

Barry E. Conway
Commandant

New Hampshire Veterans Home

139 Winter Street
Tilton, NH 03276
www.nh.gov/veterans



Telephone: (603) 527-4400
Fax : (603) 527-4850

Dear Applicant:

Thank you for your interest in the New Hampshire Veterans Home.

For more than a century, the Veterans Home has been a home and health resource for Granite State armed forces veterans. Established initially in 1890 as the Soldier's Home for Civil War Veterans, it has provided care and comfort for thousands who have served their country and fellow-citizens.

Located in the foothills of the magnificent White Mountains, the scenic beauty, along with the warm fellowship shared by residents, staff, and volunteers make for a most appropriate environment for those who have made personal sacrifices in the military and are now unable to care for themselves.

You will find the eligibility requirements within the Application packet for admission to the Home. Our own requirements, along with Federal and State regulations, necessitate that all applicants for admission provide full and complete information on the forms provided in this packet. Please note that any incomplete forms and/or information will result in a delay of the application process.

The Admissions Coordinators are available at 527-4846 or 527-4843 for questions regarding the application process and for scheduling a tour.

We look forward to hearing from you.

Sincerely,

A handwritten signature in black ink, appearing to read "Barry E. Conway".

Barry E. Conway
Commandant

BEC:amb

Enclosures

NH VETERANS HOME APPLICATION INSTRUCTIONS

If you meet the following Admissions Criteria, you are eligible for consideration for admission to the NH Veterans Home:

- Ninety days of service during time of war (as defined by Title 38 US Code Section 101) and honorably discharged.
- The applicant has been a resident of the State of New Hampshire for one (1) year preceding his or her application, or can prove New Hampshire as home of record upon discharge.
- The applicant's condition(s) are within the Home's resources and ability to treat, and the applicant does not present potential harm to self or other residents.
- Financial Certification (see page 3).

Applicant Completes the Following: (If a Physician has certified that the veteran lacks the capacity to understand his/her medical needs and has activated his Durable Power-of-Attorney for Health Care or there is a Guardian of the Person in place, then that designated person can complete the required paperwork)

- Application Sheets (pages 1 and 1A)
- Final Requests Form (page 2)
- Financial Affidavit (page 3A)
- Applicant Agreement Form (page 4)
- Three (3) Medical Release Forms (page 6)
- Review and keep Notice of Privacy Practices (page 7)
- Consent for Care & Treatment/Use of Health Care Information/ Acknowledgement of Privacy Notice (page 8)
- Security Form (Page 9)
- Criminal Record Release Authorization Form (last page) - your signature in both places must be witnessed by a notary to be valid, per State law. There is **no** fee.

Your Doctor Completes:

Medical Information, pages 5A (Department of Veterans Affairs form 10-10SH) and 5B. (Instructions to your MD/ARNP are on page 5.) This requirement includes a TB (mantoux) test, urinalysis, complete blood count, and chest X-ray required within three (3) months of the application date.

Documentation to be included:

- **Original** DD-214 or other military papers showing entry and discharge dates with type of discharge. The original will be returned to you after VA verification.
- Copies of any Health Insurance Cards, including Medicare.
- Copies of Advance Directives (Living Will, Powers of Attorney for Healthcare/Finances) or Guardianship papers.
- Certified Marriage Certificate/Civil Union Contract or Divorce Decree.
- Copy of proof of financial assets and monthly income **for one year**. Include any Trust, Long Term Care Insurance Policies, and the Deed to the house if applicable.

NH VETERANS HOME ADMISSION APPLICATION

Full Name: _____ Social Security #: _____
Address: _____ Phone: _____
City, State, Zip: _____
Where have you lived in the past two years? _____
DOB: _____ Place of Birth: _____ Male: _____ Female: _____
Mother's Maiden Name: _____
Religion: _____ Education Level: _____
Previous Occupations: _____
Married/Civil Union: _____ Divorced: _____ Widowed: _____ Single: _____ Separated: _____

MILITARY INFORMATION:

Branch of Service: _____
Service Connected Disability? _____ No _____ Yes If yes, what % _____
Type of Service Disability: _____
Date of Enlistment: _____ Place of Enlistment: _____
Date of Discharge: _____ Place of Discharge: _____
Rank: _____ Type of Discharge: _____
Veterans Service Groups: _____ Post#: _____
_____ Post#: _____

MEDICAL INSURANCE INFORMATION:

Medicare: Part A Part B Number: _____
Other Insurances: _____ Policy #: _____

MEDICAL INFORMATION:

Primary Care Physician/ARNP: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____

Please list the hospitals you have been in during the past two (2) years:

LEGAL/CONTACT INFORMATION

LEGAL INFORMATION: Do you have any of the following? If so, please include copies.

	Yes	No	Name
Power of Attorney for Healthcare	_____	_____	_____
Power of Attorney for Finances	_____	_____	_____
Living Will	_____	_____	_____
Court Appointed Guardian	_____	_____	_____

SPOUSE/ PARTNER TO A CIVIL UNION:

Name: _____
Phone Numbers: Home _____ Work _____ Cell _____
Address: _____
City, State, Zip: _____
Date of Birth: _____ Social Security #: _____
Date of Marriage or Civil Union: _____ City and State: _____
Date of Death (if applicable): _____

FIRST CONTACT PERSON:

Name: _____
Phone Numbers: Home _____ Work _____ Cell _____
Address: _____
City, State, Zip: _____
Relationship: _____ Durable Power of Attorney for Healthcare? Guardian?

SECOND CONTACT PERSON:

Name: _____
Phone Numbers: Home _____ Work _____ Cell _____
Address: _____
City, State, Zip: _____
Relationship: _____ Durable Power of Attorney for Healthcare?

Witness Signature (Required)

Veteran's Signature or Legally Authorized Person
(DPOAHC, Guardian)

Date

**NEW HAMPSHIRE VETERANS HOME
FINAL REQUESTS**

Name: _____ SS #: _____

The following instructions direct the New Hampshire Veterans Home of my wishes in regards to final services in the event of my demise while a resident of the Home.

Name of Funeral Home: _____

Address of Funeral Home: _____

City, State, Zip: _____ Phone Number: _____

Location of cemetery plot: _____

Purchaser's name of plot: _____

Have these arrangements been prepaid? Yes No

Special instructions, i.e.: military funeral, private services, cremation, etc.:

Do you have Life Insurance? Yes No

Do you have a will? Yes No

If yes, where is it located? _____

If a funeral home has not been chosen; the applicant understands that they must choose one within 60 (sixty) days of admission to the Veterans Home.

I understand that all personal possessions left at the Home 30 (thirty) days, after my departure, shall follow the procedure set forth by the NHVH's Deceased and Discharged Member Belongings Policy.

Witness Signature (Required)

Veteran's Signature or Legally Authorized Person
(DPOAHC, Guardian)

Date

FINANCIAL COST INFORMATION

The financial cost to the veteran for residing at the New Hampshire Veterans Home is dependent on the veteran's assets. The applicant's home is not an accountable asset if the spouse/civil union partner are residing in the home or if legal documents demonstrate other ownership. There is a required one-year look back of all assets. Those with assets exceeding \$275,000.00 are not eligible for admission. (This cap is set by the State of New Hampshire.) The cost of care is determined as follows:

- **With ASSETS BETWEEN \$30,000 and \$275,000:** The veteran's room and board charges will be as a self-pay resident at a rate of \$180.00 per day (subject to yearly change) until spent down to less than \$ 30,000.
- **With ASSETS less than \$30,000:** the veteran's room and board charges will be based on the veteran's total monthly income* and the following formula:

Veteran's total monthly income	=	\$ _____
Deduct \$100.00 (for the veteran)		- 100.00
New total of monthly income:	=	\$ _____
Multiply by		x .90 **
Monthly cost to the veteran	=	\$ _____

***Monthly income** represents all income received from federal, state or private companies, to include, but not limited to social security, retirement of any kind, interest income, annuities, VA disability/compensation check and other income sources received by the veteran.

****The 10% difference is for personal needs**, and expenses not covered.

Additional spousal/civil partner assistance can be addressed by contacting the Business Administrator.

ROOM AND BOARD CHARGES include: all VA formulary prescription medications, 24 hour nursing care, physical therapy for maintenance/restorative care only, recreational activities, transportation to and from medical appointments ordered by the NHVH MD, all dietary services (three meals and snacks), daily housekeeping services, laundry services, incontinency products, basic cable TV, routine dental care, management of resident account and co-ordination of VA/Pension benefits, social services, library services.

EXPENSES NOT COVERED: Additional medical services may be required that are not covered by the room and board rate and of which may or may not be covered by the VA, Medicare, or other health care insurances you may have. Other items not covered are: non-covered VA formulary brand name prescription medications, 20% Medicare co-pay, supplemental health care insurance premiums cost, haircuts, personal clothing, personal toiletries, eyeglass prescriptions, dentures/partial plates (new or repaired), hearing aides (new or repaired), personal cell phones, personal computers, private travel to local banks, fees for legal documents, legal services, personal snacks, out of house meals, entertainment equipment as TV's, DVD's, CD's, radios, etc., and some durable medical equipment.

APPLICANT'S FINANCIAL AFFIDAVIT FOR NHVH

Name: _____ SS#: _____

<u>Assets:</u>	Veteran	Spouse or Civil Union Partner	Joint	Liabilities
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Checking Accounts	\$ _____	\$ _____	\$ _____	
Savings Accounts	\$ _____	\$ _____	\$ _____	
Certificates of Deposit	\$ _____	\$ _____	\$ _____	

Investments

Annuities	\$ _____	\$ _____	\$ _____	
Mutual Funds	\$ _____	\$ _____	\$ _____	
Bonds	\$ _____	\$ _____	\$ _____	
IRAs	\$ _____	\$ _____	\$ _____	
Stocks	\$ _____	\$ _____	\$ _____	
Other Ret. Benefits	\$ _____	\$ _____	\$ _____	

Property

Residence (value)	\$ _____	\$ _____	\$ _____	\$ _____ Mortgage
Other Real Estate	\$ _____	\$ _____	\$ _____	\$ _____ Mortgage
Rental Income	\$ _____	\$ _____	\$ _____	\$ _____
Time share	\$ _____	\$ _____	\$ _____	\$ _____
Business Ownership	\$ _____	\$ _____	\$ _____	\$ _____
Loans due you	\$ _____	\$ _____	\$ _____	

Alimony/Child Support: Yes _____ No _____ How much per month? _____

Long Term Care Insurance: Yes _____ No _____ Rate per day _____

Length of coverage: _____

Trusts: Yes _____ No _____ Revocable _____ Irrevocable _____

Monthly Incomes:

	Veteran	Spouse or Civil Union Partner
Social Security	\$ _____	\$ _____
Military Retirement	\$ _____	\$ _____
Federal, State, City Retirement	\$ _____	\$ _____
Railroad Retirement	\$ _____	\$ _____
Other Retirement	\$ _____	\$ _____
Non-Service Connected Compensation	\$ _____	\$ _____
Service Connected Compensation	\$ _____	\$ _____
Interest on Investments	\$ _____	\$ _____
Income from other sources such as rental, loans due you, etc.	\$ _____	\$ _____

Total Monthly Income: \$ _____ \$ _____

**NEW HAMPSHIRE VETERANS HOME
AGREEMENT FORM**

I understand the New Hampshire Veteran's Home is owned and operated by the State of New Hampshire and therefore subject to the rules of the State.

I give permission to the NH Veterans Home to provide requested information as needed to the Department of Veterans Affairs (VA). This includes spouse's income and Social Security number, which is required to determine VA benefits.

I agree to abide by the NH Veterans Home rules and regulations established by the Commandant, the Board of Managers, and the State of New Hampshire.

I verify that the assets listed in this application are accurately stated. I verify that I have not transferred any assets in the twelve-month period prior to applying to the New Hampshire Veterans Home, for the sole purpose of complying with the eligibility requirements.

I will provide proof of financial assets and monthly income during the admission process and anytime thereafter, upon request by the Business Office, in determining my monthly cost of care.

I agree to accept transfer/discharge to another facility capable of providing for my needs if the NHVH does not have the resources and is advised by the Medical Director.

I have read, or had read to me and understand the information provided in this application.

The information given in this admission application is true and correct to the best of my knowledge and belief. The New Hampshire Veterans Home reserves the right to request updated information regarding this application.

I certify there are no willful misrepresentations or answers to questions. If an investigation discloses such misrepresentations, my admission to the Home maybe denied. If I should already be a NHVH resident, I may be discharged from the Home.

Witness Signature (Required)

Veteran's Signature or Legally Authorized Person
(DPOAHC, Guardian)

Date

NEW HAMPSHIRE VETERANS HOME

139 Winter Street
Tilton, NH 03276

INSTRUCTIONS TO PHYSICIAN/ARNP

1 - Please complete VA form 10-10SH and the NHVH Medical Information Form on behalf of your patient, who is applying to the New Hampshire Veterans Home.

2 - Results of current (within last three (3) months): Chest X-Ray, TB Test, Urinalysis, and CBC **are required**. *Note: If TB Test is positive, contact the Admissions Office for further instructions.*

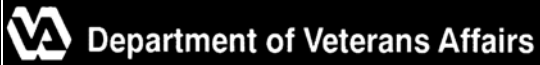
3 - The Physician or ARNP's signature is required at the bottom of VA Form 10-10SH and where indicated on the NHVH Medical Information Form.

These papers may be faxed to: 603-527-4850 or mailed to:

**Admission Coordinators
New Hampshire Veterans Home
139 Winter Street
Tilton, NH 03276**

Please call the New Hampshire Veterans Home Admission Office at 603-527-4846 or 527-4843 if you have any questions.

Thank you.



**STATE HOME PROGRAM APPLICATION FOR VETERAN CARE
 MEDICAL CERTIFICATION**

PART I - ADMINISTRATIVE

STATE HOME FACILITY		DATE ADMITTED	GENDER <input type="checkbox"/> M <input type="checkbox"/> F
RESIDENT'S NAME (Last, First, Middle) (This is a mandatory field)		SOCIAL SECURITY NUMBER. (Mandatory field)	
RESIDENT'S STREET ADDRESS		AGE	DATE OF BIRTH (mm/dd/yyyy)
CITY, STATE AND ZIP CODE		ADVANCED MEDICAL DIRECTIVE <input type="checkbox"/> NO <input type="checkbox"/> YES	

PART II - HISTORY AND PHYSICAL (Use separate sheet if necessary)

HISTORY

HEIGHT	WEIGHT	TEMP	PULSE	BP	HEAD/EYES/EAR/NOSE AND THROAT
NECK			CARDIOPULMONARY		
ABDOMEN			GENITOURINARY		
RECTAL			EXTREMITIES		
NEUROLOGICAL			ALLERGY/DRUG SENSITIVITY		

X-RAY/ LAB	CHEST X-RAY	DATE (mm/dd/yyyy)	RESULTS	CBC	DATE (mm/dd/yyyy)	RESULTS
	SEROLOGY					
	URINALYSIS	DATE (mm/dd/yyyy)	ALBUMEN	SUGAR	ACETONE	

CHECK ALL BOXES THAT APPLY OR CHECK NA

IS DEMENTIA THE PRIMARY DIAGNOSIS <input type="checkbox"/> YES <input type="checkbox"/> NO	IS THERE A DIAGNOSIS OF MENTAL ILLNESS <input type="checkbox"/> YES <input type="checkbox"/> NO	HAS RESIDENT RECEIVED MENTAL SERVICES WITHIN THE PAST 2 YEARS <input type="checkbox"/> YES <input type="checkbox"/> NO	IS CLIENT A DANGER TO SELF OR OTHERS <input type="checkbox"/> YES <input type="checkbox"/> NO
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IS THERE ANY PRESSING EVIDENCE OF MENTAL ILLNESS SUCH AS:

<input type="checkbox"/> SCHIZOPHRENIA	<input type="checkbox"/> PARANOIA	<input type="checkbox"/> OTHER PSYCHOTIC OR MENTAL DISORDERS LEADING TO CHRONIC DISABILITY
<input type="checkbox"/> MOOD SWINGS	<input type="checkbox"/> SOMATOFORM DISORDER	<input type="checkbox"/> PANIC OR SEVERE ANXIETY DISORDER
		<input type="checkbox"/> PERSONALITY DISORDER

OXYGEN <input type="checkbox"/> MASK <input type="checkbox"/> PRN <input type="checkbox"/> NASAL CANULAR <input type="checkbox"/> CONTINUOUS		<input type="checkbox"/> TUBE FEEDING <input type="checkbox"/> OSTOMY <input type="checkbox"/> TRACHOSTOMY	<input type="checkbox"/> DECUBITUS ULCERS <input type="checkbox"/> DRAINING WOUND <input type="checkbox"/> WOUND CULTURED	FOLEY CATHETER <input type="checkbox"/> TEMPORARY <input type="checkbox"/> PERMANENT
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REFERRING PHYSICIAN	PRIMARY DIAGNOSIS
SECONDARY DIAGNOSIS	TERTIARY DIAGNOSIS

TYPE OF CARE RECOMMENDED: SKILLED NURSING HOME CARE DOMICILIARY CARE ADULT HEALTH CARE HOSPITAL

MEDICATION AND TREATMENT ORDERS ON ADMISSION, CONTINUE ON SEPARATE SHEET IF NECESSARY

PRINTED OR TYPED NAME OF PRIMARY PHYSICIAN ASSIGNED	SIGNATURE OF PRIMARY PHYSICIAN ASSIGNED
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**NEW HAMPSHIRE VETERANS HOME
MEDICAL INFORMATION FORM**

Name: _____ DOB: _____ Social Security# _____

Immunizations:

Date of last Tetanus booster: _____ Date of last Pneumovax: _____

Date of last Flu shot: _____

PPD (Required within 3 months of Application Date): Date _____ Results _____

Is Applicant free of communicable disease, including TB? Yes No

Past History of TB? Yes No Date: _____ Where Treated: _____

Past History:

Mental Illness* Yes No Date: _____ Where Treated: _____

Type of Mental Illness _____

Alcohol Abuse* Yes No Date: _____ Where Treated: _____

Drug Abuse* Yes No Date: _____ Where Treated: _____

**Include copies of above Consults, if applicable*

Self Care Status: Can applicant do the following?

Dress self? Yes No

Feed self without assistance? Yes No

Use bathroom without assistance? Yes No

Incontinent? Bowel Yes No

Bladder Yes No

Does applicant exit seek? Yes No

Diet Order: _____ **Activity Order:** _____

Mobility Status: Ambulatory Cane Wheelchair Walker

Does the Applicant have the capacity to understand Health Care Issues?

Yes No

Has the Durable POA for Health Care been activated?

Yes No Date: _____

Physician/ARNP Signature: _____ **Date of Exam:** _____

Physician's Name & Address (Please print) _____

Phone: _____ Fax: _____

FOR NH VETERANS HOME PHYSICIAN USE ONLY

Recommend for Admission Not Recommended for Admission

Signature: _____ Date: _____

Comments: _____

NEW HAMPSHIRE VETERANS HOME

NOTICE OF PRIVACY PRACTICES

Effective Date: 02/15/2005

This notice describes how your health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I. Introduction. This Notice of Privacy Practices describes how New Hampshire Veterans Home may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health condition and related health care services.

II. Your Health Information Rights. While the actual records that we maintain about you belong to us, the information contained in our records belongs to you. Under the Federal Privacy Rules (45 CFR Part 160 and Part 164) you have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR Part 160.522. *Please note, however, that we are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your health information, we will notify you that your request for restriction will not be honored. If we agree to the requested restriction, we may not use or disclose your health information in violation of that restriction unless it is needed to provided emergency treatment.*
- Obtain a paper copy of this Notice of Privacy Practices upon request.
- Inspect and obtain a copy of your health record.
- Amend your health record.
- Obtain an accounting of certain disclosures.
- Receive confidential communications of your health information by alternative means or at alternative locations.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

III. Our Responsibilities. New Hampshire Veterans Home is required to:

- Maintain the privacy of your health information.
- Provide you with this Notice of Privacy Practices outlining our legal responsibilities and privacy practices.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests to communicate your health information by alternative means or at alternative locations. *We reserve the right to change our Notice of Privacy Practices and to make the new provisions effective for all protected health information we maintain. Should our Notice of Privacy Practices change, we will notify you. The most up to date copy of this Notice of Privacy Practices will be displayed in prominent locations throughout the home.*

IV. Examples of How We Will Use or Disclose Your Protected Health Information (PHI). The following are examples of the types and uses and disclosures of your PHI that we are permitted to make.

Treatment: We will use and disclose PHI to provide, coordinate, or manage your health care and any related services. For example, we may disclose PHI to your primary care physician and to other physicians who may be involved in your health care. In addition, we may disclose PHI to other health care facilities that are providing your care, such as hospitals and ambulance services, to coordinate continuing care, diagnostic testing, surgery, therapy and other services.

Payment: PHI will be used as needed to obtain payment for services that we provide to you. For example, we may disclose PHI to the Department of Veterans Affairs for benefits such as per diem payments, pharmacy and other medical benefits. We may disclose PHI to your health insurance company and its legal representatives.

Healthcare Operations: We may use or disclose your PHI as needed to support our own business activities. These activities may include quality assessment and improvement, training and supervision of staff members, or other business activities. We may share your PHI with other departments within the Home for such activities as preparing and serving of meals, housekeeping, and participation of recreational activities. For example, we may share your PHI with third party business associates that perform various services that are essential to our Home, such as Physician, Pharmacy, Dental, Rehabilitative, and Speech Services. We will limit the amount of PHI that we provide to the minimum necessary to accomplish the particular

task. We will have a written contract with Business Associates that contains terms that will protect the privacy of your PHI. We will use your protected health information to provide you with appointment reminders and to discuss treatment options or other health related benefits that may be of interest to you.

V. Uses and Disclosures We May Make Unless You Object. In the following situations, we may disclose your protected health information unless you request not to:

- To notify or assist in notifying a family member or personal representative of your health status. This person will be listed in our records as your primary person to notify. If unable to contact this person, the person listed as your secondary contact may be notified in an emergency situation.
- Your name and room number will be listed on a Home directory. Your location within the home may be released to anyone that asks for you by name. Your name will also be located on a nameplate out side your door.
- Your name, location and religious preference may be shared with clergy.
- Your name, location, service information such as branch of service, war service (WWII, Korea, etc.), and service organizations (VFW, AL, etc) may be shared with members of visiting service organizations.
- Your name and birthday will be displayed on the Home's monthly birthday list.
- Your name, basic information, such as demographics may be included in our quarterly newsletter.

VI. Uses and Disclosures Not Requiring Your Authorization. The federal privacy rules provide that we may use or disclose your protected health information without your authorization in the following circumstances (in accordance with applicable state and federal law):

- As required by Law: to the extent that the use or disclosure is required by state or federal law.
- Health Oversight Activities: in the context of audits, investigations, inspections and licensing activities.
- Food and Drug Administration (FDA): to report adverse events with respect to food, medications, products, and product defects.
- Public Health: to public health authorities charged with preventing or controlling disease, injury, or disability.
- Relating to Decedents: regarding an individual's death, to coroners, medical examiners or funeral directors.
- Organ/Tissue Donation: if you are an organ donor, to assist in procurement, banking or transportation of donated organs or tissue.
- Law Enforcement: as required by law or in response to a valid search warrant or court order.
- Legal Proceedings: in response to an order of a court, subpoena, discovery request or other lawful process.
- To Avert a Serious Threat to Health or Safety: to warn of a resident's violent behavior when a resident has communicated a serious threat of physical violence against a reasonably identifiable victim.
- Criminal Activity: to law enforcement authorities if evidence of criminal conduct on our premises, to report suspected child abuse or neglect, or abuse of incapacitated adults, or an injury that we believe may have been a result of an illegal act.
- National Security and Intelligence Activities – to authorized federal officers for national security activities

VII. Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described in this notice. You may revoke this authorization at any time in writing, except to the extent that we have already relied upon your authorization in making a disclosure.

VIII. For More Information or to Report Complaints

If you wish to exercise any of the rights outlined in this notice or if you have questions and would like additional information, you may contact our Privacy Officer at New Hampshire Veterans Home, 139 Winter St., Tilton, NH 03276. Telephone: (603) 527-4400.

If you believe that your privacy rights have been violated, you may file a complaint with our Privacy Officer. If you are not satisfied with the Home's response, you may file a complaint with the Regional Office for Civil Rights. All complaints must be submitted in writing. You will not be retaliated against for filing a complaint. To file a complaint with the government, contact: Office for Civil Rights – Attn: Regional Manager, U.S. Department of Health and Human Services, JFK Federal Building – Room 1875, Boston, MA 02203 / (617)565-1340, (617)565-1343 (TDD).

NEW HAMPSHIRE VETERANS HOME
CONSENT TO TREATMENT, USE OF HEALTH CARE INFORMATION,
AND RECEIPT OF PRIVACY NOTICE

Name of Resident: _____ MR Number: _____

_____ (Please initial) **1. Consent for Care and Treatment**

I hereby authorize New Hampshire Veterans Home, its staff, practitioners, and others involved in the provision of services on its behalf, to examine me, secure appropriate information, and perform any routine treatment that may be appropriate for my condition. I understand that the practitioner or other responsible person will explain to me any particular treatment, including both its benefits and its risks, and that I have the right to refuse any proposed treatment.

_____ (Please initial) **2. Consent to Use of Health Care Information**

I understand that New Hampshire Veterans Home will make use of my health care information for purposes of treatment and other lawful functions including securing payment and other usual health care operations. I understand that this information may be available to persons working on behalf of New Hampshire Veterans Home, who will be subject to the same duty of confidentiality as New Hampshire Veterans Home with respect to my information. I understand that if New Hampshire Veterans Homes holds certain sensitive information related to my health care such as (i) records covered by federal law governing confidentiality of alcohol or drug abuse treatment programs; (ii) records covered by state rules governing the rights of recipients of mental health services; or (iii) records concerning my diagnosis or treatment for HIV infection, then my specific authorization will be required to disclose such information to others. However, I consent to the use of such information by New Hampshire Veterans Home for purposes of my evaluation and treatment. I understand that I may refuse to allow the sharing of some or all such information, but that refusal may result in improper diagnosis or treatment or other adverse consequences.

_____ (Please initial) **3. Acknowledgement of Receipt of Privacy Notice**

I acknowledge receipt of the Notice of Privacy Practice for Protected Health Information from New Hampshire Veterans Home. I understand this notice contains important information about how my medical information may be used and disclosed and how I can get access to this information.

 Patient or Authorized Representative

Date

Relationship to Resident: Self Guardian DPOAHC Other (Please specify) _____

Witness Signature

Date

**NEW HAMPSHIRE VETERANS HOME
SECURITY FORM**

Please read this form carefully and sign/date as instructed.
Your witness does not have to be a Notary.

If you have ever been convicted of a crime (Felony or Misdemeanor) that has not been officially annulled by a Court, you **MUST** complete the following section, giving the date, location and nature of the Felony or Misdemeanor conviction. *If you leave this space blank; you are certifying that you have no current record of conviction.*

Please note: Conviction is not an automatic disqualification for admission to the New Hampshire Veterans Home. Each case is considered individually. Willful omission or misrepresentation of required information will be a basis for rejection of your application to the NHVH.

Witness Signature (required)

Veteran's Signature or Legally Authorized Person
(DPOAHC/Guardian)

Date

