

Indiana Veterans' *Home*

Serving Indiana's Veterans and Spouses



**Independent Living :: Short-term Rehabilitative Care :: Long-term Nursing Care ::
Secure Memory Care Unit**

- **On-site physicians and specialty care:**
 - ◇ Nephrologist
 - ◇ Pulmonologist
 - ◇ Endocrinology
 - ◇ Psychiatrist
 - ◇ Physical and Occupational Therapy
 - ◇ Speech therapy
 - ◇ Respiratory therapy
 - ◇ Podiatry
 - ◇ Dentistry
- ◇ 250+ wooded acres in West Lafayette, IN
- ◇ Library & media center
- ◇ Cookouts & fishing
- ◇ Crafts & hobbies
- ◇ Full calendar of recreation & activities
- ◇ Free on-site Hotel accommodations for out-of-town family members *

*Limited number of hotel rooms. For reservations, call (765) 463-1502.

FREE Nursing care

For veterans with a 70% or greater service-connected disability rating!

Indiana Veterans' *Home*

3851 N. River Road :: West Lafayette, IN 47906
(765) 463-1502 :: admissions&marketing@ivh.in.gov

Indiana Veterans' *Home*



Proudly serving those who served.

The 70% or greater service connected wartime Veteran is eligible for free nursing care at the Indiana Veterans' Home. This benefit at the Indiana State Veteran Home has no income limitation. (Reference 38 U.S.C. § 1745)

- Service connected rating is determined by the Regional VA Benefits office.
- The Veteran is entitled to keep all social security, pensions, and other income that would normally be used to offset their cost in a long term care facility.

All other Indiana honorably discharged veterans may obtain independent living, long term care, short term rehab care, and memory care if their application is approved using Medicaid, Medicare A, long term care insurance, and private insurance.

For additional information, please contact the Admissions Department at:

(765) 463-1502

admissions&marketing@ivh.in.gov

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West Lafayette, IN 47906
(765) 463-1502

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Additional Information – Application Criteria

The Indiana Veterans' Home Admissions Committee reviews the application and medical information for each applicant in order to determine whether admission is approved. All applicants are admitted based on availability of space and the ability of the Indiana Veterans' Home to provide care, services and programs which meet the medical and mental health needs of the prospective resident. The Indiana Veterans' Home reserves the right to deny admission for any applicant.

The following veterans and spouses are eligible to apply:

1. Veterans who have received an Honorable Discharge from active duty in the armed forces and have resided in Indiana for at least one (1) year immediately preceding application (or were born in Indiana, or discharged from the armed forces to Indiana). Please note: residency requirements may be waived, on a case-by-case basis, at the discretion of the Indiana Veterans' Home.
2. The spouse or surviving spouse of an eligible veteran, if the spouse was married to the veteran for at least five years, and the marriage did not end in divorce.
3. The current spouse of a veteran who already resides at the Indiana Veterans' Home.
4. Veteran's Gold Star Parent (Parents any of whose children died while serving in the Armed Forces)

Individuals requiring the following care/treatments will not be considered for admission:

1. Requiring acute medical or psychiatric hospitalization.
2. Exhibiting physical behaviors which would pose an immediate threat to Indiana Veterans' Home residents, staff, volunteers, visitors or self.
3. Requiring in-patient substance abuse treatment.

Also, individuals would not be considered for admission if any of the below are found during the criminal background check per Indiana Code:

1. Applicants for admission, in the following categories, are not accepted:
 - a. Individuals determined to not meet the criteria of an eligible applicant.
 - b. Individuals who require medical and/or psychological services which are not available at the Indiana Veterans' Home or through community services.
 - c. Individuals who refuse to provide complete information requested in the application packet, refuse to permit access to medical records or submit to a medical examination, and/or refuse to authorize a background check.
 - d. Individuals who are found by completion of a background check to have criminal offense to include: Rape; Criminal Deviate Behavior; Murder; Voluntary Manslaughter, Involuntary Manslaughter; Child Molesting; Child Exploitation; Vicarious sexual gratification; Child solicitation; Child seduction and/or Incest if victim was less than eighteen (18) of age. Individuals who are found by completion of a background checks to have criminal offenses to include: Theft and felony battery, if occurred less than five (5) years prior to application.



STATE OF INDIANA

Eric J. Holcomb, Governor

INDIANA VETERANS' HOME

3851 N. River Road
West Lafayette, IN 47906
Telephone: (765) 463-1502

Enclosed is the application for admission to the Indiana Veterans' Home. The professional and compassionate team at the Indiana Veterans' Home appreciates your interest in the only state veterans' home in Indiana.

Here are some important items to keep in mind as you complete your application:

- **Please use the checklist for required documentation for applying to the Indiana Veterans' Home.** The Admissions Department is available to complete the application for you either over the phone or in person – (will need signature upon admission.)
- **We accept Medicare A, Medicaid, private insurance and private payment. Special benefits are available for veterans with a service-connected disability rating of 70% or higher.** When applicable, veteran benefits may also help pay for a part of your stay. If your insurance and benefits do not cover the full cost of your care and you are unable to pay from your own funds, we will help you apply for Medicaid after your admission to the Indiana Veterans' Home.
 - *Enclosed is the financial checklist. The Indiana Veterans' Home will gladly provide you with an estimated rate cost upon receiving requested documentation.*
- **Veterans with a VA Service Connected Disability of 70% or greater or determined by the VA to meet the criteria for the Veterans' Administration VA Higher Per Diem Program participation, under 38 U.S.C. § 1745, qualify for free nursing care at the Indiana Veterans' Home.**
- **The current rate to reside at the Indiana Veterans' Home is \$443.85* per day.** This is a comprehensive rate and includes nursing care, room, meals, housekeeping, laundry service, and recreation activities. We will work with you to determine your best options to pay for your stay with us.
- Effective April 1, 2016, the Indiana Veterans' Home Independent Living (Domiciliary) rate is \$138.00* per day. The Indiana Veterans' Home did research and decided to reduce the domiciliary rate to the State Veterans' Home Domiciliary United States average daily rate.
- **If you currently live at home and plan to move into nursing care, please contact your local Area Agency on Aging to set up a Pre-Admission Screening (PAS).** The PAS must be completed before entering any nursing home in the state of Indiana. You can reach your Area Agency on Aging by calling (800) 986-3505. Please note: PAS is not required for applicants entering our independent living building.

The Indiana Veterans' Home encourages anyone that has financial questions regarding the daily cost of living charge, to contact our Trust Department at (765) 497-8590 to discuss the payment process.

Please contact Cheryl Coffman for any Medicaid questions. Cheryl can be reached directly by either phone, (765) 497-8693, or email, CCoffman1@ivh.in.gov.

If you have any questions about our application or the required documentation, please contact the Admissions Department at your convenience.

Best Regards,



Tamara M.D. Smith, Admissions Director

Indiana Veterans' Home :: 3851 N. River Road :: West Lafayette, IN 47906

Phone: (765) 463-1502 :: Fax (765) 497-8004 :: admissions&marketing@ivh.in.gov

*The Daily Rate is subject to change on an annual basis.



Indiana Veterans' Home Admissions Checklist

Documentation and information required to apply for admission
to the Indiana Veterans' Home

Applicant Name: _____

Indiana Veterans' Home Application

- Completed application –**
 - Admissions Department will coordinate and IVH will assist with completion of the application, if needed (either questions over phone, in person, Admissions can type out information for applicant.)

Personal Identification

- Military discharge papers (DD214) / VA Military Data Screen / VA SC Disability % Proof**
- Face sheet from current hospital / facility / or VA (if applicable)**
- Marriage certificate/death certificate/divorce decree/separation papers (if within 5 years)**
 - Required if Spouse or Surviving Spouse before admission.
- Copy of Power of Attorney(s) Medical and/or Financial, or Guardianship documents (if applicable)**
 - Required to have in place and provide copy if applicant cannot sign for self.
- Photo ID / Social Security Card / Medicare & other Health Insurance Cards**
 - Admissions Dept will scan on day of Admission if not received prior
- Birth Certificate**
 - If you do not have a copy at this time, let Admissions know and we can provide guidance on how to obtain a copy

Financial

- Copies of statements for all bank accounts**
 - Savings, checking, certificates of deposit (CDs), and retirement accounts

Medical

- Current History and Physical including all diagnoses**
- Chest x-ray Results (Per Policy – Must not be older than 6 months upon admission)**
- Complete list of current medications**
- Nursing notes**
- Social services notes**
- Psych / behavior notes (if applicable)**

Please Note: Need the most current and all applicable clinical information to determine if the IVH team can meet the needs of the applicant. IVH can provide a listing of the requested documentation to the appropriate discharge planners, doctor, nursing home, etc. prior to other provider sending clinical to discuss further and to prevent IVH requesting more paperwork that could result in a delay of the Admissions Committee decision.

PLEASE NOTE: The Financial checklist is enclosed in this packet. Copies requested are needed for IVH to determine an appropriate payer source and assist the new admission with applying for applicable benefits to offset any debt. If you are currently in a facility or in a safe environment, IVH requires that you provide all of the items on the Financial Checklist prior to being accepted to comply with applying for Medicaid upon admission. If admitting from a hospital or emergency admission from home, you will be required to supply IVH with the rest of the items needed on the Financial Checklist within 10 business days from admission. Failure to provide requested copies will result in a 30 day involuntary discharge and the resident will be invoiced for the full daily rate.

Indiana Veterans' Home
3851 N. River Road :: West Lafayette, IN 47906
(765) 463-1502 – Main Switchboard :: admissions&marketing@ivh.in.gov

Proudly serving those who served.

Indiana Veterans' *Home* Financial Checklist (Medicaid)

Applicant's Name: _____

**** PLEASE NOTE: IF LEGALLY MARRIED, WE WILL NEED A COPY OF ALL APPLICABLE DOCUMENTS BELOW FOR BOTH THE APPLICANT AND THE SPOUSE.**

PERSONAL IDENTIFICATION & LEGAL

	Photo ID
	Social Security Card
	Birth Certificate / DD214
	All Medical Insurance Cards, including Medicare (front and back)
	Marriage Certificate, Death Certificate, Divorce Decree
	POA, Guardianship Paperwork

INCOME AND ASSET INFORMATION

	Proof of all income (3 months), including, but not limited to, paycheck stubs, Social Security benefit letter, pension and other retirement income, unemployment benefits or veterans benefits
	Copies of statements for all bank accounts, including savings (3 months), checking (3 months), certificates of deposit (CDs), and retirement accounts [including IRAs and 401(k) accounts].
	Statements for all life insurance policies or annuities showing ownership, face value and current cash surrender value and effective date of policy
	Copies of all stocks or United States savings bonds
	Copy of all vehicle titles or registration
	Copy of deeds for all homes and/or property
	Copy of cemetery lot deed or burial accounts
	Letter from the Auditor's office stating that applicant has not owned property in the last 5 years.
	Copy of Prepaid Irrevocable Funeral Arrangements (contract and listing of services)
	Documentation of any prior gifts from applicant in the past 5 years (e.g., gifts to another for expenses, transfer of property or assets to another, etc.)
	Long-term care insurance policy for applicant (and/or spouse)

LIABILITY INFORMATION

	Health insurance premiums
	Prescription drug plans (premium and verification of coverage)
	Medical bills for the last 3 months (if any)

SPOUSAL EXPENSES (if living in the community)

	Utility bills (e.g., electricity, gas, water, sewage)
	Phone bills
	Homeowner's insurance
	Mortgage payments or lot rental receipts
	Property taxes
	Condo fees
	Copy of deed to home (if paid off)
	Automobile insurance
	Copy of title to car (if paid off)
	Health insurance premiums
	Other recurring spousal expenses

When completed, this form is CONFIDENTIAL.



**APPLICATION FOR ADMISSION TO
THE INDIANA VETERANS' HOME**
State Form 37561 (R10 / 4-19)

FEDERAL REGULATION Public Law 22

* This State Agency is requesting your Social Security number only to expedite the processing of this form. You are not required to provide this information and cannot be penalized for declining to provide it.

INSTRUCTIONS:

1. Every blank must be filled in. If the question does not apply, write "N/A".
2. Please provide all documentation specified on the Admissions Checklist.
3. When completed, please submit fully completed application Indiana Veterans' Home by one of the following ways:
E-mail: admissions&marketing@ivh.in.gov
or Fax: (765) 497-8004
or certified mail / FEDEX / UPS: Indiana Veterans' Home, ATTN: Admissions, 3851 North River Road, West Lafayette, IN 47906

Name (first, middle, last)		Age		
Date of birth (mm/dd/yyyy)	Place of birth			
Present address in full (number and street or Rural Route, city, state, and ZIP code)				
Telephone number (with area code) ()	Religion	Race		
Previous occupation	Mother's maiden name	Do Not Resuscitate (DNR) // Full Code		
Are you? (Check one of the below.) <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated				
Give record of all marriages below. (If additional space is needed please attach separate list.)				
Name of Spouse		Date (mm/dd/yyyy) and Place of Marriage	Date (mm/dd/yyyy) and Place of Death / Divorce	
Veteran's Military Service				
Branch	Dates of Service (mm/dd/yyyy)	Place of Enlistment and Discharge	With which VA are you associated?	
Where have you resided for the past five (5) years? (If additional space is needed please attach separate list.)				
Street Address	City	State	From (mm/dd/yyyy)	To (mm/dd/yyyy)
Additional Military Information				
American Legion?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is Veteran a former prisoner of war?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Veterans of Foreign Wars?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Was Veteran awarded the Purple Heart?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Disabled American Veteran?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Give name, address, and telephone number in order of Emergency Contacts.				
Name	Address (number and street, city, state, and ZIP code)	Relationship	Telephone Number	

When completed, this form is CONFIDENTIAL.

Financial Evaluation			
Social Security Number *		Medicare number	
Name of other insurance provider		Type of insurance provider (Check one.) <input type="checkbox"/> Advantage <input type="checkbox"/> Supplemental <input type="checkbox"/> Part D <input type="checkbox"/> Other	
Do you have any of the following income sources?			
Pension or retirement income	Pension(s) or retirement(s) provider name	Monthly amount(s) \$ // \$	
Social Security income	Do you have a Rep payee? <input type="checkbox"/> Yes <input type="checkbox"/> No	Monthly amount(s) \$ // \$	
VA income	Aid and Attendance / compensation / retirement	Monthly amount(s) \$ // \$	
VA service connected disability rating		VA service connected disability rating	
Supporting documentation attached? <input type="checkbox"/> Yes <input type="checkbox"/> No		VA facility seen for disability?	
Checking account	Name of bank	Current balance \$	
Savings account	Name of bank	Current balance \$	
Stocks, bonds, annuities, or certificates of deposit	Name of bank	Type (stock, bond, etc.)	Current balance \$
Have you owned any real property within the last three (3) years? <input type="checkbox"/> Yes <input type="checkbox"/> No			If Yes, total real property estimated value \$
Do you have a will? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have one of the following? <input type="checkbox"/> Power of Attorney (POA) <input type="checkbox"/> Health Care Representative (HCR) <input type="checkbox"/> Guardian		
Do you have a prepaid funeral? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, with whom?		
Do you have life insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, with whom?	Face value	Policy(ies) number(s)
Do you have life insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, with whom?	Face value	Policy(ies) number(s)
Are you currently a resident of a residential or care facility? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you agree to abide by all the laws and regulations governing the Home? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Residency Verification			
<i>This verification can be made by an elected township, city or county official, or by an individual not related to the applicant.</i>			
Printed or typed name		Please check one: <input type="checkbox"/> Neighbor <input type="checkbox"/> Elected or Appointed Official	
Signature			
Address (number and street, city, state, and ZIP code)			
Dated this _____ day of _____, 20_____.			
Do you, in consideration of being admitted and maintained in the Indiana Veterans' Home, understand that you or your estate are obligated to pay full cost of care and maintenance? (Depending on the amount of your current assets and income from any source this rate may be reduced.) <input type="checkbox"/> Yes <input type="checkbox"/> No			
I acknowledge by signing this form the information provided on this application is accurate to the best of my knowledge and understanding.			
Signature of applicant		Date signed (mm/dd/yyyy)	

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of my protected health information as described below. I understand signing this authorization is voluntary and I do not need to sign this form to assure treatment, payment or eligibility of benefits. I understand that the information disclosed may be subject to re-disclosure by the recipient and the privacy of the information may no longer be protected by the law.

The specific organization that is authorized to disclose my protected health information is:

(Name and Address of Facility/individual to Release the Protected Health Information)

The specific organization or individual to which the information is to be released:

(Name and Address of Facility/individual to Receive the Protected Health Information)

The specific protected health information that is authorized to be disclosed is:

- | | |
|--|---|
| <input checked="" type="checkbox"/> Physician order | <input checked="" type="checkbox"/> Medication record |
| <input checked="" type="checkbox"/> Physician progress notes | <input checked="" type="checkbox"/> Treatment record |
| <input checked="" type="checkbox"/> History and physical | <input checked="" type="checkbox"/> Laboratory results |
| <input checked="" type="checkbox"/> Immunization record & TB Screening | <input checked="" type="checkbox"/> X-ray and imaging reports |
| <input checked="" type="checkbox"/> Nurses' notes | <input checked="" type="checkbox"/> Consultation reports |
| <input checked="" type="checkbox"/> Discipline specific progress notes. Specify: _____ | |

Other: _____

The purpose of the disclosure of my protected health information is:

I understand this authorization is automatically void on the following date, event or condition _____, but in any case, is only in effect sixty (60) days from the date of signature below under Indiana Law.

I understand that I may revoke this authorization at any time by notifying the organization in writing, but if I do it won't have any effect on any actions taken before the revocation was received.

By signing this authorization, I acknowledge that I have read and understand this authorization. I understand that my protected health information will be disclosed in accordance with this authorization.

Signature of resident or authorized representative

Date

Printed name of resident or authorized representative

Description of authority, if signed by representative

Address of resident or authorized representative

Indiana Veterans' Home
Grievance Concerns and Assistance Contact Information

Each resident has the right to voice concerns or complaints regarding care and services, any infringement upon resident rights, and to make suggestions for the improvement of services provided by the Indiana Veterans' Home at any time. If a resident has a problem or concern regarding his or her care, or if a family member is concerned about the care of a loved one living at the Indiana Veterans' Home, these concerns should be conveyed to management as soon as possible.

Although it is recommended that residents report problems internally first, residents may also report a concern or voice a suggestion externally, at any time. If desired, residents may contact:

Indiana State Department of Health
Division of Long-Term Care
2 North Meridian Street
Indianapolis, IN 46204
(317) 233-7442
Toll-Free Complaint Division Number:
(800) 246-8909

Roudebush VA Medical Center
Patient Advocate
1481 West 10th Street
Indianapolis, IN 46202
(317) 554-0000

Adult Protective Services
301 Main Street
Lafayette, IN 47901-1376
(877) 749-9111 or (765) 423-9305

Protection and Advocacy Services (for developmentally disabled or mentally ill)
4701 North Keystone Avenue, Suite 222
Indianapolis, IN 46205
(317) 722-5555 or (800) 622-4845

Tippecanoe County Office, Division of Family and Children
111 N. 4th Street
Lafayette, IN 47901
(765) 742-0400

Indiana Legal Services
Local Long-Term Care Ombudsman
Andrea Smothers
639 Columbia Street
Lafayette, IN
(765) 423-5327 or (800) 382-7581

State Long-Term Care Ombudsman Program
P.O. Box 7083
Indianapolis, IN 46207-7083
(800) 622-4484 or (317) 232-7134

Additional Contacts

Phone

Superintendent	(765) 497-8501
Assistant Superintendent	(765) 497-8510
Long-term Care Ombudsman	(765) 423-5327
Adult Protective Services	(765) 420-1587
Health Department Hotline	(800) 246-8909
State Police (Lafayette, IN)	(765) 567-2125
VA Medical Center – Roudebush	(317) 554-0000
Medicare Fraud Reporting	(800) 447-8477
Medicaid Fraud Reporting	(800) 382-1039

Resident Concern Forms

Resident Concern Forms are available on each unit. Residents should ask Nursing or Social Services staff for a form and/or assistance in completing and submitting the form. Resident Concern Forms are submitted to the Indiana Veterans' Home Superintendent for appropriate action and response.