OHIO
VETERANS HOMES
Serving those who served

Ohio Veterans Homes
3416 Columbus Avenue
Sandusky, OH 44870
419-625-2454

Ohio Veterans Homes
2003 Veterans Boulevard
Georgetown, OH 45121
937-378-2900

2016
Admission Application

The Ohio Veterans Homes are a state agency comprised of two facilities, a home located in Sandusky, Ohio (approximately 60 miles west of Cleveland) and a home located in Georgetown, Ohio (approximately 45 miles east of Cincinnati). Both homes offer a quality of life which emphasizes privacy, encourages independence, provides comfort and security, and meets social needs. All residents have the freedom and convenience of a small community as well as the comforts of a home-like setting.

Both homes are licensed nursing homes providing Standard Care, Special Care (Dementia/Alzheimer) and Skilled Care. In addition, the Sandusky home also offers independent living (Domiciliary) and limited supervised care (Domiciliary Plus) for those not requiring the level of care provided to nursing home residents.

Applications may be made directly to the Sandusky or the Georgetown home. In addition, the applicant may apply for the first available bed of either home. Once admitted, residents may apply and seek approval for transfer from one facility to another. If such transfer is approved, the resident will be responsible for all costs related to the transfer.

ELIGIBILITY
To be eligible for admission into the Ohio Veterans Homes, the applicant must meet the following criteria:

1. The applicant must have been a resident of Ohio for one year during their lifetime.
2. The applicant's most recent discharge must show that he/she is an honorably discharged or separated under honorable conditions veteran of the United States Armed Forces.
3. The applicant must have served on active duty (other than for training) during a period of war or declared armed conflict **OR** have been a recipient of the Purple Heart, Armed Forces Expeditionary Medal, Navy/Marine Corps Expeditionary Medal, or the Vietnam Service Medal.
4. The applicant must have a disability due to disease, wounds or otherwise, and are, by reason of such disability, incapable of earning a living.

Please note: applicants meeting the above criteria for admission shall not be admitted if:

1. In the opinion of the home's Medical Director, the home to which the veterans is seeking admission does not provide care adequate to meet the physical, mental, or psychosocial needs of the applicant; or
2. The applicant, by virtue of one or more criminal convictions for violent crimes and/or sex crimes, has demonstrated that he/she represents a substantial risk of harm to the health, safety, or well-being of residents, their families, visitors, volunteers or agency staff.

COSTS: Once admitted the resident will be responsible to pay maximum assessment rates until all income and asset information is obtained by the Ohio Veterans Homes.

Refer to SCHEDULE OF SERVICES for maximum rates. The assessments are based on a formula prescribed by the Ohio Revised Code and Ohio Administrative Code. The monthly assessment covers all meals, primary medical care, VA formulary medications and most medical supplies. Residents may incur additional expenses not covered in their monthly assessment. These include, but are not limited to, charges for personal choice medication not covered in the VA formulary; optometric, dental, and podiatric services and supplies; lab and radiology services; barber and beautician services and telephone. Residents may also incur some co-payment charges, and be financially responsible for skilled care services, depending on their length of stay in skilled care, secondary insurance, Medicare eligibility, etc.

Call the Financial Office, in Sandusky: 419-625-2454, extension 1248; in Georgetown: 937-378-2900, extension 2715, to obtain an estimate of your projected monthly assessment.

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Sandusky, OH 44870

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2003 Veterans Boulevard
Georgetown, OH 45121

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name _____

Patient's Social Security Number _____ Date of Birth _____

I hereby authorize and direct any hospital, clinic, medical service facility, medical practice, doctor, insurance company, or other person or institution in possession of any records pertaining to my health, medical condition(s), or medical treatment(s) to release originals or copies of the same to the Ohio Veterans Home, its authorized professional medical service providers, long-term care facilities operators, and/or the medical director for each Ohio Veterans Home. A photocopy or facsimile copy of this authorization/release is as valid as the original.

I hereby release, indemnify and hold harmless forever any party who complies in good faith with this authorization from any claim by me, my guardian, my attorney in fact or any other representative, or my estate, based on an assertion of breach of privilege, privacy or other right or duty owed to me.

Medical Records to be Released to the Ohio Veterans Home_____

_____

Reason for Release_____

_____ _____

Signature of Applicant/Responsible Party Date

If you have any questions, please contact the Ohio Veterans Home, toll free at 1-866-644-6838.

Ohio Veterans Homes

ADMISSION APPLICATION INSTRUCTIONS:

Mail completed forms along with the additional required documents listed on page 5 to the facility of choice:

ADMISSIONS OFFICE
OHIO VETERANS HOMES
3416 COLUMBUS AVENUE
SANDUSKY, OH 44870
419-625-2454, EXT. 1231/1237
866-644-6838 (TOLL FREE)
FAX: 419-624-0753

ADMISSIONS OFFICE
OHIO VETERANS HOMES
2003 VETERANS BOULEVARD
GEORGETOWN, OH 45121
937-378-2900, EXT. 2724
866-644-6838 (TOLL FREE)
FAX: 937-378-2918

SANDUSKY HOME _____ **GEORGETOWN HOME _____**

APPLICANT INFORMATION

FIRST NAME	MIDDLE NAME	LAST NAME	JR./SR.	PREFERRED NAME

SOCIAL SECURITY NO.	GENDER M F	DATE OF BIRTH (mm/dd/yr)	PLACE OF BIRTH	RELIGIOUS PREFERENCE

DO YOU HAVE MEDICARE "A"? □ YES □ NO DO YOU HAVE MEDICARE "B"? □ YES □ NO DO YOU HAVE MEDICAID? □ YES □ NO	OTHER MEDICAL INSURANCE? □ YES □ NO IF YES, NAME OF COMPANY:

HAVE YOU LIVED AT THE OHIO VETERANS HOME IN THE PAST? YES □ IF YES, WHEN? _____ NO ☐	MARITAL STATUS

PRESENT LOCATION OF APPLICANT	CURRENT TELEPHONE NUMBER

CURRENT MAILING ADDRESS	CITY/STATE	COUNTY	ZIP

BRANCH OF SERVICE	RANK	SERVICE NO.	LENGTH OF SERVICE

DATE OF ENLISTMENT(S)	DATE OF DISCHARGE(S)	DISCHARGE TYPE

WARS SERVED IN?	SERVICE CONNECTED
□ WWII □ KOREA □ VIETNAM □ GULF □ OTHER _____	DISABILITY?_____%

OHIO VETERANS HOME ADMISSION APPLICATION

APPLICANT'S NAME _____

CRIMINAL BACKGROUND INFORMATION

CRIMINAL CONVICTIONS? (Misdemeanor & Felony)	IF YES, ENTER DATE(S)	TYPE OF CONVICTION(S)? (Misdemeanor & Felony)
☐ YES ☐ NO		

COUNTY & STATE WHERE CONVICTED	CRIMINAL CHARGES PENDING	TYPE OF CHARGES
	☐ YES ☐ NO	

COUNTY & STATE WHERE CHARGED	ON PROBATION/PAROLE?	PROB/PAROLE OFFICER NAME
	☐ YES ☐ NO	

PROB/PAROLE OFFICER FULL ADDRESS	PROB/PAROLE OFFICER TELEPHONE NO.
	( )

REQ. TO REGISTER AS A SEX OFFENDER WITH LOCAL PD?	CURRENTLY REGISTERED IN YOUR
☐ YES ☐ NO	☐ COMMUNITY ☐ COUNTY ☐ STATE

PRIMARY EMERGENCY CONTACT

LAST NAME	FIRST NAME	M/I	RELATIONSHIP

FULL ADDRESS

PRIMARY PHONE NO.	ALTERNATE PHONE NO.
( )	( )

SECONDARY EMERGENCY CONTACT

LAST NAME	FIRST NAME	M/I	RELATIONSHIP

FULL ADDRESS

PRIMARY PHONE NO.	ALTERNATE PHONE NO.
( )	( )

DOCUMENTS REQUESTED TO COMPLETE
THE OHIO VETERANS HOME ADMISSION APPLICATION

IF YOU ANSWERED "YES" PLEASE INCLUDE COPIES

_____

APPLICANT'S NAME

1.	Military Enlistment Record and Honorable Discharge	☐ Yes	
2.	Social Security card and Photo I.D.	☐ Yes	
3.	Birth Certificate for legal dependent children, under 23 years old, currently enrolled full-time in school or college	☐ Yes	☐ N/A
4.	Current marriage certificate, if applicable	☐ Yes	☐ N/A
5.	Medicare and Medicaid Cards and any other Health Insurance cards, (including any prescription/medication coverage). **Copy of both sides needed.**	☐ Yes	☐ No
6.	Does applicant have a Financial Power of Attorney (POA)?	☐ Yes	☐ No
7.	Does applicant have a Healthcare Power of Attorney (POA)?	☐ Yes	☐ No
8.	Does applicant have a Guardian?	☐ Yes	☐ No
9.	Does applicant have a Living Will?	☐ Yes	☐ No
10.	Does applicant have a Fiduciary appointed by the Dept. of Veteran Affairs, or a Representative Payee appointed by the Social Security Administration, to manage their benefits?	☐ Yes	☐ No
11.	Does applicant have a Service Connected Disability Award Letter from the Dept. Of Veterans Affairs?	☐ Yes	☐ No

I am applying for admission to the Ohio Veterans Homes. I have been a resident of the State of Ohio for one year. All of the statements on this application are true and complete to the best of my knowledge. I hereby give permission to the Ohio Veterans Homes to complete a financial background check to obtain any information concerning my financial records which include the US Department of Veterans Affairs (VA), Social Security, and other financial institutions. If admitted, I understand that all income, regardless of source, will be considered in the determination of my assessment. I understand that all personal expenses and/or prior existing debts are my responsibility. I agree to follow the resident rules of conduct and all policies and procedures of the Ohio Veterans Homes.

_____ _____

SIGNATURE OF APPLICANT, POA, GUARDIAN OR SPOUSE **DATE**

Ohio Veterans Home
Treasury Department
3416 Columbus Ave.
Sandusky, OH 44870
(419) 625-2454, ext. 1513

Ohio Veterans Home
Treasury Department
2003 Veterans Blvd.
Georgetown, OH 45121
(937) 378-2900, ext. 2715

The Ohio Veterans Home assesses a fee for the cost of care in accordance with Ohio Revised Code 5907.13 and Rule 5907-5-01 of the Ohio Administrative Code. Each resident is assessed a fee based on their ability to pay, and the level of care to which they will be admitted as determined by the Home, not to exceed the maximum rates as established by the Director of the Ohio Department of Veterans Services.

The table below provides the current maximum rates for each level of care.

In order to determine whether, based on your verified income and assets, you qualify for a lower assessment, please contact the Ohio Veterans Home Treasury Department.

ASSESSMENT RATES – Effective 05/01/16

Level of Care	Maximum Rate per Month (eligible for per diem)*	Maximum Rate per Day (eligible for per diem)*	Maximum Rate per Month (not eligible for per diem)*	Maximum Rate per Day (not eligible for per diem)*
Domiciliary	**$538.00**	**$17.69**	**$1,898.24**	**$62.41**
Domiciliary +	**$1,502.00**	**$49.38**	**$2,862.24**	**$94.10**
Nursing Home	**$2,223.00**	**$73.08**		
Nursing Home Special Care Unit	**$2,954.00**	**$97.12**		

***Eligibility/ineligibility as determined by the US Department of Veterans Affairs**

All rates subject to change; notification of any changes will be provided at least thirty (30) days in advance of such change.

OHIO VETERANS HOME ADMISSION HISTORY/PHYSICAL EXAM FORM

DEAR EXAMINING PHYSICIAN PLEASE COMPLETE PAGES 7 AND 8:

The Department of Veterans Affairs as well as the Ohio Revised Code require that upon application to the Ohio Veterans Homes the applicant be determined, by medical authority, to be disabled by disease, wounds or otherwise, and is, by reason of such disability, incapable of earning a living.

APPLICANT'S NAME: _____

VITAL SIGNS

Height ft. in.	Weight lbs.	Blood pressure	Pulse	Respirations	Temperature

PRIMARY DIAGNOSIS:

SECONDARY:

OTHERS:

RECENT SURGERY? (DATE)_____ **RECENT FRACTURES? (DATE) _____**

ANY PRESSURE AREAS? _____ **RECENT WEIGHT LOSS? _____**

DOES THE APPLICANT HAVE A HISTORY OF A POSITIVE TB SKIN TESTING? YES _____ NO _____
IF YES, INCLUDE A COPY OF A CURRENT CHEST X-RAY REPORT.

DATES OF MOST RECENT: PNEUMO VACCINE _____ PREVNAR 13 _____ FLU VACCINE _____
ZOSTER _____TETANUS _____ Tdap _____ Td _____

IF APPLICANT HAS BEEN HOSPITALIZED FOR ANY REASON OR RECEIVED MENTAL HEALTH OR SUBSTANCE ABUSE TREATMENT WITHIN THE PAST THREE (3) MONTHS, PLEASE ATTACH MEDICAL RECORDS, PHYSICIAN'S ORDERS AND CURRENT MEDICATIONS. LIST METHOD & FREQUENCY OF ACTUAL ADMINISTRATIONS.
IF DIAGNOSIS DOES NOT JUSTIFY MEDICATIONS ORDERED, PLEASE EXPLAIN.

MEDICATION	FREQUENCY	DIAGNOSIS

VERIFICATION OF DISABILITY AND INABILITY TO EARN A LIVING

By my signature entered below, I have completed a physical and, it is my professional opinion, that the above named veteran applicant is disabled by disease, wounds or otherwise, and is by reason of such disability incapable of earning a living.

PHYSICIAN'S SIGNATURE_____ **DATE_____**

PHYSICIAN'S NAME (PRINTED) _____ **PHONE NO._____**

ADDRESS_____,_____,_____
_
Street City State Zip Code

OHIO VETERANS HOME ADMISSION APPLICATION
ADL (ACTIVITIES OF DAILY LIVING) ASSESSMENT

TO BE COMPLETED BY PHYSICIAN.

APPLICANT'S NAME: _____

ADL'S

BATHING:	**_____ Assist**	**_____ Supervision**	**_____ Independent**
DRESSING:	**_____ Assist**	**_____ Supervision**	**_____ Independent**
HAIR CARE:	**_____ Assist**	**_____ Supervision**	**_____ Independent**
NAIL CARE:	**_____ Assist**	**_____ Supervision**	**_____ Independent**
ORAL CARE:	**_____ Assist**	**_____ Supervision**	**_____ Independent**
EATING:	**_____ Assist**	**_____ Supervision**	**_____ Independent**
TOILETING:	**_____ Assist**	**_____ Supervision**	**_____ Independent**
AMBULATION:	**_____ Assist**	**_____ Supervision**	**_____ Independent**
OR			
WHEELCHAIR MOBILITY:	**_____ Assist**	**_____ Supervision**	**_____ Independent**
TRANSFERS:	**_____ Assist**	**_____ Supervision**	**_____ Independent**
BED MOBILITY:	**_____ Assist**	**_____ Supervision**	**_____ Independent**
MEDICATION ADMINISTRATION:	**___ Assist**	**_____ Reminders**	**_____ Independent**

NEED FOR SUPERVISION TO PREVENT HARM:

_____ 24 HOURS PER DAY
_____ WANDERING
_____ FALL RISK
_____ PERIODIC SUPERVISION
_____ NO SUPERVISION NEEDED