



Margaret D. LaBrecque  
Commandant

## New Hampshire Veterans Home

139 Winter Street  
Tilton, NH 03276-5415



Telephone: (603) 527-4400  
Fax : (603) 286-4242

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 makes 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 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 cursive script that reads "Margaret D. LaBrecque".

Margaret D. LaBrecque  
Commandant

## New Hampshire Veterans Home Application for Admission Instructions/Checklist

### The applicant must meet the following criteria to be eligible to apply for admission:

1. Honorably discharged from active duty service from the armed forces or reserve or NH Army/Air National Guard
2. Residing in NH for one year immediately preceding the date of application **OR** home of record at military discharge was listed as NH
3. Financial requirements are met (assets < \$275,000, see Financial Cost Information sheet for details)
4. The applicant's condition(s) are within the Home's resources and ability to treat (determined by physician and committee review), and the applicant does not present potential harm to self or others

**The applicant completes and signs the following forms** (if a physician has certified that the veteran lacks the capacity to make medical decisions, and there is an activated Durable Power of Attorney for Healthcare or a Guardian over person in effect, that person may complete and sign the paperwork):

- Application Form, pages 1 and 1A
- Final Requests Form, page 2
- Financial Affidavit, page 3A
- Applicant Agreement Form, page 4
- Three Release of Information forms, page 6
- Consent To Treatment, Use of Health Care Information, and Receipt of Privacy Notice, page 8 (note: please review and keep Privacy Notice)(MR number will be filled in here upon admission)
- Security Form, page 9
- Criminal Record Release Authorization Form, page 10 (Please note two signatures are required and must be witnessed by a notary. There is no fee. We must have the original signed page, not a copy.)

**The applicant's primary doctor/ARNP needs to complete and sign the 2 page form and arrange required testing** (chest x-ray, complete blood count, urinalysis, and tuberculosis test) and send results to our office. If testing has been done in the past 3 months and shows no disease, those results may be sent. This is required to be done **at the time of application**. Please give your physician or ARNP:

- Instructions to Physician/ARNP, page 5, and
- Our two page medical form which includes the State Home Program Application (form 10-10SH) and our Medical Information Form

### Documentation to be included with your completed application:

- DD-214 or other discharge papers (with service number, entry/discharge dates and type of discharge)
- Copies of any advance directives (Durable Power of Attorney for Healthcare and/or Finance, Living Will, Guardianship over person and/or estate, Do Not Resuscitate form, anatomical gift form)
- Copy of marriage certificate/civil union contract **OR** divorce decree **OR** death certificate for applicant's spouse (we need only the most recent document)
- Financial Agreement for Expenses Not Covered by Medicare
- One full year of statements for any bank accounts or investments in applicant's **AND/OR** spouse's name
- Copy of any trust documents or long term care policies
- Copy of deed and most recent tax bill for any property in applicant's **AND/OR** spouse's name
- Copy of service-connected disability or VA pension approval letter
- Front and back copies of all health insurance cards, including Medicare

**Please send completed packet by mail, or bring it to the Admissions Office.**

# NH VETERANS HOME ADMISSION APPLICATION

Full Name: \_\_\_\_\_ SS #: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
\_\_\_\_\_

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, 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: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Name the hospitals you have been in the past 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

Name: \_\_\_\_\_ SS #: \_\_\_\_\_

## FINAL REQUESTS

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: \_\_\_\_\_

\_\_\_\_\_

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?  
\_\_\_\_\_

\*I understand that if a funeral home has not been chosen; that one must be chosen 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.

\*I understand the Unit Social Worker, assigned to me, will inform me of the New Hampshire Veteran's Home "Final Salute" and will address the following:

Remembrance photo: Yes \_\_\_\_\_ No \_\_\_\_\_

Final Salute participant: Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
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 up to \$275,000.00 (This cap is set by The State of New Hampshire). 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. Therefore, the cost of care is determined as follows:

- **With ASSETS BETWEEN \$30,000 – \$275,000.00** : The Veteran's room and board charges will be as a self-pay resident at a daily rate of \$300.00 per day (subject to yearly change) until spend down to less than \$30,000.00.
- **With ASSETS less than \$30,000** the Veteran's room and board charges will be based on the Veteran's **total** monthly income\* based on 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 **
This is the 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, hair cuts, 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#: \_\_\_\_\_

<b><u>Assets:</u></b>	<b>Veteran</b>	<b>Spouse or Civil Union Partner</b>	<b>Joint</b>	<b>Liabilities</b>
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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:**

	<b>Veteran</b>	<b>Spouse or Civil Union Partner</b>
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

## **INSTRUCTIONS TO PHYSICIAN/ARNP**

- 1. Please complete VA form 10-10SH & the NHVH Medical Information form on behalf of your patient who is applying to the New Hampshire Veterans Home. We are the only long term care facility for Veterans in the State.**
- 2. Results of current (within last 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 can be faxed 603-266-1266 or mailed to:  
Admission Coordinators  
New Hampshire Veterans Home  
139 Winter Street  
Tilton, NH 03276**

**Please call the Admission Office at 603- 527-4846/527-4843 if you have any questions. Thank you.**



VA FORM 10-10SH  
 STATE HOME PROGRAM APPLICATION FOR VETERAN CARE MEDICAL CERTIFICATION

**PART I - ADMINISTRATIVE**

1. STATE HOME FACILITY New Hampshire Veterans Home		2. DATE ADMITTED	
3. STATE HOME FACILITY ADDRESS (Street, City, State and Zip Code) 139 Winter Street, Tilton, NH 03276			
4. RESIDENT'S NAME (Last, First, Middle) (Mandatory field)			
5. SOCIAL SECURITY NUMBER (Mandatory field)	6. GENDER <input type="checkbox"/> M <input type="checkbox"/> F	7. AGE	8. DATE OF BIRTH (MM/DD/YYYY)
			9. ADVANCED MEDICAL DIRECTIVE <input type="checkbox"/> NO <input type="checkbox"/> YES
10. HAS THE VETERAN PROVIDED FINANCIAL DISCLOSURE FOR PURPOSES OF DETERMINING ELIGIBILITY FOR DOMICILIARY PER DIEM PAYMENTS? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <b>10-10EZ or 10-10EZR IS REQUIRED TO BE SUBMITTED EITHER IN PAPER FORM OR ELECTRONICALLY WITH THE 10-10SH</b>			

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

11. HISTORY						
12. HEIGHT	13. WEIGHT	14. TEMP	15. PULSE	16. BP	17. HEAD/EYES/EAR/NOSE AND THROAT	
18. NECK				19. CARDIOPULMONARY		
29. ABDOMEN				21. GENITOURINARY		
22. RECTAL				23. EXTREMITIES		
24. NEUROLOGICAL				25. ALLERGY/DRUG SENSITIVITY		
26. X-RAY/ LAB	CHEST X-RAY	DATE (MM/DD/YYYY)	RESULT	CBC	DATE (MM/DD/YYYY)	RESULT
	SEROLOGY					
	URINALYSIS	DATE (MM/DD/YYYY)	ALBUMIN	ACETONE	SUGAR	
CHECK ALL BOXES THAT APPLY OR CHECK N/A						
27. IS DEMENTIA THE PRIMARY DIAGNOSIS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A		28. IS THERE A DIAGNOSIS OF MENTAL ILLNESS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A		29. HAS RESIDENT RECEIVED MENTAL HEALTH SERVICES WITHIN THE PAST 2 YEARS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A		30. IS CLIENT A DANGER TO SELF OR OTHERS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
31. 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"/> N/A <input type="checkbox"/> MOOD SWINGS <input type="checkbox"/> SOMATOFORM DISORDER <input type="checkbox"/> PANIC OR SEVERE ANXIETY DISORDER <input type="checkbox"/> PERSONALITY DISORDER						
32. OXYGEN <input type="checkbox"/> MASK <input type="checkbox"/> PRN <input type="checkbox"/> N/A <input type="checkbox"/> NASAL CANNULA <input type="checkbox"/> CONTINUOUS		33. FEEDING <input type="checkbox"/> TUBE FEEDING <input type="checkbox"/> N/A <input type="checkbox"/> OSTOMY <input type="checkbox"/> TRACHEOSTOMY		34. WOUND <input type="checkbox"/> DECUBITUS ULCERS <input type="checkbox"/> N/A <input type="checkbox"/> DRAINING WOUND <input type="checkbox"/> WOUND CULTURED		35. FOLEY CATHETER <input type="checkbox"/> TEMPORARY <input type="checkbox"/> N/A <input type="checkbox"/> PERMANENT
36. REFERRING PHYSICIAN				37. PRIMARY DIAGNOSIS		
38. SECONDARY DIAGNOSIS				39. TERTIARY DIAGNOSIS		
40. ARE THE ADMITTING DIAGNOSIS RELATED TO A SERVICE CONNECTED CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN						
41. TYPE OF CARE RECOMMENDED: <input checked="" type="checkbox"/> SKILLED NURSING HOME CARE <input type="checkbox"/> DOMICILIARY CARE <input type="checkbox"/> ADULT DAY HEALTH CARE						
42. MEDICATION AND TREATMENT ORDERS ON ADMISSION, CONTINUE ON SEPARATE SHEET IF NECESSARY						
43. PRINTED OR TYPED NAME OF PRIMARY PHYSICIAN ASSIGNED					44. SIGNATURE OF PRIMARY PHYSICIAN ASSIGNED	

**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**  
**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.*

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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



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# New Hampshire Veterans Home

## Financial Agreement For Expenses Not Covered By Medicare

I, \_\_\_\_\_, Self/ Guardian of Estate/Financial POA understand that there may be medical bills not covered by Medicare for services that \_\_\_\_\_ receives.

He/She has the following Medical Insurance:  
Medicare A \_\_\_\_\_ Medicare B \_\_\_\_\_  
Other: \_\_\_\_\_

My choice for payment is:

\_\_\_\_\_ 1. I authorize the New Hampshire Veterans Home to pay the 20% co-payment that is not covered by Medicare. I understand that the payment (s) will be made from \_\_\_\_\_ Resident Account, when the funds are available, if an account has been established through the NHVH Business Office.

\_\_\_\_\_ 2. I agree to pay for expenses that Medicare does not cover from my/his/her personal account(s) that I maintain outside of the NHVH.

\_\_\_\_\_ 3. I do not agree to pay any additional expenses not covered by Medicare and will address my/his/her medical bills with the individual medical facilities and Physicians directly.

\_\_\_\_\_ 4. I agree to continue my supplemental health care insurance to pay for the co-payment not covered by Medicare. I will continue to pay these monthly premiums and will notify the Business Office if I decide to discontinue this supplemental coverage.

\_\_\_\_\_  
Self/Guardian of Estate/Financial POA

\_\_\_\_\_  
Date

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## New Hampshire Veterans Home Notice of Privacy Practices

*Effective Date: 04/01/2014*

*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.** The NH Veterans Home (NHVH) is required by law to maintain the privacy of your personal health information. We are now required by the Federal Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191, and HIPAA regulations, 45 CFR Part 160 and 164, to provide you with this Notice of Privacy Practices, our legal duties, and your rights concerning your health information. This Notice of Privacy Practices describes how the 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 need to provide emergency treatment.*

Obtain a paper copy of this Notice of Privacy Practices upon request.

Inspect and obtain a copy of your health record. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

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.

Choose someone to act for you through an agent listed in your durable power of attorney over Health Care or a legal guardian. We will make sure this person has this authority and can act for you before we take action.

File a complaint if you feel your rights have been violated by contacting us at the number listed at the end of this Notice. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877- 696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/). We will not retaliate against you for filing a complaint.

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

Maintain the privacy of your health information.

We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

Provide you with this Notice of Privacy Practices outlining our legal responsibilities and privacy practices.

Abide by the terms of this notice.

We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Notify you if we are unable to agree to a requested restriction.

For more information see:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

### **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 your 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 with the Home activities such 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 Physicians, 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 contain terms that will protect the privacy of your PHI. We will use your PHI 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 Not Requiring Your Authorization.** The federal privacy rules provide that we may use or disclose your PHI 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.

We can use or share your information for health research.

## **VI. Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization**

Other uses and disclosures of your PHI 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.

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

Share information with your family, close friends, or others involved in your care.

Share information in a disaster relief situation.

Include your name in a resident directory at the Receptionist's Desk for location in the Veterans Home unless you tell us you do not want that information in the directory.

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

We never share or sell your information for marketing, or fundraising purposes.

## **VII. Changes to the Terms of this Notice**

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.

## **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:

Thomas Heald (**Privacy Officer**) at the New Hampshire Veterans Home, 139 Winter St., Tilton, NH 03276 (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)