Department of Veterans Services

Ohio Veterans Homes

Admission Application

The Ohio Veterans Homes (OVH) are two long-term care campuses which operate under the direction of the Ohio Department of Veterans Services. OVH is dedicated to assisting Ohio combat veterans as they age. At both the Sandusky campus (approximately 60 miles west of Cleveland) and Georgetown campus (approximately 45 miles east of Cincinnati) residents are offered a quality of life which emphasizes privacy and encourages independence. All residents have the freedom and convenience of a small community as well as the comforts of a home-like setting.

Both campuses house a licensed nursing home providing Standard Care, Memory Care (Dementia/Alzheimer), and Skilled Care. OVH-Sandusky also offers an independent living/limited supervised care facility (Domiciliary).

To be eligible for admission into the Ohio Veterans Homes, the applicant must meet the following criteria:

1. The applicant must have been a citizen of Ohio for at least one year.
2. The applicant's most recent discharge must show that they were honorably discharged or separated-under-honorable-conditions from the United States Armed Forces.
3. The applicant must have served on active duty (other than for training) during a period of war or declared armed conflict OR have been a recipient of the Armed Forces Expeditionary Medal or the Vietnam Service Medal.
4. The applicant must have a disability due to disease, wounds or otherwise and, by reason of such disability, be incapable of earning a living.

Please note, applicants meeting the above criteria for admission shall not be admitted if:

1. In the opinion of the Home's Medical Director, the Ohio Veterans Home cannot provide care adequate to meet the physical, mental, or psychosocial needs of the applicant; or
2. Pursuant to Ohio Administrative Code 5907-3-01, a veteran applying for admission to one of the Ohio Veterans Homes who otherwise meets all criteria for admission shall not be admitted if by virtue of one or more criminal convictions, the veteran represents a substantial risk of harm to the health, safety, or well-being of residents, their families, visitors, volunteers, or Ohio Veterans Homes staff.

OVH conducts a comprehensive public records search, including sex offender registry in accordance to Ohio Revised Code section 3721.122, on all applicants prior to admission.

Facility Options

1. Sandusky Nursing Home – 427-bed nursing home facility offering two levels of care:
   - **a.** Standard Care for those in need of any intermediate level of care, and
   - **b.** Memory Care for those with Alzheimer's disease and other types of dementia.
2. Sandusky Domiciliary: The "Dom," short for "Domiciliary," offers 216 beds, a dining facility, sickbay, and an array of services and activities to eligible veterans capable of independent living or limited supervision.
3. Georgetown Nursing Home – 168-bed nursing home facility offering two levels of care:
   - **a.** Standard Care for veterans in need of any intermediate level of care, and
   - **b.** Memory Care for those with Alzheimer's disease and other types of dementia.

Application Checklist

For the Ohio Veterans Homes Admission Team to process the current application, the following documentation is required (if applicable). Once an application with necessary documentation is received, it will be reviewed for completeness, eligibility, and level of care. The applicant or legal representative will be notified by the OVH Admission Team to schedule a pre-admission interview, and to advise you if documentation is missing or if OVH is unable to meet the required care of the applicant.

Documents & Forms

- ☐ DD-214 discharge record
- ☐ Copy of all health ins. cards (including health/dental/vision/prescription) – front & back copies required
- ☐ Copy of Social Security card
- ☐ Copy of driver's license or state ID card – front & back copies required
- ☐ Birth certificate
- ☐ Marriage certificate or divorce decree
- ☐ Healthcare Power of Attorney, Financial Power of Attorney, Guardianship, Living Will, Advance Directives, Code Status, and other legal documents as applicable
- ☐ Pre-planned funeral wishes/instructions or agreements
- ☐ Long-term care insurance policy, if applicable
- ☐ Copy of the front and back of DoD identification card

Medical Information

- ☐ Last 12 months of medical records from any and all physicians/facilities, required
- ☐ History & Physical (must be signed by physician – either an MD or DO – 30 days prior to admission)
- ☐ Current medication and diagnosis list
- ☐ Copies of all letters of incapacity

Financial Information

- ☐ Annual VA benefit/VA Service Connection award letter
- ☐ Most recent Federal Tax return, including 1099s
- ☐ Documentation of all assets with a copy of the previous year's statements showing 12/31 balance for:
  - Stocks
  - Bonds
  - Real property
  - Annuity accounts
  - Trust accounts
  - Whole life insurance
- ☐ Current bank statement for the past 3 months on all bank accounts, which include:
  - IRAs
  - CDs
  - Money markets
  - Checking accounts
  - Savings accounts
  - Stocks and annuities
- ☐ Proof of Income: If married, will need the same documentation for spouse
  - Annual Social Security (gross monthly income, all deductions and net)
  - Retirement/pensions (gross monthly income, all deductions and net)
  - VA payments
    - Current & previous year Aide and Attendance or Pension award letter, **or**
    - Copy of bank statement showing direct deposit (only if there are no deductions, garnishments, or withholdings)
- ☐ Copy of letter from insurance company with premium amount & proof of premium payment (health, dental, vision, Rx)

Applicant Information

ARE YOU SEEKING IMMEDIATE ADMISSION?	PLACEMENT PREFERANCE:
☐ Yes ☐ No, I am estate planning and submitting my information to be filed.	☐ Georgetown Nursing Home ☐ Sandusky Nursing Home ☐ Sandusky Domiciliary (independent living)

GENERAL INFORMATION

FIRST NAME	MIDDLE NAME	LAST NAME

JR./SR.	PREFERRED NAME	EMAIL ADDRESS

APPLICANT SSN	GENDER	DOB (mm/dd/yr)	PLACE OF BIRTH	PRIMARY LANGUAGE

RACE	ETHNICITY	RELIGIOUS PREFERENCE	DIETARY RESTRICTIONS

PRESENT LOCATION OF APPLICANT	CURRENT TELEPHONE # (10 digits)

CURRENT MAILING ADDRESS	CITY/STATE	COUNTY	ZIP CODE

INSURANCE INFORMATION

DO YOU HAVE MEDICARE "A"?	DO YOU HAVE MEDICARE "B"?	DO YOU HAVE MEDICAID?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

DO YOU HAVE OTHER MEDICAL INSURANCE?	IF YES, NAME OF COMPANY
☐ Yes ☐ No	

SPOUSE INFORMATION

MARITAL STATUS	SPOUSE'S FIRST NAME	SPOUSE'S MAIDEN NAME	SPOUSE'S SSN	SPOUSE'S DOB

PRESENT LOCATION	SPOUSE'S EMAIL	CURRENT TELEPHONE # (10 digits)

CURRENT MAILING ADDRESS	CITY/STATE	COUNTY	ZIP CODE

SERVICE INFORMATION

BRANCH OF SERVICE	RANK	SERVICE #	LENGTH OF SERVICE

DATE OF ENLISTMENT(S)	DATE OF DISCHARGE(S)	DISCHARGE TYPE

SERVICE-CONNECTED DISABILITY?	IF YES, PERCENTAGE	PERIOD OF WAR/ARMED CONFLICT:
☐ Yes ☐ No		☐ WWII ☐ Korea ☐ Vietnam ☐ Gulf ☐ GWOT ☐ Other (Provide dates) _____

PRIMARY CONTACT INFORMATION

If the applicant has capacity, please complete.

I would like the Ohio Veterans Home to correspond with my primary contact during the admission process. _____ (applicant initials)

FIRST NAME	MIDDLE INIT.	LAST NAME	RELATIONSHIP

FULL ADDRESS	EMAIL ADDRESS

PRIMARY TELEPHONE # (10 digits)	SECONDARY TELEPHONE # (10 digits)

SECONDARY CONTACT INFORMATION

FIRST NAME	MIDDLE INIT.	LAST NAME	RELATIONSHIP

FULL ADDRESS	EMAIL ADDRESS

PRIMARY TELEPHONE # (10 digits)	SECONDARY TELEPHONE # (10 digits)

Applicant Information, continued

MEDICAL INFORMATION		
APPROVAL FOR OVH TO SEARCH IMPACT SIIS (VACCINE DATABASE) ☐ Yes ☐ No		
HAVE YOU BEEN HOSPITALIZED IN THE PAST YEAR? ☐ Yes ☐ No	ADMITTING DATE	DISCHARGE DATE
HAVE YOU RESIDED IN A NURSING HOME WITHIN THE PAST YEAR? ☐ Yes ☐ No	ADMITTING DATE	DISCHARGE DATE
HAVE YOU LIVED AT THE OHIO VETERANS HOME IN THE PAST? ☐ Yes ☐ No	ADMITTING DATE	DISCHARGE DATE

LIST NAME AND ADDRESS OF CURRENT FACILITY			LIST NAME AND ADDRESS OF PRIOR FACILITY		
FACILITY NAME			FACILITY NAME		
ADDRESS	PHONE #		ADDRESS	PHONE #	
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE

CRIMINAL BACKGROUND INFORMATION			
CRIMINAL CONVICTIONS? (Misdemeanor & Felony) ☐ Yes ☐ No	IF YES, ENTER DATE(S)	**ATTACHMENTS** (Attach police report, convictions, other documentation of arrest, if available)	**EXPLANATION** (Attach a narrative explanation of the offense and why you are not "a substantial risk of harm to the health, safety, or well-being of residents, their families, visitors, volunteers, or Ohio Veterans Homes staff.")
TYPE OF CONVICTIONS (Misdemeanor & Felony)	CITY & STATE WHERE CONVICTED	CRIMINAL CHARGES PENDING? ☐ Yes ☐ No	TYPE OF CHARGES (Include specific ORC citations)
COUNTY, STATE & COURT WHERE CHARGED		ON PROBATION/PAROLE? ☐ Yes ☐ No	PROBATION/PAROLE OFFICER NAME
PROBATION/PAROLE OFFICER FULL ADDRESS		PROBATION/PAROLE OFFICER PHONE # (10 digits)	
REQUIRED TO REGISTER AS A SEX OFFENDER? ☐ Yes ☐ No		CURRENTLY REGISTERED IN YOUR ☐ Community ☐ County ☐ State	

SIGNATURE

I fully understand all the requirements that must be met and all qualifications that must be possessed by an applicant for admission to the Ohio Veterans Home. I hereby certify that this application contains no willful misrepresentation or falsifications and that the information given is true and complete to the best of my knowledge and belief. This application is my free and voluntary act. I understand that verification of current financial information must be provided or waived prior to admission to the Ohio Veterans Home. I understand that all personal expenses and/or prior existing debts are my responsibility. I agree to follow the resident rules of conduct and all policies and procedures of the Ohio Veterans Homes.

SIGNATURE OF APPLICANT OR LEGAL REPRESENTATIVE	DATE
WITNESS IF SIGNED BY AN "X"	DATE
WITNESS IF SIGNED BY AN "X"	DATE

Authorization for Release of Information

Name of applicant: _____

Applicant date of birth: _____ Applicant Social Security Number: _____

I am voluntarily requesting and authorizing release and disclosure[1] of *my medical records*[2] from:

☐ All medical sources[3] or Other: _____

to the Ohio Veterans Homes (OVH) for my admission application. The following information may be released (ex. clinical summaries, lab reports, nurses' notes, or *all medical records*)

_____

I give specific authorization to disclose the following:

☐ All medical records, including (initial or check all that apply)

_____ Psychotherapy records

_____ Drug and alcohol treatment

_____ HIV status and treatment

Or all medical records, except _____

While providing information is voluntary, failure to provide information in a timely manner may prevent accurate and efficient application processing.

OVH uses information regarding treatment, healthcare and business operations, and quality improvement if I am accepted, and to help process my application and paperwork (including eligibility for support from Department of Veterans Affairs [VA], Medicare, etc.). Some additional forms for outside organizations may apply (e.g. VA form 10-5345, 10-10EZ, 10-10SH, etc.).

I understand I do not have to sign this authorization. If I do, I can always revoke it in writing to OVH, except to the extent that action was already taken to comply with it. Unless I revoke this authorization in writing, it will expire two years after an admission decision. Treatment, payment, enrollment, or eligibility for benefits is not conditioned on signing this authorization.

Re-Disclosure – I understand that after information disclosure, there is always a risk of unauthorized re-disclosure, and privacy laws may no longer protect it. OVH respects and complies with state and federal privacy laws including 45 CFR 160 & 164, 42 USC 290.

A photocopy, fax, or electronic copy of this release is as valid as the original. OVH does not receive compensation from use or disclosure of medical records. A copy of this form is easily available for me to receive.

_____ Date: _____

Signature of Applicant/Responsible Party/Legal Representative

*If Legal Representative signs on behalf of applicant, list title (e.g., Guardianship, Power of Attorney, etc.):

_____

[1] Disclosures include oral, written, electronic, or other means of submitting my medical/treatment records to OVH.

[2] All Medical Records include physician orders, history & physical, mental/behavioral health records, nurse's notes, discharge summary, addiction/alcohol, dietary notes, medication list, progress notes, immunization record, laboratory results, care plans.

[3] For example, hospitals, clinics, labs, physicians, psychiatrists/therapists, treatment providers, outpatient care, insurance companies, government agencies, long-term care facilities, or anyone else having my medical/treatment records.

History and Physical Examination Form

The Center for Medicare and Medicaid, the Department of Veterans Affairs, and the Ohio Revised Code require the following MUST be completed by a licensed physician (MD/DO).

PHYSICIAN INSTRUCTIONS

This form is to determine eligibility for residency at the Ohio Veterans Home. The veteran identified herein is a prospective resident of the Ohio Veterans Home. The information requested is required to determine if this veteran meets the need for independent or skilled nursing care. It is important that all questions are answered accurately and completely. **Please complete the form and provide ALL the following documents and health information to support this application.**

- ☐ Recent history and physical
- ☐ Any hospitalization/surgeries/procedures/acute events
- ☐ Diagnoses
- ☐ Medications
- ☐ Current labs, X-rays, scans
- ☐ Copies of all letters of incapacity

Please secure email/fax the completed, signed form and supporting documents to the Ohio Veterans Home indicated below.

☐ Ohio Veterans Home Georgetown
Admissions
phone: (937) 483-5824
fax: (419) 609-2571
ruth.gelter@dvs.ohio.gov

☐ Ohio Veterans Home Sandusky – Nursing Home
Admissions
phone: (567) 998-3680
fax: (419) 624-0753
kimberly.zeadker@dvs.ohio.gov

☐ Ohio Veterans Home Sandusky – Domiciliary (independent care)
Admissions
phone: (567) 998-3559
fax: (419) 609-2577
christina.hansen@dvs.ohio.gov

History and Physical Examination Form, continued

GENERAL INFORMATION			
PATIENT NAME			DOB
PLACE OF RESIDENCE AT TIME OF APPLICATION			SOCIAL SECURITY NUMBER
CITY	STATE	ZIP CODE	TELEPHONE NUMBER

HISTORY/PHYSICAL INFORMATION		
HEIGHT ft in	WEIGHT lbs	SPECIFIC ALLERGIES
DATE OF LAST TETANUS		DATE OF LAST PNEUMO/VAX
DATE OF LAST PREVNAR 13		DATE OF LAST FLU VACCINE
DATE OF LAST ZOSTER		DATE OF LAST TDAP
DATE OF LAST SHINGRIX		DATE OF LAST COVID-19 VACCINE AND TYPE
DOES THE APPLICANT HAVE A HISTORY OF POSITIVE TB SKIN TESTS? ☐ Yes ☐ No		IF YES, INCLUDE A COPY OF A CURRENT CHEST X-RAY REPORT
HAVE YOU EVER HAD COVID-19? ☐ Yes ☐ No		IF YES, DATE TESTED POSITIVE
LIST ALL RECENT MEDICAL INCIDENTS WITH DATES OF INCIDENTS (I.E. CVA SURGERY, FRACTURES, HEAD INJURY)		
DIAGNOSES		

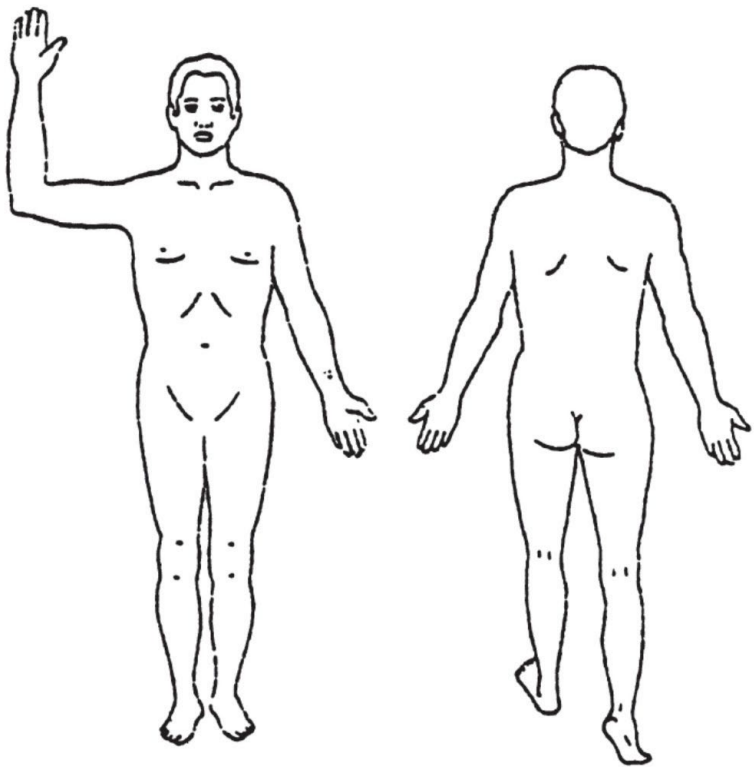
MEDICATION
LIST ALL MEDICATIONS, DOSAGE, AND FREQUENCY OF ADMINISTRATION, OR ATTACH A COPY OF THE CURRENT PHYSICIAN ORDERS

History and Physical Examination Form, continued

FUNCTIONAL INFORMATION						
CIRCLE IF PRESENT AND DESCRIBE IN "PERTINENT NURSING INFORMATION" SECTION						
DEVICES/APPLIANCES						
COLOSTOMY	CATHETER	SIDE RAILS	PROSTHESIS	APPLIANCE	CANE	WALKER
CRUTCHES	WHEELCHAIR	GERI CHAIR	SPECIAL CUSHION		IF SO, WHAT TYPE? _____	
SPECIAL MATTRESS	MOTORIZED WHEELCHAIR/SCOOTER		CHAIR		IF SO, WHAT TYPE? _____	
DISABILITIES						
PARALYSIS	AMPUTATION	CONTRACTURE	OTHER (DESCRIBE) _____			
IMPAIRMENTS						
MENTALITY	SPEECH	HEARING	SENSATION	VISION	OTHER	
INCONTINENCE						
BLADDER	BOWEL	SALIVA				
ACTIVITY TOLERANCE LIMITATIONS						
NONE	MODERATE	SEVERE				
DIET						
REGULAR	BLAND	LOW SALT	DIABETIC	MECHANICAL	TUBE FEEDING	

SKIN CONDITION

DESCRIBE LOCATION, SIZE, AND TREATMENT OF DIMINISHED SKIN INTEGRITY (INCLUDE REDNESS)



History and Physical Examination Form, continued

ASSISTANCE WITH ACTIVITIES OF DAILY LIVING (ADLS)				
ADLS	NO ASSIST	MINIMAL ASSIST	MODERATE	MAXIMUM
MEAL/FOOD CONSUMPTION				
MEDICATION ADMINISTRATION				
MOBILITY				
TRANSFERS				
BATHING				
DRESSING				
GROOMING				
TOILETING				

OTHER THERAPIES/TREATMENTS			
RESPIRATORY AIDS	YES	NO	INDICATE SPECIFIC ORDERS
OXYGEN USAGE			
C-PAP			
BI PAP			
INTERMITTENT			
CONTINUOUS			
BLOOD DRAW			
PACEMAKER			
LIFE VEST			
TRACHEOTOMY			

COMMENTS

BEHAVIOR ASSESSMENT	
DOES THE VETERAN SHOW ANY SIGNS OR SYMPTOMS OF MAJOR MENTAL DISORDER?	
☐ Yes ☐ No	If Yes, list here:
HAS THIS VETERAN EVER BEEN DIAGNOSED AS HAVING A MAJOR MENTAL DISORDER?	
☐ Yes ☐ No	If Yes, list here:
IS THE PRIMARY REASON FOR NURSING FACILITY PLACEMENT DUE TO DEMENTIA, INCLUDING ALZHEIMERS DISEASE, OR RELATED DISORDERS?	
☐ Yes ☐ No	If Yes, list diagnosis:
HAS THIS VETERAN RECEIVED IN-PATIENT PSYCHIATRIC TREATMENT IN THE LAST TWO YEARS?	
☐ Yes ☐ No	If Yes, list dates and location and submit medical records:

History and Physical Examination Form, continued

MENTAL STATUS	ALL THE TIME	FREQUENTLY	OCCASIONALLY	NEVER	BEHAVIOR	ALL THE TIME	FREQUENTLY	OCCASIONALLY	NEVER	BEHAVIOR	ALL THE TIME	FREQUENTLY	OCCASIONALLY	NEVER
ALERT	☐	☐	☐	☐	WITHDRAWN	☐	☐	☐	☐	SUNDOWN	☐	☐	☐	☐
FORGETFUL	☐	☐	☐	☐	BELLIGERENT/ AGITATED	☐	☐	☐	☐	ABLE TO FOLLOW DIRECTIONS	☐	☐	☐	☐
CONFUSED/ DISORIENTED	☐	☐	☐	☐	SUSPICIOUS	☐	☐	☐	☐	DEPRESSION	☐	☐	☐	☐
					COMBATIVE	☐	☐	☐	☐	ANXIOUS	☐	☐	☐	☐
					MAY WANDER/ EXIT SEEKING	☐	☐	☐	☐	SUICIDAL IDEATIONS	☐	☐	☐	☐
					INAPPROPRIATE BEHAVIOR	☐	☐	☐	☐	ABLE TO COMMUNICATE NEEDS	☐	☐	☐	☐

HISTORY OF DRUG ABUSE	☐ Yes ☐ No
HISTORY OF ALCOHOL ABUSE	☐ Yes ☐ No
DOES APPLICANT HAVE CAPACITY TO MAKE MEDICAL DECISIONS?	☐ Yes ☐ No
DOES APPLICANT HAVE CAPACITY TO MAKE FINANCIAL DECISIONS?	☐ Yes ☐ No

PLEASE ENSURE THIS FORM IS COMPLETED IN ITS ENTIRETY AND ALL DOCUMENTATION REQUIRED ON PAGE ONE OF THIS DOCUMENT IS INCLUDED WITH THIS FORM BEFORE SUBMITTING.

I ATTEST THAT THE INFORMATION ON THIS FORM IS COMPLETE AND ACCURATE AS KNOWN TO ME.

By my signature entered below, I have completed a physical and it is my professional opinion that the above named veteran applicant is disabled by disease, wounds, or otherwise, and is by reason of such disability incapable of earning a living.

NAME OF HEALTHCARE PROVIDER				DATE
PHYSICIAN SIGNATURE		CNP CO-SIGNATURE		
ADDRESS	CITY	STATE	ZIP	TELEPHONE #