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:

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 (*) *(Special Rules Apply For WWII. Please Call The Admissions Department.)*
Korean Conflict	June 27, 1950 - January 31, 1955
Vietnam Conflict	February 28, 1961 - May 7, 1975
Lebanon [1]	June 1, 1983 - December 1, 1987
Grenada [1]	October 23, 1983 - November 21, 1983
Panama [1]	December 20, 1989 - January 31, 1990
Persian Gulf [2]	August 2, 1990 - End of Conflict
Bosnia and Herzgegovina [3]	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: 585-345-9030

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

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 ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed		
7. Dependents Name Age		

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 ☐ Yes ☐ 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 ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed		
Dependents : Name Age:		
Relationship ☐ Spouse ☐ Widow ☐ Mother ☐ Father		
Date of Marriage	US Citizen ☐ Yes ☐ 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:

	Patient	Spouse
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_____

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

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 SPANISH, 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 MARTIAL 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)*

1A. SPOUSE'S SOCIAL SECURITY NUMBER

1B. SPOUSE'S DATE OF BIRTH *(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

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

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

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

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

2A. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)*	2B. CHILD'S SOCIAL SECURITY NO.

2C. DATE CHILD BECAME YOUR DEPENDENT *(mm/dd/yyyy)*

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

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

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

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

SECTION V - EMPLOYMENT INFORMATION

1A. VETERAN'S EMPLOYMENT STATUS *(Check one)*.
☐ FULL TIME ☐ PART TIME ☐ NOT EMPLOYED ☐ RETIRED

1B. DATE OF RETIREMENT *(mm/dd/yyyy)*

1C. COMPANY NAME. *(Complete if employed or retired)*	1D. COMPANY ADDRESS *(Complete if employed or retired - Street, City, State, ZIP)*	1E. COMPANY PHONE NUMBER *(Complete if employed or retired) (Include area code)*

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)* _____