

# Michael J. Fitzmaurice South Dakota Veterans Home

## Preliminary Financial Disclosure

### (605)745-5127

*This form is considered part of your Application*

Our **NCU/SCU area** operates under Medicaid guidelines.

Our **RLS area** operates under South Dakota Veterans Affairs Administrative Rules defined by South Dakota Codified Laws which determine your monthly fee. It is important to remember that this fee is reviewed annually and can change based on changes in your gross income and asset status, operating cost of the Home, and changes in Administrative Rules. Initial Maintenance Rent will be based on current income (and assets), or on Adjusted Gross Income from your prior year's Federal Income Tax Return (and assets), whichever is greater. Annual updates to your Financial Statement are required.

**1. INSTRUCTIONS:**

Read this form carefully and follow all instructions throughout the form.

**1. The following documents are required with your application. Attach copies of:**

- \* your previous three (3) years of federal tax returns
- \* the last three months bank statements for all accounts
- \* most recent VA award letter
- \* your most recent Social Security Award letter
- \* any other income and asset documentation
- \* non-reimbursed medical expenses paid by you (and your spouse) during prior year  
ie: prescriptions, doctor co-pay, dentist and health insurance premium for Accountant-VA form 10-10EZ
- \* previous medicaid letters from Dept of Social Services

2. Include copies of all required documents. DO NOT ATTACH ORIGINAL DOCUMENTS.

**3. You are required to provide this information before you set up your interview.**  
(If you need help completing this form contact the Vet's Home Accountant, or your County or Tribal Veteran Service Officer.)

**OPTION:** In lieu of providing all the information and documentation required by this form, you may agree to pay the full cost of care. To choose this option, complete these sections: 2, 3, 4, 5, 6, 7, 10, 11, 12, 13, 14 and sign.

**2. PERSONAL INFORMATION:**

Name (Last, First, Middle Initial)		
Birth date	Sex	Marital Status
Social Security Number		
Street Address		
City	State	Zip
Phone Number	County	

If some one else is filling out this form, provide the following information for the individual completing the form.

Name (Last, First, Middle Initial)		
Street Address		
City	State	Zip
Phone # including area code		
Relationship to Applicant		

**3. INFORMATION ON SPOUSE** (whether or not spouse is moving in):

Spouse's Name	Birth date	Sex	Social Security Number
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**4. INFORMATION ON DEPENDENTS:**

Dependents Name(s)	Birthdate(s)
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**5. LIVING ARRANGEMENTS: Check the box that describes current living conditions**

	In own Home	Renting	In Others' Home	Other (describe):	Example: Shelter
Self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

**6. INFORMATION ON MEDICARE:**

Attach copies of Medicare card(s), front and back, if you or your spouse have Medicare.

Do you have Medicare? __Yes __No	Types of Coverage (Check each box that Applies) __Part A __Part B	Effective Date	Medicare ID Number
Does your spouse have Medicare? __Yes __No	Types of Coverage (Check each box that applies) __Part A __Part B	Effective Date	Medicare ID Number

**7. INFORMATION ON MEDICAID:**

Attach copies of Medicaid card(s), front and back, if you or your spouse have Medicaid.

Do you have Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Part A <input type="checkbox"/> Part B	Effective Date	Medicaid ID Number
Does your spouse have Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Part A <input type="checkbox"/> Part B	Effective Date	Medicaid ID Number

**8. INFORMATION ON ALL OTHER INSURANCE (including prescription medication coverage):**

Do you have other health insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your Spouse have other health Insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you or your spouse have any long term care insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you have other insurance, please complete the following information.

Insurance Provider Name and Address	Annual Premium	Type: Hospital, Medigap, Rx, etc.	Effective Date(s)	Policy Number
Self				
Spouse				

**9. INCOME AND EARNINGS:**

List all types of earnings and income that you, your spouse, or dependents receive.  
 List the income amount before deductions (such as taxes and insurance) are taken out.  
 Include proof of all income (check stubs, bank statements, benefits letters, etc.)

**Make copies, do not send the Original Documents.**

*Examples of income include:*

- \* Social Security
- \* Railroad/Retirement Benefits
- \* Pensions/Retirement Benefits
- \* Social Security Income
- \* Veterans Benefits
- \* Rental Income
- \* Wages/Self-Employment
- \* Trust or Annuity Payments
- \* Oil Royalties/Mineral Rights
- \* Annuities
- \* Long Term Care Benefits

Who Receives Income	Type of Income	Amount	Source of Income	How often Received?	ID Number (if Req)

**10. ALL PROPERTY:**

Do you or your spouse own all or part of any Real Estate?  YES  NO

If yes, please complete the following for each piece of real estate.

Address	Value	Amount Owed

Do you or your spouse, own a Car, Truck, Motorcycle, Boat trailer, or other vehicles?

If Yes, please complete the following information about each vehicle:  YES  NO

Owner(s)	Year	Make	Model	Value	Amount Owed

**11. ALL RESOURCES:**

List all types of resources (assets) owned by you or your spouse. Include any accounts or properties on which your name or your spouse's name appears. Include verification (such as copies of your most recent bank statement, trust fund statements, etc.) of all resources. Examples of resources:

- \* Checking accounts
- \* Savings accounts
- \* Government bonds
- \* Trust funds
- \* Funeral plans/burial arrangements
- \* Burial Plots
- \* Stocks and Bonds
- \* Certificates of Deposit
- \* Cash on Hand
- \* Safety Deposit boxes
- \* Retirement Funds
- \* Other Income, Resources
- \* Annuities

Attach additional pages if needed.

Type of Resource	Account/Policy #	Value	Name & Address of Bank, Insurance Company or other Financial Institution

**12. STATEMENT OF PROPERTY TRANSFERS:**

I have \_\_\_\_ (or) have not \_\_\_\_ sold, transferred or conveyed any property or other assets within the last five (5) years

If so, to whom:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Description of the property or asset's: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Value of the property or assets: \_\_\_\_\_

Amount received: \_\_\_\_\_

Disposition of the proceeds: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**13. LIFE INSURANCE:**

Do you or your spouse, have a life insurance policy?

YES

NO

If yes, please complete the following information.

Policy Owner	Insurance Company Name and Address	Policy #	Face Value	Cash Value

**14. PRIVACY AND INFORMATIONAL STATEMENTS:**

Federal and state laws and regulations limit the use and disclosure of confidential information concerning applications and recipients of all information to purposes directly related to the administration of SDVH business.

**FULL COST OF CARE ESTATE RECOVERY:**

**33-18-15. Preferred claim of state for maintenance of deceased member;  
Disposition of funds realized**

If an estate is left by a deceased member of the state veterans home, the state home shall file a claim against the estate of such deceased member in the amount of the full maintenance charge for each month the member was in the home, retroactive from the date of admission with proper credits allowed to the estate of the deceased member for any payments made by the member, but such credits not to include any allowances of the state government and such moneys received from the deceased member's estate shall go to a capital fund of the state home for repairs, equipment, improvements or construction.

**APPLICANT'S STATEMENT OF UNDERSTANDING AND AGREEMENT:**

I understand that, by signing this application, I am agreeing to a review of my eligibility by state officials. This may include inquiries of employers, medical providers, financial institutions, and other business and professional persons and review of any agency records. I also agree that my application authorizes these agencies to release to this agency the information needed to determine my financial information. I agree to provide the documents necessary to establish eligibility. If documents are not available, I agree to give the name of the person or organization from which this agency may obtain the necessary verification.

I authorize the use of my (our) Social Security Number(s) for such purposes as identification, program reviews or audits, and computer matching with other agencies and institutions such as banks, saving and loan associations, and other government agencies, including Internal Revenue Service, to verify my financial status.

**15. OPTION TO PAY FULL COST OF CARE (sign initials in box at right to choose this option):**

I hereby choose and agree to pay the full cost of care in lieu of providing my financial information and documentation. I further understand that the current maintenance rent for the proposed level of care is currently \$\_\_\_\_\_ per month, and that this is recalculated on an annual basis according to the Administrative Rules of South Dakota. (Further details provided upon request) Full signature is also required below.

**APPLICANT(S) OR REPRESENTATIVE MUST READ AND SIGN:**

State law provides for fine, imprisonment, or both for any person who withholds or gives false information. I understand the questions on this application and I certify, under penalty of perjury, that the information given by me on this form is correct and complete to the best of my knowledge. I also agree that during my stay at the Home neither I nor any agent of mine will transfer any of my assets to avoid payment for my care, or if any amount is still owed based on the full cost of my care at the time of my death. I agree to notify the SDVH of changes in my income, resources, or assets which might affect my maintenance rent at the MJ Fitzmaurice SD Veterans Home.

\_\_\_\_\_  
**Signature of Applicant or Representative (REQUIRED)**

\_\_\_\_\_  
**Date:**

\_\_\_\_\_  
**Signature of Applicant's Spouse (if living)**

\_\_\_\_\_  
**Date:**