Spanish Peaks Veterans
Community Living Center

Thank you for expressing your interest in the *Spanish Peaks Veterans Community Living Center* in Walsenburg, Colorado.

The decision to come to a long-term care setting is one not easily made and it should not be taken lightly. However, we at *Spanish Peaks Veterans Community Living Center* feel confident that once you have visited us - all reservations surrounding this important decision will be erased.

If your request for this information has come at the time of a health care crisis where more immediate placement of a Veteran, a spouse/widow/widower of a Veteran, or a Gold Star parent is needed, please be advised that the expedient gathering of the required information and documents outlined is critical. A checklist has been included for you regarding the documentation you will need for admissions review and acceptance.

If you have any further questions concerning any part of the application process, please feel free to call me at 800/645-VETS (8387) or at 719/738-5133. I look forward to being of service and assisting you.

Regards,

Jan Novak
- US Army Veteran
SPVCLC Admissions Coordinator
Phone 719/738-5133
FAX 719/738-4522
Email jnovak@sprhc.org

Spanish Peaks Veterans
Community Living Center

Picture This…

All Inclusive Daily Rate:

24-Hour Nursing Care
Medications, Oxygen, Personal Care Products
Restorative Therapy Programs
Social Services, VA Benefit Assistance
Transportation to Appointments
Memory Care Unit (secure)
Semi-Private/Private Rooms
Resident /Family Support Groups
Therapeutic Activity Program
Wi-Fi Access, Basic Cable Service

Eligibility Requirements:

Veterans, spouses, widows/widowers, and Gold Star parents
Military discharge other than dishonorable
In need of 24-hour nursing care — respite admissions welcome
Medical (Medicare) services provided by the *Spanish Peaks Regional Health Center* which is physically connected to *Spanish Peaks Veterans Community Living Center*

Daily Rates as of December 1, 2017:

Semiprivate room $262.01
*Less VA per diem $112.36
YOU PAY $149.65

Private room $276.71
*Less VA per diem..... $112.36
YOU PAY $164.35

Memory Care Unit $269.91
*Less VA per diem $112.36
YOU PAY $157.55

> Private Pay and Medicaid accepted

> Service-Connected Veterans may qualify to have their entire care paid for by the VA.

> Additional VA benefits are available to Veterans and widows who qualify. For example, a wartime Veteran may be eligible for an improved pension with Aid & Attendance. A widow of a wartime Veteran may also be eligible. This is an income-based benefit that can further reduce your out-of-pocket expenses. Contact the Admissions Coordinator for more information.

*Please Note - Spouses/widows/widowers of Veterans and Gold Star Parents do not receive the VA per diem and must pay the full daily room rate

Colorado Residency Not Required

COLORADO
Department of Human Services

COLORADO
Department of Human Services
Veterans Community Living Centers

Admission Application

Veterans Community Living Centers

Fitzsimons	Florence	Homelake/Monte Vista	Rifle	**Walsenburg**
1919 Quentin Street	903 Moore Drive	P.O. Box 97	851 East 5th Street	**23500 US Hwy 160**
Aurora, CO 80045	Florence, CO 81226	Homelake, CO 81135	Rifle, CO 81650	**Walsenburg, CO 81089**
720-857-6406	719-784-6331	719-852-5118	970-625-0842	**719-738-5100**

Applicant's name: _____ _____ Sex _____
Last First Full Middle

Address: _____
Street City County State Zip

Phone number(s): _____ Religion: _____

Date of birth: _____ Place of birth: _____
City County State Country

Marital status: Married _____ Divorced _____ Widowed _____ Separated _____ Never married _____

Applicant is a: Veteran _____ Veteran's spouse _____ Veteran's widow _____ Gold-Star Parent _____

Military Information

Branch of service: _____ Service number: _____
Date entered: _____ Date discharged: _____
Does the applicant have a service-connected disability rated by the VA? Yes _____ No _____
If yes, please list disability: _____ Percent disability: _____

Medical and Health Insurance Information

Applicant's Social Security Number: _____ Medicare number: _____
Does applicant have: Medicare Part A? Yes _____ No _____ Medicare Part B? Yes _____ No _____
Does an HMO manage the applicant's Medicare? Yes _____ No _____
Secondary/supplemental insurance: _____ Insurance ID number: _____
Medicare Part D/other prescription coverage: _____ Insurance ID number: _____
Does applicant have Medicaid? Yes _____ No _____ If yes, provide Medicaid ID number: _____
Has applicant received medical care from the VA? Yes ____ No ____ VA claim #: _____
If yes, where, when and for what did the applicant receive treatment? _____
_____
Does applicant have any of the following?:
Medical Power of Attorney (POA): ___ General POA: ___ Living Will: ___ Guardian/Conservator: ___

Spouse Information

Spouse's name: _____ Maiden name (if any): _____
Last First Middle Date of Marriage: _____
Spouse's address: _____ Phone #: (_____)_____
Street City State Zip
Spouse's Social Security Number: _____ Spouse's Date of Birth: _____

Emergency Notification:

1) Name: _____ Relationship: _____
Address: _____
Street City County State Zip
Phone number(s): _____

2) Name: _____ Relationship: _____
Address: _____
Street City County State Zip
Phone number(s): _____

3) Name: _____ Relationship: _____
Address: _____
Street City County State Zip
Phone number(s): _____

If admitted to the Veterans Community Living Center, who will handle your financial affairs? *(Provide name and phone):*_____

Financial Information:

The following financial information is required to determine eligibility for benefits and ability to pay. Please state gross monthly amounts before any deductions.

Monthly Income	**Applicant**	**Spouse**
Social Security:	$ _____	$ _____
Civil Service:	$ _____	$ _____
Railroad retirement:	$ _____	$ _____
Military retirement (not VA):	$ _____	$ _____
VA service-connected disability compensation:	$ _____	$ _____
VA pension:	$ _____	$ _____
Other pensions (specify): _____	$ _____	$ _____
Gross wages (employment):	$ _____	$ _____
Total Monthly Income:	**$ _____**	**$ _____**

Assets	**Applicant**	**Spouse**
Cash/checking account/savings:	$ _____	$ _____
Investments:	$ _____	$ _____
Trusts:	$ _____	$ _____
Real estate (other than your residence):	$ _____	$ _____
Other:	$ _____	$ _____

Please attach copies of the following:

- Military separation orders or discharge papers (DD214 or similar document)
- Service-Connected Disability Award Letter from the VA, if applicable
- Front and back of all insurance cards
- Medical POA, General POA, guardian/conservatorship documents and living will, if available

I understand that it may be necessary for me to provide copies of bank statements periodically to verify my financial position, and that I must keep my account current.

If I am admitted, I agree to abide by the rules and regulations of the Veterans Community Living Center. I realize that the facility is operated in full compliance with the Civil Rights Act of 1964, and the Americans with Disabilities Act of 1990, and that I am to cooperate with the nursing home in maintaining full compliance.

I authorize the Veterans Community Living Center to verify any and all information provided on this form. The information I have provided is true and complete to the best of my knowledge and belief.

Signature: _____ Date: _____
(Applicant or POA)

Spanish Peaks Regional Health Center

Spanish Peaks Veterans Community Living Center

AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION

Request for Release by:

Facility: _____

Address: _____

City/State/Zip: _____

Telephone/Fax: _____

_____
Patient Name

_____
Mailing Address

_____
City State Zip

_____
Phone Fax

Release to: Spanish Peaks Veterans Community Living Center
Attn: **Jan Novak**
23500 US Highway 160
Walsenburg, CO 81089
Telephone: 719-738-5133
Fax: 719-738-4522

Patient's Date of Birth: _____

Patient's Last 4 Digits of SSN: _____

Email Address: _____

Patient:	☐ Pick Up	☐ Fax	☐ Mail
Other Person:	☐ Pick Up	☐ Fax	☐ Mail
Facility:	☐ Secure Email	☐ Fax	☐ Mail

INFORMATION TO BE COPIED AND RELEASED (CHECK ALL THAT APPLY):

Date(s) of service: _____

☐ Emergency Room Report	☐ Nurses Notes	☐ Respiratory	☐ Immunization Records
☐ Discharge Summary	☐ Medication Records	☐ Rehab Services	☐ Billing Records
☐ History & Physical	☐ Physician Orders	☐ Patient Care Photos	☐ Other: _____
☐ Consultation Reports	☐ Lab/Pathology Results	☐ Non-SPRHC Med Recs	
☐ Operative Reports	☐ Radiology Report	☐ Behavioral Notes	
☐ Physician Progress Notes	☐ Radiology Images	☐ Social Services Notes	

I DO ☐ or I DO NOT ☐ consent to release of information relating to psychiatric or psychological testing or treatment, alcohol, and/or drug abuse diagnosis, prognosis and treatment, and /or HIV(AIDS) testing and/or results, genetic testing/results, sickle cell anemia testing/results. ***NOTE: If this section is not completed, then records of this type, if they exist for this patient, will not be released. ***

THE PURPOSE FOR THIS RELEASE:

☐ Continuity of Medical Care ☐ Damage/Claim Information ☐ Personal Use ☐ Legal
☐ Applicant to Veterans Nursing Home ☐ Other: _____

AUTHORIZATION: I hereby give the releasing facility permission to disclose my individually identifiable health information as listed above. I understand once this information is disclosed, it may no longer be protected. I understand this authorization is voluntary, that further treatment cannot be conditioned upon my signing this authorization. I acknowledge incomplete forms cannot be processed and there may be a cost to copy these records.

I understand **this consent expires one year from the date of my signature** unless otherwise specified as follows: _____.
I understand I can take back permission to release my medical records at any time, except to the extent that action has already been taken to comply with it. I understand I must provide notice in writing if I choose to revoke this authorization before the date/event of expiration, and the written revocation must be signed and dated with a date that is later than the date on this authorization. A copy, fax or scan of this form is to be considered as valid as the original. **Please retain a copy of your records for your personal use.**

~~~~~~~PLEASE ALLOW 10 BUSINESS DAYS FOR YOUR RECORDS REQUEST TO BE PROCESSED.~~~~~~~

_____ _____ _____ _____
Signature of Patient/Representative Date/Time Signature of Witness Date/Time

Name of Staff person who released medical records: _____ Date: _____

OFFICE USE ONLY: Proof of Identification: _____
Number of pages released: _____ Completion date: _____ Delivery method: _____
Name of individual who received request: _____ Date received: _____
Patient Medical Record Number / Account Number: _____

REV/NOV 2019

Spanish Peaks Veterans Community Living Center

Spanish Peaks Veterans Community Living Center
FUNCTIONAL ASSESSMENT

APPLICANT NAME: _____

LAST FIRST FULL MIDDLE NAME

GOALS

- IS DISCHARGE A GOAL? ☐ YES ☐ NO
- IF "YES", WHAT GOALS NEED TO BE ACCOMPLISHED BEFORE DISCHARGE CAN HAPPEN?: _____
- WHAT ARE THE APPLICANT'S PERSONAL GOALS OVERALL?: _____

GENERAL INFORMATION

- REASON FOR NURSING HOME PLACEMENT: _____
- LENGTH OF STAY: ☐Long-term Care ☐Short-term Care ☐Rehab Only
- CODE STATUS: ☐Do Not Resuscitate ☐Full Code
- HEIGHT: _____ WEIGHT: _____ WEIGHT LOSS IN LAST 30 DAYS? ☐Yes ☐No
- AT-HOME MEDICATION LIST (use addt'l paper if necessary): _____

OXYGEN INFORMATION

- OXYGEN USE: ☐Yes ☐No OXYGEN SETTING: _____
- CPAP USE: ☐Yes ☐No CPAP SETTINGS: _____
- BPAP USE: ☐Yes ☐No BPAP SETTINGS: _____

WOUND INFORMATION

- OPEN WOUND PRESENT: ☐Yes ☐No WOUND MEASUREMENTS: _____
- WOUND LOCATION: _____
- WOUND TREATMENT REGIMEN: _____

ASSISTED DEVICES / SAFETY NEEDS

- WHEELCHAIR: ☐Yes ☐No
- CANE: ☐Yes ☐No
- SLIDE BOARD: ☐Yes ☐No
- WALKER: ☐Yes ☐No
- TRANSFER BAR: ☐Yes ☐No
- GERI CHAIR: ☐Yes ☐No
- RECLINER: ☐Yes ☐No
- LOW BED: ☐Yes ☐No
- REACHER: ☐Yes ☐No
- AIR MATTRESS: ☐Yes ☐No
- SAFETY HELMET: ☐Yes ☐No
- SPECIAL SHOES: ☐Yes ☐No
- OTHER: _____

POWER/MOTORIZED CHAIR

- IF THE APPLICANT CANNOT PASS A POWER/MOTORIZED CHAIR SAFETY ASSESSMENT BY THE *SPRHC* PHYSICAL THERAPY DEPARTMENT, THE APPLICANT MAY NOT BE ABLE TO USE THE DEVICE AT THE *SPVCLC*. DOES THE APPLICANT UNDERSTAND THIS PREREQUISITE?:
  ☐Yes ☐No ☐N/A
- IN SOME CASES THE SAFETY ASSESSMENT MAY BE PASSED BUT THE SPEED OF THE CHAIR MAY NEED TO BE REDUCED FOR CONTINUED SAFETY. DOES THE APPLICANT UNDERSTAND THIS POTENTIAL ACTION?:
  ☐Yes ☐No ☐ N/A
- PLEASE BE ADVISED THAT THE *SPVCLC* HAS THE RIGHT TO REMOVE THE CHAIR IF THE APPLICANT CAUSES INJURY TO SELF OR OTHERS - OR - CAN NO LONGER SAFELY OPERATE THE DEVICE.

FALLS

- WHEN WAS LAST FALL?: _____ REASON FOR FALL: _____
- NUMBER OF FALLS IN LAST 30 DAYS: _____ NUMBER OF FALLS IN LAST 31-60 DAYS: _____

SPLINTS & BRACES

- SPLINT: ☐Yes ☐No TYPE/LOCATION: _____
- BRACE: ☐Yes ☐No TYPE/LOCATION: _____

PACEMAKER

- PACEMAKER ☐Yes ☐No
- LAST TIME CHECKED: _____
- OFFICE THAT REMOTELY TESTS/CHANGES SETTINGS: _____

BEHAVIORAL INFORMATION

- BEHAVIORAL CONCERNS: ☐Yes ☐No
- DESCRIBE: _____
- TRIGGERS: _____
- HOW ARE THE BEHAVIORS HANDLED?: _____

ASSISTANCE REQUIRED

- EATING: ☐Yes ☐No
- GROOMING: ☐Yes ☐No
- HYGIENE: ☐Yes ☐No
- LOCOMOTION: ☐Yes ☐No
- DRESSING: ☐Yes ☐No
  ○1-person assist ○2-person assist
- SITTING: ☐Yes ☐No
  ○1-person assist ○2-person assist
- BATHING: ☐Yes ☐No
  ○1-person assist ○2-person assist
- STANDING: ☐Yes ☐No
  ○1-person assist ○2-person assist
- SHOWERING: ☐Yes ☐No
  ○1-person assist ○2-person assist
- TOILETING: ☐Yes ☐No
  ○1-person assist ○2-person assist
- WEIGHT BEARING: ☐Full weight ☐Partial Weight ☐Non-weight bearing
- TRANSFER ASSIST: ☐1-person stand-by assist ☐1-person pivot/transfer assist ☐2-person pivot/transfer assist ☐1-person physical assist ☐2-person physical assist ☐Stand-up lift ☐Hoyer lift ☐No assist

ASSISTANCE REQUIRED (CON'T)

- DESCRIBE WHAT THE APPLICANT CAN DO FOR FOR THEIR SELF: _____

BOWEL & BLADDER INFORMATION

- BLADDER: ☐ Continent ☐ Incontinent
- SELF-CATH: ☐ Yes ☐ No
- TYPE SIZE OF CATHETER: _____
- SELF-CATH FREQUENCY: _____
- INDWELLING CATHETER: ☐ Yes ☐ No
- ATTENDS: ☐ Yes ☐ No SIZE: _____
- PULL-UPS: ☐ Yes ☐ No SIZE: _____

- BOWEL: ☐ Continent ☐ Incontinent
- OSTOMY: ☐ Yes ☐ No OSTOMY SUPPLIES: _____

VISION, HEARING, DENTAL

- VISUALLY IMPAIRED: ☐ Yes ☐ No
- EYEGLASSES: ☐ Yes ☐ No
- HARD OF HEARING: ☐ Yes ☐ No
- HEARING AIDS: ☐ None ☐ Left ☐ Right ☐ Both
- UPPER PARTIAL ONLY: ☐ Yes ☐ No
- LOWER PARTIAL ONLY: ☐ Yes ☐ No
- UPPER & LOWER PARTIALS: ☐ Yes ☐ No
- UPPER DENTURE ONLY: ☐ Yes ☐ No
- LOWER DENTURE ONLY: ☐ Yes ☐ No
- UPPER & LOWER DENTURES: ☐ Yes ☐ No

- DENTAL ISSUES: ☐ Yes ☐ No DESCRIBE: _____

SLEEP PATTERN

- TROUBLE SLEEPING AT NIGHT: ☐ Yes ☐ No
- TIME PREFERENCE FOR RISING: _____
- TIME PREFERENCE FOR BEDTIME: _____
- PREFERENCE FOR SLEEPWEAR ATTIRE: _____
- NAPS DURING THE DAY: ☐ Yes ☐ No
- NAP TIMES: _____

COMMUNICATION

- COMMUNICATION NEEDS: ☐ Yes ☐ No
- EXPLANATION: _____
- COMMUNICATION BOARD: ☐ Yes ☐ No

DIETARY/NUTRITION

- PEG TUBE: ☐ Yes ☐ No PEG TUBE SUPPLIES: _____
- FOOD ALLERGIES: ☐ Yes ☐ No FOOD ALLERGY LIST: _____
- FOOD PREFERENCES: _____
- FOOD DISLIKES: _____
- REGULAR DIET: ☐ Yes ☐ No
- MECHANICAL DIET: ☐ Yes ☐ No
- CCHO DIET: ☐ Yes ☐ No
- HEART HEALTHY DIET: ☐ Yes ☐ No
- LIQUID DIET: ☐ Yes ☐ No
- PLATE GUARD: ☐ Yes ☐ No
- CLEAR LIQUID DIET: ☐ Yes ☐ No
- FULL LIQUID DIET: ☐ Yes ☐ No
- RENAL DIET: ☐ Yes ☐ No
- DIABETIC DIET: ☐ Yes ☐ No
- PUREE DIET: ☐ Yes ☐ No
- ARTHRITIC TABLEWARE: ☐ Yes ☐ No

ACTIVITIES OF INTEREST

- BIBLE STUDY: ☐ Yes ☐ No
- COMMUNION: ☐ Yes ☐ No
- CHURCH SERVICES: ☐ Yes ☐ No
- GROUP ACTIVITIES: ☐ Yes ☐ No
- CARD GAMES: ☐ Yes ☐ No
- PUPPY POWER HOUR: ☐ Yes ☐ No
- TRIVIA QUESTIONS: ☐ Yes ☐ No
- COUNTRY DRIVES: ☐ Yes ☐ No
- PET COMPANION PRGM: ☐ Yes ☐ No
- BINGO: ☐ Yes ☐ No
- ARTS & CRAFTS: ☐ Yes ☐ No
- TV/MOVIES: ☐ Yes ☐ No
- EXERCISE GROUP: ☐ Yes ☐ No
- HOBBIES: _____

SELF-ADMINISTERED MEDICATIONS

- IF THE APPLICANT CANNOT PASS A SELF-ADMINISTERED MEDICATION ASSESSMENT, PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS WILL NOT BE ALLOWED TO BE KEPT AT BEDSIDE (EXP: EYE DROPS, COUGH DROPS, PAIN RELIEVERS, ANTACIDS, ETC).

- IS THE APPLICANT INTERESTED IN SELF-ADMINISTERING THEIR OWN PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS?:
  ☐ Yes ☐ No

- IF "YES", DOES THE APPLICANT UNDERSTAND THAT A SELF-ADMINISTERED MEDICATION ASSESSMENT WILL BE COMPLETED UPON ADMISSION - AND - THE PHYSICIAN MUST APPROVE SELF-ADMINISTERED MEDICATIONS IF THE RESIDENT DOES PASS THE SELF-ADMINISTERED MEDICATION ASSESSMENT?:
  ☐ Yes ☐ No ☐ N/A

MISCELLANEOUS

- ANYTHING ELSE YOU'D LIKE US TO KNOW?: _____

_____

_____

_____

FORM COMPLETED BY: _____

NAME OF ADMISSION COORDINATOR DATE

Please review selections/answers to ensure they are clearly marked and legible ~ Thank you!

Spanish Peaks Veterans
Community Living Center

APPLICATION CHECK-LIST

The following is a convenient check-list (for your use only) of documents necessary (or requested) to review an applicant for admission to the *Spanish Peaks Veterans Community Living Center*. Once you have these items available, the application package is ready for submission. Should you have any questions or concerns, please contact me at 719/738-5133 (or 800/645-VETS).

❖ ALL APPLICANTS

- ☐ **ADMISSION APPLICATION FORM**
  NOTE: Only the applicant or Medical/Financial Power-of-Attorney (if either are in effect) may sign
- ☐ **CONSERVATORSHIP/GUARDIANSHIP DOCUMENT** (if applicable)
- ☐ **CPR DIRECTIVE** (if applicable)
- ☐ **FINANCIAL POWER-OF-ATTORNEY DOCUMENT** (requested)
- ☐ **FUNCTIONAL ASSESSMENT**
- ☐ **INSURANCE CARDS** (front/back copies of insurance cards such as Medicaid, Medicare, Tri-Care, RX, etc)
- ☐ **LIST OF AT-HOME MEDICATIONS ACTUALLY TAKEN** to include prescription and over-the-counter
- ☐ **LIST OF MEDICAL ENTITIES** (with the name/town seen in the last year (exp: primary physician, emergency room, hospital, specialist, rehab center, nursing home, assisted living facility, etc)
- ☐ **LIVING WILL** (if applicable)
- ☐ **LONG-TERM CARE POLICY** (if applicable)
- ☐ **MEDICAL POWER-OF-ATTORNEY DOCUMENT** (or Medical Proxy)
- ☐ **MILITARY SEPARATION DOCUMENT** (for self or for spouse (commonly referred to as the DD-214 document)
- ☐ **MORTUARY NAME & LOCATION** (also designate whether or not there is a pre-paid plan established)
- ☐ **MOST FORM** (if applicable)
- ☐ **RELEASE OF INFORMATION FORM**

❖ ONLY APPLICANTS APPLYING WITH A PAYER SOURCE OF PRIVATE PAY OR MEDICAID:

- ☐ **Financial Statements** (for last two months such as checking, savings, stocks, bonds, etc)

❖ ONLY VETERANS WITH A 70%-100% VA-RATED SERVICE-CONNECTED DISABILITY:

- ☐ **VA Award Letter** of percentage rating (ONLY if applying as a 70-100% disabled Veteran)

❖ ONLY APPLICANTS APPLYING AS A VETERAN'S SPOUSE/WIDOW/WIDOWER :

- ☐ **Marriage Certificate Document**
- ☐ **Death Certificate Document**