Mississippi VA
660 North Street • Jackson, MS 39206
P.O. Box 5947 • Pearl, MS 39288-5947
Phone: 601-576-4850 • Fax: 601-576-4868

Mississippi VA
VETERANS HOME

Application for Admission to a Mississippi Veterans Home

To be completed by applicant or authorized representative

Dear Applicant,

Thank you for your interest in the **Mississippi Veterans Home System.** This pre-admission package has been assembled to provide you with the information necessary to aid the Department of Veterans Affairs (VA) and MSVA in determining your eligibility for benefits and processing your application in the most expedient manner.

Each of the attached forms must be reviewed thoroughly and completely filled out. Particular attention to requirements for physicians' signatures should be adhered. In addition, the applicant or legal conservator (Court or VA appointed) must sign each form that requires a signature. Failure to complete all information requested or to obtain proper signatures could delay the processing of your application. Your completed application and a copy of your DD214/Discharge should be submitted to the home of your first choice.

CONTENTS

These forms can be submitted when complete			
FORM	DD214	Discharge/Discharge Certificate	
FORM	Social History	Within 30 Days of admittance	Applicant
FORM	General Information		Applicant
FORM	Smoking Policy		Applicant
FORM	VA Form 10-10-EZ	Application for Health Benefits	Applicant
CARDS	Identification/Medical Cards	Social Security, Medicare, Drivers License, VA ID, Other Insurance Cards	
	Durable Power of Attorney, General Power of Attorney, Health Care Directives, Conservatorship		
These forms can be submitted later if not ready when applicant completes above forms			
FORM	Medical History & Physical	Within 30 Days of admittance	Physician
FORM	Statement of Attending Physician	Within 30 Days of admittance	Physician
FORM	Pulmonary History	Within 30 Days of admittance	Physician
FORM	Admitting Orders	Within 5 Days of admittance	Physician
TEST	Chest X-Ray	Within 30 Days of admittance	Physician
TEST	TB Test	Within 30 Days of admittance	Physician
TEST	COVID Test (PCR ONLY)	Within 7 Days of admittance	Physician

A copy of your **DD 214** or **Discharge from Service** must be attached with your application. If you do not have a copy, please contact MS VA at 601-576-4850 or website at msva.ms.gov

DAILY CHARGE FOR CARE AT A MISSISSIPPI VETERANS HOME

VETERAN (Beginning June 1, 2022) ..... **$65.00** */ day*

This charge includes comprehensive medical care (staff, doctors and medications), nursing care, laundry, room and board. Home residents who are away from the home on a non-medical pass for more than twelve (12) days will be charged an additional $129.97 per day for each day they remain away from the home.

VETERAN WITH SERVICE CONNECTED RATING OF 70% OR GREATER ..... **NO CHARGE**

VETERAN'S SPOUSE (Beginning June 9, 2023)..... **$215.00** */ day*

Note: You will be notified prior to any changes in charges.

You will be notified concerning any action on your application. You can contact the Veteran Service Officer if you have any concerns or questions on any actions of your application.

If you have any questions, please call the State Veterans Home of your choice.

Mississippi State Veterans Home | Collins
3261 Hwy 49 South • Collins, MS 39428
(601) 765-0403

Mississippi State Veterans Home | Kosciusko
310 Autumn Ridge Drive • Kosciusko, MS 39090
(662) 289-7044

Mississippi State Veterans Home | Jackson
4607 Lindbergh Drive • Jackson, MS 39209
(601) 354-7205

Mississippi State Veterans Home | Oxford
120 Veterans Drive • Oxford, MS 38655 (662) 236-7641

ADMISSION & RESIDENCY REQUIREMENTS

Preface

To be admitted to a Mississippi State Veterans Home (MSVA Home) (or be placed on the waiting list for admission), a veteran must meet criteria outlined in the sub-paragraphs below:

1. A veteran must be or have been a Mississippi resident.

2. The veteran must have had active duty in the armed forces and have been discharged under other than dishonorable conditions (applicant must supply DD214 or equivalent Report of Separation from Service). Peacetime veterans will be listed on a separate waiting list; however, they will not be given preference over a wartime veteran. In addition, veterans not meeting (a) above (is resident of another state) may be admitted to a Mississippi State Veterans Home to fill vacant bed(s), up to a total of 148 occupied beds, but only when there is not Mississippi residents on the active waiting list or ready to enter the Home. However, the cost of care for such resident will be at no expense to the State of Mississippi regardless of length of stay. In the event that this should occur, such resident shall not be discharged from the Home for the sole purpose of vacating a bed to accommodate a subsequent Mississippi resident who desire admission.

3. Veterans shall have had medical examination, TB test, and chest X-ray by personal or VA physician within 30 days of admission request and as a result, it is shown that he/she does not
    A. Have a communicable disease.
    B. Require medical or hospital care for which the Homes are not equipped or staffed to provide.
    C. Have violent traits which may prove dangerous to the physical well being of residents, employees, or the veteran.
    D. The MSVA requires that signed physician's orders be submitted to the Nursing Home 24 hours prior to the admission of the resident.

Note: When a bed in a MSVA Home becomes available, first priority will be given to current residents in the MSVA Veteran Home System who desire a transfer to the relevant facility. Priority will next be given to veteran on the waiting list for admission to the relevant Home. Applicants on the waiting list who refuse an available bed will lose their priority status on the list. Likewise, any applicant who declines a bed on two or more occasions will be placed on the inactive waiting list until they inform the agency that they are ready to return to the active waiting list.

4. All veterans shall consent to abide by all rules and/or regulations governing the Homes, and to follow the course of treatment prescribed by the Veterans Home medical staff, both before and after admission to the Home. Failure to do so can result in denial of admission or discharge from the home.

5. Residents shall accept discharge from the Homes when medical and/or administrative review determines such action to be appropriate. Residents desiring discharge from the Home are required to provide a three (3) day notice. Failure to do so will result in resident being charged for three (3) days beyond discharge date.

6. Residents desiring transfer to a different State Veterans Home shall be responsible for all associated costs.

7. Residents shall accept transfer to other facilities (including those operated by the Department of Veterans Affairs) if medical condition mandates, as determined by the Veterans Home Medical Staff and agree to pay all costs not covered by the Department of Veterans Affairs or other third-party payers. The MSVA will not be responsible for any co-payments/deductibles for medical service provided to residents.

8. Residents requiring dental care will be responsible for all associated costs of said care.

9. Residents shall furnish their own items or personal clothing and bring with them any orthopedic appliances, braces, wheel chairs, walkers, etc., with the exception of beds, which may have been issued to them by the Department of Veterans Affairs.

10. Each Resident, upon admission, shall designate a beneficiary to receive all personal belongings, to include funds on deposit with the Agency, should the resident expire or be incapacitated at the time of discharge.

11. Residents may sign in/out unless medically contraindicated (as documented by the physician in the individual's medical record): If medically contraindicated, resident must be signed out/in and accompanied by a member of the MSVA staff, or a family member or other responsible party.

12. The Home shall charge veterans for comprehensive care. Every resident of the Home shall be responsible for full payment of the comprehensive care charge which must be paid in advance (remainder of month) upon admission and by the 10th day of each succeeding month. Comprehensive care charges shall be set by the Agency and may be periodically revised. Charge for less than complete month will be prorated.

I. HOSPITALIZATION

a. The veteran will pay the current daily resident charge for up to fourteen (14) consecutive overnight absences at a VA or other hospital in order for the veteran's bed to be held at the Home.

b. However, any resident who is hospitalized for more than fourteen (14) consecutive days shall be discharged from the facility. The resident will remain responsible for charges set forth in preceding paragraphs until the actual date of discharge from the Veterans Home. Upon discharge from the hospital, the resident will be given priority placement within the State Veterans Homes.

II. VOLUNTARY PASS OTHER THAN HOSPITALIZATION

If the resident is on pass other than for hospitalization, the bed will be held for resident as follows:

a. If the veteran returns to the Home after having been on pass for less than twelve (12) days in a calendar year, the veteran is responsible for payment of only the regular daily resident's charge for each day he/she was on pass. However, if veteran is rated as in need of nursing home care for a VA adjudicated service-connected disability; or the veteran has a singular or combined service connected rating of seventy percent (70%) or more based on one or more service-connected disabilities or a rating of total (100%) disability based on individual unemployability, the veteran will not have a charge to hold his bed at the Home for the first 12 days in a calendar year.

b. Any veteran who remains away from the Home for more than twelve (12) days in a calendar year, he/she is responsible for payment (beginning with the 13th day) of the regular daily residents charge for each day on pass plus the current daily VA per diem rate for each day on pass. This adjustment to the charge for nursing home care is necessary to cover the loss of VA per diem (which helps keep the regular rate down).

III. Residents shall apply for all state and federal monetary/medical benefits for which he/she may be entitled. He/ she shall be counseled about benefit entitlement by a representative of the MSVA.

IV. Failure to pay for comprehensive care or repeated late payment may result in dismissal from the Home. Such dismissal shall require four-fifths (4/5) vote of MSVA Board members that are present. The Executive Director is authorized to use all state laws to recoup monies due to the Home for comprehensive care.

13. There shall not be any income and/or net worth bar for admission to a MSVA Home.

    PRIVATE ROOMS: The policy and priority for private room assignment is as follows:

    i. Contagious or infectious disease.
    ii. Terminally ill.
    iii. Female admission (where a private room is available and female is number one on the waiting list and home occupancy would preclude admittance of the female).
    iv. First-come-first-serve (any occupant of a private room, due strictly to the choosing of the resident, will be charged an additional $300.00 per month).

    NOTE: Private room occupants in categories i, ii, and/or iii will vacate the private room when the condition(s) and/or situation is resolved. Private room occupants from category iv will be required to vacate the private from for category i and/or ii residents on a list first-in, first-out basis (name would be placed back at top of the first-come-first-served waiting list).

14. Residents are encouraged to deposit excess personal funds with the MSVA. Such funds will be held on deposit in a local bank account. Interest will be credited to individual veterans' accounts. No service charge will be charged for accounts.

15. If requested and appointed by appropriate authority, the MSVA will act as fiduciary for incompetent residents. However, MSVA will NOT accept this appointment unless ALL income (from all sources) is also under MSVA's control. This is to permit the MSVA to be able to comply with regulations and policies requiring timely and accurate reporting of the resident's income and assets (as fiduciary, the MSVA becomes liable for the consequences of inaccurate and/or untimely reports).

16. SEARCHES: All packages being taken in and out of a MSVA Home are subject to inspection by Security personnel to verify contents.

17. ADVANCED DIRECTIVES:

A competent person, of legal age, has the right to accept or refuse medical or surgical treatment. In general, an individual has the right to make health care decisions which will become effective if the individual is no longer competent to make treatment decisions. These instructions are commonly referred to as "Advance Directives." An Advance Directive can be a LIVING WILL, A DURABLE POWER OF ATTORNEY for HEALTH CARE, or other evidence of the individual's wishes concerning health care decisions.

A. A Living Will is a directive to be allowed to die naturally. The Living Will comes into play only when the attending physician, along with two (2) other physicians, believes that the individual will not regain consciousness or a state of health that is meaningful to the individual and but for the use of life-sustaining mechanisms, the individual would soon die.

B. A Durable Power of Attorney for Health Care (DPAHC) is a document where an individual designates someone as their agent to make health care decisions for them if they are unable to make such a decision. The DPAHC must specifically authorize the individual's attorney in fact to make health care decisions for the individual and must contain the standard language set out in the law. Otherwise, the DPAHC can contain any instruction, which the individual wishes.

C. Decisions to accept or refuse treatment, internal nutrition via feeding tubes or gastric devices, and/or artificial hydration rest with the resident or appropriate legal representative. The MSVA Home and employees have no official opinion on the care and treatment decisions of the individual residents.

D. It is the policy of MSVA Homes to follow the directions given by each resident with regard to accepting or refusing treatment to the extent permitted by law and within MSVA policy.

E. No individual shall be discriminated against or have care conditioned on whether the individual has executed any advance directive.

F. SUCCESSION OF SURROGATES: If an incompetent resident does not execute an advance directive specifying care and treatment decisions while still competent, MSVA Home will consult with the person from the following list of successions:
    1. Attorney-in-fact (designated by the Durable Power of Attorney for Health Care)
    2. Court appointed guardian
    3. Spouse
    4. Adult children (all adult children are co-equal)
    5. Parent(s)
    6. Adult siblings (all adult siblings are co-equal)
    7. Grandparents (maternal and paternal grandparents are co-equal if the father is authorized and is legitimate, other, maternal grandparents shall have priority over paternal grandparent

18. SUSTENANCE POLICY
    It is the policy of the MSVA to follow the dietary order of the physician of the Home.

19. CARDIOPULMONARY RESUSCITATION (CPR) POLICY:
    In the event of a cardiopulmonary arrest:

    A. Basic CPR will be performed if there is a staff member available with the requisite skills and knowledge to perform basic CPR, UNLESS, in the opinion of the physician, this intervention is medically unnecessary or inappropriate OR the resident (or surrogate) has directed AGAINST this action.

    B. An ambulance will be summoned unless, in the opinion of the physician, this intervention is medically unnecessary or inappropriate.

20. Residents shall recognize that the Homes will be operated in full compliance with the Civil Rights Act without discrimination as to race, creed or religion.

Mississippi VA

ITEMS TO BRING UPON ADMISSION

1. Copies of the following items (Front and Back Needed)
    a. Durable Power of Attorney or Living Will
    b. Medicare Card
    c. Other Insurance Cards
    d. Driver's Licenses
    e. SS Card
    f. VA Card
    g. Conservatorship
2. A check, cash or money order for the amount of the current month's admission ($65/day prorated for number of days left in the month)
3. Items to bring with you at admission:
    a. Seven (7) changes of comfortable clothes (e.g., pants, shirts, sweatshirts/pants, fleece jacket)
    b. Underwear & T-shirts
    c. Comfortable non-skid shoes
    d. Pajamas, robe, and house shoes
    e. Electric shaver
    f. Photos/Pictures in frames (Glass must be removed from frames)
    g. Small dresser drawer (Optional as one is already provided in room)
    h. Lap blanket or Afghan if desire
    i. Any other personal items to make resident comfortable
4. You may bring a personal wheelchair and/or walker
    a. DO NOT bring an electric or motorized wheelchair until it is authorized by the Director of VA Home
5. DO NOT bring any of the following:
    a. Personal refrigerators
    b. Microwave
    c. Coffee Pots
    d. Hot Plates
    e. Air Mattresses (unless approved by Director)
6. On the day of admission, the responsible party or family member must accompany the Veteran upon entrance into the VA Home. The Veteran cannot be admitted without this person present.
7. ***Must arrive at the facility no later than 1:00 pm on day of admission.***
8. You may also consider bringing some money to be placed in the resident's personal funds that the resident may withdraw from if needs to purchase an item.
9. Contact the VSO with any other questions or if you have an issue on day of admission.

Mississippi VA

Mississippi VA SOCIAL HISTORY

We have found through experience that the more we know about our residents when they come into our facility the better care we can give. Often details of a person's past life which we never thought of asking about turn out to be important factors in their happiness here. Your replies are completely confidential and will be used only for professional purposes. Sending the completed form in advance will save you time on admission. If you are uncertain about any questions, you can discuss them with one of us.

LAST NAME **FIRST NAME**

CURRENT SITUATION

Dressing	☐ Alone	☐ Needs help	☐ Unable
Washing hands and face	☐ Alone	☐ Needs help	☐ Unable
Bathing and skin care	☐ Alone	☐ Needs help	☐ Unable
Getting in and out of bed	☐ Alone	☐ Needs help	☐ Unable
Getting in and out of a chair	☐ Alone	☐ Needs help	☐ Unable
Hair care	☐ Alone	☐ Needs help	☐ Unable
Fingernail care	☐ Alone	☐ Needs help	☐ Unable
Toenail care	☐ Alone	☐ Needs help	☐ Unable
Shaving	☐ Alone	☐ Needs help	☐ Unable
Brushing teeth and/or dentures	☐ Alone	☐ Needs help	☐ Unable
Toilet use	☐ Alone	☐ Needs help	☐ Unable

BOWEL CONTROL
☐ Normal ☐ Occasional loss of control ☐ Unable to control ☐ Enemas ☐ Uses suppositories
FREQUENCY
TIME OF DAY
ANY HELP USED

BLADDER CONTROL
☐ Normal ☐ Occasional loss of control ☐ Unable to control ☐ Catheter
FREQUENCY
TIME OF DAY

RESIDENT NAME _____ **PHYSICIAN** _____

NAME PREFERRED TO BE CALLED _____ **DATE** _____

WALKING (CHECK ALL THAT APPLY)

- ☐ Normal
- ☐ Slow but steady
- ☐ Unsteady
- ☐ Not walking
- ☐ Up in chair only
- ☐ Cane(s)
- ☐ Crutch(es)
- ☐ Walker
- ☐ Climb stairs
- ☐ Bedridden
- ☐ Wheel chair
- ☐ Brace
- ☐ Artificial limb

SLEEPING (CHECK ALL THAT APPLY)

- ☐ Restless
- ☐ Daytime dozing
- ☐ Wandering at night
- ☐ Needs side rails
- ☐ Unable to use nurse call signal

USUAL BEDTIME
USUAL WAKE-UP TIME
IF TAKES NAP, TIME

DESCRIBE ANY FALLS OR INJURIES

_____

_____

EATING

FOODS RESIDENT DISLIKES				
FOODS WHICH CAUSE ALLERGIES				
FOODS WHICH CAUSE INDIGESTION				
APPETITE (CHECK ONE)	☐ Poor	☐ Normal	☐ Overeats	
EATING (CHECK ONE)	☐ Feeds self	☐ Needs help	☐ Spoon fed	☐ Tube fed
DESCRIBE USE OF ALCOHOLIC DRINKS				
ANY OBJECTION TO ALCOHOLIC DRINKS PRESCRIBED BY PHYSICIAN?	☐ No	☐ Yes		
DOES RESIDENT SMOKE?	☐ No	☐ Yes | *type and supply:*		
DOES HE/SHE OBJECT TO BEING WITH THOSE WHO SMOKE?	☐ No	☐ Yes		

DESCRIBE ANY IMPAIRMENTS OR PROBLEMS	
SPEECH IMPAIRMENTS	IF IMPAIRED, HOW DOES THE RESIDENT COMMUNICATE?
WRITING IMPAIRMENTS	☐ Right-handed ☐ Left-handed ☐ Both
VISION IMPAIRMENTS	☐ Glasses reading ability | *explain:*
HEARING IMPAIRMENTS *better ear:*	☐ Hearing aid | *type:* *battery #:* *where to buy batteries?* *where to repair?*
TEETH AND MOUTH IMPAIRMENTS	☐ Upper ☐ Lower ☐ Dentures
SKIN IMPAIRMENTS	
BEDSORES	
FEET	
OTHER PHYSICAL CONDITIONS REQUIRING CARE	
PROBLEMS GETTING RESIDENT TO TAKE MEDICINE OR TREATMENT	
MEDICINES OR TREATMENT RESIDENT HAS REACTED UNFAVORABLY TO OR IS ALLERGIC TO	

PRESENT CONDITIONS (CHECK ALL THAT APPLY) | *if only occasionally, indicate when | star (*) items developed in recent months*		
☐ Sociable	☐ Prefers to be alone	☐ Slightly forgetful
☐ Cheerful	☐ Prefers groups	☐ Very forgetful
☐ Independent	☐ Silent	☐ Depressed
☐ Too independent	☐ Cooperative	☐ Often angry
☐ Mentally alert	☐ Reserved	☐ Worrier
☐ Confused	☐ Aggressive	☐ Easily fatigued
☐ Tempter outbursts	☐ Has talked of suicide	☐ Fears of death
☐ Cries easily	☐ Has attempted suicide	☐ Dizziness
☐ Excessive laughing	☐ Withdrawn	☐ Fainting
☐ Wants to get well	☐ Chronic complainer	☐ Convulsions
☐ Noisy	☐ Sensitive	☐ Headaches
☐ Loss of self-esteem	☐ Hears things that are not there	☐ Poor judgment
☐ Believes people are against them	☐ Sees things that are not there	

PAST LIFE

EARLY FAMILY LIFE	
BORN AND RAISED	
IF FOREIGN BORN, AGE CAME TO U.S.	CITIZEN NOW?
FATHER'S NAME	BIRTHPLACE
MOTHER'S MAIDEN NAME	BIRTHPLACE
NAMES, AGES, AND DESCRIPTIONS OF BROTHERS AND SISTERS OF RESIDENT AND PRESENT CONTACT AND RELATIONSHIP WITH RESIDENT	

EDUCATION	
GRADE COMPLETED	ON THE JOB TRAINING

OCCUPATION
MAIN JOBS

TRAVEL
WHERE AND WHEN?

RETIREMENT	
PLANNING IN ADVANCE	☐ Voluntary ☐ Involuntary
DATE OF RETIREMENT	REACTION OF RETIREMENT
WORK SUBSEQUENT TO RETIREMENT	

MARRIAGE (IF WIFE, GIVE MAIDEN NAME)	
SPOUSE'S NAME	☐ Divorced ☐ Widowed
DATE OF MARRIAGE	REACTION TO DEATH OF SPOUSE
DESCRIBE THE IMPORTANT CHARACTERISTICS OF THE MARRIAGE AS YOU KNOW THEM	

CHILDREN		
NAME	NAME	NAME
SPOUSE	SPOUSE	SPOUSE
GRANDCHILDREN	GRANDCHILDREN	GRANDCHILDREN
PRESENT CONTACTS AND RELATIONSHIPS WITH RESIDENT	PRESENT CONTACTS AND RELATIONSHIPS WITH RESIDENT	PRESENT CONTACTS AND RELATIONSHIPS WITH RESIDENT

RESIDENT'S MENTAL/EMOTIONAL STATUS

ARE THERE ANY PROBLEMS WE CAN EXPECT? SUGGESTIONS FOR HANDLING?

HOW DOES THE RESIDENT ACCEPT REALITY?

WHAT WAS THE RESIDENT'S USUAL TEMPERAMENT OR DISPOSITION DURING EARLIER ADULT LIFE?

HOW IS THE PRESENT TEMPERAMENT OF MENTAL ATTITUDE OF THE RESIDENT DIFFERENT FROM THE PAST? *(FOR EXAMPLE, HOW DO THEY GET ALONG WITH PEOPLE? WHAT UPSETS THEM?)*

WHAT SATISFACTION DOES THE RESIDENT HAVE IN PRESENT LIFE?

WHAT FRUSTRATIONS?

ANY MEDICINE RESIDENT USES REGULARLY?

ADMISSION DECISION
DESCRIBE IN YOUR OWN WORDS WHY THE RESIDENT IS COMING INTO THE FACILITY. INCLUDE DETAILS THAT YOU CONSIDER SIGNIFICANT
WHO WAS MOST INFLUENTIAL IN MAKING THE FINAL DECISION AND HOW DID THIS COME ABOUT?

PRESENT LIVING ARRANGEMENTS

RESIDENT IS PRESENTLY LOCATED	
HOW LONG?	
OWNED THEIR HOME?	
ANY PLANS TO DISPOSE OF HOME?	
WHOM DOES THE RESIDENT TRUST MOST?	
WHOM DOES THE RESIDENT TRUST LEAST?	
ARE THERE ANY FINANCIAL PROBLEMS THE RESIDENT IS WORRIED ABOUT?	
CAN RESIDENT MANAGE OWN POCKET MONEY?	HOW MUCH?
ABLE TO TAKE CARE OF OWN VALUABLES (WATCH, RINGS, ETC.)?	
PRECAUTIONS	

MISCELLANEOUS CURRENT INFORMATION

WHAT HAS THE RESIDENT BEEN TOLD ABOUT THEIR CONDITION AND THE OUTLOOK FOR THE FUTURE?

WHAT WAS HIS/HER REACTION?

WHAT HAS THE RESIDENT BEEN TOLD ABOUT THESE PLANS AND WHAT IS THEIR REACTION?

WHERE WOULD THEY PREFER TO LIVE?

WHICH FUNERAL HOME WILL THEY USE?	PHONE

IS THERE ANY OTHER INFORMATION YOU THINK WE SHOULD KNOW TO ASSIST US IN CARING FOR HIM/HER?

ADMISSION DATE

COMPLETED BY **DATE**

REVIEWED BY **DATE**

Mississippi VA GENERAL INFORMATION

Please provide the following information and return with your completed VA Form 10-10 EZ

VETERAN'S NAME	
VETERAN'S SOCIAL SECURITY NUMBER	
VETERAN'S DATE OF BIRTH	DATE OF RETIREMENT

HEALTH INSURANCE COMPANY
INSURANCE COMPANY'S ADDRESS
POLICY NUMBER

HEALTH INSURANCE COMPANY
INSURANCE COMPANY'S ADDRESS
POLICY NUMBER

SPOUSE'S NAME	
SPOUSE'S SOCIAL SECURITY NUMBER	
SPOUSE'S DATE OF BIRTH	
DATE OF MARRIAGE	DATE MARRIAGE ENDED (IF APPLICABLE) ☐ Death ☐ Divorce

RESPONSIBLE PARTY

NAME	RELATIONSHIP
ADDRESS	
HOME PHONE	CELL PHONE
EMAIL ADDRESS	

EMERGENCY CONTACT

NAME	RELATIONSHIP
ADDRESS	
HOME PHONE	CELL PHONE
EMAIL ADDRESS	

☐ I would like to opt out of receiving information from MSVA.

Mississippi VA

SMOKING POLICY

NOTICE: **Smoking and Tobacco Policy** for **ALL** new and future admissions/residents

All of the Mississippi State Veterans Homes are **NON-SMOKING** and **TOBACCO-FREE** facilities. There is no smoking or tobacco use allowed in the buildings for residents, family members and/or visitors.

A notice of understanding will be signed by the (RP) responsible party as well as the Veteran to ensure full compliance of this policy upon admission.

SIGNATURE **DATE**

OMB Control No. 2900-0091
Estimated Burden Avg. 30 min.
Expiration Date: 06/30/2024

Department of Veterans Affairs

VA DATE STAMP
(For VHA Use Only)

APPLICATION FOR HEALTH BENEFITS

SECTION I - GENERAL INFORMATION

Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)

TYPE OF BENEFIT(S) APPLYING FOR:

☐ **ENROLLMENT** - VA Medical Benefits Package (Veteran meets and agrees to the enrollment eligibility criteria specified at 38 CFR 17.36)

☐ **REGISTRATION** ***(Complete Sections I, II, and III)*** - VA Health Services (Veterans meets the "Enrollment not required" eligibility criteria specified at 38 CFR 17.37)

1A. VETERAN'S NAME *(Last, First, Middle Name)*	1B. PREFERRED NAME	2. MOTHER'S MAIDEN NAME

3A. BIRTH SEX	3B. SELF-IDENTIFIED GENDER IDENTITY	4. ARE YOU HISPANIC OR LATINO?
☐ MALE ☐ FEMALE	☐ MAN ☐ WOMAN ☐ TRANSGENDER MAN ☐ TRANSGENDER WOMAN ☐ NON-BINARY ☐ PREFER NOT TO ANSWER ☐ A GENDER NOT LISTED HERE	☐ YES ☐ NO

5. WHAT IS YOUR RACE? *(You may check more than one. Information is required for statistical purposes only.)*	6. SOCIAL SECURITY NO.
☐ ASIAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ WHITE ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ CHOOSE NOT TO ANSWER	

7A. DATE OF BIRTH *(mm/dd/yyyy)*	7B. PLACE OF BIRTH *(City and State)*	8. PREFERRED LANGUAGE	9. RELIGION

10A. MAILING ADDRESS *(Street)*	10B. CITY	10C. STATE	10D. ZIP CODE	10E.COUNTY

10F. HOME TELEPHONE NO. *(optional)* *(Include Area Code)*	10G. MOBILE TELEPHONE NO. *(optional)* *(Include Area Code)*	10H. E-MAIL ADDRESS *(optional)*

11A. HOME ADDRESS *(Street)*	11B. CITY	11C. STATE	11D. ZIP CODE	11E.COUNTY

12. CURRENT MARTIAL STATUS

☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED

13A. NEXT OF KIN NAME	13B. NEXT OF KIN ADDRESS	13C. NEXT OF KIN RELATIONSHIP

13D. NEXT OF KIN TELEPHONE NO. *(Include Area Code)*	14A. EMERGENCY CONTACT NAME	14B. EMERGENCY CONTACT TELEPHONE NO. *(Include Area Code)*

15. DESIGNEE - INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH (*Note: This does not constitute a will or transfer of title*)

16. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? *(for listing of facilities visit www.va.gov/find-locations)*	17. WOULD YOU LIKE FOR VA TO CONTACT YOU TO SCHEDULE YOUR FIRST APPOINTMENT? ☐ YES ☐ NO

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

SECTION II - MILITARY SERVICE INFORMATION

1A. LAST BRANCH OF SERVICE	1B. LAST ENTRY DATE *(mm/dd/yyyy)*	1C. FUTURE DISCHARGE DATE *(mm/dd/yyyy)*	1D. LAST DISCHARGE DATE *(mm/dd/yyyy)*

1E. DISCHARGE TYPE	1F. MILITARY SERVICE NUMBER

2. MILITARY HISTORY *(Check yes or no)*	YES	NO		YES	NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?	☐	☐	F. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	☐	☐
B. ARE YOU A FORMER PRISONER OF WAR?	☐	☐	G. DID YOU SERVE IN AN AGENT ORANGE LOCATION BETWEEN JANUARY 9, 1962 AND JULY 31, 1980?	☐	☐
C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?	☐	☐	H. DID YOU SERVE IN AN IONIZING RADIATION LOCATION AND PARTICIPATE IN ANY NUCLEAR TESTING, TREATMENTS, OR CLEAN UP?	☐	☐
D. WERE YOU DISCHARGED OR RETIRED FROM MILITARY FOR A DISABILITY INCURRED IN THE LINE OF DUTY?	☐	☐	I. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	☐	☐
E. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998?	☐	☐	J. DID YOU SERVE ON ACTIVE DUTY AT LEAST 30 DAYS AT CAMP LEJEUNE FROM AUGUST 1, 1953 THROUGH DECEMBER 31, 1987?	☐	☐

SECTION III - INSURANCE INFORMATION *(Use a separate sheet for additional information)*

1. ENTER YOUR HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER *(include coverage through spouse or other person)*

2. NAME OF POLICY HOLDER	3. POLICY NUMBER	4. GROUP CODE

5. ARE YOU ELIGIBLE FOR MEDICAID? *(Federal health insurance for low income adults)*	6A. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A?	6B. EFFECTIVE DATE *(mm/dd/yyyy)*	6C. MEDICARE NUMBER:
☐ YES ☐ NO	☐ YES ☐ NO		

SECTION IV - DEPENDENT INFORMATION *(Use a separate sheet for additional dependents)*

1. SPOUSE'S NAME *(Last, First, Middle Name)*	2. CHILD'S NAME *(Last, First, Middle Name)*	
1A. SPOUSE'S SOCIAL SECURITY NUMBER	2A. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)*	2B. CHILD'S SOCIAL SECURITY NO.
1B. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)*	2C. DATE CHILD BECAME YOUR DEPENDENT *(mm/dd/yyyy)*	

1C. SPOUSE'S SELF-IDENTIFIED GENDER IDENTITY

☐ MAN ☐ WOMAN ☐ TRANSGENDER MAN
☐ TRANSGENDER WOMAN ☐ NON-BINARY
☐ PREFER NOT TO ANSWER ☐ A GENDER NOT LISTED HERE

2D. CHILD'S RELATIONSHIP TO YOU *(Check one)*

☐ SON ☐ DAUGHTER ☐ STEPSON ☐ STEPDAUGHTER

1D. DATE OF MARRIAGE *(mm/dd/yyyy)*

2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18?

☐ YES ☐ NO

1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP if different from Veteran's)*

2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR?

☐ YES ☐ NO

2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(e.g., tuition, books, materials)*

3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT?

☐ YES ☐ NO

SECTION V - EMPLOYMENT INFORMATION

1A. VETERAN'S EMPLOYMENT STATUS *(Check one)*.

☐ FULL TIME ☐ PART TIME ☐ NOT EMPLOYED ☐ RETIRED

1B. DATE OF RETIREMENT *(mm/dd/yyyy)*

1C. COMPANY NAME. *(Complete if employed or retired)*	1D. COMPANY ADDRESS *(Complete if employed or retired - Street, City, State, ZIP)*	1E. COMPANY PHONE NUMBER *(Complete if employed or retired) (Include area code)*

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

SECTION VI - FINANCIAL DISCLOSURE

Disclosure allows VA to accurately determine whether certain Veterans will be charged copays for care and medications, their eligibility for other services and enrollment priority. Veterans are not required to disclose their financial information. Veterans who choose not to disclose financial information may not be eligible for enrollment or may be responsible for any applicable VA copayments, if they are enrolled. **Recent Combat Veterans (e.g., OEF/OIF/OND)** may answer YES in Section VI and complete Sections VII and VIII to have their priority for enrollment and financial eligibility for travel assistance, cost-free medications and/or medical care for services unrelated to military experience.

☐ **No, I do not wish to provide financial information in Sections VII through VIII.** If I am enrolled, I agree to pay applicable VA copayments. Sign and date the form in the Assignment of Benefits section.

☐ **Yes, I will provide my household financial information for last calendar year.** Complete applicable Sections VII and VIII. Sign and date the form in the Assignment of Benefits section.

SECTION VII - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN

(Use a separate sheet for additional dependents)

	VETERAN	SPOUSE	CHILD 1
1. GROSS ANNUAL INCOME FROM EMPLOYMENT *(wages, bonuses, tips, etc.)* EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
3. LIST OTHER INCOME AMOUNTS *(e.g., Social Security, compensation, pension, interest, dividends)* EXCLUDING WELFARE.	$	$	$

SECTION VIII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE *(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home) VA will calculate a deductible and the net medical expenses you may claim.*	$
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES (INCLUDING PREPAID BURIAL EXPENSES) FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD *(Also enter spouse or child's information in Section VI.)*	$
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES *(e.g., tuition, books, fees, materials) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.*	$

SECTION IX - CONSENT TO COPAYS AND TO RECEIVE COMMUNICATIONS

By submitting this application, you are agreeing to pay the applicable VA copayments for care or services (including urgent care) as required by law. You also agree to receive communications from VA to your supplied email, home phone number, or mobile number. However, providing your email, home phone number, or mobile number is voluntary.

ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section 1729 and 42 U.S.C. 2651, the Department of Veterans Affairs (VA) is authorized to recover or collect from my health plan (HP) or any other legally responsible third party for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse. Furthermore, I hereby assign to the VA any claim I may have against any person or entity who is or may be legally responsible for the payment of the cost of medical services provided to me by the VA. I understand that this assignment shall not limit or prejudice my right to recover for my own benefit any amount in excess of the cost of medical services provided to me by the VA or any other amount to which I may be entitled. I hereby appoint the Attorney General of the United States and the Secretary of Veterans' Affairs and their designees as my Attorneys-in-fact to take all necessary and appropriate actions in order to recover and receive all or part of the amount herein assigned. I hereby authorize the VA to disclose, to my attorney and to any third party or administrative agency who may be responsible for payment of the cost of medical services provided to me, information from my medical records as necessary to verify my claim. Further, I hereby authorize any such third party or administrative agency to disclose to the VA any information regarding my claim.

ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS WHICH DEFINE WHO CAN SIGN ON BEHALF OF THE VETERAN.

SIGNATURE OF APPLICANT *(Sign in ink)* _____

DATE *(mm/dd/yyyy)* _____

Mississippi VA

VA PENSION INFORMATION AND FACT SHEET

You may be eligible for a VA Pension. I've attached a worksheet to help determine if you may be eligible. These amounts may range from $100 up to $2,000 a month if qualify based on income and medical expenditures. You are not required to fill out this form. All information will be part of Veteran's file and used to file for pension if meets all criteria.

What Are Pension Benefits?
Pension is a needs-based benefit. It is paid to wartime Veterans with financial needs and their survivors.

If you are a Veteran, you are eligible for pension if all of the following are true:

- You were discharged from service under other than dishonorable conditions, AND
- You served 90 days of active duty with at least one day during wartime*, AND
- Your countable income is below the maximum annual pension rate (MAPR), AND
- You meet net worth limitations, AND

- You meet one of the following criteria:
    - You are age 65 or older.
    - You have a permanent and total nonservice-connected disability.
    - You are a patient in a nursing home due to mental or physical incapacity.
    - You are receiving Social Security disability benefits.

*Veterans who entered active duty after Sept. 7, 1980, must serve at least 24 months of active-duty service. If the length of service is less than 24 months, the Veteran must have completed their entire tour of active duty.

Housebound is an increased monthly pension amount. It is paid to a Veteran or surviving spouse who is confined to their home because of a permanent disability. You may be eligible for Housebound benefits if you are eligible for basic pension benefits and one of the following is true: • You have a 100 percent disabling permanent disability. Due to this disability, you are confined to your home. • You have one disability evaluated as 100 percent disabling and another evaluated as at least 60 percent disabling.

Aid and Attendance (A&A) is an increased monthly pension amount. It can be paid to either a Veteran or surviving spouse. You may be eligible for A&A if you are eligible for basic pension benefits and one of the following is true: • You require aid to perform daily living activities. • You are bedridden. • You are a patient in a nursing home due to mental or physical incapacity. • You have corrected visual acuity of 5/200 or less in both eyes. • You have concentric contraction of the visual field to five degrees or less.

660 NORTH STREET, SUITE 200 • JACKSON, MS 39202 • P.O. BOX 3439 • JACKSON, MS 39207 • PHONE: 601-576-4850 • FAX: 601-576-4870

Items Needed to Complete Packet

Social Security Award Statement (Annual)
Bank Statement showing exact deposit amounts for income
Statements showing IRA
Statements showing Stocks/Bonds/Interest/Dividends
Statement of Medical Insurance Bills
Adaptive Equipment Contracts
Hospice Care Cost printout

Household Income

Type Income (Not all Inclusive)	Veteran	Spouse
Gross Social Security Benefits		
Gross Earnings for employment		
VA SC Disability Income		
Gross Retirement Income		
Interest/Dividends		
Unemployment compensation		
Net business or rental Income		
Gross withdrawals from IRAs		

Medical Expenses

Medical Expense Deductions (Not counted until date awarded)	Veteran	Spouse
Nursing Home Care		
Medicare Part B & D Premiums		
Private Medical Insurance Premiums		
Prescriptions that are not covered by MSVA (Excessive Cost) Predicted		
Insurance co-pays		
OTC Drugs, medical supplies, vitamins, ($1,500 per year max) Predicted		
Adaptive Equipment		
Reimbursement for travel to medical appointments Predicted		

Verifying net-worth limit less than $130,773:

Countable Income Gross earnings from Above	Veteran	Spouse
Assets		
Land (Greater than 2 acres)		
Other Homes		
Furniture		
Boats		
Recreational Vehicles		
Investment/Stocks/Bonds (Not mentioned as Income)		
Rental Property		

Assets include the fair market value of all your real and personal property, minus the amount of any mortgages you may have. "Real property" means any land and buildings you may own. Your personal property assets include any of these items:

Assets don't include:

- Your primary residence (the home where you live most or all of the time)
- Your car

Please have your physician complete this form. All questions on this form must be answered. Return this form along with your application package.

Mississippi VA MEDICAL HISTORY & PHYSICAL

Must be completed within thirty (30) days prior to applying for admission to the State Veterans Home.

APPLICANT'S NAME	SSN
APPLICANT'S ADDRESS	

MOST RECENT ATTENDING PHYSICIAN	PHONE NUMBER
ADDRESS	

☐ Living Will ☐ Medical/Durable Power of Attorney *(if yes, please attach copy)*

PERTINENT MEDICAL HISTORY

☐ Diabetes	☐ Pneumonia Vaccine	*date*:
☐ Epilepsy	☐ Flu Vaccine	*date*:
☐ Arthritis	☐ Wanderer	*specify*:
☐ Body/Organ Donor	☐ Seizure Disorder	*specify*:
☐ Mental Illness	☐ Other Disease	*specify*:
	☐ COVID-19 Vaccine	*date*:

CONDITION	LAST DIAGNOSIS	DATE
Kidney		
CVA		
Chest X-Ray		
Other Lung Conditions		
Heart		
Cancer		

PERIODS OF HOSPITALIZATION
NAME OF HOSPITAL
HOSPITAL ADDRESS
PERMANENT DISABILITIES:
OPERATIONS:

HABITS				
☐ Coffee	☐ Tea	☐ Smoke	☐ Alcohol	☐ Narcotics

DIETARY HISTORY
DRUG SENSITIVITY
ALLERGIES

CONTINENCE		
☐ Continent	☐ Continent, feces only	☐ Incontinent urine
☐ Continent, urine only	☐ Incontinent feces	☐ Incontinent, both

CURRENT MEDICATIONS

RESTORATIVE TREATMENT

CHIEF COMPLAINTS (CURRENT)

PHYSICAL EXAMINATION

AGE	SEX	HEIGHT	WEIGHT
BLOOD PRESSURE	TEMPERATURE	PULSE	RESPIRATION

PHYSICAL CONDITION	MENTAL CONDITION	AMBULATION
☐ Good	☐ Clear	☐ Self
☐ Fair	☐ Partly Confused	☐ Assisted
☐ Poor	☐ Badly Confused	☐ Non-Ambulatory

EYES / EARS / TEETH

X-RAY, BIOPSY, LAB ANALYSIS, ETC.

BEHAVIOR PROBLEMS

COMMUNICABLE DISEASE

☐ Yes | *explain:*

☐ No

SKIN CONDITION TO INCLUDE DECUBITIS

EXPLAIN ANY OTHER SPECIAL PROBLEMS, SUCH AS EMOTIONAL DISORDERS, SPEECH, PARALYSIS, ARTHRITIC, OR ARTERIOSCLEROSIS CONDITION

FUNCTIONAL LIMITATIONS OR SPECIAL NEEDS, SUCH AS RESIDENT HAS GLASSES, DENTURES, OR PROSTHESIS, REQUIRES HELP GETTING IN AND OUT OF BED, ETC.

ADMISSION DIAGNOSIS

ADMITTING ORDERS (INCLUDE MEDICATIONS, DIET, TREATMENT RESTORATIVE MEASURES, SHORT AND LONG TERM GOALS)

PHYSICIAN'S SIGNATURE **DATE**

Please have your physician complete this form. All questions on this form must be answered. Return this form along with your application package.

Mississippi VA STATEMENT OF ATTENDING PHYSICIAN

VETERAN'S NAME
VETERAN'S CLAIM NUMBER

GUARDIAN'S NAME	RELATIONSHIP
GUARDIAN'S ADDRESS	

PATIENT'S CURRENT SYMPTOMS AND COMPLAINTS

DIAGNOSIS OF PATIENT'S DISABILITIES	SEVERITY
1	
2	
3	
4	
5	

HOW OFTEN AND UNDER WHAT CIRCUMSTANCES DOES PATIENT LEAVE HOME OR PREMISES?

WHAT AIDS ARE REQUIRED FOR LOCOMOTION OR MOVEMENT?		
☐ Cane	☐ Walker	☐ Braces
☐ Wheel Chair	☐ Crutches	☐ Lift Chair / Sling

☐ Yes	☐ No	Is the patient bedridden?
☐ Yes	☐ No	Is the patient blind?
☐ Yes	☐ No	Is there loss of anal sphincter control?
☐ Yes	☐ No	Is there loss of bladder sphincter control?
☐ Yes	☐ No	Can patient walk and get around without assistance?
☐ Yes	☐ No	Can patient dress and undress without assistance?
☐ Yes	☐ No	Can patient use the bath/toilet without assistance?
☐ Yes	☐ No	Can patient wash and keep him/herself clean & presentable?
☐ Yes	☐ No	Can patient feed him/herself without assistance?
☐ Yes	☐ No	Can patient protect him/herself from the hazards of life?

IS THE PATIENT IN A NURSING HOME?	☐ Yes	☐ No	
IF SO, WHAT LEVEL OF CARE?	☐ Personal Care	☐ Intermediate Care	☐ Skilled
NAME OF NURSING HOME			
ADDRESS			

PHYSICIAN'S SIGNATURE **DATE**

ADDRESS OF PHYSICIAN

Please have your physician complete this form. All questions on this form must be answered. Return this form along with your application package.

Mississippi VA

PULMONARY HISTORY

RESIDENT NAME	ROOM NUMBER
PHYSICIAN	MED. RECORD NUMBER

REASON FOR PULMONARY HISTORY		
☐ New Resident	☐ Annual Screening	☐ +PPD

PLEASE RESPOND TO EACH LISTED SYMPTOM WITH A CHECK IN THE APPROPRIATE BOX			
☐ Yes	☐ No	Completed preventative treatment (if yes, give dates)	FROM _____ TO _____ NUMBER OF MONTHS ON TREATMENT _____
☐ Yes	☐ No	A cough exists	IF YES ☐ PRODUCTIVE ☐ NON-PRODUCTIVE
☐ Yes	☐ No	Night sweats	
☐ Yes	☐ No	Hemoptysis (spitting up blood)	
☐ Yes	☐ No	Smoker	IF YES, NUMBER OF YEARS _____
☐ Yes	☐ No	Weight loss	HOW MANY POUNDS? _____ HOW MANY MONTHS? _____
☐ Yes	☐ No	Chest pains	
☐ Yes	☐ No	Fever	
☐ Yes	☐ No	Weakness / tired / general malaise	
☐ Yes	☐ No	Loss of appetite	
☐ Yes	☐ No	Difficulty in breathing	
☐ Yes	☐ No	Recent URI prolonged (7-10 days)	

ADDITIONAL HISTORY / RISK FACTORS
REFERRAL INFORMATION: _____

Signature: The information given is true to the best of my knowledge. The general symptoms of the disease and reason for screening and surveillance test have been explained and appropriate referrals offered.

PHYSICIAN'S SIGNATURE **DATE**

Please have your physician complete this form. All questions on this form must be answered. Return this form along with your application package.

Mississippi VA ADMITTING ORDERS

Must be completed within five (5) days prior to admission to the State Veterans Home, and must be hand-delivered or faxed to the Home prior to admission.

LAST NAME **FIRST NAME** **MIDDLE NAME** **DATE OF BIRTH**

MEDICATIONS	DIAGNOSIS / REASON FOR USE	FREQUENCY OF ADMINISTRATION
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9
10	10	10

COMMUNICABLE DISEASE ☐ No ☐ Yes | *explain:*

DATE OF LAST CHEST X-RAY	RESULTS OF LAST CHEST X-RAY

DATE TB SKIN TEST (1ST STAGE) APPLIED	RESULTS	DATE INTERPRETED
DATE TB SKIN TEST (2ND STAGE) APPLIED	RESULTS	DATE INTERPRETED

DIET

REHABILITATION

SPECIAL ORDERS BY M.D.

PRINT NAME OF ATTENDING PHYSICIAN **ADDRESS**

PHYSICIAN'S SIGNATURE **DATE**

Mississippi VA

ADMITTING ORDERS *(ADDITIONAL)*

PRINT NAME OF ATTENDING PHYSICIAN

ADDRESS

PHYSICIAN'S SIGNATURE

DATE