EDWARD C. ALLWORTH
OREGON VETERANS' HOME
LEBANON ★ THE PLACE WHERE HONOR LIVES

ADMISSION PACKET

IMPORTANT SUBMISSION INSTRUCTIONS

This OREGON VETERANS' HOME ADMISSION PACKET contains the forms required by the Oregon Department of Veterans' Affairs (ODVA) to apply for residency at one of the Oregon Veterans' Homes located in The Dalles and Lebanon.

Included in this packet are the ODVA forms needed to apply for admission to the veterans' homes:

- ☐ Application for Admission, Form VH3000-1
- ☐ Notice of Privacy Practices, Form HP4000
- ☐ Authorization to Use and Disclose Protected Health Information (PHI), Form HP4001
- ☐ Acknowledgement of Receipt of the Notice of Privacy Practices, Form HP4002
- ☐ Authorization for Health Provider to Disclose Protected Health Information (PHI) to the Oregon Veterans' Home, Form HP4007

The following documents are also required to be submitted with this application as part of the admission process:

- ☐ The veteran's DD Form 214, Certificate of Release or Discharge from Active Duty (military discharge papers)
- ☐ VA Form 1010EZ Application For Health Benefits
- ☐ The current insurance card for the responsible party (veteran or spouse)
- ☐ A marriage certificate (only for spouses of veterans)
- ☐ Power of attorney papers

Submit all of the required documentation to:

ODVA Program Director
Edward C. Allworth Veterans' Home
600 North 5th Street
Lebanon, Oregon 97355-2876

EDWARD C. ALLWORTH OREGON VETERANS' HOME
LEBANON ★ THE PLACE WHERE HONOR LIVES

APPLICATION FOR ADMISSION

VETERAN INFORMATION

Name (Last, First, Middle)			Gender
			☐ Male ☐ Female
Social Security Number	**Date of Birth** (mm-dd-yyyy)		**Religious Preference**

Marital Status

☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Never Married

Home Address	City		State	Zip Code
County	**Home Telephone**	**Mobile Telephone**	**Email Address**	

SPOUSE INFORMATION

Name (Last, First, Middle)			Gender
			☐ Male ☐ Female
Social Security Number	**Date of Birth** (mm-dd-yyyy)		**Religious Preference**

Marital Status

☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Never Married

Home Address	City		State	Zip Code
County	**Home Telephone**	**Mobile Telephone**	**Email Address**	

PARENT INFORMATION

Name (Last, First, Middle)			Gender
			☐ Male ☐ Female
Social Security Number	**Date of Birth** (mm-dd-yyyy)		**Religious Preference**

Marital Status

☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Never Married

Home Address	City		State	Zip Code
County	**Home Telephone**	**Mobile Telephone**	**Email Address**	

STATUS INFORMATION

Veteran Status	United States Citizen?		Resident of Oregon?	
☐ Veteran of U.S. Armed Forces	☐ Yes	☐ No	☐ Yes	☐ No
☐ Spouse or Surviving Spouse	☐ Yes	☐ No	☐ Yes	☐ No
☐ Parent who has lost a child to war-time service (Gold Star)	☐ Yes	☐ No	☐ Yes	☐ No

VETERAN MILITARY SERVICE INFORMATION

Branch of U.S. Service

☐ Army	☐ Navy	☐ Air Force	☐ Marine Corps	☐ Coast Guard	☐ Army National Guard
☐ Army Reserves	☐ Navy Reserves	☐ Air Force Reserves	☐ Marine Corps Reserves	☐ Coast Guard Reserves	☐ Air National Guard
☐ Other (specify):		☐ Other (specify):		☐ Other (specify):	

EDWARD C. ALLWORTH OREGON VETERANS' HOME
LEBANON ★ THE PLACE WHERE HONOR LIVES

APPLICATION FOR ADMISSION

Period of Service					
☐ World War I	☐ World War II	☐ Korean War	☐ Vietnam Era	☐ Post-Vietnam	☐ Lebanon
☐ Grenada	☐ Panama	☐ Persian Gulf	☐ Somalia	☐ Bosnia	☐ Kosovo
☐ Peacetime	☐ Iraq	☐ Afghanistan		☐ Other (specify):	

Last Discharge Character of Service		Service Number	Last Discharge Date
☐ Honorable	☐ General, under honorable conditions		

Are you a former Prisoner of War (POW)?		Do you have a Service-Connected Disability?		If yes, what percent?
☐ Yes	☐ No	☐ Yes	☐ No	%

Have you received medical care from the VA?		If yes, where?	VA Claim Number
☐ Yes	☐ No		

GENERAL AND INSURANCE INFORMATION

How did you hear about the Oregon Veterans' Homes?

Does anyone have Power of Attorney or Conservatorship for you?		Is anyone a Guardian or Healthcare Power of Attorney for you?		Is anyone a Representative Payee for your affairs?	
☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

Name of Responsible Person	Relationship

Address	City	State	Zip Code

Email Address	Home Telephone	Mobile Telephone	Work Telephone

Name of Personal Care Physician (PCP) / Specialists	Office Telephone	Fax Number

Medicare Number	Medicare Number	Medicare D Plan
☐ A	☐ B	

Do you have supplemental medical insurance?		Do you have supplemental dental insurance?		Medical Insurance #	Dental Insurance #
☐ Yes	☐ No	☐ Yes	☐ No		

Have you been a patient in a nursing home any time in the last year?	☐ Yes	☐ No

Facility Name	Telephone Number	Fax Number

Have you been hospitalized in the last year?	☐ Yes	☐ No

Hospital Name(s)	Telephone Number	Fax Number

EDWARD C. ALLWORTH OREGON VETERANS' HOME
LEBANON ★ THE PLACE WHERE HONOR LIVES

APPLICATION FOR ADMISSION

Where do you currently live?				Telephone Number	Fax Number
☐ Home	☐ Hospital	☐ Nursing Home	☐ Other		
Address	City			State	Zip Code

ABUSE DISCLOSURE INFORMATION

According to the Federal Requirement on Abuse (42 C.F.R. §483.13(b) at F223), the resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment and involuntary seclusion.

Effective March 15, 1999, all potential admissions will be screened, via their medical records, for evidence of any history of abuse (physical, or verbal) behavior within the last three months.

Potential residents will not be admitted if their records indicate this type of behavior has been present within the last three months.

HIPAA AND AMERICANS WITH DISABILITIES ACT INFORMATION

The Oregon Department of Veterans Affairs (ODVA) complies with Title II, Subtitle F of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The ODVA privacy program policies ensure the privacy of residents and all information regarding protected health information (PHI).

ODVA complies with the Americans with Disabilities Act (ADA) PL101-336. The ADA provides that no qualified person with a disability shall be kept from participation in (or be denied a benefit of) the services, programs, or activities of ODVA because of that disability. For additional information or how to file a complaint, please contact ODVA's ADA Coordinator.

ADA Coordinator 503-373-2380

DOCUMENT CHECKLIST

The following documents are required to apply for admission to the Oregon Veterans' Homes:

- ☐ Application for Admission, Form VH3000-1 (this form)
- ☐ Authorization to Use and Disclose Protected Health Information (PHI), Form HP4001
- ☐ Acknowledgement of Receipt of the Notice of Privacy Practices, Form HP4002
- ☐ Authorization for Health Provider to Disclose Protected Health Information (PHI) to the Oregon Veterans' Home, Form HP4007
- ☐ The veteran's DD Form 214, Certificate of Release or Discharge from Active Duty (military discharge papers)
- ☐ VA Form 1010EZ Application For Health Benefits
- ☐ The current insurance card for the responsible party (veteran or spouse)
- ☐ A marriage certificate (only for spouses of veterans)
- ☐ Power of attorney papers

Submit all required documentation to:

ODVA Program Director
Edward C. Allworth Veterans' Home
600 North 5th Street
Lebanon, Oregon 97355-2876

CERTIFICATION AND SIGNATURE

I fully understand all requirements that must be met and all qualifications that must be possessed for admission to the Oregon Veterans' Home.

I hereby certify that this application contains no willful misrepresentation or falsification and that the information given is true and complete to the best of my knowledge and belief.

I also understand that failure to supply this information may mean my eligibility cannot be determined.

Signature of Veteran or Responsible Person	Date
✕	

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

It is the policy of the Oregon Department of Veterans' Affairs (ODVA) to protect the privacy of your personal information. This Notice of Privacy Practices (Notice) is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). It describes how ODVA may use or disclose your protected health information and with whom that information may be shared. This Notice also describes your rights to access and amend your protected health information. You have the right to approve or refuse the release of specific information outside of our system except when the release is required or authorized by law or regulation. We will abide by and follow the HIPAA privacy practices that are described in this Notice while it is in effect.

CHANGES TO THIS NOTICE

ODVA reserves the right to change this Notice. Its effective date is shown above. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. To obtain a copy of the Notice of Privacy Practices:

- Access ODVA's website at www.oregon.gov/odva;
- Call ODVA at 1-800-828-8801 or 503-373-2373;
- Write to ODVA's Privacy Officer to have a copy mailed to you; or
- Ask for a copy the next time you visit ODVA.

ACKNOWLEDGMENT OF RECEIPT OF THIS NOTICE

You may be asked to provide a signed acknowledgment of receipt of this Notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. If you decline to provide a signed acknowledgment, ODVA may determine not to continue to provide you with requested services. ODVA will disclose your protected health information for treatment, payment, and health care operations when necessary.

WHICH PROGRAMS WILL FOLLOW THIS NOTICE

This Notice describes ODVA's practices regarding your protected health information. For this Notice, ODVA includes the following:

- ODVA's Veterans' Home Loan Program;
- ODVA's Claims, Counseling, Educational Aid, and Conservatorship Programs; and
- The Oregon Veterans' Homes.

OUR DUTIES TO YOU REGARDING PROTECTED HEALTH INFORMATION

Protected Health Information is individually identifiable health information. This information relates to your past, present or future physical or mental health or condition and related health care services. ODVA is required by law to do the following:

- Make sure that your protected health information is kept private;
- Give you a copy of this Notice of our legal duties and privacy practices for the use and disclosure of your protected health information;
- Follow the terms of the Notice currently in effect;
- Communicate any changes in the Notice to you.

Other ways ODVA safeguards your personal health information:

- Treats all of your personal information that we collect as confidential;
- States confidentiality policies and practices in our employee handbook;
- Restricts access to your personal information to only those employees who need to know your personal information in order to provide services to you, such as approval for a home loan, or submitting a claim for a covered benefit;
- Discloses only your personal information necessary for a service provider to perform its functions on your behalf, and the provider agrees to protect and maintain the confidentiality of your personal information; and
- Maintains physical, electronic, and procedural safeguards that comply with federal and state regulations to guard your personal information.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We only disclose your personal information when allowed or required by law to make the disclosure, or if you (or your authorized representative) give us permission. Uses and disclosures, **other than those listed below**, require your authorization. If there are other legal requirements that further restrict our use or disclosure of your personal information, we will comply with those legal requirements as well. Following are types of disclosures allowed or required by law.

TREATMENT: ODVA may use your medical information to provide you with access to medical treatment or services. We may disclose your medical information to doctors, nurses, or health care providers who are involved in your treatment. Treatment activities include disclosing your personal information to a provider in order for that provider to treat you. For example, we will disclose your protected health information, as necessary, to the Health Care Professionals who provide care at the Oregon Veterans' Home. We may disclose your protected health information to the U.S. Department of Veteran's Affairs (USDVA). **IN EMERGENCIES,** ODVA will use and disclose your protected health information to assist you in obtaining treatment.

PAYMENT: ODVA may use and disclose your medical information so that the treatment and services you receive may be properly billed and paid. For example, ODVA may use your medical information from surgery you received at a hospital so the hospital can be reimbursed. We may also use your information to obtain prior approval for treatment.

HEALTH CARE OPERATIONS: ODVA may use and disclose your protected health information to support activities related to your health care. ODVA will share your protected health information with third-party business associates who perform various activities (for example, billing or transcription services) for ODVA.

DEATH; ORGAN DONATION: ODVA may disclose protected health information of a deceased person to a coroner, funeral director, or organ procurement organization for certain purposes. For example, we may disclose protected health information to a funeral director to enable them to carry out their duties.

LEGAL PROCEEDINGS; CRIMINAL ACTIVITY: ODVA may disclose protected health information during any judicial or administrative proceeding, in response to a court order, subpoena, discovery request, or other lawful process. For example, if you are a victim of a crime or you commit a crime, ODVA may disclose information to law enforcement.

MILITARY ACTIVITY AND NATIONAL SECURITY: ODVA may also disclose your protected health information to authorized officials conducting national security and intelligence activities.

PUBLIC HEALTH AND SAFETY: ODVA may disclose your protected health information if we believe disclosure is necessary to avert a serious and imminent threat to your health or safety or the health or safety of others. For example, we may disclose your protected health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or other crimes.

REQUIRED USES AND DISCLOSURES: By law, ODVA must make disclosures when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 of HIPAA.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

In some circumstances, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. The following are examples in which your agreement or objection are required:

- ODVA will use and disclose in the Oregon Veterans' Home inpatient directory the resident's name, condition (in general terms), and religious affiliation. This information, except religious affiliation, will be disclosed to people who ask for the resident by name. Only members of the clergy will be told a resident's religious affiliation.
- ODVA may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. We may also give information to someone who helps pay for your care. Additionally, we may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person who is responsible for your care, general condition, or disposition upon death.

EXERCISING YOUR RIGHTS – You may exercise the following rights by submitting a request to ODVA's Privacy Officer. Depending on your request, you may also have rights under the Privacy Act of 1974. ODVA's Privacy Officer can guide you in pursuing these options. Please be aware that ODVA may deny your request; however, you may seek a review of the denial.

- **Inspect and Copy** – You have the right to inspect and obtain a copy of your protected health information that ODVA maintains in a "designated records set". A designated record set contains medical and billing records which ODVA uses for making decisions about you. ODVA may charge you a nominal fee for providing you with copies of your protected health information.
- **Restriction Requests –** You have the right to request that ODVA place additional restrictions on our use or disclosure of your protected health information for treatment, payment, health care operations, or to persons you identify. Your request must be in writing to ODVA's Privacy Officer. ODVA is not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in an emergency or as required by law.
- **Request Confidential Communications –** You may request that we communicate with you using alternative means or at an alternate location. We will accommodate reasonable requests, when possible.
- **Amendment** – If you believe that the information ODVA has about you is incorrect or incomplete, you may request an amendment to your protected health information. Your request must be in writing and it must identify the information that you think is incorrect and explain why the information should be amended. While ODVA will accept requests for amendment, we are not required to agree to the amendment. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.
- **Accounting of Disclosure** – You have the right to receive a list of instances in which we disclose your protected health information for purposes other than those described in "HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION" earlier in this Notice. You are entitled to this accounting for the 6 years prior to your request, though not for disclosures made prior to April 14, 2003. ODVA will provide you with the date on which we made a disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed and the reason for the disclosure. If you request this list more than once in a 12-month period, ODVA may charge you a reasonable fee for responding to these additional requests.

FEDERAL PRIVACY LAWS

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). There are several other privacy laws that also apply including the Freedom of Information Act, the Privacy Act, and the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act. These laws have not been superseded and have been taken into consideration in developing our policies and this notice of how we will use and disclose your protected health information.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a written complaint with ODVA's Privacy Officer, the Governor's Office, or the U.S. Department of Health and Human Services. No retaliation will occur against you for filing a complaint.

CONTACT ODVA FOR INFORMATION

You may contact ODVA's Privacy Officer for further information about the complaint process, or for further explanation c this document. ODVA's Privacy Officer may be contacted at ODVA, 700 Summer St. NE, Salem OR 97301-1285, or b phone at 503-373-2000 or toll-free at 1-800-828-8801 (Inside Oregon Only).

ODVA intends to comply with the Americans with Disabilities Act (ADA), PL101-336. The ADA provides that no qualified person with a disability shall be kept from participation in (or be denied a benefit of) the services, programs, or activities of ODVA because of that disability.

For additional information or how to file a complaint, please contact ODVA's ADA Coordinator at 503-373-2380.

This information is also available in alternate formats, upon request.

OREGON DEPARTMENT of VETERANS' AFFAIRS

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

VETERAN INFORMATION

Name (Last, First, Middle)	Date of Birth	Social Security #	VA Claim Number

Service Number	Service Branch	Conservatorship #	Educational Aid #	ODVA Loan Number	OVH Resident #

CLAIMANT INFORMATION (if other than Veteran)

Name (Last, First, Middle)	Relationship to Veteran	Date of Birth	Social Security #	VA Claim Number

DISCLOSURE INFORMATION

I authorize the Oregon Department of Veterans' Affairs (ODVA) to use and disclose a copy of the specific health information described below:

The information is to be released to:

The information is to be used for the purpose of:

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information:

_____ HIV/AIDS information _____ Mental Health information _____ Genetic testing information _____ Drug/Alcohol diagnosis, treatment, or referral information

I understand that signing this authorization is voluntary. Refusal to sign this authorization will not adversely affect my ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. My refusal to sign this authorization does not adversely affect my enrollment in a health plan or eligibility for health benefits, unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.

I may revoke this authorization in writing at any time. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with my permission cannot be undone.

To revoke this authorization, please send a written statement to the attention of: ODVA Privacy Officer, 700 Summer Street NE, Salem, Oregon 97301-1285, and state that you are revoking this authorization.

SIGNATURE AND AUTHORIZATION

Unless revoked, this authorization expires upon the following date or event:

☐ _____ (DATE) ☐ ODVA Power of Attorney Terminates ☐ Conservatorship Terminates ☐ _____ Years ☐ Does Not Expire

☐ I have received a copy of ODVA's Notice of Privacy Practices. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment, or referral information. I have read this authorization and I understand it.

Signature	Date
✕	

Description of personal representative's authority:

☐ Spouse ☐ Power of Attorney ☐ Court-Appointed Guardian ☐ Other:

OREGON DEPARTMENT of VETERANS' AFFAIRS

ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices, ODVA Form HP4000, tells you how the Oregon Department of Veterans' Affairs (ODVA) may use and disclose information about you. Not all situations will be described. ODVA is required to give you a notice of our privacy practices for the information we collect and keep about you.

ACKNOWLEDGEMENT AND SIGNATURE (To be completed and signed by the individual receiving the Notice of Privacy Practices)

☐ I have been given a copy of ODVA's Notice of Privacy Practices and have had a chance to ask questions about how my information will be used.

VETERAN INFORMATION

Printed Name (Last, First, Middle)			Date of Birth	Social Security #	VA Claim Number
Service Number	**Service Branch**	**Conservatorship #**	**Educational Aid #**	**ODVA Loan Number**	**OVH Resident #**

CLAIMANT INFORMATION

Printed Name (Last, First, Middle)	Relationship to Veteran	Date of Birth	Social Security #	VA Claim Number
Signature				**Date**
✕				

Description of personal representative's authority:

☐ Spouse ☐ Power of Attorney ☐ Court-Appointed Guardian ☐ Other:

OREGON DEPARTMENT of VETERANS' AFFAIRS

AUTHORIZATION FOR HEALTH PROVIDER TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI) TO THE OREGON VETERANS' HOME

VETERAN INFORMATION

Printed Name (Last, First, Middle)	Date of Birth	Social Security #	VA Claim Number

Military Service #	Service Branch	Conservatorship #	Medicare Number	Medicaid Number	OVH Resident #

CLAIMANT INFORMATION (if other than Veteran)

Printed Name (Last, First, Middle)	Relationship to Veteran	Date of Birth	Social Security #	VA Claim Number

DISCLOSURE INFORMATION

I authorize (Provider):

to disclose a copy of specific health information regarding (Name of Veteran or Claimant):

and consisting of any and/or all medical information for the past six (6) months to:

☐ Oregon Veterans' Home The Dalles
700 Veterans' Drive
The Dalles, Oregon 97058-9757

☐ Edward C. Allworth Veterans' Home
600 North 5th Street
Lebanon, Oregon 97355-2876

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information:

_____ HIV/AIDS information _____ Mental Health information _____ Genetic testing information _____ Drug/Alcohol diagnosis, treatment, or referral information

NOTICE TO THE PROVIDER

The undersigned may revoke this authorization in writing at any time. If the authorization is revoked, the information described above may no longer be disclosed to the Oregon Veterans' Home for the purposes described in this written authorization. To expedite the disclosure of PHI to the Oregon Veterans' Home, the signer below has authorized disclosure prior to signing your individual authorization form.

SIGNATURE AND AUTHORIZATION

Unless revoked, this authorization expires upon the following date or event:

☐ _____ (DATE) ☐ Death of Veteran or Claimant ☐ Veteran or Claimant Discharged from Facility ☐ _____ Years ☐ Does Not Expire

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment, or referral information. I have read this authorization and I understand it.

Signature	Date
✕	

Description of personal representative's authority:

☐ Spouse ☐ Power of Attorney ☐ Court-Appointed Guardian ☐ Other: