

NEW YORK STATE DEPARTMENT OF HEALTH  
New York State Veterans Homes at Batavia, Montrose, Oxford and St. Albans  
APPLICATION FOR ADMISSION

Date Application Received	Date Admitted	Registration Number:
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*Pursuant to the Provisions of Title VI of the Civil Rights Act of 1964, and the Regulations issued hereunder, it is the policy of the New York State Veterans Homes to admit and treat all patients without regard to race, creed, color, national origin, sex, sponsor, or handicap.*

NYS Public Health Law limits eligibility for admission to the New York State Veterans Homes to Veterans and their qualified dependents. To be eligible for admission to the Home, certain criteria must be met.

**VETERAN ELIGIBILITY**

- The veteran must have entered active duty from the State of New York or be a New York State resident for one year prior to the date of application for admission.
- The veteran must have had an honorable discharge from the United States Armed Forces.
- The veteran must have had at least 30 days of active service.
- Veterans accompanied by their spouses (both whom require skilled nursing care) will receive the highest priority for admission followed by wartime veterans, non-wartime veterans, and then other qualified applicants such as spouses, un-remarried surviving spouses, and Gold Star mothers and fathers. Special rules apply for admitting non-veterans. The Veterans Homes must maintain 75% or greater veteran occupancy before a non-veteran is eligible for admission. Please call the Admission Department with specific questions. *(See the following page for specific applicant designations.)*

**DOCUMENTS REQUIRED FOR ADMISSION**

- A. Completed application form provided by the New York State Department of Health (Department).
- B. Medical History Report and Certification by a physician on form provided by the Department.
- C. Veteran's Military Discharge, original or certified copy (DD-214).
- D. Documentation of monthly income and assets (see enclosed **Financial Report**).
- E. Veteran's Marriage Certificate (if applicant is the spouse or widow of an eligible veteran).
- F. Veteran's Birth Certificate (if applicant is the mother or father of an eligible veteran).
- G. Birth Certificate or proof of age.
- H. Completed funeral plans and means for paying anticipated costs.
- I. Patient Review Instrument & Screen completed by Public Health Nurse or health care facility.
- J. Copies of Social Security card, Medicare card, and all other insurance cards.
- K. Copy of Power of Attorney, Conservatorship, etc., papers, if applicable.

**PRIVACY LAW STATEMENT**

The authority to request this information is contained in §206 of the New York State Public Health Law. The principal purpose of the information is to assist the Department of Health in determining your eligibility for admission to the New York State Veterans Home. Failure to provide the requested data will result in your not being admitted to the Veterans Home. This data will be maintained in the patient history systems of records by the Administrator, New York State Veterans Home.

**MEDICAL ELIGIBILITY**

Each applicant admitted to the Veterans Home must require skilled nursing care. Each application is reviewed and a pre-admission interview is conducted to determine the applicant's need for care.

**INSTRUCTIONS**

1. Read the eligibility section and determine whether you qualify for admission.
2. If you qualify, fill out each question on the application form in **Part I** (Veteran Identification). Complete **Part II** only if a dependent is applying for admission.
3. Have your physician examine you and fill out the Medical History Form and forward to the NYS Veterans Home if you are applying from home. If you are in a Veterans Affairs (VA) or private hospital, have the facility forward your Admission History and Physical. An assessment called the Patient Review Instrument (PRI) Form is to be completed by a nurse at the hospital or a certified PRI nurse in the community and forwarded to the Veterans Home.
4. Read and sign the bottom of page 2.
5. Send the application form and other necessary information to the Veterans Home.  
The following page contains the contact information for each Veterans Home.

## VETERAN ELIGIBILITY: SPECIFIC APPLICANT DESIGNATIONS

The admission criteria for the Department of Health operated Veterans Homes is established in New York State Public Health Law §2632. The statute specifies "wartime" veteran as a veteran who served in the United States military during any one of the following time frames:

Spanish American War	April 21, 1898 - April 11, 1899
Philippine Insurrection	April 11, 1899 - July 4, 1902
World War I	April 6, 1917 - November 11, 1918
World War II	December 7, 1941 - December 31, 1946 (*) <i>(Special Rules Apply For WWII. Please Call The Admissions Department.)</i>
Korean Conflict	June 27, 1950 - January 31, 1955
Vietnam Conflict	February 28, 1961 - May 7, 1975
Lebanon <sup>1</sup>	June 1, 1983 - December 1, 1987
Grenada <sup>1</sup>	October 23, 1983 - November 21, 1983
Panama <sup>1</sup>	December 20, 1989 - January 31, 1990
Persian Gulf <sup>2</sup>	August 2, 1990 - End of Conflict
Bosnia and Herzegovina <sup>3</sup>	November 21, 1995 - November 1, 2007

1. If recipient of Armed Forces, Navy, or Marine Corps expeditionary medal for participation in Lebanon, Grenada and/or Panama.
2. Persian Gulf conflict includes military service in Operation Enduring Freedom, Operation Iraqi Freedom, Operation New Dawn or Operation Inherent Resolve and was the recipient of the global war on terrorism expeditionary medal or the Iraq campaign medal or the Afghanistan campaign medal.
3. Participation in conflict or a recipient of the Kosovo campaign medal.

### **Public Health Law also includes the following veteran eligibility:**

- Veterans who were exposed to radiation during military service in a "radiation-risk activity" defined as participation in the Occupation of Hiroshima or Nagasaki, Japan from August 6, 1945 - July 1, 1946.
- Veterans who were prisoners of war in Japan during World War II.
- Veterans with onsite participation in a test involving the atmospheric detonation of a nuclear device, whether or not the testing nation was the United States.

### **A dependent of a veteran is defined as:**

- The spouse of a qualified veteran, unless legally separated, and married to that qualified veteran for a least one (1) year prior to the date of application for admission.
- The un-remarried surviving spouse of a qualified veteran, and married to that qualified veteran for a least one (1) year prior to the date of application for admission.
- The un-remarried surviving spouse, mother, or father of any member of the United States Armed Forces who died while on active duty.

## CONTACT INFORMATION

### Batavia

Admissions Coordinator  
New York State Veterans Home at Batavia  
220 Richmond Avenue  
Batavia, NY 14020  
585-345-2049  
fax: 585-345-0743

### Montrose

Admissions Coordinator  
New York State Veterans Home at Montrose  
2090 Albany Post Road  
Montrose, NY 10548  
914-788-6144  
fax: 914-788-6134

### Oxford

Admissions Coordinator  
New York State Veterans Home at Oxford  
4207 State Highway 220  
Oxford, NY 13830  
607-843-3121  
fax: 607-843-3174

### St. Albans

Admissions Coordinator  
New York State Veterans Home at St. Albans  
178-50 Linden Boulevard  
Jamaica, NY 11434  
718-990-0353  
fax: 718-481-6994

**VETERAN IDENTIFICATION**

**PLEASE PRINT**

1. Name: Last			First	Middle	2. Social Security Number	
3a. Legal Address Street				City	Zip	County
				b. How long at this address? __Years __Months		4. Telephone Home ( ) Business ( )
5a. Date of Birth				b. Place of Birth		
6. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed (un-remarried)						
7. Dependents			<u>Name</u>	<u>Age</u>		
8. War in which Service was rendered, if applicable		9. Date of entry into active duty		10. Date of Discharge		11. Type of Discharge
12a. State of Residency at Time of Entry				b. Us Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No		
13. Service Serial Number				If Veteran is deceased, what is the Date of Death		

**PART 11 SPOUSE, WIDOW (un-remarried), MOTHER OR FATHER IDENTIFICATION**

1. Name: Last			First	Middle	2. Social Security Number	
Legal Address Street				City	Zip	County
				How long at this address __Years __Months		Telephone Home ( ) Business ( )
Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed						
Dependents			<u>Name</u>	<u>Age</u>		
Relationship to Veteran <input type="checkbox"/> Spouse <input type="checkbox"/> Widow <input type="checkbox"/> Mother <input type="checkbox"/> Father						
Date of Marriage				US Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No		

1. If admitted, I agree to furnish upon request certification as to my property, income and sources of income from time to time, but not more often than intervals of twelve (12 months).
2. I agree to pay for my cost of care from my income and assets according to current rates set by the State of New York as long as I am a resident. When my funds are not enough, I agree to comply with Medicaid eligibility requirements and will apply for assistance through my county of legal residence.
3. I agree to provide a completed burial plan and means for paying the anticipated costs.
4. I agree not to transfer any property or assets without notice to the Fiscal Office.

A person of whom an oath is required by law, who willfully swears falsely in regard to any matter or thing respecting which such oath is required shall be guilty of perjury and shall be prosecuted to the full extent of the law. I understand all the questions and answers on this form, and the printed provision. To the best of my knowledge and belief, the answers to all questions are true, correct, and complete, as required by law.

Applicant Signature

Date

Name and Address of Witness (if signed by mark)

Sworn before me this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_

Notary Public

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New York State Veterans Home at St. Albans  
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Jamaica, NY 11434  
718-990-0353  
fax: 718-481-6994

**PART I VETERAN IDENTIFICATION**

Please Print

1. Name: Last			First	Middle	2. Social Security Number		
3a. Legal Address Street				City	State	Zip	County
				b. How long at this address? __ Yrs. __ Mos.		4. Telephone Home ( ) Business ( )	
5a. Date of Birth				b. Place of Birth			
6. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed							
7. Dependents <u>Name</u> <u>Age</u>							
8. War in which Service was rendered, if applicable			9. Date of Entry		10. Date of Discharge		11. Type of Discharge
12a. State of Residency at the Time of Entry					b. U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No		
13. Service Serial Number					If Veteran is deceased, what is the date of death		

**PART II SPOUSE, WIDOW, MOTHER OR FATHER IDENTIFICATION**

1. Name: Last			First	Middle	2. Social Security No.		
Legal Address Street				City	State	Zip	County
				How Long at this address? __ Yrs. __ Mos.		Telephone Number Home ( ) Business ( )	
Date of Birth				Place of Birth			
Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed							
Dependents : <u>Name</u> <u>Age</u>							
Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Widow <input type="checkbox"/> Mother <input type="checkbox"/> Father							
Date of Marriage				US Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No			

1. If admitted, I agree to furnish upon request certification as to my property, income and sources of income from time to time, but not more often than intervals of twelve (12) months.
  2. I agree to pay for my cost of care from my income and assets according to current rates set by the State of New York as long as I am a resident. When my funds are not enough I agree to comply with Medicaid eligibility requirements and will apply for assistance through my county of legal residence.
  3. I agree to provide a completed burial plan and means for paying the anticipated costs.
  4. I agree not to transfer any property or assets without notice to the Fiscal Office.
- A person of whom an oath is required by law, who willfully swears falsely in regard to any matter or thing respecting which such oath is required shall be guilty of perjury and shall be prosecuted to the full extent of the law. I understand all the questions and answers on this form, and the printed provision. To the best of my knowledge and belief, the answers to all questions are true, correct, and complete, as required by law.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

Name and Address of Witness (if signed by mark) \_\_\_\_\_

Sworn before me this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_

Notary Public \_\_\_\_\_

**New York State Veterans' Home Financial Report**

**NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**MONTHLY INCOME:**

	<u>Patient</u>	<u>Spouse</u>
Social Security/SSI	_____	_____
Veteran's Pension	_____	_____
Retirement Pension	_____	_____
Railroad Retirement	_____	_____
Compensation/Disability	_____	_____
Wages/Employment	_____	_____
Mortgage/Rental	_____	_____
Trust/Lawsuit Settlement	_____	_____
Business/Farm/Other	_____	_____

**CASH ASSETS:**

Bank \_\_\_\_\_ Location \_\_\_\_\_  
Checking Account #: \_\_\_\_\_ Savings Account #: \_\_\_\_\_  
Balance in Account \$: \_\_\_\_\_ Balance in Account: \$ \_\_\_\_\_  
CD/Money Market Yes \_\_\_ No \_\_\_ If yes, approximate amount: \$ \_\_\_\_\_  
IRA/Annuity/Keough/401K Yes \_\_\_ No \_\_\_ If yes, approximate amount: \$ \_\_\_\_\_  
Safe Deposit Box: Yes \_\_\_ No \_\_\_  
If yes, Bank location: \_\_\_\_\_

**OTHER ASSETS**

Burial Fund: Yes \_\_\_ No \_\_\_  
If yes, Bank name: \_\_\_\_\_ Amount: \$ \_\_\_\_\_  
Real Estate-Own Home: Yes \_\_\_ No \_\_\_ Outstanding Mortgage Amt: \$ \_\_\_\_\_  
Other Real Estate (i.e. camps, rentals, businesses)  
Yes \_\_\_ No \_\_\_ Outstanding Mortgage Amt: \$ \_\_\_\_\_

Insurance Policies: \_\_\_\_\_

**INVESTMENTS:**

Stocks: \_\_\_\_\_  
Bonds: \_\_\_\_\_  
Mutual Funds: \_\_\_\_\_  
Other: \_\_\_\_\_

**OUTSTANDING DEBTS:**

Bank Loans: \_\_\_\_\_  
Charge Cards: \_\_\_\_\_

**GIFTS/SALES/TRANSFERS:** Of cash, income, real estate, or personal property by you and your spouse during the last five (5) years: Yes \_\_\_ No \_\_\_

If Yes, Date: \_\_\_\_\_ Amount: \$ \_\_\_\_\_

**FOR VETERANS ONLY:**

Funeral or burial expenses paid last calendar year for you, spouse or dependent child?  
If yes, amount? \_\_\_\_\_

Medical expenses not paid by Medicare, Medicaid, insurance last calendar year for you or your spouse. If yes, amount? \_\_\_\_\_

College/vocational expenses in last calendar year for yourself: \$ \_\_\_\_\_

Were you exposed to Agent Orange/radiation while in the military? Yes \_\_\_ No \_\_\_

Do you have a military dental/spinal cord injury? Yes \_\_\_ No \_\_\_

Are you retired from the military? Yes \_\_\_ No \_\_\_

Was retirement a result of disability? Yes \_\_\_ No \_\_\_

Receives VA Pension? Yes \_\_\_ No \_\_\_

VA Service-Connected Pension? Yes \_\_\_ No \_\_\_ If yes, percentage: \_\_\_\_\_

Receives Medication from VA? Yes \_\_\_ No \_\_\_

Prisoner of War? Yes \_\_\_ No \_\_\_

Purple Heart? Yes \_\_\_ No \_\_\_

NAME OF APPLICANT \_\_\_\_\_

DATE \_\_\_\_\_

**MEDICAL HISTORY**

(To Be Completed By Physician or Designee)

Last hospitalization: Adm. Date: \_\_\_\_\_ Disc. Date: \_\_\_\_\_

Reason for hospitalization: \_\_\_\_\_

Problem List: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**DISEASE DIAGNOSES/HEALTH CONDITIONS:**

Check only those diseases present that have a relationship to the applicant's current Activities of Daily Living Status, cognitive status, behavioral status, medical treatments, or risk of death (do not check old/inactive diagnoses).

**1. DISEASES**

**HEART/CIRCULATION**

- \_\_\_\_\_ Arteriosclerotic heart Disease (ASHD)
- \_\_\_\_\_ Cardiac Dysrhythmia
- \_\_\_\_\_ Congestive heart failure
- \_\_\_\_\_ Hypertension
- \_\_\_\_\_ Hypotension
- \_\_\_\_\_ Peripheral vascular disease
- \_\_\_\_\_ Other cardiovascular disease

**NEUROLOGICAL**

- \_\_\_\_\_ Alzheimer's
- \_\_\_\_\_ Dementia other than Alzheimers
- \_\_\_\_\_ Aphasia
- \_\_\_\_\_ Cerebrovascular Accident (stroke)
- \_\_\_\_\_ Multiple Sclerosis
- \_\_\_\_\_ Parkinson's disease

**PULMONARY**

- \_\_\_\_\_ Emphysema/Asthma/COPD
- \_\_\_\_\_ Pneumonia

**PSYCHIATRIC/MOOD**

- \_\_\_\_\_ Anxiety disorder
- \_\_\_\_\_ Depression
- \_\_\_\_\_ Manic depressive (bipolar disease)

**SENSORY**

- \_\_\_\_\_ Cataracts
- \_\_\_\_\_ Glaucoma

**OTHER**

- \_\_\_\_\_ Anemia
- \_\_\_\_\_ Arthritis
- \_\_\_\_\_ Cancer
- \_\_\_\_\_ Diabetes mellitus
- \_\_\_\_\_ Explicit terminal prognosis
- \_\_\_\_\_ Hypothyroidism
- \_\_\_\_\_ Osteoporosis
- \_\_\_\_\_ Seizure disorder
- \_\_\_\_\_ Septicemia
- \_\_\_\_\_ Urinary tract infection (in last 30 days)

**ALLERGIES**

- \_\_\_\_\_ List: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**2. PROBLEMS/CONDITIONS AND SIGNS/SYSTEMS**

- \_\_\_\_\_ Constipation
- \_\_\_\_\_ Diarrhea
- \_\_\_\_\_ Dizziness/Vertigo
- \_\_\_\_\_ Fecal Impaction
- \_\_\_\_\_ Fever
- \_\_\_\_\_ Hallucinations/Delusions
- \_\_\_\_\_ Internal Bleeding
- \_\_\_\_\_ Joint pain
- \_\_\_\_\_ Pain (daily/almost daily)
- \_\_\_\_\_ Recurrent lung aspirations in last 90 days
- \_\_\_\_\_ Shortness of breath (Dyspnea)
- \_\_\_\_\_ Syncope (fainting)
- \_\_\_\_\_ Vomiting
- \_\_\_\_\_ Respiratory infection
- \_\_\_\_\_ Chest pain
- \_\_\_\_\_ Other
- \_\_\_\_\_ Location: \_\_\_\_\_

**3. EDEMA (Check all that apply in the prior 7 days)**

- \_\_\_\_\_ Edema - none
- \_\_\_\_\_ Edema - generalized
- \_\_\_\_\_ Edema - localized not pitting
- \_\_\_\_\_ Edema - pitting
- \_\_\_\_\_ Edema - other

**4. CONDITIONS RELATED TO MR/DD STATUS (Check all conditions that are related to MR/DD Status, that were manifested before age 22, and are likely to continue indefinitely).**

- \_\_\_\_\_ Not applicable – No MR/DD
- \_\_\_\_\_ MR/DD with Organic Condition
- \_\_\_\_\_ Cerebral Palsy
- \_\_\_\_\_ Down’s Syndrome
- \_\_\_\_\_ Autism
- \_\_\_\_\_ Epilepsy
- \_\_\_\_\_ Other organic condition related to MR/DD
- \_\_\_\_\_ MR/DD with no organic condition
- \_\_\_\_\_ Unknown

**5. RESIDENTIAL HISTORY (PAST 5 YEARS) (Check all settings lived in during the past 5 years prior to admission)**

- \_\_\_\_\_ Prior stay at this nursing facility
- \_\_\_\_\_ Other nursing facility/residential facility
- \_\_\_\_\_ MH/psychiatric setting
- \_\_\_\_\_ MR/DD setting
- \_\_\_\_\_ NONE OF ABOVE

**6. MENTAL HEALTH HISTORY Does applicant’s RECORD indicate any history of mental retardation, mental illness, or any other mental health problems?**

- \_\_\_\_\_ No
- \_\_\_\_\_ Yes

**Specify:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**7. IMMUNIZATION HISTORY**

- |                      |             |           |             |
|----------------------|-------------|-----------|-------------|
| PCV 13 Pneumococcal  | Date: _____ | Hepatitis | Date: _____ |
| PPSV 23 Pneumococcal | Date: _____ | Tetanus   | Date: _____ |
| Influenza            | Date: _____ | D-Tap     | Date: _____ |

**Laboratory Test Results Including Blood/Urine/Cultures (Describe or include copy)**

**PPD/Mantoux (Date/Results)**

**EKG (Summarize and include copy)**

**MEDICATION(S) (Dosage, frequency, and length of time prescribed)**

**X-Rays**

**Chest (date)**

**Other (dates)**

**Surgical History and Dates**

# PHYSICAL EXAMINATION

**(To Be Completed By Physician or Designee)**

BP \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ T \_\_\_\_\_ Wt \_\_\_\_\_ Ht \_\_\_\_\_

	NORMAL	ABNORMAL (EXPLAIN)
EARS: LEFT		
RIGHT		
EYES		
NOSE		
THROAT		
TEETH		
NECK		
BREASTS		
HEART		
LUNGS		
TRUNK/BACK		
ABDOMEN		
GENITAL/PELVIC		
RECTAL		
LOWER EXT.		
VEINS/ARTERIES		
LYMPH NODES		
SKIN		
NEUROLOGICAL		

\_\_\_\_\_ **Print Physician's Name**

\_\_\_\_\_ **Signature**



**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).
- Access VA's website at <http://www.va.gov> and select "Contact the VA."
- 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.

**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-VI:**

**Financial Disclosure: ONLY NSC AND 0% NONCOMPENSABLE SC VETERANS MUST COMPLETE THIS SECTION TO DETERMINE ELIGIBILITY AND COPAY RESPONSIBILITY 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 Vietnam between January 9, 1962 and May 7, 1975; 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.

Continued ...

**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 - 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 VI - 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 VII - 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.



Department of Veterans Affairs

# 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)

1A. VETERAN'S NAME (Last, First, Middle Name)			1B. PREFERRED NAME		2. MOTHER'S MAIDEN NAME	
3A. BIRTH SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	3B. SELF-IDENTIFIED GENDER IDENTITY <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	4. ARE YOU SPANISH, HISPANIC, OR LATINO? <input type="checkbox"/> YES <input type="checkbox"/> NO	5. WHAT IS YOUR RACE? (You may check more than one. Information is required for statistical purposes only.) <input type="checkbox"/> ASIAN <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> WHITE <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER			6. SOCIAL SECURITY NO.
7. VA CLAIM NUMBER		8A. DATE OF BIRTH (mm/dd/yyyy)		8B. PLACE OF BIRTH (City and State)		9. RELIGION
10A. PERMANENT ADDRESS (Street)			10B. CITY	10C. STATE	10D. ZIP CODE	10E. COUNTY
10F. HOME TELEPHONE NO. (Include area code)		10G. MOBILE TELEPHONE NO. (Include area code)		10H. E-MAIL ADDRESS		
11A. RESIDENTIAL ADDRESS (Street)			11B. CITY	11C. STATE	11D. ZIP CODE	11E. COUNTY
12. TYPE OF BENEFIT(S) APPLYING FOR (You may check more than one) <input type="checkbox"/> ENROLLMENT/HEALTH SERVICES <input type="checkbox"/> DENTAL			13. CURRENT MARTIAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			
14A. NEXT OF KIN NAME		14B. NEXT OF KIN ADDRESS			14C. NEXT OF KIN RELATIONSHIP	
14D. NEXT OF KIN TELEPHONE NO. (Include Area Code)	14E. NEXT OF KIN WORK 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. I AM ENROLLING TO OBTAIN MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT <input type="checkbox"/> YES <input type="checkbox"/> NO		17. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? (for listing of facilities visit <a href="http://www.va.gov/directory">www.va.gov/directory</a> )			18. WOULD YOU LIKE FOR VA TO CONTACT YOU TO SCHEDULE YOUR FIRST APPOINTMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	

## SECTION II - MILITARY SERVICE INFORMATION

1A. LAST BRANCH OF SERVICE		1B. LAST ENTRY DATE		1C. FUTURE DISCHARGE DATE		1D. LAST DISCHARGE DATE	
1E. DISCHARGE TYPE					1F. MILITARY SERVICE NUMBER		
2. MILITARY HISTORY (Check yes or no)				YES		NO	
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?		<input type="checkbox"/>	<input type="checkbox"/>	G. DO YOU HAVE A VA SERVICE-CONNECTED RATING?		<input type="checkbox"/>	<input type="checkbox"/>
B. ARE YOU A FORMER PRISONER OF WAR?		<input type="checkbox"/>	<input type="checkbox"/>	IF "YES", WHAT IS YOUR RATED PERCENTAGE _____ %			
C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?		<input type="checkbox"/>	<input type="checkbox"/>	H. DID YOU SERVE IN VIETNAM BETWEEN JANUARY 9, 1962 AND MAY 7, 1975?		<input type="checkbox"/>	<input type="checkbox"/>
D. WERE YOU DISCHARGED OR RETIRED FROM MILITARY FOR A DISABILITY INCURRED IN THE LINE OF DUTY?		<input type="checkbox"/>	<input type="checkbox"/>	I. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?		<input type="checkbox"/>	<input type="checkbox"/>
E. ARE YOU RECEIVING DISABILITY RETIREMENT PAY INSTEAD OF VA COMPENSATION?		<input type="checkbox"/>	<input type="checkbox"/>	J. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?		<input type="checkbox"/>	<input type="checkbox"/>
F. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998?		<input type="checkbox"/>	<input type="checkbox"/>	K. DID YOU SERVE ON ACTIVE DUTY AT LEAST 30 DAYS AT CAMP LEJEUNE FROM AUGUST 1, 1953 THROUGH DECEMBER 31, 1987?		<input type="checkbox"/>	<input type="checkbox"/>

<b>APPLICATION FOR HEALTH BENEFITS</b> <i>Continued</i>	VETERAN'S NAME <i>(Last, First, Middle)</i>	SOCIAL SECURITY NUMBER
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**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? <input type="checkbox"/> YES <input type="checkbox"/> NO	6A. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A? <input type="checkbox"/> YES <input type="checkbox"/> NO  6B. EFFECTIVE DATE <i>(mm/dd/yyyy)</i>
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**SECTION IV - DEPENDENT INFORMATION** *(Use a separate sheet for additional dependents)*

1. SPOUSE'S NAME <i>(Last, First, Middle Name)</i>	2. CHILD'S NAME <i>(Last, First, Middle Name)</i>
1A. SPOUSE'S SOCIAL SECURITY NUMBER	2A. CHILD'S DATE OF BIRTH <i>(mm/dd/yyyy)</i>
2B. CHILD'S SOCIAL SECURITY NO.	2C. DATE CHILD BECAME YOUR DEPENDENT <i>(mm/dd/yyyy)</i>
1B. SPOUSE'S DATE OF BIRTH <i>(mm/dd/yyyy)</i>	1C. SPOUSE SELF-IDENTIFIED GENDER IDENTITY <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
1D. DATE OF MARRIAGE <i>(mm/dd/yyyy)</i>	2D. CHILD'S RELATIONSHIP TO YOU <i>(Check one)</i> <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> STEPSON <input type="checkbox"/> STEPDAUGHTER
1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER <i>(Street, City, State, ZIP if different from Veteran's)</i>	2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? <input type="checkbox"/> YES <input type="checkbox"/> NO
3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT? <input type="checkbox"/> YES <input type="checkbox"/> NO	2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? <input type="checkbox"/> YES <input type="checkbox"/> NO
2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING <i>(e.g., tuition, books, materials)</i>	

**SECTION V - EMPLOYMENT INFORMATION**

1A. VETERAN'S EMPLOYMENT STATUS <i>(Check one)</i> . <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> NOT EMPLOYED <input type="checkbox"/> RETIRED	1B. DATE OF RETIREMENT	
1C. COMPANY NAME <i>(Complete if employed or retired)</i>	1D. COMPANY ADDRESS <i>(Complete if employed or retired -Street, City, State, ZIP )</i>	1E. COMPANY PHONE NUMBER <i>(Complete if employed or retired) (Include area code)</i>

**SECTION VI - 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 <i>(wages, bonuses, tips, etc.)</i> EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	\$ _____	\$ _____	\$ _____
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	\$ _____	\$ _____	\$ _____
3. LIST OTHER INCOME AMOUNTS <i>(e.g., Social Security, compensation, pension interest, dividends)</i> EXCLUDING WELFARE.	\$ _____	\$ _____	\$ _____

**SECTION VII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES**

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE <i>(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home)</i> 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 <i>(Also enter spouse or child's information in Section VI.)</i>	\$ _____
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES <i>(e.g., tuition, books, fees, materials)</i> DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.	\$ _____

<b>APPLICATION FOR HEALTH BENEFITS</b> <i>Continued</i>	VETERAN'S NAME ( <i>Last, First, Middle</i> )	SOCIAL SECURITY NUMBER
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**SECTION VII - CONSENT TO COPAYS AND TO RECEIVE COMMUNICATIONS**

**By submitting this application you are agreeing to pay the applicable VA copays for treatment or services of your NSC conditions as required by law. You also agree to receive communications from VA to your supplied email or mobile number.**

**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.**

<b>SIGNATURE OF APPLICANT</b> <i>(Sign in ink)</i> _____	<b>DATE</b> _____
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