State of New Jersey

Department of Military and Veterans Affairs
Division of Veterans Healthcare Services
P.O. BOX 340 (101 Eggerts Crossing Road)
Trenton, New Jersey 08625-0340

APPLICATION FOR ADMISSION
to a
NEW JERSEY VETERANS MEMORIAL HOME

(Instructions for Completing Application)

This application for admission to a New Jersey Veterans Memorial Home consists of sixteen (16) parts. The **applicant** or their **responsible agent** must complete each section in ink or use a typewriter; or complete on-line, then print out the completed forms (they will not be saved). A **physician** or **financial institution** must complete where indicated; and a **notary public** must certify the indicated sections.

Once the application is filled out in its entirety, mail it to the Veterans Memorial Home of your choice. PLEASE DO NOT APPLY TO MORE THAN ONE FACILITY! Once approval for admission has been determined, the Admissions Office will forward approved application to other VMHs indicated on Page 3 as applicable.

Part 1	-	Personal Information
Part 2	-	Military Service Information
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Part 10	-	Applicant's Information
Part 11	-	Medical Information & Questionnaire (to be completed by your **physician**)
Part 12	-	Financial Information
Part 13	-	Affidavit Regarding Income Tax Return (must be **notarized**)
Part 14	-	Financial Release Request (to be completed by your **financial institution**)
Part 15	-	Advance Directives for Health Care (must be **notarized** or **witnessed**)
Part 16	-	Certification (must be **notarized**)

APPLICATION FOR ADMISSION

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NEW JERSEY VETERANS MEMORIAL HOME

(Instructions for Completing Application)

-continued-

Appendix A - New Jersey Administrative Code (N.J.A.C.) 5A: 5 – Chapter 5

Appendix B - Notice of Information Practices – Resident's Privacy Rights - HIPAA Information

Appendix C - Calculating Financial Costs – An Overview

►The information requested is necessary to determine your eligibility for admission to a New Jersey Veterans Memorial Home in accordance with New Jersey Administrative Code 5A: 5 – Chapter 5.

►Please **PRINT OUT** this application, fill in all the required information in **ink** (or use a typewriter), and then **mail** the completed application to the Veterans Memorial Home to which you want to apply.

►If the required information is not furnished, the application will not be processed until the entire application is completed. This will delay admission. Failure to inform the facility of any change of address or telephone number could cancel the admission process entirely.

►Please review the **"Work-Sheet"** at the back of this application for a check-off list of documents that must be submitted with this application.

To establish the basic eligibility of all applicants, the following documentation is required:

- Proof of an other than dishonorable discharge (e.g. DD-214)
- Birth certificate
- Verification of marital status (e.g. marriage certificate, divorce papers)
- Verification of New Jersey residency
- Proof that the person has Medicare Part A and Part B
- Proof that the person has other health insurance(s) including supplemental health insurance
- Financial eligibility (please see Parts 12, 13, 14, and Appendix C of this application)
- **Medical information**, including but not limited to:
    - History and Physical examination (recent)
    - List of current medications, dosage, frequency
    - List of current treatments person is receiving
    - List of current laboratory reports, test results (e.g. CAT scan, MRI, EKG, Holter Monitor)
    - List of any surgical procedures, date procedure was performed, and prognosis
    - Discharge summaries from any recent hospitalizations
    - Assessment data and progress notes from Assisted Living or Adult Day Care
    - Most recent Minimum Data Set (MDS) Assessment from a current or prior nursing facility
    - Persons with a Pacemaker or Defibrillator must submit all information regarding the specific device (or a copy of the accompanying booklet)
    - Persons on Dialysis must arrange for transfer to a Dialysis Center near the Veterans Memorial Home they wish to enter
    - Persons with a Psychiatric Diagnosis must submit a recent, full Psychiatric Evaluation (DMS-IV Multiaxial System)
    - Date and result of most recent PPD (TB) test
    - Date of last tetanus, influenza, and pneumonia immunizations

►Please Note that if the person is currently receiving **Hospice services**, these Hospice services can be continued in the Veterans Memorial Home.

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-continued-

PLEASE NOTE: Only the original application, with original signatures and original notary stamps, will be accepted and must be mailed directly to the FACILITY OF CHOICE.
For quality control purposes, PLEASE Do not apply to more than one facility.
If you have interest in other facilities, please check the box(es) below and that information will be made available to admissions officer(s) after consideration of your application.

☐ **New Jersey Veterans Memorial Home at MENLO PARK**
Attention: Social Service Department
P.O. Box 3013; 132 Evergreen Road
Edison, New Jersey 08818-3013
Main Telephone: (732) 452-4100
Admissions Officer: (732) 452-4272
http://www.nj.gov/military/veterans/menloparkmh/index.html

☐ **New Jersey Veterans Memorial Home at PARAMUS**
Attention: Social Service Department
1 Veterans Drive
Paramus, New Jersey 07652
Main Telephone: (201) 634-8200
Admissions Officer: (201) 634-8435
http://www.nj.gov/military/veterans/paramusmh/index.html

☐ **New Jersey Veterans Memorial Home at VINELAND**
Attention: Social Service Department
524 North West Boulevard
Vineland, New Jersey 08360-2895
Main Telephone: (856) 405-4200
Admissions Officer: (856) 405-4261
http://www.nj.gov/military/veterans/vinelandmh/index.html

Thank you for your interest in our New Jersey Veterans Memorial Homes (VMH). Please do not hesitate to call us at one of the above telephone numbers if you have additional questions, or if we can be of assistance to you and your family.

"SERVING THOSE WHO SERVED"

State of New Jersey
DEPARTMENT OF MILITARY AND VETERANS AFFAIRS
APPLICATION FOR ADMISSION

NO INDIVIDUAL WILL, ON THE GROUNDS OF RACE, COLOR, CREED, AGE, SEX, DIFFERENTLY ABLED, NATIONAL ORIGIN OR ABILITY TO PAY, BE DENIED ADMISSION, CARE OR ANY OTHER BENEFIT PROVIDED BY THE NEW JERSEY DEPARTMENT OF MILITARY AND VETERANS AFFAIRS.

PART 1 – PERSONAL INFORMATION

NAME (Last) (First) (Middle)	SOCIAL SECURITY NUMBER _____ - _____ - _____
ADDRESS (Permanent)	TELEPHONE NUMBER ( ) -

CITY	COUNTY	ZIP CODE
PRESENT LOCATION (Facility Name or Home)	DATE OF BIRTH _____/_____/_____	GENDER: ◯(M) ◯(F) RACE _____
ADDRESS	PLACE OF BIRTH	RELIGION

MARITAL STATUS (Verification Required)

Married ☐ Single ☐ Widowed ☐ Divorced ☐ Legal Separation ☐ (How Long? _____ years)

NAME OF SPOUSE	SPOUSE'S SOCIAL SECURITY #: _____ - _____ - _____
SPOUSE'S ADDRESS	SPOUSE'S DATE OF BIRTH _____/_____/_____
PLACE OF MARRIAGE	DATE OF MARRIAGE _____/_____/_____

PART 2 - MILITARY SERVICE INFORMATION
(IMPORTANT: Attach Copy of Release or Military Discharge – DD-214)

BRANCH AND SERVICE NUMBER	DATE AND STATE OF ENLISTMENT	DATE AND PLACE OF DISCHARGE	TYPE OF DISCHARGE

Do you have any service-connected disability that is confirmed by an award letter? ☐ YES ☐ NO

Percentage of Disability _____ Reason for disability _____

VETERAN'S CLAIM NUMBER:

PART 3 - ELIGIBILITY REQUIREMENTS

In compliance with the eligibility requirement, I do hereby apply for admission to the _____ veterans' long-term care facility and declare the following statements and information to be true. I am applying as a:

Veteran ☐ Gold Star Parent ☐ Widow-Widower ☐ Spouse ☐

RESIDENCE CERTIFICATE FOR THE STATE OF NEW JERSEY

I, the undersigned, am a resident of the State of New Jersey, or meet the eligibility requirements in accordance with N.J.A.C. 5A: 5-1.2.

_____ _____

Applicant's Signature Date

PART 4 – INPATIENT FACILITY HISTORY INFORMATION

HAVE YOU BEEN A PATIENT IN A **HEALTH CARE FACILITY** WITHIN THE LAST SIX MONTHS?
☐ YES ☐ NO IF yes, explain: _____

FACILITY(IES):_____DATE(S) OF ADMISSION:_____

HAVE YOU EVER BEEN A PATIENT IN A **PSYCHIATRIC CARE FACILITY**?
☐ YES ☐ NO IF yes, explain: _____

FACILITY(IES):_____DATE(S) OF ADMISSION(S):_____

NAME OF PHYSICIAN: _____PHYSICIAN'S PHONE #: _____

PART 5 - INSURANCE INFORMATION

APPLICANT'S MEDICARE #_____ EFFECTIVE DATE: _____/_____/_____ PART A☐ PART B☐ PART D☐	SPOUSE'S MEDICARE # _____ EFFECTIVE DATE: _____/_____/_____ PART A ☐ PART B☐ PART D ☐
OTHER MEDICAL/ LTC/ PDP Insurance: _____ I.D. #:_____ INSURANCE CO. NAME: _____	OTHER MEDICAL/ LTC/ PDP Insurance: _____ I.D. #:_____ INSURANCE CO. NAME: _____

LIST INSURANCE POLICIES WHICH YOU AND/OR YOUR SPOUSE HAVE: (Burial, Life, Long Term Care)
Give name of the company, the face and/or current cash value.

_____

PART 6 – ADVANCE DIRECTIVE INFORMATION

Type of Advance Directive: _____
POLST Form: ☐ YES ☐ NO

Legal Guardian:_____
Power of Attorney:_____
Conservator: _____

PART 7 - EMERGENCY CONTACT

PERSON TO BE NOTIFIED IN AN EMERGENCY. (List two. If applicant has a Guardian, Conservator, or Power of Attorney, copies of the legal documents establishing such authority must be attached.)

POA NAME: _____ ADDRESS: _____ CITY, STATE, ZIP CODE:	RELATIONSHIP: _____ WORK PHONE NUMBER: ( ) - HOME PHONE NUMBER: ( ) - CELL PHONE NUMBER: ( ) -
NAME: _____ ADDRESS: _____ CITY, STATE, ZIP CODE:	RELATIONSHIP: _____ WORK PHONE NUMBER: ( ) - HOME PHONE NUMBER: ( ) - CELL PHONE NUMBER: ( ) -

PART 8 - BURIAL ARRANGEMENT

NAME OF UNDERTAKER: _____

ADDRESS AND PHONE NUMBER:_____

Person responsible for funeral expenses:

_____ _____
(Print Name) (Signature)

Address:_____
Relationship to Resident _____Telephone: Home ( )_____ Work ( ) _____
Do you have a Will? ☐ Yes ☐ No Executor's Name: _____
Executor's Address:

State of New Jersey
DEPARTMENT OF MILITARY AND VETERANS AFFAIRS

PART 9 – AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize disclosure of the following protected health information regarding:_____, Date of Birth:_____ Social Security Number:_____, Home Address:_____ City:_____ , to the New Jersey Veterans Memorial Home for the purpose of applying for admission to their long-term care facility.

Please send copies of the following:

- ☐ History and Physical Examination (most recent, including all Diagnosis - mandatory)
- ☐ List of Current Medications, Dosage, Frequency(current–within the past 30 days - mandatory)
- ☐ Infectious Diseases History (please specify)
- ☐ Psychiatric Diagnoses and Current Treatment
- ☐ History of Drug and/or Alcohol Abuse and Current Treatment
- ☐ Nurse's/Progress Notes – last____days
- ☐ Minimum Data Set (MDS) – (current)
- ☐ Physician's Orders – (current)
- ☐ Pacemaker or Defibrillator information
- ☐ Date/result of PPD (TB test)
- ☐ Discharge Summary – Face Sheet (if applicant has been recently discharged from a facility)

Other (specify):_____

This authorization is subject to revocation at any time except to the extent that the facility has already taken action in reliance on it. If not previously revoked, this authorization will terminate upon final determination regarding admission to the facility or denial thereof. Refusal to give this authorization of disclosure will not result in withholding of care or treatment. The applicant or undersigned agent may inspect the information to be disclosed.

Signed:_____ Date:_____
(◯) Applicant (◯) Legal Guardian (◯) Power of Attorney (◯) Next of Kin (◯) Other

Witness' Name:_____ Signature:_____
For VERBAL CONSENT, a second witness is required:

Witness' Name:_____ Signature:_____

"This information has been disclosed from records protected by Federal Confidentiality Rules (42 CFR Part 2). These rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse by a resident."

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT INFORMATION: 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 the information including the last four of your Social Security Number (SSN) and Date of Birth (used 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 treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VHA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10P2 "Patient Medical Record – VA" and in accordance with the VHA Notice of Privacy Practices. 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.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Address of VA Health Care Facility)*

LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

VETERAN'S REQUEST

I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

- ☐ DRUG ABUSE
- ☐ SICKLE CELL ANEMIA
- ☐ ALCOHOLISM OR ALCOHOL ABUSE
- ☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

DESCRIPTION OF INFORMATION REQUESTED

Check applicable box(es) and state the extent or nature of information to be provided:

- ☐ HEALTH SUMMARY *(Prior 2 Years)*
- ☐ 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 _____
- ☐ OTHER *(Describe)*: _____

_____

PURPOSE(S) OR NEED

Information is to be used by the individual for:

☐ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ OTHER *(Specify below)*

_____

LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

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.

☐ UPON SATISFACTION OF THE NEED FOR DISCLOSURE

☐ ON _____ *(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	RELEASED BY:

State of New Jersey
Department of Military and Veterans Affairs

Part 10 – Applicant's Information

Our ability to determine if we can adequately care for an individual is dependent on the information provided in this application.

Part 10: To be completed by the applicant, the family or the caregiver.

Applicants Name: ____ Date of Birth ____________________

(Please Print)

Applicants Current Address: ____

Gender: ☐Male ☐Female Height: ________ Weight: _________

At the time of application, this person resides at: ☐-Own Home; ☐-Assisted Living; ☐-Nursing Home; ☐-Hospital; ☐-Other (please explain):____

Facility Name and Address: ____

Applicant **understands** and is **aware** that s/he is being admitted to a nursing home? ☐ YES ☐NO

Please provide the name and contact information for the caregiver who could give the most accurate information regarding the applicant's hygiene practices and preferences, eating abilities, dressing abilities, ambulation abilities, etc.

Caregiver's Name: ____

(Please Print)

Relationship - Check most appropriate: ☐ - Relative; ☐ - Home health staff; ☐ - Assisted living staff; ☐- Hospital staff; ☐- Nursing home staff; ☐- Other (specify): _________________________________

Home Phone #: _______________ Mobile Phone #: _______________Work Phone#:_________________

Please complete legibly. Please **send** any available medical records, reports and diagnostic studies **with the application**.

Please give a list of **physicians**, **hospitals**, and/or other **health care facilities** where medical records can be obtained. Please be sure to have the applicant or applicant's Power of Attorney complete & sign **Part 9** of the application, the **"Authorization for Disclosure of Protected Health Information"**

Doctor's or Facility's Name	Doctor's or Facility's Address

★★

Part 11: Medical Information (To be completed by the Applicant's Physician)

1. **BEHAVIOR**:☐-Alert; ☐-Confused; ☐-Oriented to Time, Place & Person; ☐-Forgetful; ☐-Suspicious; ☐-Short-Term Memory Deficit; ☐-Long-Term Memory Deficit; ☐-Withdrawn; ☐-Combative; ☐-Noisy.
2. **IMPAIRMENTS:**☐-Mentality; ☐-Speech; ☐-Hearing; ☐-Vision; ☐-Sense of Touch; ☐-Other_________________
3. **ADAPTIVE EQUIPMENT:**☐-Cane;☐-Crutches;☐-Walker;☐-Wheelchair;☐-Oxygen;☐-Prosthesis; ☐-Other_______
4. **INCONTINENCE**:☐-Bladder; ☐-Bowels; ☐-Saliva.
5. **MOUTH**: ☐-Natural Teeth; ☐-Edentulous; ☐-Dentures
6. **SLEEPING HABITS:**☐-Normal;☐-Awake freq. at night;☐-Day Naps;☐-Difficulty Falling Asleep;☐-Other_________
7. **FALLS:**☐-Within last week;☐-Within last month;☐-Within last 3 months;☐-Within last 6 months or longer
8. Does the applicant need a locked or secured unit? ☐YES ☐NO
9. Does the applicant exhibit wandering behaviors? ☐YES ☐NO

Applicant's Name_____ **Part 11: Medical Information (continued)**

If "Yes" is checked for A, B, or C below, **please submit a summary** of both past and present treatments the applicant has received. If "Yes" is checked for C, please list the **specific diagnosis**:

A. History of Alcoholism	☐ Yes	☐ No	☐ Active	☐ Remission
B. History of Drug Addiction	☐ Yes	☐ No	☐ Active	☐ Remission
C. History of Psychiatric Illness	☐ Yes	☐ No	☐ Active	☐ Remission

Has the applicant been evaluated by, or is he/she currently under the care of a psychiatric professional? ☐YES ☐NO
Has the applicant ever expressed thoughts of harming himself/herself or attempted suicide? ☐YES ☐NO

COMMUNICABLE DISEASES:

1. **PPD/TB Skin Test is required or the application will be considered incomplete and returned**
   Date of PPD/ TB skin test: _____ Results:_____

   If PPD/TB Skin Test is Positive, chest x-ray is required
   Date of chest x-ray: _____ Radiologist's findings: _____

2. Does the applicant have a current diagnosis of, or past history of, any of the following:

a. Clostridium difficile:	☐ Current	☐ History	☐ None	☐ Unknown
b. Conjunctivitis:	☐ Current	☐ History	☐ None	☐ Unknown
c. Extended Spectrum Beta Lactamases:	☐ Current	☐ History	☐ None	☐ Unknown
d. Hepatitis A:	☐ Current	☐ History	☐ None	☐ Unknown
e. Hepatitis B:	☐ Current	☐ History	☐ None	☐ Unknown
f. Hepatitis C:	☐ Current	☐ History	☐ None	☐ Unknown
g. HIV infection:	☐ Current	☐ History	☐ None	☐ Unknown
h. MRSA:	☐ Current	☐ History	☐ None	☐ Unknown
i. Pneumonia:	☐ Current	☐ History	☐ None	☐ Unknown
j. Respiratory infection:	☐ Current	☐ History	☐ None	☐ Unknown
k. Scabies	☐ Current	☐ History	☐ None	☐ Unknown
l. Septicemia:	☐ Current	☐ History	☐ None	☐ Unknown
m. Shingles	☐ Current	☐ History	☐ None	☐ Unknown
n. STDs:	☐ Current	☐ History	☐ None	☐ Unknown
o. UTI during last 30 days:	☐ Current	☐ History	☐ None	☐ Unknown
p. VRE:	☐ Current	☐ History	☐ None	☐ Unknown
q. Wound infection:	☐ Current	☐ History	☐ None	☐ Unknown
r. Other Infection - please list:				

Please Explain & Provide Lab Results: _____

VACCINATION STATUS:

Influenza Vaccine - Date received: _____ Shingles Vaccine – Date received: _____
Pneumovax - Date received: _____ Hepatitis A & B Vaccine:_____
Tetanus Booster – Date received: _____ Other Vaccine:_____

DIALYSIS STATUS:

Is this applicant on **Hemodialysis**? ☐-Yes ☐-No -- Is this applicant on **Peritoneal Dialysis**? ☐-Yes ☐-No
Frequency of treatments: _____ X per week – Fluid Restrictions: _____
Dialysis Center: _____

HOSPICE:

Is this applicant receiving Hospice services? ☐-Yes ☐-No **NOTE**: ***If Yes, attach current Plan of Care***

Hospice Agency: _____

Applicant's Name_____ **Part 11: Medical Information (continued)**

Pain - Describe the applicant's reports of pain: *frequency*; *intensity* (on a scale of 1-10; ten being the worst); and the *site of the pain*.

Pain Site	Pain Frequency	Intensity (1-10)	Pain Treatment

Allergies - (Please list):

Please indicate Behavioral/Psychiatric Diagnoses below ↓

Diagnosis	Current	History	Diagnosis	Current	History
Alzheimer's Disease			Depression		
Antisocial Personality Disorder			Post Traumatic Stress (PTSD)		
Anxiety Disorder			Psychosis		
Bipolar/Manic Depression			Schizophrenia		
Dementia (with Behavior Disturbances)			Substance Abuse		
Dementia (without Behavior Disturbances)			**Other Diagnoses** (list below):		

Please indicate the Primary (#1); Secondary (#2); Tertiary (#3); (and other) Diagnoses below ↓

Diagnosis	Current	History	Diagnosis	Current	History
Acute Myocardial Infarction			Hyperthyroidism		
Anemia			Hypotension		
Aphasia			Hypothyroidism		
Arteriosclerotic Heart Disease (ASHD)			Macular Degeneration		
Arthritis			Missing limb (Which limb?): _____		
Asthma			Movement Disorder/Chorea		
Cancer (type:_____)			Multiple Sclerosis		
Cardiac Dysrhythmias			Osteoporosis		
Cardiovascular Disease			Pain (daily or intractable?)		
Cataracts			Paraplegia		
Cerebral Palsy			Parkinson's Disease		
Cerebrovascular Accident			Peripheral Vascular Disease		
Congestive Heart Failure			Pressure Ulcers		
Deep Vein Thrombosis			Quadriplegia		
Diabetes Mellitus			Renal Failure / Kidney Disease / Kidney Stones (please circle)		
Diabetic Retinopathy			Seizure Disorder		
Emphysema / COPD			Stasis Ulcer(s)		
Glaucoma			Transient Ischemic Attacks (TIA)		
Hemiplegia / Hemiparesis			Traumatic Brain Injury (TBI)		
Hip Fracture – Left / Right			**Other Diagnoses** (list below):		
History of Falls					
Hypertension					

Applicant's Name_____ **Part 11: Medical Information (continued)**

Medications: Medication list is to include all **scheduled**, as well as **PRN** [*as needed*], medications

Applicant's Medications	Dose	Time	Route	Reason

Treatments: Please list any treatments, or attach a copy of a treatment list which includes this information

Applicant's Treatments	Dose	Time	Route	Reason

At this Physical Examination the Applicant's Vital Signs were as follows:

Blood Pressure:_____ Pulse (Apical):_____ Pulse (Radial):_____ Temperature:_____

Cardiac Rhythm:_____ Needs Rehabilitation: ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

Prognosis: ☐ Stable ☐ Improving ☐ Deteriorating ---- **Rehabilitation Potential:** ☐ Good ☐ Limited ☐ Poor

PLEASE LIST THE MAIN REASON(S) THAT THIS APPLICANT REQUIRES 24/7 SKILLED NURSING CARE:_____

Must be Signed by a Licensed Physician; Advance Practice Nurse; or N.J. Physician's Assistant

Professional's Signature: _____

Name and Title (please print): _____

Address: _____

Telephone #_____ Fax #_____

Date Signed:_____

State of New Jersey
Department of Military and Veterans Affairs (DMAVA)
New Jersey Veterans Memorial Homes (VMH)

EVALUATION OF ACTIVITIES OF DAILY LIVING

TO BE COMPLETED BY PRIMARY CAREGIVER! (Family Member, Home Health Aide, or Facility Caregiver)

(Check that which applies in each category)

COMMUNICATION	☐ Transmits messages/receives information ☐ Limited ability ☐ Nearly or totally unable	SPEECH	☐ Transmits messages/receives information ☐ Limited ability ☐ Nearly or totally unable
HEARING	☐ Good ☐ Hearing slightly impaired ☐ Nearly or totally unable ☐ Virtually/completely deaf	SIGHT	☐ Good ☐ Vision adequate/unable to read/see details ☐ Vision limited – Gross object differentiation ☐ Blind
TRANSFER	☐ No assistance ☐ Equipment only ☐ Supervision only ☐ Requires human transfer w/wo equipment ☐ Bedfast	AMBULATION	☐ Independent w/wo assistive device ☐ Walks with supervision ☐ Walks with continuous human support ☐ Bed to chair (total help) ☐ Bedfast
ENDURANCE	☐ Tolerates distances (250 feet sustained activity) ☐ Needs intermittent rest ☐ Rarely tolerates short activities ☐ No tolerance	MENTAL AND BEHAVIOR STATUS	☐ Alert ☐ Agreeable ☐ Confused ☐ Disruptive ☐ Disoriented ☐ Apathetic ☐ Comatose ☐ Well motivated
TOILETING	☐ No assistance ☐ Bathroom ☐ Assistance to and from and transfer ☐ Bedside commode ☐ Total assistance including personal hygiene, help w/clothes ☐ Bedpan	BATHING	☐ No assistance ☐ Tub ☐ Supervision only ☐ Shower ☐ Assistance ☐ Sponge bath ☐ Is bathed
DRESSING	☐ Dresses self ☐ Minor assistance ☐ Needs help to complete dressing ☐ Has to be dressed	FEEDING	☐ No assistance ☐ Minor assistance, needs tray set up only ☐ Help feeding/encouraging ☐ Is fed
BLADDER CONTROL	☐ Continent ☐ Rarely incontinent ☐ Occasional-once/week or less ☐ Frequent – up to once a day ☐ Total incontinence ☐ Catheter, Indwelling	BOWEL CONTROL	☐ Continent ☐ Rarely incontinent ☐ Occasional-once/week or less ☐ Frequent – up to once a day ☐ Total incontinence ☐ Ostomy
SKIN CONDITION	☐ Intact ☐ Dry/Fragile ☐ Irritations (Rash) Number_____ ☐ Open wound Stage_____ ☐ Decubitus	WHEELCHAIR USE	☐ Independence ☐ Assistance in difficult maneuvering ☐ Wheels a few feet ☐ Unable to use ☐ N/A

SIGNATURE OF PERSON COMPLETING THIS FORM: **Date__/__/__**

_____ _____ _____

FAMILY MEMBER HOME HEALTH AIDE FACILITY CAREGIVER

State of New Jersey
Department of Military and Veterans Affairs (DMAVA)
New Jersey Veterans Memorial Homes (VMH)

QUESTIONNAIRE ON BEHAVIORAL NEEDS

Applicant's Name:							**Date:**
		FREQUENCY					
	BEHAVIORS	DAILY	UP TO 5 DAYS/ WEEK	NOT IN LAST 30 DAYS	NOT IN LAST 6 MONTHS	NEVER	COMMENTS
1	Wandering or getting lost						
2	Exit seeking or elopement risk						
3	Refuses to take medications as ordered						
4	Resists necessary care						
5	Difficulty getting along with others						
6	Sleeps during day and awake all night						
7	Verbally abusive to others						
8	Attempting to break furniture or glass						
9	Attempts to hit, punch, kick, choke or spit at others unprovoked						
10	Screaming or yelling						
11	Physically aggressive behavior towards you, other family members or staff/others at a facility						
12	Attempting to throw furniture at others						
13	Attempts to throw self on floor						
14	Taking others belongings						
15	Being suspicious, accusative and/or paranoid						
16	Seeing or talking to people or things that are not there						
17	Suicidal or homicidal ideations						
18	Exposing self to others						
19	Rummaging through others belongings						
20	Hiding things (money, jewelry, keys, etc.)						
21	Hoarding things						
22	Attempting to eat non-food items						
23	Sexually inappropriate touching						
24	Voiding or defecating in inappropriate locations						
25	Makes overtly sexual remarks, jokes, comments etc.						
26	Attempting to have non-consensual sexual intercourse or sexual contact with others						
27	Attempts to bruise, cut or hurt self						

If the applicant lives in the community, please have the applicant's **Physician** complete this form:

_____ _____ _____/_____/_____

PHYSICIAN'S SIGNATURE PHYSICIAN'S NAME (Please Print) DATE

If the applicant lives in a nursing home, assisted living or other type of facility, please have the **Charge Nurse** or **Social Worker** complete this form:

_____ _____ _____/_____/_____

NURSE'S or SOCIAL WORKER'S SIGNATURE NURSE'S or SOCIAL WORKER'S NAME (Please Print) DATE

PART 12 - FINANCIAL INFORMATION

NAME:
(PRINT)

GIVE SOURCE AND AMOUNT OF INCOME PER MONTH FOR YOU AND/OR YOUR SPOUSE

VETERANS ADMINISTRATION	**PERCENT OF COMPENSATION**	**SOCIAL SECURITY**
☐ Pension: $ _____	Disability: _____%	Applicant: $ _____
☐ Compensation: $_____	Monthly Award: $_____	Spouse: $ _____

RAILROAD RETIREMENT: Applicant $_____ Spouse $_____	**OTHER PENSION OR RETIREMENT:** Applicant $_____ Spouse $_____
INTEREST/DIVIDENDS: Applicant $_____ Spouse $_____	**OTHER INCOME: (Employment)** Applicant $_____ Spouse $_____

If separated or divorced, do you contribute to spouse's support? ☐ Yes ☐ No
Amount contributed to spouse's support: $_____

NOTE: Please provide copies of the following applicable documents for the previous 36 months immediately prior to the application date.

	CURRENT CASH VALUE BALANCE AS OF Month _____ Year _____		**ACTUAL ESTIMATED ANNUAL INCOME FROM ASSETS/SOURCES**	
	APPLICANT	**SPOUSE/OTHER**	**APPLICANT**	**SPOUSE/OTHER**
Trust Fund/Income:	$	$	$	$
Legal Settlements: ( ) Yes ( ) No				
TAX DEFERRED INVESTMENTS:				
IRAs Maturity Date: _____				
KEOGH Maturity Date: _____				
BONDS/NOTES List: _____				
ANNUITIES List: _____				
OTHER List:_____				
TAXABLE INVESTMENTS:				
STOCKS/DIVIDENDS List: _____				
BONDS/INTEREST List: _____				
OTHER SECURITIES List: _____				
List: _____				
Savings Accounts Total:……....				
Checking Accounts Total:…….				
Money Market Accounts Total:				
(Total Investment _____)				
CD's Cash Value Total:				
(Total Investment _____)				
Safety Deposit Box Valued Assets Total:				
Real Estate Value (NOT Primary Residence)				
Real Estate Rental Incomes:				
Vehicles (other than primary)				
List #1: _____				
List #2: _____				
List Other Assets and Cash Values:				
1. _____				
2. _____				
3. _____				
TOTAL ASSETS/INCOME:	$	$	$	$

NOTE WELL

FEDERAL AND STATE INCOME TAX REPORTS FOR PREVIOUS 3 YEARS ARE REQUIRED. In a trust or transfer of assets, which occurred within 36 months of the application, the value of that trust and/or assets will be deemed an accountable asset for the balance of the 36-month period. The applicant will be required to pay the actual cost for services and/or delay admission for the balance of the 36-month period.

I certify that all accounts are accurately listed as of this date.

_____ Signature

_____ Date

State of New Jersey
DEPARTMENT OF MILITARY AND VETERANS AFFAIRS

PART 13 - AFFIDAVIT REGARDING INCOME TAX RETURN

This will serve to affirm that I, _____ and/or
(Applicant's Name - Please Print)

my spouse, _____ are (exempt) (non exempt)
(Name of Spouse - Please Print) (Please Circle Correct Answer)

from a federal and state income tax return due to the level of my/our income and assets.

I further authorize that this information be verified and released to the New Jersey Veterans Memorial Home (VMH) upon their request, by the New Jersey Division of Taxation.

SIGNED: _____
(Signature of Applicant)

_____
(Signature of Spouse)

SWORN AND SUBSCRIBED TO ME THIS

_____ DAY OF _____, YEAR OF _____.

_____
Notary Public Signature

Affix Seal

State of New Jersey
DEPARTMENT OF MILITARY AND VETERANS AFFAIRS

PART 14 – FINANCIAL RELEASE REQUEST

_____/_____/_____
DATE

_____ Owners: _____
Financial Institution

_____
Address

_____
City, State, Zip Code

Social Security Number _____-_____-_____
(Applicant)
Social Security Number _____-_____-_____
(Spouse)
Social Security Number _____-_____-_____
(Other)

Dear Sir/Madam:

Please provide us with information on all accounts that were or are now being held by your institution for the above referenced applicant from the previous 36 months to the present.

TYPE OF ACCOUNT	ACCOUNT NUMBER	36-MONTH HIGH BALANCE & DATE	AVERAGE BALANCE	CURRENT BALANCE

_____ _____/_____ _____
Date Signature of Bank Official (Please Print Name) Telephone Number

Your prompt response to this request is greatly appreciated.

☐ Elizabeth Schiff-Heedles, CEO
Menlo Park Veterans Memorial Home
132 Evergreen Road, P.O. Box 3013
Edison, New Jersey 08818-3013
(732) 452-4100

☐ Matthew Schottlander, CEO
Paramus Veterans Memorial Home
1 Veterans Drive
Paramus, New Jersey 07653
(201) 634-8200

☐ Allyson Bailey, CEO
Vineland Veterans Memorial Home
524 North West Boulevard
Vineland, New Jersey 08360-2895
(856) 405-4200

AUTHORIZATION
I authorize the financial institution named above to supply any information regarding my/our accounts as requested by the New Jersey Veterans Memorial Home checked above.

Date:_____ NAME:_____

SIGNATURE:_____

Date:_____ NAME:_____

SIGNATURE:_____

State of New Jersey
DEPARTMENT OF MILITARY AND VETERANS AFFAIRS

PART 15 – ADVANCE DIRECTIVES FOR HEALTH CARE: "LIVING WILL" or "DURABLE POWER OF ATTORNEY for HEALTH CARE"

New Jersey law recognizes **"Advance Directives for Health Care"**, more commonly known as a **"Living Will"** or a **"Durable Power of Attorney for Health Care"** as legal documents, which indicate an individual's medical treatment or financial preferences.

As a competent adult, you have the right to make decisions about what medical treatment you want, or do not want to receive. What happens to that right if you become physically or mentally unable to communicate your wishes and values? You can decide in advance what treatment you would want, and put that decision in writing. You may also name someone else, who understands and shares your values, to exercise that right for you. This is called an Advance Directive for Health Care.

Advance Directive for Health Care – Any written directions you prepare in advance to say what kind of medical care you want in the event you become unable to make decisions for yourself.

There are three (3) kinds of Advance Directives for Health Care:

1. **Proxy Directives** – Designate a person (a **proxy**) you trust and give that person the legal authority to decide for you if you are unable to make decisions for yourself. Your proxy (also known as your **Health Care Representative**) serves as your substitute, "standing in" for you in discussions with your physician. A **Proxy Directive** is also called a **"Durable Power of Attorney for Health Care."**

2. **Instruction Directives** – Written directions that spell out in advance what medical treatments you wish to accept or refuse and the circumstances in which you want your wishes implemented. **Instruction Directives** are also called a **"Living Will."**

3. **Combined Directives** – A third way combines both the proxy and the instruction directives. Combined Directives mean a single document in which you select a health care representative (a proxy) and provide that person with a written statement of your medical treatment preferences (a living will).

- An Advance Directive is not required for admission to a hospital, nursing home or other health care facility.
- Serious injury, illness or mental incapacity may make it impossible for you to make health care decisions for yourself. In these situations, those responsible for your care will have to make decisions for you.
- A clearly written Advance Directive helps prevent disagreements among those close to you and alleviates some of the burdens of decision-making which are often experienced by family members, friends, and health care professionals.
- Your Advance Directive takes effect when you are no longer able to make decisions about your health care.

PART 15 – ADVANCE DIRECTIVES FOR HEALTH CARE: "LIVING WILL" or "DURABLE POWER OF ATTORNEY for HEALTH CARE"

SUGGESTED TOPICS to DISCUSS with YOUR HEALTH CARE REPRESENTATIVE and PHYSICIAN

Before designating a health care representative, you should discuss your beliefs and wishes with her/him and your physician. To stimulate discussion and clear understanding, we suggest you consider the following questions:

1. Do you think you want to have any of the following medical treatments performed on you:

   (1) As temporary treatments; (2) As life prolonging measures, with no reasonable expectation of recovery?

   A. Cardiopulmonary resuscitation (CPR) (an emergency, temporary measure used if the heart stops beating).

   B. Respirator (machine used if you are unable to breathe on your own).

   C. Artificial nutrition (liquid food delivered by tube if you are unable to eat food).

   D. Artificial hydration (fluid delivered into your vein if you are unable to drink fluids).

   E. Kidney Dialysis (machine used if your kidneys stop working).

2. Do you want to donate parts of your body to someone in need at the time of your death (Organ Donation)?

3. How important is independence and self-sufficiency in your life? Ability to communicate, perform personal hygiene, ability to move independently, to be aware and interactive with people and surroundings?

4. What will be important to you when you are dying (e.g., physical comfort, no pain, family members present, etc.)?

5. How do you feel about the use of life prolonging measures in the face of (A) terminal illness, (B) persistent vegetative state (Karen Ann Quinlan), (C) Alzheimer's Disease, and (D) Chronic neurological disorder?

6. How do your religious beliefs affect your attitude and decisions regarding medical treatment?

7. Do you expect that your friends, family and/or others will support your decisions regarding medical treatment?

If, over time, your beliefs and/or decisions change, you should inform your health care representative, physician, and make appropriate changes to your Advance Directive or execute a new document and distribute the updated version to the appropriate individuals: (1) Family; (2) Physician; (3) Nursing Home or Hospital; (4) Health Care Representative.

ᔓ In **Section C** on the next page, you may specify in more detail the conditions in which you choose to forgo life-sustaining measures. This can be a statement of your values and the quality of life that is acceptable to you. You may want to include your wishes regarding artificially administered fluids and nutrition. You may want to include your wishes regarding at home or hospital care at the end of life or you might wish to give more specific instructions. If you need more space than is provided, you can attach an additional statement to the Directive.

ᔓ In **Section D** you may authorize that your representative assume financial responsibilities for your welfare.

ᔓ In **Section E** you have the opportunity to designate a representative to help make decisions for you in the event you are incapacitated. This individual should make decisions in accordance with your wishes. If your wishes are not clear, or a situation arises that was not anticipated, the representative is expected to make decisions in your best interest based on what is known of your wishes. It is important that you discuss these matters in advance with the designated representative. You do not need an attorney or a physician to complete an Advance Directive, although you may wish to consult with one. You may have your Advance Directive witnessed by two adults or you may have it notarized. If you designate a representative he or she cannot be a witness. After completing the form, share it with family members, your doctors, friends and other persons who should know your health care preferences. Review your Advance Directive periodically to make sure it still expresses your intent, then initial and date your review.

DURABLE POWER OF ATTORNEY for HEALTH CARE and FINANCIAL MATTERS

This **Advance Directive-Durable Power of Attorney for Health Care and Financial Matters** form is one of the many forms which are available. Others are equally valid. Completion of a Durable Power of Attorney form is voluntary. Your admission is not contingent upon your completion of a Durable Power of Attorney. Please consider whatever directive you may choose carefully. It is important that you, as a person completing the Durable Power of Attorney, be fully informed as to its meaning and implications.

To my family, doctors and others concerned with my health care and financial welfare.

A. I, _____, being of sound mind, hereby make known my instructions for future health care and financial matters in the event that, for reasons due to physical or mental incapacity, I am unable to participate in decisions regarding my welfare.

B. Please initial the statement or statements with which you agree:
(Select #1 or #2, but not both. Everyone may also select #3.)

1. _____ I direct that all medically appropriate measures be provided to sustain my life, regardless of my physical or mental condition(s).

2. _____ If I experience extreme mental or physical deterioration such that there is no reasonable expectation of recovery or regaining a meaningful quality of life, life-prolonging measures should not be initiated or if they have been, they should be discontinued. Those life-sustaining procedures or treatments that may be withheld or withdrawn include, but are not limited to: cardiac resuscitation; respiratory support (ventilator); and/or artificially administered fluids and/or nutrition.

3. _____ I direct that I be given all appropriate care to alleviate pain and to keep me clean and comfortable.

C. Additional comments or instructions:

D. _____ I authorize my Durable Power of Attorney to do anything necessary and proper to pay all debts incurred by me or on my behalf, or any evidence of any debt or obligation that I may incur or which may be incurred on my behalf or for my benefit, and to do all things necessary and proper to satisfy and discharge any and all such debts or obligations, to enter into any contract whatsoever including but not limited to contracts or agreements with medical doctors, nurses, hospitals and any medical institution such as nursing homes or other institutions, and to pay any and all bills that I may incur as a result of such contracts and/or agreements.

State of New Jersey
DEPARTMENT OF MILITARY AND VETERANS AFFAIRS

PART 15 – ADVANCE DIRECTIVES FOR HEALTH CARE: "LIVING WILL" or "DURABLE POWER OF ATTORNEY for HEALTH CARE"

E. **Designation of Durable Power of Attorney–Healthcare Representative:** I hereby designate the person named below as my health care and financial representative to make decisions about accepting, refusing, withdrawing or withholding any treatment, service or procedure in accordance with my wishes as stated in this document. In the event my wishes are not clear, or a situation arises that I did not anticipate, my representative is authorized to make decisions in my best interest, based upon what is known of my wishes. **Alternative Representative**-If the person I have designated is unable, unwilling, or unavailable to act as my health care representative, I hereby designate the alternate person to do so:

REPRESENTATIVE:

Name:_____

Address:_____

_____
City State Zip Code

Home Phone No.:_____

ALTERNATE REPRESENTATIVE:

Name:_____

Address:_____

_____
City State Zip Code

Home Phone No.:_____

F. **SIGNATURE:** By writing this Durable Power of Attorney for Health Care, I attest that I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

PRINT NAME:_____

SIGNATURE:_____ **Date:**_____

G. **WITNESSES:** New Jersey law mandates that an Advance Directive for Health Care be signed in front of two witnesses or a Notary Public, or signed in front of a lawyer.

I declare that the person who signed this document did so in my presence, that he or she appears to be of sound mind and free of duress or undue influence. I am 18 years of age or older, and am not designated by this or any other document as this person's health care representative nor as an alternate health care representative nor, to the best of my knowledge, am I named in his/her will.

Witness #1 or Attorney:

Witness Name:_____

Address:_____

City, State, Zip:_____

Signature:_____

Date:_____

Witness #2

Witness Name:_____

Address:_____

City, State, Zip:_____

Signature:_____

Date:_____

H. **NOTARY PUBLIC WITNESS:**

SWORN AND SUBSCRIBED TO ME ON THIS

_____ **DAY OF** _____ **Year of** _____**.**

_____

NOTARY PUBLIC SIGNATURE **(AFFIX SEAL)**

State of New Jersey
DEPARTMENT OF MILITARY AND VETERANS AFFAIRS

PART 16 – CERTIFICATION

I _____ (please print full name) do solemnly affirm that all questions asked and all statements by me on this application are true. I affirm that, because of physical disability, I am unable to continue living in my home. I agree to accept transfer to any health care facility, or to my home, if in the opinion of the staff such transfer is required.

I have provided all information regarding my assets, indebtedness, and income (including that related to my spouse) and affirm that the information is complete and correct. I understand that misrepresentation of my financial status may result in discharge from the New Jersey Veterans Memorial Home (VMH).

As a condition of my admission and continued stay at the New Jersey Veterans Memorial Home I must maintain primary and supplemental health insurance policies. I consent that if for any reason either or both of these policies are canceled, the facility may obtain health care insurances for me at my expense. It will be my responsibility (guardian or financially responsible agent) to incur all medical or medical-related costs which include but are not limited to: physician services, transportation, consultation services, hospitalization, diagnostic services, pharmaceuticals, and deductible fees not covered by medical insurances.

I agree to pay the maintenance charges and to inform the facility immediately of any changes in my financial circumstances that may affect my fee. I understand that, although my estate and I remain obligated to pay the actual cost of services, the amount of periodic payments may be reduced depending on the amount of my income and assets. If a trust or transfer of assets occurs within 36 months of application, I will be responsible to pay the actual cost of services.

I understand that the professional staff at the facility shall have the right to deny admission if, in their opinion, my needs cannot be adequately met at the facility.

At the time of death, a Surrogates Order will be required for release of my personal belongings with the exception of my clothing which will be released to the individual I have designated as the person of contact. All accounts will be held for 30 days for processing and closing.

I authorize the New Jersey Veterans Memorial Home to apply for any financial benefits to which I may be entitled and approve that all sources of income, to include Social Security, will be considered when determining my care and maintenance fee. I agree to abide by all rules and regulations governing the facility.

NOTARY SWORN AND SUBSCRIBED TO ME ON THIS

_____ Day of _____ ,Year of _____ _____
Applicant's Signature

_____ _____
Notary Public Signature Date

AFFIX SEAL

NOTE: If applicant is unable to sign this application, person signing for the applicant must indicate legal authority for signing, such as Power of Attorney, Court Order, Guardianship, etc.

DEPARTMENT OF MILITARY & VETERANS AFFAIRS
NEW JERSEY VETERANS MEMORIAL HOME

Insurance
Acknowledgement

I understand that pursuant to N.J.A.C. 5A:5-3.1(a)(1)(iv)(2-4), at the time of admission to the New Jersey Veterans Memorial Home I am required to have "adequate health insurance." Adequate health insurance usually includes either Medicare Parts A, and B as my primary insurance and Medicare D or a creditable prescription plan, or, an adequate retiree health insurance plan such as Tri care, or a working group health plan.

If Medicare A, B is my primary insurance, I must have and maintain a secondary (Supplemental Medigap Insurance) to cover all co-insurance. If I fail to have and maintain a Secondary Medigap Insurance to Medicare A, B and D or other prescription coverage, or if I do not have and maintain adequate health insurance, I will be responsible for all charges incurred as a result.

The New Jersey Veterans Memorial Homes do not participate in any HMOs. If I have an HMO as my primary insurance coverage it will not cover the cost of any/all treatments or therapies prescribed by my physician, and I will be responsible for covering those costs. I understand that I may discuss with the Business Office insurance plans that are available to me that would cover such expenses in lieu of an HMO.

If I have a retiree health insurance plan or a working group health plan or a PPO, I can contact the Business Department for assistance in evaluating the legal, prudent and financial considerations in switching from or adding to my current health care plan.

Finally, I am aware that the New Jersey Veterans Memorial Home does not accept, and is not a Medicaid facility.

_____

Resident's Name (Printed)

_____ _____

Signature Self ( ) POA ( ) Next of Kin ( ) Other ( ) Date

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).
- 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.

OMB Approved No. 2900-0091
Estimated Burden Avg. 30 min.

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	3B. SELF-IDENTIFIED GENDER IDENTITY	4. ARE YOU SPANISH, HISPANIC,OR LATINO?	5. WHAT IS YOUR RACE? *(You may check more than one. Information is required for statistical purposes only.)*	6. SOCIAL SECURITY NO.
☐ MALE ☐ FEMALE	☐ MALE ☐ FEMALE	☐ YES ☐ NO	☐ ASIAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ WHITE ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	

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)*	13. CURRENT MARTIAL STATUS
☐ ENROLLMENT/HEALTH SERVICES ☐ DENTAL	☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ 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	17. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? *(for listing of facilities visit www.va.gov/directory)*	18. WOULD YOU LIKE FOR VA TO CONTACT YOU TO SCHEDULE YOUR FIRST APPOINTMENT?
☐ YES ☐ NO		☐ YES ☐ 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		YES	NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?	☐	☐	G. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	☐	☐
B. ARE YOU A FORMER PRISONER OF WAR?	☐	☐	IF "YES", WHAT IS YOUR RATED PERCENTAGE _____ %		
C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?	☐	☐	H. DID YOU SERVE IN VIETNAM BETWEEN JANUARY 9, 1962 AND MAY 7, 1975?	☐	☐
D. WERE YOU DISCHARGED OR RETIRED FROM MILITARY FOR A DISABILITY INCURRED IN THE LINE OF DUTY?	☐	☐	I. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?	☐	☐
E. ARE YOU RECEIVING DISABILITY RETIREMENT PAY INSTEAD OF VA COMPENSATION?	☐	☐	J. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	☐	☐
F. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998?	☐	☐	K. DID YOU SERVE ON ACTIVE DUTY AT LEAST 30 DAYS AT CAMP LEJEUNE FROM AUGUST 1, 1953 THROUGH DECEMBER 31, 1987?	☐	☐

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

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

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)*	1C. SPOUSE SELF-IDENTIFIED GENDER IDENTITY ☐ MALE ☐ FEMALE	2C. DATE CHILD BECAME YOUR DEPENDENT *(mm/dd/yyyy)*	
1D. DATE OF MARRIAGE *(mm/dd/yyyy)*		2D. CHILD'S RELATIONSHIP TO YOU *(Check one)* ☐ SON ☐ DAUGHTER ☐ STEPSON ☐ STEPDAUGHTER	
1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP if different from Veteran's)*		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	
3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT? ☐ 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	
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)*

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 *(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 VII - 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.*	$

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

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.

SIGNATURE OF APPLICANT
(Sign in ink) _____ **DATE** _____

Dear Veteran:

Please complete and update the following information (NEED A COPY OF DD214)

Veteran's Full Social Security Number: Date of Birth (MO/DD/YY):

Veteran's Last Name:_____First Name:_____Middle Initial:_____

Veteran's Address:_____City/State:_____ Zip Code:_____

Home Phone No: Cell No: Work No:

Mother's Last Name:_____ First Name:_____Mother's Maiden Name:_____

Father's Last Name:_____ First Name:_____

Employment Information:
Veteran's Occupation (Job Title):
(If retired or unemployed or current job please use the last known job)
Spouse's Employment Status: (Check one):
(☐) Full Time (☐) Part Time (☐)Not Employed (☐) Retired (☐) Date of Retirement:

Employer's Name, Address & Telephone (use the last known):

Veteran's Spouse's Occupation (Job Title):
(If retired or unemployed or current job please use the last known job)
Spouse's Employment Status: (Check one):
(☐) Full Time (☐) Part Time (☐)Not Employed (☐) Retired (☐) Date of Retirement:

Employer's Name, Address & Telephone (use the last known job):

_____

[1] Next of Kin: (please provide your next of Kin)

Last Name:_____ First Name;_____

Relationship:_____ Address (*street*):_____

City:_____ State & Zip Code:_____

Home Phone:_____ Work Phone: _____ Cell No:_____

[2] Emergency contact: Please provide if different than Number 1

Last Name:_____ First Name;_____

Relationship:_____ Address (*street*):_____

City:_____ State & Zip Code:_____

Home Phone:_____ Work Phone: _____ Cell No:_____

Signature of Applicant:_____ Date:_____

State of New Jersey
DEPARTMENT OF MILITARY AND VETERANS AFFAIRS

"WORK-SHEET" FOR APPLICANTS / FAMILIES REQUIRED COPIES OF DOCUMENTS

- ☐ BIRTH CERTIFICATE / SOCIAL SECURITY CARD (see PART 1)
- ☐ VERIFICATION of MARRIAGE STATUS (see PART 1)
- ☐ DIVORCE DECREE / SEPARATION PAPERS (see PART 1)
- ☐ DEATH CERTIFICATE (see PARTS 1 and 3)
- ☐ MILITARY RECORDS (DD 214) (see PART 2)
- ☐ AWARD LETTER (Proof of service-connected disability)
- ☐ 1010 EZ FORM
- ☐ VERIFICATION OF NEW JERSEY RESIDENCY (see PART 3)
- ☐ INSURANCE CARDS (see PART 5)

(Please be sure to copy the FRONT and BACK of ALL INSURANCE CARDS)

- ☐ MEDICARE CARD – PART A and B (see PART 5)
- ☐ MEDICARE PART D – PRESCRIPTION DRUG PLAN (PDP) AND I.D. #
- ☐ MEDICADE CARD (see PART 5)
- ☐ ADVANCE DIRECTIVE/ GUARDIAN / POWER OF ATTORNEY (PART 6)
- ☐ ADVANCE DIRECTIVES for HEALTH CARE (see PART 15)
- ☐ POLST Form
- ☐ MEDICAL INFORMATION (see PARTS 4, 9, 10 and 11)
- ☐ COPY OF CURRENT PSYCHIATRIC CONSULT (If applicable)
- ☐ FINANCIAL DOCUMENTS (see PART 12 and PART 14)
- ☐ FEDERAL INCOME TAX (PREVIOUS THREE YEARS) (see PART 12)
- ☐ STATE INCOME TAX (PREVIOUS THREE YEARS) (see PART 12)
- ☐ AFFIDAVIT REGARDING INCOME TAX (IF REQUIRED) (see PART 13)

State of New Jersey

Department of Military and Veterans Affairs
Division of Veterans Healthcare Services
P.O. Box 340, Eggert Crossing Road
Trenton, New Jersey 08625-0340

Application for Admission
to a
New Jersey Veterans Memorial Home

Appendix A

New Jersey Administrative Code (N.J.A.C.) 5A: 5 - Chapter 5

TITLE 5A. MILITARY AND VETERANS' AFFAIRS
CHAPTER 5. NEW JERSEY VETERANS' MEMORIAL HOMES

N.J.A.C. 5A:5 (2014)

Title 5A, Chapter 5 -- Chapter Notes

NOTES:

CHAPTER AUTHORITY: N.J.S.A. 38A:3-2.2, 38A:3-2.b, 38A:3-6.4, 38A:3-6.5, 38A:3-6.6, 38A:3-6.8, 38A:3-6.9, and 38A:3-6.12; and P.L. 1988, c. 444.

CHAPTER SOURCE AND EFFECTIVE DATE: R.2014 d.022, effective December 23, 2013. See: 45 N.J.R. 2065(a), 46 N.J.R. 204(a).

CHAPTER EXPIRATION DATE: Chapter 5, New Jersey Veterans' Memorial Homes, expires on December 23, 2020.

CHAPTER HISTORICAL NOTE:

Chapter 5, New Jersey Veterans' Facilities, was adopted as R.1992 d.372, effective September 21, 1992. See: 24 N.J.R. 2499(b), 24 N.J.R. 3311(a). The expiration date of Chapter 5, New Jersey Veterans' Facilities, was extended by gubernatorial directive from September 21, 1997 to February 27, 1998. See: 29 N.J.R. 4287(b).

Pursuant to Executive Order No. 66(1978), Chapter 5, New Jersey Veterans' Facilities, was readopted as R.1998 d.3, effective November 26, 1997. See: 29 N.J.R. 4215(b), 30 N.J.R. 63(a).

Chapter 5, New Jersey Veterans' Facilities, was readopted as R.2003 d.244, effective May 23, 2003. See: 35 N.J.R. 62(a), 35 N.J.R. 2641(a).

Chapter 5, New Jersey Veterans' Facilities, was readopted as R.2008 d.298, effective September 11, 2008. See: 40 N.J.R. 3782(a), 40 N.J.R. 5580(a).

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 5, New Jersey Veterans' Facilities, was scheduled to expire on September 11, 2015. See: 43 N.J.R. 1203(a).

Chapter 5, New Jersey Veterans' Facilities, was readopted as R.2014 d.022, effective December 23, 2013. As a part of R.2014 d.022, the chapter was renamed New Jersey Veterans' Memorial Homes; Subchapter 3, Pre-Admission Screening of Applicants, was renamed The Admission Process; and Subchapter 6, Resident Transfer Or Discharge, was renamed Resident Transfer, Discharge, Or Death, effective January 21, 2014. See: Source and Effective Date. See, also, section annotations.

SUBCHAPTER 1. GENERAL PROVISIONS

§ 5A:5-1.1 Purpose

The purpose of this chapter is to establish requirements for eligibility for admission, pre-admission screening, admission review and implementation, computation of the care maintenance fee for New Jersey veterans' facilities, and the basis for discharge or transfer from such facilities.

§ 5A:5-1.2 Definitions

The words and terms, as used in this chapter, shall have the following meanings. All other words shall be given their ordinary meaning unless the content of their use clearly indicates otherwise.

"Accountable assets" means all items that have a determined value and are owned solely by the applicant or spouse, or owned jointly with spouse, jointly with others, or jointly by the spouse and others, and must be spent down or liquidated and used toward payment of the resident's care and maintenance fee. IRAs and annuities are considered as accountable assets and will be treated as income.

"Admission" means the procedure for entering one of the New Jersey veterans' memorial facilities.

"Aid and attendance" means supplemental income provided by the U.S. Department of Veterans' Affairs for extended care services.

"Allied veterans" means those veterans of nations allied or associated in conflicts against an enemy of the United States during World War I or II. This is inclusive of members of the armed forces of Czechoslovakia or Poland. Allied veterans are required to have been a citizen of the United States for at least 10 years.

"Allowable deductions" means those approved items which will be subtracted from the gross income, including the personal needs allowance, when calculating care and maintenance fee.

"Asset determination" means an investigation and evaluation of the financial circumstances of a person applying for admission to a New Jersey veterans' memorial facility.

"Care and maintenance" means the actual cost of services for an individual in one of the New Jersey veterans' memorial facilities.

"Community spouse" means the married spouse of a veterans' memorial home resident who does not receive long-term care in a medical institution or nursing facility.

"Conservatorship" means the appointment of a person by the court to manage the financial affairs of a conservatee. A "conservatee" is one who has not been judicially declared incompetent, but who by reason of advanced age, illness, or physical infirmity, is unable to care for or manage his or her property or who has become unable to provide for himself or herself or others dependent upon him or her for support.

"Dependent" means a child of the Veteran Home Resident who is under the age of 21 or a child of any age who is blind or totally and permanently disabled. In the event that the child does not have a determination from the Social Security Administration of blindness or disability, the blindness or disability shall be evaluated by the Disability Review Section of the Division of Medical Assistance and Health Services in accordance with the provisions of N.J.A.C. 10:71-3.13.

"Discharge" means the permanent removal from a New Jersey veterans' memorial facility.

"Durable power of attorney" means a legal document that enables an individual to designate another person(s) to act on his or her behalf, in the event the individual becomes disabled or incapacitated. A health proxy, also known as a durable power of attorney for healthcare, can also be appointed for medical decisions. The durable power of attorney terminates upon the death of the originator.

"Eligible others" as defined and listed in order of priority below will be admitted to a New Jersey veterans' memorial home, as long as the census of non-veterans does not exceed 25 percent of the total population.

1. "Gold Star parent" means the mother or father of a person who was a resident of New Jersey at the time of service entry, and who died an honorable death in time of war or emergency while in the active military service of the United States, provided that the parent has been a resident of New Jersey for at least two years prior to the date of application.

2. "Surviving spouse" means the widow or widower of a person who died an honorable death while in the active military service of the United States, or who was a disabled veteran at the time of death, provided that the surviving spouse was the person's spouse at the time of the person's service or was married to the person not less than 10 years prior to the date of application and has not married since the person's death, and provided that the surviving spouse has been a resident of New Jersey for at least two years prior to the date of application.

3. "Spouse" means the person legally married with a valid marriage license that is in accord with New Jersey law to an individual who has been other than dishonorably discharged from the active military of the United States, provided that the spouse is not less than 50 years of age, has been married to such person for a period of not less than 10 years, and meets the New Jersey residency requirement as described in paragraph 1 of the definition of "veteran" below.

"Extraordinary expense deduction" means a financial deduction as a major excessive expense to maintain the basic household, medical, or transportation needs.

"Facility resident" means an individual residing in a New Jersey veterans' memorial home.

"Gross income" means all income and/or revenue received by resident for a given period. Includes, but not limited to, funds received for labor or services, social security, pensions, aid and attendance, net rental income of property, and/or the proceeds of business or enterprises and investments not to include losses. Service connected disability compensation funds shall not be counted as gross income.

"Guardian" means a person who has been entrusted as the legal representative of one who has been adjudicated incapacitated by a court of law and requires a legal representative to act on their behalf for all matters.

"Guardianship" means the process by which an individual is appointed the legal representative of another person who has been adjudicated incapacitated by a court of law and requires a legal representative to act on their behalf for all matters.

"Irrevocable trust" means the funds set aside in a trust not to be recalled, revoked or annulled.

"Lien application" means a process initiated to obtain financial payment for all delinquent accounts for services received.

"Living will" means a legal document that provides instructions and directions regarding healthcare in the event that the individual subsequently lacks such decision-making capability.

"Maximum allowable asset" means that all sources of accountable assets shall not exceed $ 24,000 for a single applicant or $ 110,000 for a married applicant.
"Medicare" means a system of governmental insurance for providing medical and hospital care for the aged from Federal social security funds.

"Net income" means the total gross income received, minus allowable deductions.

"Non-accountable assets" means those items of determined value that are owned solely by the applicant or spouse. The following are considered non-accountable assets:

1. The primary residence and any appurtenance thereto, including proceeds from the sale of the residence. However, if the property is sold, any income earned from the investment of any or all of the proceeds will be counted as income.

2. All of the household effects therein; and

3. An automobile if there is a community spouse.

"Personal needs account" means an account maintained at the veterans' facility for deposit of the personal funds of the resident and which will be considered part of the accountable assets. This account shall be administered by the veterans' facility or treasurer of the State of New Jersey.

"Personal needs allowance" means a set amount received by a resident for individual use and spending. The personal needs allowance shall be as follows:

1. A resident whose source of monthly income exceeds $ 100.00 will retain a minimum of $ 100.00 for personal needs.

2. A resident whose source of monthly income does not exceed $ 100.00 will retain all of their monthly income.

3. A resident who has no source of funds will be provided a monthly allowance for personal needs of $ 50.00.

4. The welfare fee will be reduced to maintain the minimum of $ 100.00 for the resident's personal needs.

"Physician Orders for Life Sustaining Treatment (POLST)" is a New Jersey law designed to provide a mechanism to further define preferences for healthcare concerning life-sustaining treatment of other interventions for progressive illnesses and/or end of life decisions.

"Representative Payor" means a designated person or institution responsible for the payment of the resident's financial obligations.

"Resident" means a legal inhabitant of the state where the primary domicile is located.

"Resident fee" means the monthly charges billed by the veterans' facility to the resident for their cost of care and maintenance.

"Service connected disability" means a disability sustained by veterans who were disabled by an injury or illness that was incurred or aggravated during active military service. These disabilities are considered service-connected. Disability is determined by the United States Department of Veterans' Affairs in accordance with 38 CFR 51.41.

"Spend down" means that which occurs when accountable assets exceed the maximum amount allowed and are liquidated and spent towards the actual care and maintenance cost. This process will continue as long as the accountable assets exceed the maximum amount allowed.

"Transfer" means the placement of a resident to a more suitable environment to meet individual needs.

"Veteran" means:

1. A person who has been other than dishonorably discharged from the active military service (90 days total active duty service, unless discharged early for service connected disability) of the United States and has been a resident of New Jersey for at least two years prior to the date of application;

2. A person who was a citizen of the State of New Jersey at the time of entrance into the active military service of the United States, and who is qualified for admission except for the required period of State residence. Preference shall be given to persons who have been residents of the State for a period of at least two years prior to application; or

3. A person who is not a citizen of the State of New Jersey and who is classified by the Federal Veterans Affairs Administration as Priority I, II, III, or catastrophic Priority IV.

"Veterans' memorial home" means any home, institution, hospital, or part thereof, the admission to which is under the jurisdiction of the Department of Military and Veterans' Affairs, being the facilities at Menlo Park, Paramus, Vineland, and such other veterans' facilities as may be developed.

"Welfare fund" means an account established at each facility pursuant to N.J.S.A. 38A:3-6.16 for the specific purpose of accepting monies that will be spent for and on behalf of residents' programs, special events and services. It is composed of interest, funds specifically donated, and from monies which have escheated to the welfare fund from the personal needs account of deceased residents leaving no will or next of kin. This fund will provide for and maintain a quality of life which might otherwise not be possible for the residents and shall be administered by the Adjutant General in accordance with the provisions of N.J.S.A. 38A:3-6.16.

"Working spouse" means the married spouse of an individual residing in a New Jersey veterans' memorial home who finds it necessary to continue employment to meet financial needs.

HISTORY:

Amended by R.1998 d.3, effective January 5, 1998. See: 29 N.J.R. 4215(b), 30 N.J.R. 63(a). Amended "Accountable assets", "Allowable deductions", "Care and maintenance", "Community Spouse", "Dependent", "Eligible others", "Needy veteran", "New resident", "Nonaccountable assets", "Personal needs account", "Personal needs allowance", "Veteran", and "Welfare fund"; added "Discharge", "Gross income", "Irrevocable trust", "Maximum allowable asset", "Medicare" and "Transfer"; and deleted "Income".

Amended by R.2003 d.244, effective June 16, 2003. See: 35 N.J.R. 62(a), 35 N.J.R. 2641(a). In "Accountable assets", added the last sentence; added "Allied veterans", "Extraordinary expense deduction", "Indigent", "Lien application", "National Guard/Reserve Component", "Respite Care Program" and "Working spouse"; in "Eligible others", rewrote 3i and added 3iii through 3iv.

Amended by R.2006 d.209, effective June 5, 2006. See: 38 N.J.R. 1271(a), 38 N.J.R. 2418(b). In definition "Eligible others" substituted "20" for "five" and inserted "by the Director, Veterans Healthcare Services" in the introductory paragraph, inserted present 1, recodified 1 through 3 as 2 through 4, deleted "Spousal priority is as follows:" from the end of 4 and deleted 4i through 4iv; in definition "Maximum allowable asset", substituted "$ 20,000" for "$ 15,000" and "$ 45,000" for "$ 40,000"; added the last sentence in definition "National Guard/Reserve Component"; deleted definition "New resident"; substituted "healthcare and respite care services" for "long term and respite care services as defined in this chapter" in definition "Respite Care Program"; and in definition "Veteran", deleted "or" from end of 1, substituted "; or" for a period at end of 2 and inserted 3.

Recodified from N.J.A.C. 5A:5-2.1 and amended by R.2008 d.298, effective October 6, 2008. See: 40 N.J.R. 3782(a), 40 N.J.R. 5580(a). In definition "Maximum allowable asset", substituted "$ 80,000" for "$ 45,000".

Amended by R.2014 d.022, effective January 21, 2014. See: 45 N.J.R. 2065(a), 46 N.J.R. 204(a). Rewrote definitions "Accountable assets", "Community spouse", "Durable power of attorney", "Eligible others", and "Resident"; in definition "Extraordinary expense deduction", deleted "one time" preceding "major", and inserted a comma following "medical"; in definitions "Guardian" and "Guardianship", substituted "incapacitated" for "incompetent"; in definition "Maximum allowable asset", deleted "as defined above" following "assets", and substituted "$ 24,000" for "$ 20,000" and "$ 110,000" for "$ 80,000"; in definition "Transfer", deleted "within the Department of Military and Veterans Affairs" following "environment"; added definitions "Facility resident", "Living will", "Physician Orders for Life Sustaining Treatment (POLST)", and "Service connected disability"; deleted definitions "Indigent", "Medically needy applicants", "National Guard/Reserve Component", "Needy veteran", and "Respite Care Program"; and substituted definition "Non-accountable assets" for definition "Nonaccountable assets" and definition "Veterans' memorial home" for definition "Veterans' facility"; and rewrote definition "Non-accountable assets".

SUBCHAPTER 2. ELIGIBILITY CRITERIA

§ 5A:5-2.1 Admission eligibility

(a) Eligibility for admission to the New Jersey veterans' memorial homes is considered on financial and qualified medical needs. Veterans shall be given preference and non-veterans shall be admitted to veterans memorial homes, as long as the census of non-veterans does not exceed 25 percent of the total population. The following individuals, in order of priority, are eligible for admission consideration:

1. A New Jersey veteran that meets the New Jersey residency requirement as described in paragraph 1 of the definition of "veteran" in N.J.A.C. 5A:5-1.2.

2. A spouse of a New Jersey veteran who is eligible as a "spouse" or "surviving spouse" as described in paragraphs 2 and 3 of the definition of "eligible others" in N.J.A.C. 5A:5-1.2 and is a resident of this State.

3. Gold Star parents.

4. A veteran who is not a New Jersey resident.

(b) All accountable assets shall be spent down and liquidated and used to pay resident's actual care and maintenance until:

1. A single applicant's maximum allowable assets do not exceed $ 24,000 from all sources of accountable assets;

2. A married couple's maximum allowable assets do not exceed $ 110,000 from all sources of accountable assets.

(c) Admission eligibility is contingent upon a veterans' memorial home's ability to meet the applicant's individual health care needs, which will be reviewed and determined by the admission committees of each veterans' memorial home and bed availability. The applicant shall also sign an Admission Agreement that he or she will accept placement in the veterans' memorial home designated by the Adjutant General, that he or she understands all sources of income to include Social Security shall be considered when determining the care and maintenance fee, and that he or she will abide by the rules, regulations, and discipline of the veterans' memorial home to which admitted. The obligation of such an Admission Agreement shall remain in effect, as long as the resident remains on the census of one of the New Jersey veterans' memorial homes.

(d) The following shall be denied admission into a New Jersey veterans' memorial home:

1. Applicants who require treatment beyond the facilities' ability to meet the applicants' individual health care and psychological needs;

2. Applicants who are active substance abusers, exhibit active psychiatric problems, or exhibit behaviors that may pose a danger to self or others;

3. Applicants who refuse to sign the required Admission Agreement under (c) above;

4. Applicants who do not require 24-hour skilled nursing care;

5. Applicants who have been denied admission to another New Jersey veterans' memorial home; and

6. A dependent child.

(e) An approved applicant shall be subject to reevaluation in the following circumstances:

1. Prior to admission;

2. A change in medical or psychological status; or

3. An omission or misrepresentation of significant medical or financial information.

(f) Significant changes in the information required under (e)2 or 3 above may result in denial of admission by the admissions committee as per N.J.A.C. 5A:5-4.1.

(g) Criteria for admitting applicants who are incapable of making decisions for themselves are as follows:

1. Any applicant who is adjudicated legally incompetent is required to have a legal guardian.

i. A copy of the guardianship document shall be submitted with the application prior to admission being scheduled.

2. Any applicant who has a conservatorship shall submit a copy of the document prior to admission being scheduled.

3. Any applicant who has a durable power of attorney for both medical and financial matters shall submit a copy of the document for guardianship criteria to be waived. The document shall be notarized, witnessed and signed by the applicant while competent.

4. In the absence of a durable advance directive or other legal documents, or the next of kin, the facility and its personnel shall act to preserve life when a resident is incapable of making decisions for themselves.

HISTORY:

Amended by R.1998 d.3, effective January 5, 1998. See: 29 N.J.R. 4215(b), 30 N.J.R. 63(a). Inserted new (a)3 and recodified (a)3 and 4 as (a)4 and 5; in (a)4, rewrote list of "Needy eligible others"; in (a)5 added list of "Eligible others"; deleted (e)1, recodified (e)2 and 3 as (e)1 and 2, and inserted new (e)3, inserted new (g)4.

Amended by R.2003 d.244, effective June 16, 2003. See: 35 N.J.R. 62(a), 35 N.J.R. 2641(a). In (e), added a new 2 and recodified former 2 and 3 as 3 and 4.

Amended by R.2006 d.209, effective June 5, 2006. See: 38 N.J.R. 1271(a), 38 N.J.R. 2418(b). In (a), substituted "15" for "five" in the introductory paragraph, deleted former (a)2, recodified former (a)3 as (a)2 and inserted current (a)3 through (a)6, inserted "New Jersey" in (a)2; recodified former (a)4 and (a)5 as (a)7 and (a)8, rewrote (a)7 and (a)8 and inserted (a)9; substituted "$ 20,000" for "$ 15,000" in (c)1; and "$ 45,000" for "$ 40,000" in (c)2; and substituted "who are incapable of making decisions for themselves" for "with special needs" in the introductory paragraph of (g) and inserted "a" and "or next of kin," in (g)4.

Recodified from N.J.A.C. 5A:5-2.2 and amended by R.2008 d.298, effective October 6, 2008. See: 40 N.J.R. 3782(a), 40 N.J.R. 5580(a). In (c)2, substituted "$ 80,000" for "$ 45,000". Former N.J.A.C. 5A:5-2.1, Definitions, recodified to 5A:5-1.2.

Amended by R.2014 d.022, effective January 21, 2014. See: 45 N.J.R. 2065(a), 46 N.J.R. 204(a). Rewrote the section.

SUBCHAPTER 2. ELIGIBILITY CRITERIA

§ 5A:5-2.2 (Reserved)

HISTORY:

Recodified to N.J.A.C. 5A:5-2.1 by R.2008 d.298, effective October 6, 2008. See: 40 N.J.R. 3782(a), 40 N.J.R. 5580(a). Section was "Admission eligibility".

SUBCHAPTER 3. THE ADMISSION PROCESS

§ 5A:5-3.1 Application requirement

(a) Applicants shall be eligible for admission consideration upon completion of the documentation and information reviews as follows:

1. To establish basic eligibility of all applicants, the following documentation and information reviews are required:

i. A completed application for admission;

ii. Service history:

(1) Proof of an other than dishonorable discharge; and

iii. Social history:

(1) A birth certificate;

(2) Marital status verification; and

(3) Verification of residency;

iv. Medical status:

(1) An application for Health Benefits (VA 10-10EZ);

(2) Medicare Part A, B, and D or other creditable prescription coverage;

(3) Other health insurances, including supplemental;

(4) The coverages under (a)1iv(1) and (2) above must be in effect at the time of admission if eligible and must remain in effect, as long as the individual is a resident of one of the New Jersey veterans' memorial homes. Eligible residents who do not maintain Medicare Part A and B and other supplemental health insurance shall not be allowed any medical fee deductions against their care and maintenance fee and shall be responsible for all related fees, as long as they select not to maintain medical insurance;

(5) A Medical History Release Form as determined by the U.S. Veterans' Administration; and

(6) A Medical Certification VA 10-10SH;

v. Financial disclosure:

(1) Assets will be reviewed and considered in determining financial responsibility;

(2) All financial transactions and transfer of resources, which have occurred within 36 months preceding the date of application, will be reviewed and considered as accountable assets;

(3) The value of all assets will be determined as of the date of application and revalued on the date of admission;

(4) Income from all sources shall be disclosed. Income shall be verified by submitting the most recent copy of the Federal and State income tax reports and other such documents as may be required;

(5) A copy of the applicant's long-term care insurance plan shall be provided during the admission process, if applicable; and

(6) A review shall be conducted of all irrevocable trusts;

vi. Verification of admission eligibility as defined in N.J.A.C. 5A:5-2.1; and

vii. Other:

(1) Verification of the responsible party for funeral arrangements and responsibility.

(A) Prepaid burial fund allowance not to exceed a face value of $ 12,000;

(2) Submission of advance directives for health care, if desired by the applicant, such as:

(A) A proxy directive (durable power of attorney for healthcare);

(B) An instructive directive (for example, a living will);

(C) A combined directive (durable power of attorney for health and fiscal matters);

(D) A Physician Order for Life Sustaining Treatment (POLST); and

(E) Appointment of a representational payor, if desired by the applicant.

(b) Applicants shall be admitted to the New Jersey veterans' memorial home upon completion of the following:

1. Approval of the admission committee (N.J.A.C. 5A:5-4);

2. A signed Admission Agreement;
3. VA forms (as determined by the U.S. Veterans' Administration);

4. A Medical History Release Form (VA 10-10SH); and

5. The social services packet with facility release forms.

HISTORY:

Amended by R.1998 d.3, effective January 5, 1998. See: 29 N.J.R. 4215(b), 30 N.J.R. 63(a). Inserted new (a)1iii(1)(C) and (a)1iv (6); in (a)1vi(1)(A) substituted "prepaid burial fund allowance" for "burial insurance" and "$ 7,500" for "$ 10,000"; and inserted new (a)1vi(2)(E) and (F).

Amended by R.2003 d.244, effective June 16, 2003. See: 35 N.J.R. 62(a), 35 N.J.R. 2641(a). In (a), substituted "VA 10-10EZ" for "VA 10-10" in the introductory paragraph of 1iii(1) and for "VA 10-10m" in 1iii(2), and rewrote 1iv(6).

Amended by R.2006 d.209, effective June 5, 2006. See: 38 N.J.R. 1271(a), 38 N.J.R. 2418(b). Deleted the last sentence of (a)1iii(1)(C), which required a written request to be submitted to the Chief Executive Officer within 30 days after initial admission, deleted "; (A) This Requirement" from (a)1iii(3) and substituted "36" for "18" in (a)1iv(3).

Amended by R.2008 d.298, effective October 6, 2008. See: 40 N.J.R. 3782(a), 40 N.J.R. 5580(a). In the introductory paragraph of (a)1iii(1), substituted a colon for a semicolon at the end; in (a)1iii(1)(A), deleted "and" from the end; in (a)1iii(1)(B), inserted "and" at the end; in (a)1iii(1)(C), inserted a comma following "effect", deleted the last sentence and substituted a semicolon for a period at the end; in (a)1iii(2), inserted a semicolon at the end; in (a)1iv(5), deleted "and" from the end; added new (a)1iv(6); recodified former (a)1iv6 as (a)1iv(7); in the introductory paragraph of (a)1vi(1), substituted a period for a semicolon at the end; in (a)1vi(1)(A), substituted "$ 12,000" for "$ 7,500"; and in (a)1vi(3), substituted "; and" for a period at the end.

Amended by R.2014 d.022, effective January 21, 2014. See: 45 N.J.R. 2065(a), 46 N.J.R. 204(a). Section was "Sequence of screening activities". Rewrote the section.

SUBCHAPTER 4. ADMISSION REVIEW AND IMPLEMENTATION

§ 5A:5-4.1 Admission review policy

(a) It is the policy of the New Jersey veterans' memorial homes to have an admission committee at each home review all completed and tentatively approved applications for appropriateness of placement. A tentatively approved application is one which has produced all required documents and meets admission and financial eligibility requirements. The following areas will be considered in all applications for admission and may be grounds for rejection:

1. Medical and psychosocial needs;

2. Present medical condition;

3. Evaluation of medical acuity levels;

4. Treatments/care required to meet the applicant's individual health care and psychological needs that are beyond the scope of the veterans' memorial home to provide;

5. Applicants who are active substance abusers and/or exhibit active psychiatric problems and/or exhibit behavioral actions that may pose a threat to self or others;

6. Applicants who refuse to sign the required Admission Agreement;

7. Applicants who do not require 24-hour skilled nursing care; and

8. Applicants who have been denied admission to another New Jersey veterans' memorial home.

(b) Within the guidance delineated in this section, the admissions committees of the veteran memorial homes shall determine the eligibility for entrance to their respective veteran home.

(c) If the committee rejects an applicant, the veterans' memorial home will provide written notice of denial and the reason for denial within 14 days to the applicant or representative. The notice of denial issued the applicant shall reference the manner in which, and to whom, the denial may be appealed by written request to The Adjutant General or designee within 30 days of the written notice of denial by the veterans' memorial home. The appeal letter shall be submitted by the applicant, family member, legal

power of attorney, or legal guardian only. The decision on the appeal will be considered the final agency action. The adverse decision appeal process is as follows:

1. In situations of medical need where the Admission Committee requires additional information, follow up evaluation or participation in various counseling programs, consideration will be given for placement on the waiting list, following completion and receipt of documentation requested and requirements of the Admission Committee.

2. When the admission committee requirements have been met, the applicants(s) awaiting guardianship or a final determination of an appeal process shall remain on the waiting list in the sequence effective the date the application was originally received, and in accordance with (f) below.

(d) The decision appeal process is as follows:

1. In situations where the admissions committee requires additional information, follow-up evaluation, or participation in various counseling programs, consideration will be given for placement on the waiting list, following completion and receipt of documentation requested and requirements of the admission committee.

2. When the admission committee requirements have been met, the applicant(s) awaiting a final determination of an appeal process shall remain on the waiting list in the sequence effective the date the application was originally received, and in accordance with (f) below.

(e) Approved applicants will be placed on the approved waiting list.

(f) The waiting list process is as follows:

1. All completed applications with the required documentation will be timed and dated when received.

2. Once the applicant is approved for admission, his or her name will be placed on the bottom of the approved waiting list. An applicant, who is awaiting guardianship, or has an appeal pending for a notice of denial, will remain on the waiting list in sequence pending guardianship appointment or final determination of the appeal.

3. There will be no consideration for bypassing approved applicants on the waiting list, except when bed availability is based on gender, veteran preference, and treatment needs (that is, specialty units, infectious diseases, etc.) or the applicant is a spouse of a residing resident.

4. If an approved applicant refuses admission at the time offered, the applicant will be placed at the bottom of the waiting list. This is called an approved deferred admission.

5. The waiting list is a confidential document; numerical assignment will be provided when requested.

HISTORY:

Amended by R.1998 d.3, effective January 5, 1998. See: 29 N.J.R. 4215(b), 30 N.J.R. 63(a). In (a), deleted (a)2 and recodified (a)3 through 7 as (a)2 through 6; in (b), inserted language detailing limitations period for appeal of denied admission.

Amended by R.2003 d.244, effective June 16, 2003. See: 35 N.J.R. 62(a), 35 N.J.R. 2641(a). In (a), rewrote 5; rewrote (b); in (c), rewrote 1 and 2 and deleted the second sentence in 4.

Amended by R.2006 d.209, effective June 5, 2006. See: 38 N.J.R. 1271(a), 38 N.J.R. 2418(b). Deleted the designation for (b)1, recodified former (b)1i through (b)1iii as (b)1 through (b)3 and inserted "Admission Committee's" in the last sentence of current (b)2.

Amended by R.2008 d.298, effective October 6, 2008. See: 40 N.J.R. 3782(a), 40 N.J.R. 5580(a). Added new (b); recodified former (b) and (c) as (c) and (d); and in (d)3, inserted "or the applicant is a spouse of a residing resident".

Amended by R.2014 d.022, effective January 21, 2014. See: 45 N.J.R. 2065(a), 46 N.J.R. 204(a). Rewrote the section.

SUBCHAPTER 5. CARE MAINTENANCE FEE COMPUTATION

§ 5A:5-5.1 General requirements for computing skilled nursing monthly resident fee

(a) The requirement for establishing a computation for the monthly fee is to ensure that individuals requesting admission to a State of New Jersey veterans' memorial facility pay a portion of the care and maintenance fee based on their monthly income and ability to pay, but not to exceed the established rate as set forth annually by The Adjutant General.

1. The recommended daily rate is to be forwarded to the Director, Division of Budget and Accounting, Department of Treasury for publication no later than November 10 of each year.

(b) At the time of admission and annually thereafter, based on a determined date, the computation of the monthly resident fee is calculated with the resident or representative payor. The calculation is determined by review of Federal and State income tax returns and all financial statements, income, inclusive of IRAs and annuities as accountable assets, as well as any other financial transactions. This asset review will be required by May 15 with a return date no later than June 30 of each year. As of September 21, 1992, the resident fee will be based on 80 percent of the net income for all residents admitted thereafter. Those individuals residing in the veterans' memorial homes prior to September 21, 1992, will have the resident fee based on 60 percent of the net income.

(c) Residents who sell their house or acquire additional financial assets following admission to the New Jersey veteran's memorial home are required to report these transactions during their annual asset review described in (b) above.

(d) The welfare fund is an account established at each veterans' memorial home pursuant to N.J.S.A. 38A:3-6.16. It is composed of funds specifically donated to the veterans' memorial home welfare fund, or monies, which have escheated to the welfare fund from the personal needs account of deceased residents, leaving no will or next of kin. This trust fund is to be utilized for the benefit and general welfare of the resident population of the institution as a whole. This fund shall provide for, and maintain, a quality of life that might otherwise not be possible for the residents and shall be administered by the Adjutant General in accordance with the provisions of N.J.S.A. 38A:3-6.16. Residents will be required to pay a monthly welfare fee of $ 20.00 or 12 percent of the balance of their monthly income, whichever is less, excluding all allowable deductions and the care maintenance fee payment. These monies will be deposited in the veterans' memorial home's welfare fund.

(e) Payment for the resident care and maintenance fee is due the first of each month.

(f) At the time of admission, a resident will be assessed care and maintenance fees charges for that month prorated according to the date of admission.

(g) At the time of discharge, prepaid care and maintenance fees shall be rebated based upon proration of days.

(h) Yearly care and maintenance increases will be in accordance with established yearly Social Security rate increases.

(i) An Admissions Agreement must be signed by the resident, resident POA or legally appointed guardian delineating fiscal payment responsibilities to the veteran home of choice prior to admission.

(j) Care and maintenance fee accounts that become delinquent are referred to the Department of the Treasury for lien application proceedings as defined in the Department of the Treasury Policy and Procedure for Delinquent Accounts.

(k) Service connected disability status shall be considered as part of the annual maintenance fee computations.

HISTORY:

Amended by R.1998 d.3, effective January 5, 1998. See: 29 N.J.R. 4215(b), 30 N.J.R. 63(a). Inserted new (a) explaining computation of monthly resident fee, recodified (a) through (f) as (b) through (g); in (d), defined how a welfare fund may be established and utilized; in (g), substituted " prepaid care and maintenance fees shall be rebated based upon proration of days" for "there will be no reimbursement to the resident of the resident's estate for prepaid care and maintenance fees".

Amended by R.2003 d.244, effective June 16, 2003. See: 35 N.J.R. 62(a), 35 N.J.R. 2641(a). In (a), added 1; in (b), rewrote the second sentence and added the third sentence; added a new (d) and recodified former (d) through (g) as (e) through (h); added (i) and (j).

Amended by R.2006 d.209, effective June 5, 2006. See: 38 N.J.R. 1271(a), 38 N.J.R. 2418(b). Section was "General requirements for computing monthly resident fee". Substituted "report these transactions during their annual asset review described in (b) above" for "retain 50 percent of the asset received for payment toward their care and maintenance fee" in (d).

Amended by R.2008 d.298, effective October 6, 2008. See: 40 N.J.R. 3782(a), 40 N.J.R. 5580(a). Added new (j); and recodified former (j) as (k).

Amended by R.2014 d.022, effective January 21, 2014. See: 45 N.J.R. 2065(a), 46 N.J.R. 204(a). Rewrote the section.

§ 5A:5-5.2 Formula for computing single resident's skilled nursing monthly resident fee based on an 80/20 percentage

(a) The monthly resident fee for a single 80/20 resident is based on the total gross income, minus allowable deductions. This figure is the net income. Eighty percent of the net income will be the resident fee charged. An additional $ 20.00 or 12 percent of the balance of their monthly income, whichever is less will be deposited in the welfare fund of the facility. The remainder of the net income will be deposited in the resident's personal needs account.

(b) The allowable deductions for a single resident are as follows:

1. The personal needs allowance;

2. Health insurance premiums;

3. Prepaid burial fund account: Fund allowances shall not exceed a face value of $ 12,000;

4. Court order encumbrances; and

5. Other expenses or other financial issues as may be individually approved by the Deputy Commissioner of the Department of Military and Veterans' Affairs or designee.

(c) Any interest or payment received from a trust transfer will be treated as income. Furthermore, in situations where a trust or transfer of assets has occurred within 36 months of submitting an admission application, the value of the trust and/or assets will be deemed an accountable asset for the balance of the 36-month period.

HISTORY:

Amended by R.1998 d.3, effective January 5, 1998. See: 29 N.J.R. 4215(b), 30 N.J.R. 63(a). In (b)3, deleted language referring to life insurance in lieu of prepaid burial accounts, inserted new (b)4 and recodified (b)4 as (b)5; and inserted new (c) explaining treatment of interest and payments received from a trust transfer.

Amended by R.2006 d.209, effective June 5, 2006. See: 38 N.J.R. 1271(a), 38 N.J.R. 2418(b). Section was "Formula for computing single resident's monthly resident fee based on an 80/20 percentage".

Amended by R.2008 d.298, effective October 6, 2008. See: 40 N.J.R. 3782(a), 40 N.J.R. 5580(a). In (b)3, substituted "$ 12,000" for "$ 7,500"; and in (c), substituted "36" for "18" preceding "months" and "36-" for "18" preceding "month".

§ 5A:5-5.3 Formula for computing a married resident's skilled nursing monthly resident fee based on an 80/20 percentage

(a) The monthly resident fee for a married resident is based on the total personal income of the resident, minus allowable deductions. This figure is the net income. Eighty percent of the net income will be the resident fee charged. An additional $ 20.00 or 12 percent of the balance of their monthly income, whichever is less, will be deposited in the welfare fund of the veterans' memorial home.

(b) The community spouse must divulge all sources of the monthly income in order to file for consideration of allowable deductions.

1. If a working spouse has an income greater than the total of the monthly allowable deductions, then the calculations for the married resident will be as for a single resident.

2. Failure to make a full and complete disclosure will constitute a breach of the veterans' memorial home's regulations and may be grounds for removal as provided in N.J.S.A. 38A:3-6.9.

(c) In the event that each individual of the marriage is a resident, the resident fee for each will be calculated as for single resident and no married deductions will be allowed.

(d) If, at a later date, assets that were not reported upon admission are discovered, they will be added to the net income and worth of the resident, computed retroactively to the date of admission. This may necessitate a recalibration of the resident maintenance fee schedule.

(e) Service connected disability status shall be considered as part of the annual maintenance fee computations.

(f) The allowable deductions for a married resident are as follows:

1. Personal needs allowance;

2. Health and prescription insurance premiums;

3. Court order encumbrances;

4. Rent/primary residence first mortgage or home equity loan: The mortgage/home equity loan must have been in effect 36 months prior to the date of application. Verification of mortgage/home equity loan payment schedule is required. The actual cost of property taxes and insurance for the primary residence will be deducted equally over the 12-month period. Verification shall be required;

5. Second mortgages on the primary residence will not be considered as deductions for computation of the resident maintenance fee, if obtained within 36 months of the submission of an application for admittance. Similarly, second and/or third homes will not be considered as deductions for the computation of the resident maintenance fee;

6. Food deductions shall be $ 400.00 for the community spouse and $ 185.00 per additional dependent per month;

7. Heat/electric deduction shall be based on preceding year usage and cost. The deduction will be divided equally over the 12-month period;

8. Water/sewage deduction shall be the actual annual cost. The deduction will be divided equally over the 12-month period;

9. Automobile/transportation deduction shall be $ 350.00 per month, utilized for car maintenance, not for car purchase payments;

10. Clothing deduction shall be $ 75.00 per month per dependent;

11. Telephone/television/internet service deduction shall be $ 125.00 per month;

12. Trash disposal deduction shall be the actual annual cost. The deduction will be divided equally over the 12-month period;

13. Home maintenance deduction shall be $ 100.00 per month;

14. Prepaid burial fund accounts: Fund allowances shall not exceed a face value of $ 12,000. This deduction can be considered for both the applicant and spouse with verification of payment schedule. If a prepaid burial fund account is not in effect, then a maximum burial account not to exceed a face value of $ 12,000 is to be purchased upon admission and shall be considered an allowable deduction to be divided equally over 24 months;

15. Guardianship/advance directives: The actual cost of legal fees up to a maximum of $ 2,400 may be deducted. This deduction will be divided into 24 monthly installments, which will only be permitted as long as the resident resides in the veterans' memorial home. This deduction will only be approved for a guardianship hearing/advance directive protocol, which was processed no later than one year prior to the date of application. Verification of cost and date of action shall be required; and

16. Other extraordinary expenses or other financial issues as may be individually approved by the Director of Veterans' Healthcare Services.

(g) No deduction beyond the approved listing shall be permitted until all accountable assets, to include the personal needs account, are depleted.

(h) Any interest or payment received from a trust transfer will be treated as income. Furthermore, in situations where a trust or transfer of assets has occurred within 36 months of submitting an admission application, the value of the trust and/or assets will be deemed an accountable asset for the balance of the 36-month period.

HISTORY:

Amended by R.1998 d.3, effective January 5, 1998. See: 29 N.J.R. 4215(b), 30 N.J.R. 63(a). Inserted new (d)3 and recodified (d)3 through (d)14 as (d)4 through (d)15; in (d)5, 8, 12, and 13 amended the amount of deductions for services; in (d)13, deleted language referring to life insurance in lieu of prepaid burial accounts and added language concerning mandatory purchase of burial insurance; and inserted (g) regarding interest as income.

Amended by R.2003 d.244, effective June 16, 2003. See: 35 N.J.R. 62(a), 35 N.J.R. 2641(a). Added a new (c) and recodified former (c) as (d); recodified former (d) as (e), added 2i and rewrote 8; recodified former (e) and (f) as (f) and (g).

Amended by R.2006 d.209, effective June 5, 2006. See: 38 N.J.R. 1271(a), 38 N.J.R. 2418(b). Section was "Formula for computing a married resident's monthly resident fee based on an 80/20 percentage". Substituted "The actual cost of" for "Maximum allowable of $ 150.00 per month as requirement for" in (e)2i, in (e)4, inserted "or home equity loan" and inserted "/home equity loan" two times and substituted "18" for "30" in (e)5, substituted "$ 270.00" for "$ 225.00" and "$ 185.00" for "$ 155.00", substituted "$ 240.00" for "$ 200.00" in (e)8 and "$ 60.00" for "$ 50.00" in (e)9, in (e)10, inserted "/television service" and substituted "$ 40.00" for "($ 25.00)" and substituted "$ 90.00" for "$ 75.00" in (e)12.

Amended by R.2008 d.298, effective October 6, 2008. See: 40 N.J.R. 3782(a), 40 N.J.R. 5580(a). Deleted (e)2i; in (e)4, substituted "36" for "18"; in (e)5, substituted "$ 400.00" for "$ 270.00"; in (e)6 and (e)7, substituted "12-month" for "12 month"; in (e)8, substituted "$ 350.00" for "240.00"; in (e)10, substituted "$ 100.00" for "$ 40.00"; in (e)13, substituted "$ 12,000" for "$ 7,500" twice; in (e)15, substituted "Director of Veterans' Healthcare Services" for "Deputy Commissioner of the Department of Military and Veterans' Affairs or designee"; and in (g), substituted "36" for "18" preceding "months" and "36-" for "18" preceding "month".

Amended by R.2014 d.022, effective January 21, 2014. See: 45 N.J.R. 2065(a), 46 N.J.R. 204(a). Rewrote the section.

§ 5A:5-5.4 Financial responsibilities for veterans' memorial home resident

(a) An eligible applicant who desires admission and whose assets are in excess of the maximum allowable assets may be admitted on a bed available basis. They will be billed for and required to pay the cost of care and maintenance as determined by the Adjutant General until their resources meet the maximum allowable assets.

(b) When an account exceeds the maximum allowable assets, the resident will be billed and required to pay the cost of care and maintenance until the maximum allowable asset limit is reached.

(c) The resident or the person who has control of the resident's financial accounts, income, and assets will be responsible for all financial obligations for the services not provided by the veterans' memorial home. This includes, but is not limited to:

1. Transportation;

2. Medical appointments;

3. Hospitalization;

4. Specialized services/programs/treatments;

5. Adaptive equipment;

6. Diagnostic services;

7. Other outside services as requested by the resident;

8. Deductible fees not covered by medical insurances;

9. Payment for pharmaceuticals to reimburse Medicaid as required;

10. Telephone;

11. Television;

12. Outside personal laundry services;

13. Outside physician services;

14. Any non-payment of debts incurred by the resident, including healthcare costs; and

15. Personal purchases.

(d) The facility will not accept responsibility for any nonpayment of debts incurred by a resident including health care costs.

(e) All personal property of the resident is the responsibility of the resident or guardian. The facility assumes no responsibility and will not reimburse a resident for loss or damage of personal items.

(f) Any resident who is transferred to an outside facility for any period of time is required to continue to pay the care and maintenance fee in order that placement in the facility be guaranteed.

HISTORY:

Amended by R.1998 d.3, effective January 5, 1998. See: 29 N.J.R. 4215(b), 30 N.J.R. 63(a). In (d), inserted new (d)9, requiring Medicaid reimbursement for pharmaceutical payments; and inserted new (g) explaining responsibility for payment in the event of a transfer to an outside facility.

Amended by R.2006 d.209, effective June 5, 2006. See: 38 N.J.R. 1271(a), 38 N.J.R. 2418(b). Section was "Financial responsibilities for veterans' facility resident". Deleted (b) and recodified (c) through (g) as (b) through (f).

Amended by R.2014 d.022, effective January 21, 2014. See: 45 N.J.R. 2065(a), 46 N.J.R. 204(a). Section was "Financial responsibilities for veterans' skilled nursing facility". Rewrote the introductory paragraph of (c); in (c)8, deleted "and" from the end; in (c)9, substituted a semicolon for a period at the end; and added (c)10 through (c)15.

§ 5A:5-5.5 (Reserved)

HISTORY:

New Rule, R.2006 d.209, effective June 5, 2006. See: 38 N.J.R. 1271(a), 38 N.J.R. 2418(b).

Repealed by R.2008 d.298, effective October 6, 2008. See: 40 N.J.R. 3782(a), 40 N.J.R. 5580(a). Section was "General requirements for computing veterans' assisted living monthly resident fee".

SUBCHAPTER 6. RESIDENT TRANSFER, DISCHARGE, OR DEATH

§ 5A:5-6.1 Transfer, discharge, or death of a resident

(a) Any resident may be removed from a veterans' memorial home on being restored to an ability to promote his or her own support and welfare in the community, for immorality, for fraud or willful misrepresentation, or refusal to abide by the rules, regulations, and discipline of the veterans' memorial home, as well as:

1. In an emergency, with notification of the resident's physician, next of kin or guardian;

2. For medical reasons or to protect the resident's welfare or the welfare of others;

3. For nonpayment of fees, in situations not prohibited by law. All endeavors will be implemented and utilized inclusive of lien application; or

4. Violation of Federal, State, or local laws, rules, or regulations.

(b) An approved transfer from one New Jersey veterans memorial facility to another shall not occur unless all financial obligations have been met. The resident or representative payor shall remain responsible for charges and financial obligations accrued up to and including the date of transfer.

(c) No further charges or financial obligations shall be accrued beginning with the day immediately following the date of discharge. The resident or representative payor shall remain responsible for financial obligations accrued up to and including the date of discharge.

(d) Pre-paid care and maintenance fees shall be rebated to the resident/representative based upon the pro-rating of days and reconciliation of insurance claims after discharge or death.

(e) A resident who has been discharged or who voluntarily discharges him- or herself and wishes to return to a veterans' memorial home must submit a complete application for admission packet to be considered for readmission. The process will be in accordance with N.J.A.C. 5A:5-3 and 4.

(f) Upon the death of a resident, the veterans' memorial home will follow the procedures as given in the Division of Veterans' Healthcare Policy and Procedure manual, Business Office section, subsections 44-02-010, 44-02-011, and 44-02-013.

HISTORY:

Amended by R.1998 d.3, effective January 5, 1998. See: 29 N.J.R. 4215(b), 30 N.J.R. 63(a). Inserted new (b) and (c) explaining financial obligations in the event of a transfer to another veterans memorial facility.

Amended by R.2003 d.244, effective June 16, 2003. See: 35 N.J.R. 62(a), 35 N.J.R. 2641(a). In (a), added 3i.

Amended by R.2006 d.209, effective June 5, 2006. See: 38 N.J.R. 1271(a), 38 N.J.R. 2418(b). Substituted a period for a colon at the end of the first sentence of (a)3 and deleted the (a)3i designation.

Amended by R.2014 d.022, effective January 21, 2014. See: 45 N.J.R. 2065(a), 46 N.J.R. 204(a). Section was "Transfer or discharge of a resident". In (a), substituted "memorial home" for "facility" twice, deleted "or" preceding and following "for immorality,", and inserted a comma following "regulations"; rewrote (a)4; and added (d) through (f).

State of New Jersey

Department of Military and Veterans Affairs
Division of Veterans Healthcare Services
P.O. Box 340, Eggert Crossing Road
Trenton, New Jersey 08625-0340

Application for Admission
to a
New Jersey Veterans Memorial Home

Appendix B

Notice of Information Practices – Resident's Privacy Rights

HIPAA Information

NEW JERSEY DEPARTMENT OF MILITARY AND VETERANS AFFAIRS
NEW JERSEY VETERANS MEMORIAL HOMES

ACKNOWLEDGMENT OF RESIDENTS' PRIVACY RIGHTS

Applicant / Resident's Name_____
PLEASE PRINT NAME

I,_____, hereby acknowledge that I have been advised of the reasons for the solicitation and disclosure of personal **"Protected Health Information" ("PHI")** pursuant to the Privacy Act, Title 5 U.S.C. § 552a .

A. AUTHORITY. The authority for disclosure of PHI is 45 C.F.R. § 164.502(a). PHI may not be disclosed except with my consent or authorization or as explicitly permitted or required by the regulation.
B. PRINCIPAL PURPOSES. The principal purposes for disclosing PHI are (1) to the resident; (2) pursuant to a valid consent by the resident that meets the requirements of the above regulation to carry out treatment, payment or healthcare operations; (3) pursuant to a valid authorization of the resident that meets the requirements of the above regulation; (4) pursuant to an agreement under, or as otherwise permitted by the regulation, and as permitted by 45 C.F.R. § 164.502(a)(1); and (5) as required by 45 C.F.R. § 164.502(a)(2).
C. ROUTINE USES. PHI is required to be disclosed (1) to the resident who is the subject of the PHI when the individual requests it; and (2) to the Secretary of Health and Human Services when the Secretary is investigating a complaint or determining a covered entity's compliance with the regulation. PHI is permitted to be disclosed (3) to the resident him or herself; and, pursuant to valid consent or authorization of the resident (4) to carry out treatment, payment or healthcare operations; and (5) pursuant to an agreement under, or as otherwise permitted by, the regulation.

Signature:_____
[ ] Resident [ ] Legal Guardian [ ] Power of Attorney [ ] Next of Kin [ ] Other – Please Specify

Print Name: _____

Date: _____

APPLICANT: RETAIN /KEEP THE "NOTICE OF INFORMATION PRACTICES", RETURN THIS SIGNED ACKNOWLEDGEMENT FORM WITH YOUR APPLICATION FOR ADMISSION.

Admissions Officer: File **original** in Social Services section of medical chart
File **copy** in Admissions File

New Jersey Veterans Memorial Homes

NOTICE OF INFORMATION PRACTICES

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

Understanding Your Health Record Information

Each time you visit a hospital, physician, or other healthcare provider, the provider makes a record of your visit. Typically, this record contains your health, mental and social history, current symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third party payer can verify that you actually received the services billed
- A tool in medical education
- A source of information for public health officials charged with improving the health of the regions they serve
- A tool to assess the appropriateness and quality of care you received
- A tool to improve the quality of healthcare and achieve better patient outcomes
- A source of information for certifying and regulatory agencies

Understanding What Is In Your Health Records And How Your Health Information Is Used Helps You To:

- Ensure its accuracy and completeness
- Understand who, what, where, why, and how others may access your health information
- Make an informed decision about authorizing disclosure to others
- Better understand the health information rights detailed below
- Better participate in the management of your own healthcare

Your Rights Under The Federal Privacy Standard:

Although your records are the physical property of the healthcare provider who completed them, you have certain rights with regard to the information contained therein. **You have the right to:**

- Request restriction on uses and disclosures of your health information for treatment, payment, and health care operations. "Health care operations" consist of activities that are necessary to carry out the operations of the provider, such as quality assurance and peer review. We do not, however, have to agree to the restriction. If we do, however, we will adhere to it unless you request otherwise or we give you advance notice. You may also ask us to communicate with you by alternate means and, if the method of communication is reasonable, we must grant the alternate communication not requiring an authorization communication request. The right to request restriction does not extend to uses or disclosures permitted or required under ξξ164.502(a)(2)(I) (disclosures to you), 164.510(a) (for facility directories, but note that you have the right to object to such uses), or 164.512 (uses and disclosures not requiring an authorization). The latter uses and disclosures include, for example, those required by law, such as mandatory communicable disease reporting. In those cases, you do not have a right to request restriction.

❖ Obtain a copy of this notice of information practices. Although we have posted a copy in prominent locations throughout the facility and on our website, you have a right to a hard copy upon request.

❖ Inspect and copy your health information upon request. Again, this right is not absolute. In certain situations, such as if access would cause harm, we can deny access. You do not have a right of access to the following:

❖ Psychotherapy notes. Such notes comprise those that are recorded in any medium by a healthcare provider who is a mental health professional documenting or analyzing a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of your medical record.

❖ Information compiled in a reasonable anticipation of or for use in civil, criminal, or administrative actions or proceedings.

❖ **Protected Health Information (PHI)**, that is subject to the Clinical Laboratory Improvement Amendments of 1988 ("CLIA"), 42 U.S.C ξ 263A, to the extent that the provision of access to the individual would be prohibited by law.

❖ Information that was obtained from someone other than a healthcare provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information. In other situations, the provider may deny you access but, if it does, the provider must provide you with a review of the decision denying access. These **"reviewable"** grounds for denial include:

❖ Licensed healthcare professionals have determined, in the exercise of professional judgment, that the access is reasonably likely to endanger the life or physical safety of the individual or another person.

❖ PHI makes reference to another person (other than a healthcare provider) and a licensed healthcare provider has determined, in the exercise of professional judgment, that the access is reasonably likely to cause substantial harm to such other person.

❖ The request is made by the individual's personal representative and a licensed healthcare professional has determined, in the exercise of professional judgment, that the provision of access to said personal representative is reasonably likely to cause substantial harm to the individual or another person.

For these **reviewable** grounds, another licensed professional must review the decision of the provider denying access within 60 days. If we deny you access, we will explain why and what your rights are, including how to seek review.

❖ If we grant access, we will tell you what, if anything, you have to do to get access.

(We Reserve The Right To Charge A Reasonable, Cost-Based Fee For Making Copies)

❖ Request amendment/correction of your health information. We do not have to grant the request if:

❖ We did not create the record. If, as in the case of a consultation report from another provider, we did not create the record, we cannot know whether it is accurate or not. Thus, in such cases, you must seek amendment/correction from the party creating the record (s). If they amend or correct the record, we will put the corrected record in our records.

- The records are not available to you as discussed immediately above.

- The record is accurate and complete

- If we deny your request for amendment/correction, we will notify you why, how you can attach a statement of disagreement to your records (which we may rebut), and how you can complain. If we grant the request, we will make the correction and distribute the correction to those who need it and those you identify to us that you want to receive the corrected information.

❖ Obtain an accounting of **"non-routine"** uses and disclosures (those other than for treatment payment, and health care operations) to individuals regarding your protected health information.
We do not need to provide an accounting for:

- The facility directory or to persons involved in the individual's care or other notification purposes as provided in ξ 164.510 (uses and disclosures requiring an opportunity for the individual to agree or to object, including notification to family members, personal representatives, or other persons responsible for the care of the individual, of the individual's location, general condition, or death).

- National safety or intelligence purposes under ξ 1640512(k))(2) (disclosures not requiring consent, authorization, or an opportunity to object.)

- Correctional institutions or law enforcement officials under 164.512(k)(5) (disclosures not requiring consent, authorization, or an opportunity to object).

- That which occurred before April 14, 2003.

- We must provide the accounting within 60 days. The accounting must include:

  - Date of each disclosure.

  - Name and address of the organization or person who received the protected health information.

  - Brief description of the information disclosed.

  - Brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure or, in lieu of such statement, a copy of your written authorization, or a copy of the written request for disclosure.

  The first accounting in any 12-month period is free. Thereafter, we reserve the right to charge a reasonable, cost-based fee.

  - Revoke your authorization to use or disclose health information except to the extent that we have already taken action in reliance on the authorization.

Our Responsibility Under The Federal Privacy Standard -

In addition to providing you your rights, as detailed above, the federal privacy standards requires us to:

- ❖ Maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information.
- ❖ Provide you with this notice as to our legal duties and privacy practices with respect to individually identifiable health information we collect and maintain about you.
- ❖ Abide by the terms of this notice.
- ❖ Train our personnel concerning privacy and confidentiality.
- ❖ Implement a sanction policy to discipline those who breach privacy/confidentiality or our policies with regard thereto.
- ❖ Mitigate (lessen the harm of) any breach of privacy/confidentiality.

WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES AND TO MAKE THE NEW PROVISIONS EFFECTIVE FOR ALL INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION WE MAINTAIN. SHOULD WE CHANGE OUR INFORMATION PRACTICES, WE WILL MAIL A REVISED NOTICE TO THE ADDRESS YOU HAVE SUPPLIED US.

We will not use or disclose your health information without your consent or authorization, except as described in this notice or otherwise required by law.

How To Get More Information Or To Report A Problem:

If you have questions and/or would like additional information, you may contact the **Privacy Officer** at:
Menlo Park - (732) 452-4100 - Paramus – (201) 634-8200 - Vineland - (856) 405-4200

Examples Of Disclosures For Treatment, Payment, And Health Operations:

"We Will Use Your Health Information For Treatment"

Example: A physician, nurse, or other member of your healthcare team will record information in your record to diagnose your condition and determine the best course of treatment for you. The primary caregiver will give treatment orders and document what he or she expects other members of the healthcare team to do to treat you. Those other members will then document the actions they took and their observations. In that way, the primary caregiver will know how you are responding to treatment.

We will also provide your physician, other healthcare professionals, or subsequent healthcare provider with copies of your records to assist them in treating you once we are no longer treating you.

"We Will Use Your Health Information For Payment"

Example: We may send a bill to you or to a third-party payer, such as a health insurer. The information on or accompanying the bill may include information that identifies you, your diagnosis, treatment received, and supplies used.

"We Will Use Your Health Information For Health Operations"

Examples: Members of the medical staff, the risk or quality improvement manager, or members of the quality assurance team may use information in your health record to assess the care and outcomes in your cases and the competence of the caregivers. We will use this information in an effort to continually improve the quality and effectiveness of the healthcare and services we provide.

Business associates: We provide some services through contracts with business associates. Examples include certain diagnostic tests, rehabilitation services, transportation services and pharmacy services. When we use these services, we may disclose your health information to the business associate so they can perform the function (s) we have contracted with them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and/or veterans organizations for the purpose of providing you with the benefit of their volunteer services, and except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication With Family: Unless you object, health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant in your care, or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information, and you have consented to such research.

Funeral Directors: We may disclose health information to funeral directors consistent with applicable law to enable them to carry out their duties.

Marketing Continuity Of Care: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund-Raising: We may contact you as part of a fund-raising effort. You have the right to request not to receive subsequent fund-raising materials.

Facility Activities: We may include your name, biography, birthday, picture or other information as part of our Resident Newsletter or Volunteer or Activities Program. Your name may be posted on a facility trip list for a trip you requested.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse effects/events with respect to food, drugs, supplements, product or product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law Enforcement: We may disclose health information as required by law or in response to a valid subpoena.

Health Oversight Agencies And Public Health Authorities: If a member of our work-force or a business associate believes, in good faith, that we have engaged in unlawful conduct or otherwise violated professional or clinical standards and potentially endangered one or more patients, workers, or the public, they may disclose your health information to health oversight agencies and/or public health authorities, such as the Department of Health and Senior Services, and other public health agencies.

The Department of Health and Senior Services (DHSS) and the Veterans Administration (VA):
Under the Privacy standards, we must disclose your health information to DHSS, and the Veterans Administration, as necessary for them to determine our compliance with State and Federal standards.

State of New Jersey

Department of Military and Veterans Affairs
Division of Veterans Healthcare Services
P.O. Box 340, Eggert Crossing Road
Trenton, New Jersey 08625-0340

Application for Admission
to a
New Jersey Veterans Memorial Home

Appendix C

Calculating Financial Costs
An Overview

State of New Jersey
DEPARTMENT OF MILITARY AND VETERANS AFFAIRS
NEW JERSEY VETERANS MEMORIAL HOMES (VMH)

Appendix C- Calculating Financial Costs – An Overview

- The **monthly resident care and maintenance fee** is based on:
  a) The person's monthly Income and their ability to pay. (Please see Appendix A).
  b) The value of all accountable assets determined as of **the date of application** and **revalued** on the **date of admission**.
- Income from all sources shall be disclosed. Income shall be verified by submitting copies of the **Federal and State Income tax** reports for the past three (3) years, as well as other financial documents from financial Institutions.
- All financial transactions and transfer of resources, which have occurred **within 36 months preceding the date of application**, will be reviewed and considered as accountable assets.
- The monthly resident care and maintenance fee is set annually by **The Adjutant General (TAG)** of the **New Jersey Department of Military and Veterans Affairs (DMAVA)** and is determined by the average costs encountered in running the three New Jersey Veterans Memorial Homes.

*Applicants who exceed the **maximum allowable assets** will be required to pay the **actual cost of care**, which is:

$285.00 per day
Minus **$107.16** per day reimbursement of **veterans ONLY** from the VA/Federal government
Plus **$20.00** Per month Welfare Fund fee (12% of Income, but no more than $20/month)

- **Maximum Allowable Assets:**

Single Applicants: Maximum allowable assets = $24,000.00

Married Applicants: Maximum allowable assets= $110,000.00 per the couple

- Residents who are **above** the maximum allowable asset threshold will have to pay the **full cost of care** until they have "spent down" to the amounts stated above.
- At **the time of admission** and **annually thereafter**, the monthly resident fee is calculated with the resident or their representative, and is determined by a review of the Federal and State Income tax returns, and all Income, financial statements, and financial transactions.
- **IRAs** and **ANNUITIES** are considered accountable assets. (Please see Appendix A)
- **IRREVOCABLE TRUSTS** will be subjected to legal review.

- **HOME (Primary)** – is **NOT** considered an asset for purposes of spend-down determination
- **SECOND HOME** – Please note that a second home **IS** considered an asset, and the admission package should contain a recent assessment of the second home.
- Residents who sell their house or acquire additional financial assets following admission to a New Jersey Veterans' Memorial Home are required to report these transactions during their annual asset review as described in Chapter 5, 5A:5-5.1(b). (See Appendix A)
- **STOCKS** are to be valued at current value at admission.
- **VETERANS BENEFITS** – Service Connected Disability benefits **shall not be** calculated as Income. Aid and Attendance (A&A) benefits are calculated as Income.
- **DEDUCTIONS** must be verified with receipts, cancelled checks, statements or bills. You will be required to submit **verification** on or before the day of admission. The **actual amounts of the expenses** will be deducted, and will vary from family to family.

HOW to CALCULATE the RESIDENT'S MONTHLY CARE and MAINTENANCE FEE:

Single Resident:

- The total gross monthly Income, minus allowable deductions, equals the net Income.
- 80% of the net Income will be the resident's monthly care and maintenance fee.
- An additional $20 **or** 12% of the balance of the Income (whichever is LESS) will be deposited in the **Welfare Fund** of the veterans Memorial Home each month.
- **The Welfare Fund** means an account established at each veterans Memorial Home for the benefit and general welfare of the resident population of the Institution as a whole, on behalf of residents' programs, special events and services. This fund will provide for and maintain a quality of life which might otherwise not be possible for the residents, and shall be administered by the Adjutant General (TAG).

- **Allowable Deductions for Single Residents:**
    1. Personal needs allowance - $100.00 per month.
    2. Health Insurance premiums and prescriptions – the actual cost.
    3. Prepaid burial fund account, not to exceed $12,000.00.
    4. Court-ordered encumbrances.
    5. Other expenses as approved by the Deputy Commissioner.

PLEASE NOTE: Any interest or payment received from a trust transfer will be treated as income. In situations where a trust or transfer of assets has occurred with 36 months of submitting an admission application, the value of the trust and/or assets will be deemed an accountable asset for the balance of the 36-month period.

Married Resident:

- The total personal monthly Income, minus allowable deductions, equals the net Income.
- 80% of the net Income will be the resident's monthly care and maintenance fee.
- An additional $20 **or** 12% of the balance of the Income (whichever is LESS) will be deposited in the **Welfare Fund** of the veterans Memorial Home each month.
- **The Welfare Fund** means an account established at each veterans Memorial Home for the benefit and general welfare of the resident population of the Institution as a whole, on behalf of residents' programs, special events and services. This fund will provide for and maintain a quality of life which might otherwise not be possible for the residents, and shall be administered by the Adjutant General (TAG).
- The resident's care and maintenance fee wil be based solely on the applicant's Income.
- Additional Income received by a working spouse, following admission of the veteran, will remain an income to the working spouse.
- The **"community spouse"** must divulge all sources of their monthly Income in order to file for consideration of allowable deductions. Allowable deductions will be offset by the community spouse's monthly Income before the applicant's monthly Income will be considered.
- In the event that each individual of the marriage is a resident, the resident fee for each will be calculated as for a single resident. Failure to make a full and complete disclosure will constitute a breach of the facility regulations and may be grounds for removal.

- **Allowable Deductions for Married residents:**
    1. Personal needs allowance - $100.00 per month.
    2. Health Insurance premiums – the actual cost.
    3. Court-ordered encumbrances.
    4. Rent/primary residence first mortgage/home equity loan.
    5. Food deduction - $400.00 per month/community spouse;$185.00 additional dependent.
    6. Heat/electric deduction – based on preceding year usage and cost.
    7. Water/sewage deduction – the actual annual cost.
    8. Automobile/transportation deduction - $350.00 per month for car maintenance.
    9. Clothing deduction - $75.00 per month per dependent.
    10. Telephone/television service deduction - $125.00 per month.
    11. Trash disposal deduction – the actual annual cost.
    12. Home maintenance deduction - $100.00 per month.
    13. Prepaid burial fund account, not to exceed $12,000.00.
    14. Guardianship/Advance Directives – the actual cost of legal fees up to a maximum of $2,400.00 (Please see Appendix A – Chapter 5, for details).
    15. Other extraordinary expenses or other financial issues as approved by the Deputy Commissioner.
    16. No deduction beyond the approved listing shall be permitted until all accountable assets, to include the personal needs account are depleted.

PLEASE NOTE: Any Interest or payment received from a trust transfer will be treated as Income. In situations where a trust or transfer of assets has occurred within 36 months of submitting an admission application, the value of the trust and/or assets will be deemed an accountable asset for the balance of the 36-month period.

Other Financial Obligations for Residents:

The resident or the person who has control of the resident's finances will be responsible for all financial obligations for services not provided by the New Jersey Veterans Memorial Home. This includes, but is not limited to:

- Transportation
- Medical appointments
- Hospitalization
- Specialized services/programs/treatments
- Adaptive equipment
- Diagnostic services
- Other outside services as requested by the resident
- Deductible fees not covered by medical insurance(s)
- Payment for pharmaceuticals to reimburse Medicaid as required
- Personal purchases
- Telephone
- Television
- Outside personal laundry services
- Outside physician services
- Any non-payment of debts, Income by the resident including healthcare costs

Please Note: This section, ***"Appendix C – Calculating Financial Costs – An Overview",*** is only a **brief outline** to assist you in understanding how the **monthly resident care and maintenance fee** is calculated.

Please see "Appendix A – New Jersey Administrative Code (N.J.A.C.) 5A:5 – Chapter 5", for full legal definitions, details and descriptions of the requirements for eligibility for admission, pre-admission screening, admission review and implementation, computation of the monthly resident care and maintenance fee, and the basis for discharge or transfer from a New Jersey Veterans Memorial Home (VMH).

Thank you.