

Worksheet Checklist -Nebraska Veterans' Home

Complete the Worksheet and obtain all necessary documents BEFORE contacting the Sarpy County Veterans' Service Office at 402-593-2203 to schedule an appointment to complete the application. If any question does not apply, answer "NA or NONE".

Veteran – Spouse, Surviving Spouse – Gold Star Parent

1. Use numbers to indicate your preference for admission to the Nebraska Veterans Home (s) ONLY where you want to reside
2. Provide complete names, addresses, phone numbers, e-mail addresses, SSNs and dates in questions 1 to 13
3. The Medical Report for Admission to Nebraska Veterans' Home **MUST** be completed and signed by Applicant's doctor. It **MUST** be completed within 30 days prior to your signing and our submission of your Nebraska Veterans' Home application
4. You must provide all financial information including income, assets, investments and life insurance policies
5. Provide all documents as appropriate for your application, to include, but may not be limited to:
 - A copy of Veteran's Military service – all DD214(s) or statements of service
 - All Marriage Certificate(s), All Divorce Decree(s) and spouse Death Certificate(s)
 - Court Orders, Probation Orders, Child Support, Garnishments
 - Power of Attorney (POA), Durable Power of Attorney and/or Durable Power of Health Attorney and/or Durable Power of Attorney that includes health care decisions also Living Will and DNR/DRI
 - Court appointed Guardianship and/or Conservatorship
 - Proof of Nebraska residency – minimum 2 years
 - Nursing Home and/or Long Term Care Insurance Policies
 - Medical Insurance Coverage cards, including Medicare and Medicaid & DVA Healthcare card
 - Supplemental Medicare Insurance Policy or card and documentation of costs
 - Documented sources of All Income, Retirement, VA Benefits, Social Security and Investment Income
 - Documented sources of All Income from Business, Partnership, Farm and/or Rental Income
 - Home and Business/Rental Real Estate valuation to include county assessor's real estate tax assessment
 - Personal property to include, but not limited to, vehicles, farming and/or business equipment
 - Current Bank Account statements for checking and/or savings listing balances and joint owner's information
 - CDs, IRAs, 401Ks, Stocks, Bonds, Investment portfolios, end of year statements and Trusts
 - Life insurance policies – cash/surrender value or face value/value upon death
 - Land Contracts or Sale of Property Contracts, property transaction recordings within the past 2 years

If you have any questions regarding this worksheet or required documents, please contact us at 402-593-2203

Spouse is eligible for admittance with the Veteran simultaneously or after the Veteran has become a resident of the Veteran's Home System. Separate applications are required for the Veteran and the Spouse. Monthly maintenance fees assessed for each member.

Surviving Spouse is eligible for admittance providing they have not remarried since the Veteran's death. Provide a copy of Veteran's Death Certificate and **Affidavit of No Remarriage**.

Gold Star Parent is eligible for admittance providing Veteran's death was during active duty or service connected death. Provide copy of Veteran's Birth Certificate to establish parental relationship.

Nebraska Department of Veterans' Affairs
Veterans' Homes Board Guidelines

Schedule of Allowances

Effective 01/01/2016

The maintenance charge is determined on the household's ability to pay. The minimum maintenance charge is \$0.

\$ 3,811.00	Maximum maintenance charge.
\$ 7,622.00	Maximum maintenance charge for couples.
\$ 9,809.00	Assets allowed for single members.
\$ 19,618.00	Assets allowed for married members.
\$ 65,395.00	Assets allowed if spouse lives outside the Veterans' home.
\$ 8,501.00	Irrevocable burial trust allowed for single members.
\$ 17,002.00	Irrevocable burial trust allowed for couples.
\$ 263.00	Monthly allowance for single members.
\$ 526.00	Monthly allowance for couples.
\$1,797.00	Monthly allowance for spouse living outside the Veterans' home except no monthly allowance is given for a spouse in a private or public institution when payment for his/her care is from the public agency.
\$ 273.00	Monthly allowance for each dependent child except no monthly allowance is given for a dependent child in a private or public institution when payment for his/her care is from a public agency.
\$ 323.00	Maximum monthly allowance for prescriptions for spouse living outside the Veterans' home with proof of such expense.
No Cap	Maximum monthly allowance for health insurance premiums for members and/or their spouses who are not eligible for Medicare coverage with proof of such expense.
No Cap	Maximum monthly allowance for extended Medicare coverage for member with proof of such expense.
No Cap	Maximum monthly allowance for extended Medicare coverage for spouse living outside the Veterans' home with proof of such expense.
No Cap	Maximum monthly allowance for Medicare Part D for member with proof of such expense.
No Cap	Maximum monthly allowance for Medicare Part D for spouse living outside the Veterans' home with proof of such expense.

- ❖ Sale of home is immediately counted as an asset.
- ❖ Personal home is exempt as an asset for 12 months after admission.
- ❖ Hospital credit will be issued if hospitalized off campus for 30 days or more.

MEDICAL REPORT FOR ADMISSION TO NEBRASKA VETERANS' HOME

Patient Name: _____ Birth Date: _____ Male Female

I hereby, authorize the release of necessary medical information from hospitals and other medical providers to the Nebraska Health and Human Services, the Nebraska Department of Veterans' Affairs, the appropriate County Veterans' Service Office, and the Veterans' Homes Board in order to establish eligibility for admission to the Nebraska Veterans' Home System.

Date: _____ Patient or Authorized Signature: _____

ALL SECTIONS MUST BE COMPLETED. IF IT DOES NOT APPLY MARK WITH N/A OR NONE.

Does patient have capacity to make health care decisions? Yes No

Diagnosis (include alcoholism, drug abuse and psychopathology)

- | | | |
|----------|----------|----------|
| 1. _____ | 2. _____ | 3. _____ |
| 4. _____ | 5. _____ | 6. _____ |
| 7. _____ | 8. _____ | 9. _____ |

CHECK ANY OF THE FOLLOWING IF THEY ARE PRESENT:

					Test	Date	Results
Disabilities	Impairments	Mild	Mod.	Sev.	Activity Tol. Limits	Chest x-ray	
<input type="checkbox"/> Amputation	Speech				<input type="checkbox"/> None	C.V.C.	
<input type="checkbox"/> Paralysis	Hearing				<input type="checkbox"/> Moderate	Serology	
<input type="checkbox"/> Contracture	Vision				<input type="checkbox"/> Severe	Urinalysis	
<input type="checkbox"/> Decub. Ulcer	Sensation						
<input type="checkbox"/> Other	Tremors						

Infections - please specify (MRSA, VRE, IV antibiotics, etc.)

None

<input type="checkbox"/> Tetanus Shot	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____
<input type="checkbox"/> Influenza Shot	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____
<input type="checkbox"/> Pneumococcal Polysaccharide Vaccine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____

Behavioral issues - please specify (wandering, anger, etc.)

<input type="checkbox"/> Wandering	<input type="checkbox"/> Anger Outbursts	<input type="checkbox"/> Delusional Behaviors
<input type="checkbox"/> Resists cares	<input type="checkbox"/> Sexual Inappropriateness	<input type="checkbox"/> None
<input type="checkbox"/> Compulsive Behaviors	Specify: _____	

Present Medications: (an attached printout is acceptable)

- | | | | |
|----------|-----------|-----------|-----------|
| 1. _____ | 2. _____ | 3. _____ | 4. _____ |
| 5. _____ | 6. _____ | 7. _____ | 8. _____ |
| 9. _____ | 10. _____ | 11. _____ | 12. _____ |

Allergies - please specify NKA _____

Diet: Regular Modified (specify e.g., salt free, 1800 calorie limit etc.)

Patient

Acceptance of illness / disability	Understands reason for placement	Participated in Plan
<input type="checkbox"/> Good	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> Fair	<input type="checkbox"/> Partly	<input type="checkbox"/> No
<input type="checkbox"/> Poor	<input type="checkbox"/> No	<input type="checkbox"/> N/A

Family

Participated in Planning	Accepted Nursing Home Plan	Expected to Visit
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> No	<input type="checkbox"/> Reluctantly	<input type="checkbox"/> No
<input type="checkbox"/> N/A	<input type="checkbox"/> No	<input type="checkbox"/> N/A

Patient Name: _____ **Social Security #** _____

Self-Care Status:	Independent	Needs Assistance	Unable to do	Assistive Devices:	Has	Uses	Needs
Personal Hygiene				Eyeglasses			
				Dentures			
Feeding				Hearing Aid			
				Walker			
Locomotion				Crutches			
				Cane			
Transfers				Wheelchair			
				Other: (specify)			
Elimination:	Ostomy	Continent	Incontinent				
Bowel				Remarks:			
Bladder							

Patient's Sociability:

Sociable
 Withdrawn at times
 Combative

Patient's Mental Status:

Alert / Oriented / Responsive
 Diagnosed Dementia
 Occasionally Disoriented / Confused
 Hospitalized for Psychiatric Treatment
 Diagnosed Mental Illness

Does Patient Know Diagnosis? Yes No

Other: (Include observations, instructions given to patient / family regarding illness, treatment, etc.)

None

PHYSICIAN'S RECOMMENDATIONS

Special Treatments:

None
 Feeding Tube
 Oxygen

Specify: _____

Physician's Printed Name, Address & Telephone No.

Name: _____

Address: _____

City, St. Zip: _____

Telephone: _____

SIGNATURE & DATE: X _____

Prognosis:

Anticipated Rehabilitation Needs:

None

Anticipated Level of Care:

PLEASE RECHECK TO MAKE SURE ALL SECTIONS ARE COMPLETED OR THIS FORM WILL BE RETURNED

Sarpy County Worksheet

10. Contact Person (other than spouse):

Name	Relationship		
Address	City	State	Zip
Email	<input type="checkbox"/> Cell <input type="checkbox"/> Home Phone No.		Daytime Phone Number

11. Contact Person (other than spouse):

Name	Relationship		
Address	City	State	Zip
Email	<input type="checkbox"/> Cell <input type="checkbox"/> Home Phone No.		Daytime Phone Number

12. Has applicant executed (a) power of attorney? Yes No (b) power of health attorney? Yes No
 (c) power of attorney that includes health care decisions? Yes No **ATTACH COPY OF LEGAL INSTRUMENT**
 (d) Living Will? Yes No **ATTACH COPY OF LEGAL INSTRUMENT**

13. Does applicant have a court-appointed guardian/conservator? Yes No
 a. If yes, name, address and phone number of guardian/conservator **ATTACH COPY OF LEGAL INSTRUMENT**

Name	Relationship		
Street Address	City	State	Zip Code
<input type="checkbox"/> Cell <input type="checkbox"/> Home Phone No.	Daytime Phone Number		Email

14. Has the Veteran lived in Nebraska for two years at any time? Yes No
 15. Have you, the applicant, lived in Nebraska for two years at any time? Yes No
 16. Have you ever made application and/or been a member of a Nebraska Veterans Home? Yes No
 If yes, date of application and/or admission _____ Date of Discharge _____
 17. Have you ever been convicted of a felony? Yes No If so, state offense _____

18. Does applicant have nursing home insurance? Yes No
 19. Are you currently enrolled in the USVA Health Care System? Yes No

	Yes	No	Premium	Annual	Monthly
20. Does the applicant have supplemental insurances to Medicare?	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
21. If married, does the spouse have supplemental insurances?	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
22. Does the applicant have Medicare Part D?	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
23. If married, does the spouse have Medicare Part D?	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
24. Does the applicant have primary health insurance other than Medicare?	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
25. If married, does the spouse have primary health insurance other than Medicare?	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>

Sarpy County Worksheet

FINANCIAL STATEMENT

Monthly Income

Complete entries below showing all income of the applicant and spouse.

If additional space is needed, please attach separate sheet of paper.

<u>APPLICANT</u>		<i>Monthly Amount:</i>		<u>SPOUSE</u>		<i>Monthly Amount:</i>
26. VA Compensation –				VA Compensation –		
Service Connected (_____ %):		\$ _____		Service Connected (_____ %):		\$ _____
Non-Service Connected Pension:		\$ _____		Non-Service Connected Pension:		\$ _____
Aid & Attendance: <input type="checkbox"/> Yes <input type="checkbox"/> No				Aid & Attendance: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Housebound: <input type="checkbox"/> Yes <input type="checkbox"/> No				Housebound: <input type="checkbox"/> Yes <input type="checkbox"/> No		
27. Dependency & Indemnity Compensation (DIC):		\$ _____		27. Dependency & Indemnity Compensation (DIC):		\$ _____
28. Death Pension (Dependent):		\$ _____		28. Death Pension (Dependent):		\$ _____
29. Social Security –				29. Social Security –		
Medicare Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No				Medicare Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Medicare Number: _____				Medicare Number: _____		
Monthly Premium \$ _____				Monthly Premium \$ _____		
Net		\$ _____		Net		\$ _____
30. Retirement Income (LIST SOURCES) –				30. Retirement Income (LIST SOURCES) –		
_____		\$ _____		_____		\$ _____
_____		\$ _____		_____		\$ _____
_____		\$ _____		_____		\$ _____
_____		\$ _____		_____		\$ _____
_____		\$ _____		_____		\$ _____
31. Dividends and Annuities:		\$ _____		31. Dividends and Annuities:		\$ _____
32. Interest:		\$ _____		32. Interest:		\$ _____
33. Rental Property Income:		\$ _____		33. Rental Property Income:		\$ _____
34. Farm Rent:		\$ _____		34. Farm Rent:		\$ _____
35. Farm Income (include previous year taxable income):		\$ _____		35. Farm Income (include previous year taxable income):		\$ _____
36. Land Contract Income (provide a copy):		\$ _____		36. Land Contract Income (provide a copy):		\$ _____
37. Other Income (LIST SOURCES) –				37. Other Income (LIST SOURCES) –		
_____		\$ _____		_____		\$ _____
_____		\$ _____		_____		\$ _____
_____		\$ _____		_____		\$ _____
_____		\$ _____		_____		\$ _____
_____		\$ _____		_____		\$ _____
_____		\$ _____		_____		\$ _____
38. TOTAL		\$ _____		38. TOTAL		\$ _____

WHEN YOU HAVE COMPLETED
THIS WORKSHEET AND
SECURED ALL THE SUPPORTING
DOCUMENTATION, PLEASE
CONTACT THE VETERANS
SERVICE OFFICE TO SCHEDULE
AN APPOINTMENT TO
COMPLETE YOUR APPLICATION
FOR ADMISSION TO A
NEBRASKA VETERANS' HOME.
SARPY COUNTY VETERANS
SERVICE OFFICE PHONE
NUMBER IS 402-593-2203