



RETURNING THE HONOR TO SERVE.

Hello,

Thank you for expressing your interest in the Spanish Peaks Veterans Community Living Center (SPVCLC). Located in beautiful Southern Colorado, our facility is a Veterans Administration (VA) nursing home offering excellent long-term and short-term care. I invite you to learn more about what makes SPVCLC unique and the services we provide not only to our highly respected Veterans/ residents but also to their families and friends. You can visit our website at sprhc.org for additional information on the acute care hospital that we share a location with.

The staff at SPVCLC possesses the extensive capability to meet a wide variety of needs, combined with a sincere understanding of the individual experiences of our Residents. Each Resident is treated as the unique person they have become over their lifetime. I encourage you to review the following information, including the application and the list of required or requested documents, to help us better serve the applicant. Our SPVCLC Admissions Committee will evaluate the submitted materials and make a recommendation to the Medical Director, who will make the final decision regarding acceptance. Please be assured that this process can proceed quickly if all requested documentation is provided.

As the Admissions Manager at SPVCLC, I can guide you through the various Medicaid and Veterans Administration benefits available, such as obtaining a copy of the military discharge document. We can also discuss other long-term and short-term care options and additional services. I understand that this can be an emotional and stressful time, but you have taken a significant step by reaching out to SPVCLC for this application packet. This is the beginning of the process. I look forward to assisting you.

Sincerely,

Lainie Tenorio
SPVCLC, Admissions Manager
Phone 719.738.4565 Fax 719.738.5147
Email: ltensorio@sprhc.org

OVERVIEW

The *SPVCLC* is a 90-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.



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

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 people to a room). We only have a limited number of private rooms. I encourage you to call admissions to discuss payment options.

• 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 VA 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

Please contact the Admissions Manager for the most current daily rate which includes oxygen, adult Attends/ pull-up briefs, and prescription services. 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. It is our privilege to return the honor of service.

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"



Admission Application

Veterans Community Living Centers

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

2) Name: _____ Relationship: _____

Address: _____

Street City County State Zip

Phone number(s): _____ Email: _____

3) Name: _____ Relationship: _____

Address: _____

Street City County State Zip

Phone number(s): _____ Email: _____

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

Financial Information:

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

Monthly Income

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

Assets

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

Please attach copies of the following:

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

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

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

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

Signature: _____ Date: _____

(Applicant or POA)

OXYGEN INFORMATION

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

WOUND INFORMATION

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

ASSISTED DEVICES / SAFETY NEEDS

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

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 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
- LOWER PARTIAL ONLY: Yes No
- UPPER & LOWER PARTIALS: Yes No
- UPPER DENTURE ONLY: Yes No
- LOWER DENTURE ONLY: Yes No
- UPPER & LOWER DENTURES: Yes No
- DENTAL ISSUES: Yes No DESCRIBE: _____

SLEEP PATTERN

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

COMMUNICATION

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

TOBACCO, ALCOHOL, & OTHER SUBSTANCES

- CHECK ALL THAT APPLY:
- CIGARETTES CIGARS ELECTRIC CIGARETTES MARIJUANA
- HOOKAHS PIPES ALHOHOL Describe type/amt: _____
- OTHER SUBSTANCES: EXPLAIN: _____
- NONE
- LAST DATE OF USE OF TOBACCO, ALCOHOL, OR SUBSTANCE ABUSE PRODUCTS: _____

DIETARY/NUTRITION

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

ACTIVITIES OF INTEREST

- BIBLE STUDY: Yes No
- COMMUNION: Yes No
- CHURCH SERVICES: Yes No
- GROUP ACTIVITIES: Yes No
- CARD GAMES: Yes No
- PUPPY POWER HOUR: Yes No
- 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 ARE UNDECIDED AT THIS TIME.

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.

MISCELLANEOUS

- ANYTHING ELSE YOU WOULD 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!

AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION

| | |
|--|---|
| <p>Request for Release by:</p> <p>Facility: _____</p> <p>Address: _____</p> <p>City/State/Zip: _____</p> <p>Telephone/Fax: _____</p> <p>_____ Patient Name</p> <p>_____ Mailing Address</p> <p>_____ City State Zip</p> <p>_____ Phone Fax</p> | <p>Release to: Spanish Peaks Veterans Community Living Center Attn: Lainie Tenorio 23500 US Highway 160 Walsenburg, CO 81089 Telephone: 719-738-4565 Fax: 719-738-5147 Email: ltenorio@sprhc.org</p> <p>Patient's Date of Birth: _____</p> <p>Patient's Last 4 Digits of SSN: _____</p> <p>Email Address: _____</p> <p>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 checked="" type="checkbox"/> Secure Email <input checked="" type="checkbox"/> Fax <input type="checkbox"/> Mail</p> |
|--|---|

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

Date(s) of service: _____

| | | | |
|--|--|--|---|
| <input type="checkbox"/> Emergency Room Report | <input checked="" type="checkbox"/> Nurses Notes | <input type="checkbox"/> Respiratory | <input checked="" type="checkbox"/> Immunization Records |
| <input type="checkbox"/> Discharge Summary | <input checked="" type="checkbox"/> Medication Records | <input type="checkbox"/> Rehab Services | <input type="checkbox"/> Billing Records |
| <input checked="" type="checkbox"/> History & Physical | <input type="checkbox"/> Physician Orders | <input type="checkbox"/> Patient Care Photos | <input checked="" type="checkbox"/> Other: <u> FACESHEET </u> |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Lab/Pathology Results | <input type="checkbox"/> Non-SPRHC Med Recs | <input type="checkbox"/> DHS/DSS: (Financial Records, Medical Info., Medicaid Application Progress, Medicaid Eligibility/Benefits, Form 5615) |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Radiology Report | <input type="checkbox"/> Behavioral Notes | |
| <input checked="" 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 checked="" 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: _____                |                 |

|                                                        |                        |                        |                |
|--------------------------------------------------------|------------------------|------------------------|----------------|
| <b>OFFICE USE ONLY: Proof of Identification:</b> _____ |                        |                        |                |
| Number of pages released: _____                        | Completion date: _____ | Delivery method: _____ |                |
| Name of individual who received request: _____         | Date received: _____   |                        | Patient        |
| Medical Record Number / Account Number: _____          |                        |                        | REV/MARCH 2025 |



REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPERWORK REDUCTION ACT INFORMATION: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out this form. The execution of this form does not authorize the release of information other than that specifically described below.

The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if information needed to locate records for release is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually identifiable health information for such research is required. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10A7 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS (Name and Location of the VA Health Care Facility)

LAST NAME- FIRST NAME- MIDDLE NAME

DATE OF BIRTH (mm/dd/yyyy)

PATIENT'S MAILING ADDRESS (including City, State and Zip Code)

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

- TREATMENT BENEFITS LEGAL EMPLOYMENT OTHER (Please specify below):

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

- HEALTH SUMMARY (Prior 2 Years)
PATIENT MEDICAL RECORDS (Dates):
INPATIENT DISCHARGE SUMMARY (Dates):
PROGRESS NOTES:
SPECIFIC CLINICS (Name & Date Range):
SPECIFIC PROVIDERS (Name & Date Range):
DATE RANGE:
OPERATIVE/CLINICAL PROCEDURES (Name & Date):
LAB RESULTS:
SPECIFIC TESTS (Name & Date):
DATE RANGE:
RADIOLOGY REPORTS (Name & Date):
LIST OF ACTIVE MEDICATIONS:
VACCINATION (Dose, Lot Number, Date & Location):
ADMINISTRATIVE RECORDS:
OTHER (Describe):

|                                    |                            |
|------------------------------------|----------------------------|
| LAST NAME- FIRST NAME- MIDDLE NAME | DATE OF BIRTH (mm/dd/yyyy) |
|------------------------------------|----------------------------|

**SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.**

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.

- DRUG ABUSE   
  ALCOHOLISM OR ALCOHOL ABUSE   
  SICKLE CELL ANEMIA  
 HUMAN IMMUNODEFICIENCY VIRUS (HIV)

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

- I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

**AUTHORIZATION:** I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

**EXPIRATION:** Without my express revocation, the authorization will automatically expire (select one of the following):

- AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED  
 ON (mm/dd/yyyy) \_\_\_\_\_ (enter a future date other than date signed by patient)  
 UNDER THE FOLLOWING CONDITION(S): \_\_\_\_\_  
 \_\_\_\_\_

|                                 |                   |
|---------------------------------|-------------------|
| PATIENT SIGNATURE (Sign in ink) | DATE (mm/dd/yyyy) |
|---------------------------------|-------------------|

|                                                              |                   |
|--------------------------------------------------------------|-------------------|
| LEGAL REPRESENTATIVE SIGNATURE (if applicable) (Sign in ink) | DATE (mm/dd/yyyy) |
|--------------------------------------------------------------|-------------------|

|                                    |                         |
|------------------------------------|-------------------------|
| PRINT NAME OF LEGAL REPRESENTATIVE | RELATIONSHIP TO PATIENT |
|------------------------------------|-------------------------|

**FOR VA USE ONLY**

|                                      |
|--------------------------------------|
| TYPE AND EXTENT OF MATERIAL RELEASED |
|--------------------------------------|

|                            |              |
|----------------------------|--------------|
| DATE RELEASED (mm/dd/yyyy) | RELEASED BY: |
|----------------------------|--------------|

# 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 Manager at 719-738-4565.

## ❖ ALL APPLICANTS

- ADMISSION APPLICATION FORM**  
NOTE: Only the applicant or MPOA, FPOA, Medical Proxy, Guardian, of Conservator may sign
- MEDICAL POWER OF ATTORNEY, MEDICAL PROXY, or GUARDIANSHIP DOCUMENT**  
(for medical purposes)
- COVID-19 VACCINATION CARD** (copy only)
- CPR DIRECTIVE** (if applicable)
- FINANCIAL POWER-OF-ATTORNEY or CONSERVATORSHIP DOCUMENT** (for financial purposes)
- FUNCTIONAL ASSESSMENT FORM**
- INSURANCE CARDS** (front/back copies of insurance cards such as Medicaid, Medicare, Tricare, RX, COVID, etc)
- LIVING WILL** (if applicable)
- LONG-TERM CARE INSURANCE POLICY** (if applicable)
- MILITARY SEPARATION DOCUMENT** (commonly referred to as the Veteran's DD-214 document)
- MOST FORM** (Medical Orders for Scope of Treatment, if applicable)
- RELEASE OF INFORMATION FORM** (For both the SPVCLC & the VA [if applicable])
- MORTUARY AGREEMENT/POLICY/PRE-PAID PROOF** (if applicable)

## ❖ 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**