



RETURNING THE HONOR TO SERVE.

Thank you for expressing your interest in the *Spanish Peaks Veterans Community Living Center (SPVCLC)* - the Veterans Administration (VA) nursing home located in beautiful southern Colorado. Although the COVID-19 pandemic has resulted in a current restriction of visitations and tours of our wonderful long-term and short-term care facility, I encourage you to read about our distinctiveness and what the *SPVCLC* has to offer not only to its highly respected Residents - but to their families and friends, as well. You may also want to visit our website at www.sprhc.org.

The *SPVCLC* and its staff not only have the extensive capability to fully handle a wide variety of needs, but also the sincere understanding that goes along hand-in-hand. Every Resident is treated as that same unique person they have spent their lifetime becoming.

Please take a moment to review the following information, the application, and the list of documents that are either required or requested to better serve the applicant. Our *SPVCLC* Admissions Committee will review the collected information and then offer its recommendation to the Medical Director who will make the final determination as to acceptance. Please know that this process can go very quickly as long as all the requested documentation is in place.

As the *SPVCLC* Admissions Coordinator, I can also help guide you regarding any possible Medicaid and Veterans Administration benefits to include obtaining a copy of a military discharge document. We can also discuss other possible choices for long-term and short-term care, other services, and health care options.

As a military Veteran myself and family member of an *SPVCLC* Resident, it is my sincere honor and privilege to help guide you through the admission application process. From my first-hand experience, I do understand what an emotional and stressful time this may be. But you've taken the first step by contacting the *SPVCLC* and requesting this application packet. This is where you begin.

Looking forward to assisting you,

A handwritten signature in black ink, appearing to read "Jan Novak", written in a cursive style.

Jan Novak
US Army Veteran
- *SPVCLC* Admissions Coordinator
Ph 719/738-5133 FAX 719/738-4522
Ph 800/645-VETS Email jnovak@sprhc.org

OVERVIEW

The *SPVCLC* is a 120-bed non-skilled nursing home facility offering a memory care unit for those Residents with Alzheimer's Disease and dementia special needs. It is easily accessible via Interstate 25 just a few miles west from the town of Walsenburg on US Hwy 160. Visitation is 24-hours a day and seven days a week.



Spanish Peaks Regional Health Center / Spanish Peaks Veterans Community Living Center & Specialty Clinic

★ ALL-INCLUSIVE DAILY RATE

- 24-hour Nursing Care
- Activities Department Offering Various Interests at Multiple Degrees of Capabilities
- Bathing Aide Services
- Computer Use with Internet Access
- Hospital Bed, Clothing Cabinet, Bed-Side Cabinet with Drawers, Hospital Bed-side Table
- Care Plan Meetings
- Diet Customization & Snacks
- DISH Basic Cable TV Access
- Various Types of Entertainment and Games
- Housekeeping & Laundry Services Provided
- Hydration Aides
- Library
- Mail Room Service In-House
- Meal Choices
- Medications, Oxygen, Adult Attends
- Memory Care Unit Alternative w/Fenced Garden
- Personal Care Items
- Restorative Therapy Programs
- SCANDENT - A Loss Prevention System
- Secure & Private Outdoor Areas
- Semi-Private or Private Room, as Applicable
- Shopping Trips
- Social Services Department
- VA Remote Tele-Health Counseling
- Transportation to Appointments with CNA's
- Veteran Service Officer for VA Benefit Assistance
- Volunteers to Assist with Various Activities
- Wi-Fi Access
- Oxygen, Attends/Pull-up Briefs, Prescriptions

Also available at the *SPVCLC* and on-campus are an in-house pharmacy, gift shop, barber/beauty salon, accessible physician and physician assistant services, complimentary Notary Public services, and the *Spanish Peaks Regional Health Center (SPRHC)* complex. The *SPRHC* is home to a Level IV Trauma Center and hospital with a surgical center, the Medicaid Swing Bed Unit, and a cafeteria offering a short-order grill.

Our *Specialty Clinic* houses the "Fresenius Kidney Care" dialysis center and visiting physicians who specialize in various medical fields for the convenience of the *SPVCLC* Residents and southern Colorado. The *Spanish Peaks Family Clinic* is open to the public for medical services. The *SPVCLC* overlooks the wonderful Lathrop State Park from its second-floor scenic advantage point. Residents may join in fishing outings and picnics at this very convenient picturesque spot during the summer months.

Should hospice care ever become necessary, please know that the *SPVCLC* is currently served by the outstanding *Sangre de Cristo Hospice* organization based in Trinidad.

★ ELIGIBILITY

- ✓ Veterans, spouses/widows/widowers of Veterans, and Gold Star parents may be accepted from all fifty U.S. states and territories
- ✓ Colorado residency is *not* a requirement
- ✓ Veterans must have a military discharge type other than dishonorable which meets criteria
- ✓ Spouses & widows/widowers of Veterans must have a Veteran marriage relationship with the same military discharge criteria as noted above. Divorcees of Veterans and widows/widowers of Veterans who later married a non-Veteran are not eligible to apply.
- ✓ Long-term care, short-term care (respite), and physical rehabilitation stays are available for qualified Veterans, spouses/widows/widowers of Veterans, and Gold Star parents



Spanish Peaks Mountain View from West-side Outdoor Area

★ PAYER SOURCES

The *SPVCLC* accepts the following payer sources for room and board services. Most of the *SPVCLC* rooms are semi-private (two persons to a room). We only have a limited number of private rooms. I encourage you to call me to discuss payment options to include possible Medicaid eligibility. You won't know until you ask!

• VETERANS

- Private Pay, Colorado Medicaid, and long-term care insurance are accepted
- There is no charge for room and board if a Veteran has a V.A. service-connected disability rating of 70-100%

• SPOUSES & WIDOWS/WIDOWERS OF VETERANS

- Private Pay, Colorado Medicaid, and long-term care insurance are accepted

• GOLD STAR PARENTS

- Private Pay, Colorado Medicaid, and long-term care insurance are accepted

★ CURRENT DAILY RATES

The current daily rate includes oxygen, adult Attends/pull-up briefs, and prescription services:

> VETERANS

- PRIVATE PAY

<i>Semi-Private Room</i>	\$262.01
- Less VA Per Diem	<u>\$112.36</u>
= Final Daily Cost	\$149.65

<i>Private Room</i>	\$276.71
- Less VA Per Diem	<u>\$112.36</u>
= Final Daily Cost	\$164.35

- 70-100% DISABLED SERVICE-CONNECTED

No room and board charge

- Colorado Medicaid & Long-Term Care Insurance Accepted

<i>Memory Care Unit</i>	\$269.91
- Less VA Per Diem	<u>\$112.36</u>
= Final Daily Cost	\$157.55

> SPOUSES & WIDOWS/WIDOWERS OF VETERANS

- PRIVATE PAY

<i>Semi-Private Room</i>	\$262.01
<i>Private Room</i>	\$276.71
<i>Memory Care</i>	\$269.91

- Colorado Medicaid & Long-Term Care Insurance Accepted

> GOLD STAR PARENTS

- PRIVATE PAY

<i>Semi-Private Room</i>	\$262.01
<i>Private Room</i>	\$276.71
<i>Memory Care</i>	\$269.91

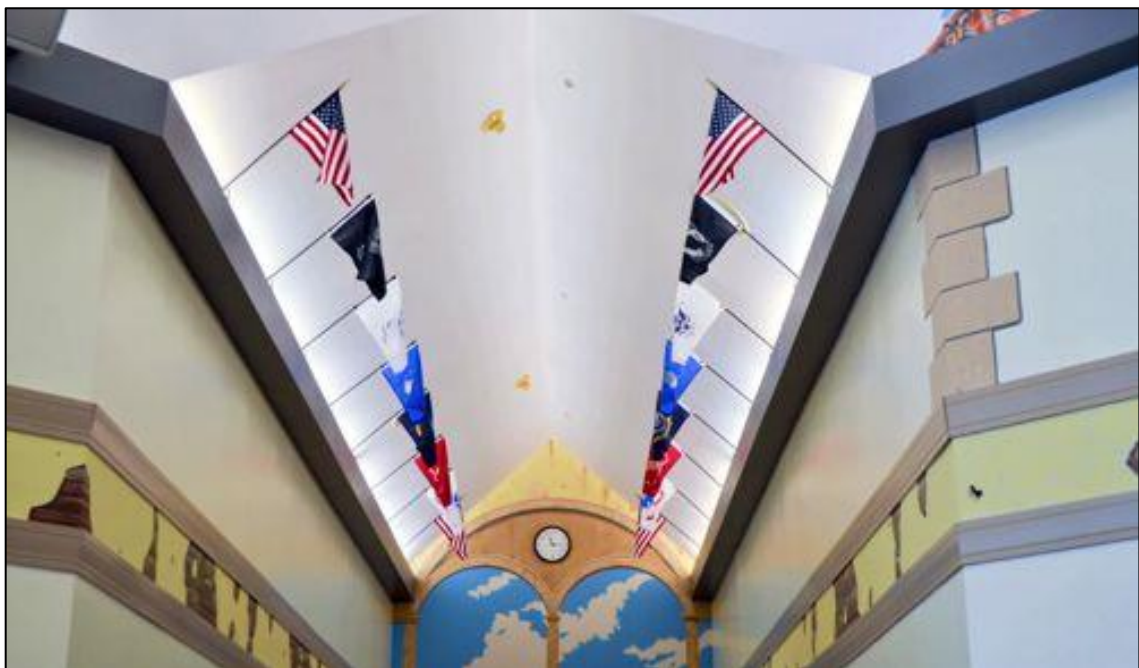
- Colorado Medicaid & Long-Term Care Insurance Accepted

Should you have any questions or concerns, please do not hesitate to contact me. Remember - I can help guide you regarding the payer sources, Colorado Medicaid, and the applicant's Veteran Service Officer in their county and state.

At first glance, I understand that this admission process might appear to be overwhelming - but I assure you that it is not. Please know that we at the *SPVCLC* only exist to serve our nation's Veterans, the spouses/widows/widowers of Veterans, and the Gold Star parents.

As part of the *Spanish Peaks Regional Health Care* complex in Walsenburg, the *SPVCLC* proudly shares the same motto:

"To Improve the Lives We Touch"



Main Hallway Honoring the U.S. Military Branches of Service



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: Last First Full Middle Sex

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: Street City State Zip Phone #: 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.

	Applicant	Spouse
Monthly Income		
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:	\$ _____	\$ _____

	Applicant	Spouse
Assets		
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)

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: <input type="checkbox"/> Yes <input type="checkbox"/> No | • REACHER: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • CANE: <input type="checkbox"/> Yes <input type="checkbox"/> No | • AIR MATTRESS: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • SLIDE BOARD: <input type="checkbox"/> Yes <input type="checkbox"/> No | • SAFETY HELMET: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • WALKER: <input type="checkbox"/> Yes <input type="checkbox"/> No | • SPECIAL SHOES: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • TRANSFER BAR: <input type="checkbox"/> Yes <input type="checkbox"/> No | • MOTOR/POWER CHAIR* <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • GERI CHAIR: <input type="checkbox"/> Yes <input type="checkbox"/> No | • OTHER: _____ |
| • RECLINER: <input type="checkbox"/> Yes <input type="checkbox"/> No | (*Note: Motor/power chairs must be approved by the
SPVCLC PT Department for use in the nursing home) |
| • LOW BED: <input type="checkbox"/> Yes <input type="checkbox"/> No | |

FALLS

- WHEN WAS LAST FALL?: _____ REASON FOR FALL: _____
• NUMBER OF FALLS IN LAST 30 DAYS: _____ NUMBER OF FALLS IN LAST 31-60 DAYS: _____
• WHAT INTERVENTIONS HAVE BEEN HELPFUL TO REDUCE FALLS?: _____

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
- DRESSING: Yes No
 1-person assist 2-person assist
- BATHING: Yes No
 1-person assist 2-person assist
- SHOWERING: 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
- DESCRIBE WHAT THE APPLICANT CAN DO FOR FOR THEIR SELF: _____

- HYGIENE: Yes No
- LOCOMOTION: Yes No
- SITTING: Yes No
 1-person assist 2-person assist
- STANDING: Yes No
 1-person assist 2-person assist
- TOILETING: Yes No
 1-person assist 2-person assist

BOWEL & BLADDER INFORMATION

- BLADDER: Continent Incontinent
- DIAGNOSIS FOR CATHETER: _____
- SELF-CATH: Yes No
- TYPE SIZE OF CATHETER: _____
- SELF-CATH FREQUENCY: _____
- BOWEL: Continent Incontinent
- OSTOMY: Yes No OSTOMY SUPPLIES: _____
- DIAGNOSIS FOR OSTOMY: _____
- INDWELLING CATHETER: Yes No
- ATTENDS: Yes No SIZE: _____
- PULL-UPS: Yes No SIZE: _____

VISION, HEARING, DENTAL

- VISUALLY IMPAIRED: Yes No
- EYEGASSES: Yes No
- HARD OF HEARING: Yes No
- HEARING AIDS: None Left Right Both
- UPPER PARTIAL ONLY: Yes No
- DENTAL ISSUES: Yes No DESCRIBE: _____

- 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

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
- COMMUNICATION BOARD: Yes No
- EXPLANATION: _____

DIETARY/NUTRITION

- PEG TUBE: Yes No
- FOOD ALLERGIES: Yes No
- 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
- PEG TUBE SUPPLIES: _____
- FOOD ALLERGY LIST: _____
- 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
- EXERCISE GROUP: Yes No
- HOBBIES/SPECIAL INTERESTS: _____
- TRIVIA QUESTIONS: Yes No
- COUNTRY DRIVES: Yes No
- PET COMPANION PGRM: Yes No
- BINGO: Yes No
- ARTS & CRAFTS: Yes No
- TV/MOVIES: Yes No

PAIN HISTORY

LOCATION OF PAIN	PAIN DIAGNOSIS	PAIN MEDICATION

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

MORTUARY

IT IS IMPORTANT THAT THE FINAL WISHES OF THE APPLICANT BE HONORED. PLEASE PROVIDE THE MORTUARY NAME, LOCATION, AND CONTACT INFORMATION. PLEASE ALSO DESIGNATE WHETHER OR NOT THE PLAN IS PRE-PAID. THE ADMISSIONS COORDINATOR MAY BE ABLE TO PROVIDE YOU WITH A FEW OPTIONS IF YOU HAVE NOT ALREADY DECIDED ON ONE.

MORTUARY NAME

CITY/STATE

TELEPHONE NUMBER

IS THIS A PRE-PAID PLAN? Yes No

- Please submit a copy of the plan if there is one.

MISCELLEOUS

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

FORM COMPLETED BY: _____
NAME OF PERSON COMPLETING FORM DATE

FORM REVIEWED BY: _____
NAME OF ADMISSION COORDINATOR DATE

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



Spanish Peaks Regional Health Center



AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION

Request for Release by:		Release to:	
Facility: _____		Spanish Peaks Veterans Community Living Center	
Address: _____		Attn: Jan Novak	
City/State/Zip: _____		23500 US Highway 160	
Telephone/Fax: _____		Walsenburg, CO 81089	
		Telephone: 719-738-5133	
		Fax: 719-738-4522	
Patient Name: _____		Patient's Date of Birth: _____	
Mailing Address: _____		Patient's Last 4 Digits of SSN: _____	
City: _____ State: _____ Zip: _____		Email Address: _____	
Phone: _____ Fax: _____		Patient: <input type="checkbox"/> Pick Up <input type="checkbox"/> Fax <input type="checkbox"/> Mail	
		Other Person: <input type="checkbox"/> Pick Up <input type="checkbox"/> Fax <input type="checkbox"/> Mail	
		Facility: <input type="checkbox"/> Secure Email <input type="checkbox"/> Fax <input type="checkbox"/> Mail	

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

Date(s) of service: _____

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

<input type="checkbox"/> Continuity of Medical Care	<input type="checkbox"/> Damage/Claim Information	<input type="checkbox"/> Personal Use	<input type="checkbox"/> Legal
<input type="checkbox"/> Applicant to Veterans Nursing Home	<input type="checkbox"/> 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



# 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 the *SPVCLC* Admissions Coordinator 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)
- LIVING WILL** (if applicable)
- LONG-TERM CARE INSURANCE 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)
- 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**