitution under Public Law 100-383; cash surrender value of life insurance; lump-sum proceeds of life insurance policy on a Veteran; and payments received under the Medicare transitional assistance program.

Section VIII - Previous Calendar Year Deductible Expenses

Report non-reimbursed medical expenses paid by you or your spouse. Include expenses for medical and dental care, drugs, eyeglasses, Medicare, medical insurance premiums and other health care expenses paid by you for dependents and persons for whom you have a legal or moral obligation to support. Do not list expenses if you expect to receive reimbursement from insurance or other sources. Report last illness and burial expenses, e.g., prepaid burial, paid by the Veteran for spouse or dependent(s).

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.

Submitting Your Application

1. You or an individual to whom you have delegated your Power of Attorney must sign and date the form. If you sign with an "X", 2 people you know must witness you as you sign. They must sign the form and print their names. If the form is not signed and dated appropriately, VA will return it for you to complete.
2. Attach any continuation sheets, a copy of supporting materials and your Power of Attorney documents to your application.

Where do I send my application?

Mail the original application and supporting materials to the Health Eligibility Center, 2957 Clairmont Road, Suite 200, Atlanta, GA 30329.

PAPERWORK REDUCTION ACT AND PRIVACY 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 Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 30 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Privacy Act Information: VA is asking you to provide the information on this form under 38 U.S.C. Sections 1705,1710, 1712, and 1722 in order for VA to determine your eligibility for medical benefits. Information you supply may be verified from initial submission forward through a computer-matching program. 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 systems of records notices and in accordance with the VHA Notice of Privacy Practices. Providing the requested information is voluntary, but if any or all of the requested information is not provided, it may delay or result in denial of your request for health care benefits. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify Veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

OMB Control No. 2900-0091
Estimated Burden Avg. 30 min.
Expiration Date: 06/30/2024

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

3A. BIRTH SEX	3B. SELF-IDENTIFIED GENDER IDENTITY	4. ARE YOU HISPANIC OR LATINO?
☐ MALE ☐ FEMALE	☐ MAN ☐ WOMAN ☐ TRANSGENDER MAN ☐ TRANSGENDER WOMAN ☐ NON-BINARY ☐ PREFER NOT TO ANSWER ☐ A GENDER NOT LISTED HERE	☐ YES ☐ NO

5. WHAT IS YOUR RACE? *(You may check more than one. Information is required for statistical purposes only.)*	6. SOCIAL SECURITY NO.
☐ ASIAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ WHITE ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ CHOOSE NOT TO ANSWER	

7A. DATE OF BIRTH *(mm/dd/yyyy)*	7B. PLACE OF BIRTH *(City and State)*	8. PREFERRED LANGUAGE	9. RELIGION

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

10F. HOME TELEPHONE NO. *(optional)* *(Include Area Code)*	10G. MOBILE TELEPHONE NO. *(optional)* *(Include Area Code)*	10H. E-MAIL ADDRESS *(optional)*

11A. HOME ADDRESS *(Street)*	11B. CITY	11C. STATE	11D. ZIP CODE	11E.COUNTY

12. CURRENT MARITAL STATUS

☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED

13A. NEXT OF KIN NAME	13B. NEXT OF KIN ADDRESS	13C. NEXT OF KIN RELATIONSHIP

13D. NEXT OF KIN TELEPHONE NO. *(Include Area Code)*	14A. EMERGENCY CONTACT NAME	14B. EMERGENCY CONTACT TELEPHONE NO. *(Include Area Code)*

15. 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*)

16. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? *(for listing of facilities visit www.va.gov/find-locations)*	17. WOULD YOU LIKE FOR VA TO CONTACT YOU TO SCHEDULE YOUR FIRST APPOINTMENT? ☐ YES ☐ NO

APPLICATION FOR HEALTH BENEFITS *Continued*	VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

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?	☐	☐	F. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	☐	☐
B. ARE YOU A FORMER PRISONER OF WAR?	☐	☐	G. DID YOU SERVE IN AN AGENT ORANGE LOCATION BETWEEN JANUARY 9, 1962 AND JULY 31, 1980?	☐	☐
C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?	☐	☐	H. DID YOU SERVE IN AN IONIZING RADIATION LOCATION AND PARTICIPATE IN ANY NUCLEAR TESTING, TREATMENTS, OR CLEAN UP?	☐	☐
D. WERE YOU DISCHARGED OR RETIRED FROM MILITARY FOR A DISABILITY INCURRED IN THE LINE OF DUTY?	☐	☐	I. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	☐	☐
E. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998?	☐	☐	J. DID YOU SERVE ON ACTIVE DUTY AT LEAST 30 DAYS AT CAMP LEJEUNE FROM AUGUST 1, 1953 THROUGH DECEMBER 31, 1987?	☐	☐

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)*	6A. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A?	6B. EFFECTIVE DATE *(mm/dd/yyyy)*	6C. MEDICARE NUMBER:
☐ YES ☐ NO	☐ YES ☐ NO		

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

1. SPOUSE'S NAME *(Last, First, Middle Name)*	2. CHILD'S NAME *(Last, First, Middle Name)*	
1A. SPOUSE'S SOCIAL SECURITY NUMBER	2A. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)*	2B. CHILD'S SOCIAL SECURITY NO.
1B. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)*	2C. DATE CHILD BECAME YOUR DEPENDENT *(mm/dd/yyyy)*	

1C. SPOUSE'S SELF-IDENTIFIED GENDER IDENTITY

☐ MAN ☐ WOMAN ☐ TRANSGENDER MAN
☐ TRANSGENDER WOMAN ☐ NON-BINARY
☐ PREFER NOT TO ANSWER ☐ A GENDER NOT LISTED HERE

2D. CHILD'S RELATIONSHIP TO YOU *(Check one)*

☐ SON ☐ DAUGHTER ☐ STEPSON ☐ STEPDAUGHTER

1D. DATE OF MARRIAGE *(mm/dd/yyyy)*

2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18?

☐ YES ☐ NO

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

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 FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(e.g., tuition, books, materials)*

3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT?

☐ YES ☐ NO

SECTION V - EMPLOYMENT INFORMATION

1A. VETERAN'S EMPLOYMENT STATUS *(Check one)*.	1B. DATE OF RETIREMENT *(mm/dd/yyyy)*
☐ FULL TIME ☐ PART TIME ☐ NOT EMPLOYED ☐ RETIRED	

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)*

APPLICATION FOR HEALTH BENEFITS *Continued*	VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

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)

	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)* _____

APPLICATION ATTACHMENT E

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 individually-identifiable 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 ATTACHMENT F

State of Connecticut
Department of Veterans Affairs

287 West Street
Rocky Hill, Connecticut 06067

CONNECTICUT DEPARTMENT OF VETERANS AFFAIRS ("DVA")
SUMMARY OF YOUR HIPAA PRIVACY RIGHTS

(Health Insurance Portability Accountability Act)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

DVA'S DUTIES:

The Connecticut Department of Veterans Affairs (DVA) is required by law to keep your protected health information private, to provide you with notice of our legal duties and privacy practices concerning your protected health information and to notify you following a breach of unsecured protected health information. The DVA must also follow all of the rules listed in this notice and send or give you a new notice if we make important changes to our privacy rules and practices. The DVA reserves the right to change its privacy practices. If the privacy practices change, the DVA will send you a new notice. The new privacy practices will apply to the information the DVA already has about you.

YOUR RIGHTS:

While the records we maintain about you belong to the agency, under federal privacy law, you have a variety of rights with respect to the information in those records. For example:

- You have the right to **inspect and request a copy of your health records.** Apply to Medical Records in writing. There will be a charge for providing you with copies.
- You may request that we **amend your medical record** if you believe your record is incorrect or incomplete. Apply to Medical Records in writing.
- You may request a list of **whom we sent information about you to** up to the last six years. Apply to Medical Records in writing.
- **You may request restrictions or limitations on your health information** we disclose (see below). Again, apply to Medical Records in writing.
- You may request we **communicate with you about medical matters** in **a certain way** or at a certain location. Apply to Medical Records in writing.
- **You may authorize (in writing) other releases** of your health information not described above.
- Except for legal disclosures described below, **your authorization is necessary** before your health records are shared for any other reason.
- You have **the right to file a complaint** (see below) if you believe your rights have been violated. **You will not be penalized if you file a complaint**.

LEGAL DISCLOSURES THAT WE MAY MAKE WITHOUT YOUR PERMISSION:

We may use and disclose your protected health information to carry out **Treatment, Payment,** or **Healthcare Operations** without your permission. Below are examples of when we may disclose your information:

- To exchange information with other state agencies as required by law.
- To avert a serious threat to your health or safety or the health and safety of the public.
- To treat you in an emergency or something is preventing us from communicating with you.
- To health insurance companies we may bill
- For organ and tissue donation.
- To communicate with law enforcement if you are the victim of a crime, involved in a crime, or threatening to commit a crime.
- If it is believed that you have been a victim of abuse or domestic violence.
- To the Food and Drug Administration to report adverse events, product defects, and so on.
- To coroners, medical examiners, and funeral directors so they may do their job.
- To healthcare oversight agencies such as the State Health Department for audits, investigations, inspections, or licensing purposes.
- For lawsuits and disputes when ordered to do so by a court or administrative order.
- As required by state, federal, or local law.

FOR FURTHER INFORMATION OR QUESTIONS:

As this document nor the Full Notice of Privacy Practices covers every possible use or disclosure, for further information, please contact your DVA Social Worker or HIMS (DVA Medical Records Department) at (860) 616-3763.

IF YOU THINK THE DVA SHARED YOUR INFORMATION INCORRECTLY:

You may complain in writing to the DVA HIPAA Officer at 287 West Street, Rocky Hill, CT 06067 or to the Connecticut Attorney General's Office at 165 Capitol Avenue, Hartford, CT 06106.

You may also file complaint with the federal Office for Civil Rights, U.S. Department of Health and Human Services by mail, fax, email or via the online OCR Complaint Portal (encouraged method). Mailing address is: Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201. Email address is OCRComplaint@hhs.gov. Complaint is to be filed within 180 days of when the problem occurred. Your benefits will not be affected if you make a complaint.