Department of Veterans Affairs
Michael J. Fitzmaurice
South Dakota Veterans Home
2500 Minnekahta Avenue
Hot Springs, SD 57747
Phone 605.745.5127

REQUIRED DOCUMENTATION CHECKLIST

Please review and return the below checklist to ensure all additional items are included with the application or indicate why they are not included. Please send copies of the items below with the application. Thank you.

Applicant Name:

Not Applicable	Included	Required Documentation
☐	☐	Previous three (3) months bank statements
☐	☐	Any "other" income documentation
☐	☐	Authorization for Release of Health Information (For Providers, Clinics, Hospitals outside of the VA)
☐	☐	VA Request for and Authorization to Release Health Information (Form 10-5345)
☐	☐	Most recent VA pension / disability award letter
☐	☐	DD-214
☐	☐	Most recent Social Security Award letter
☐	☐	Medicare Card: Part A ☐ Part ☐ Part D (Prescripti☐
☐	☐	Supplemental insurance card
☐	☐	Medicaid Card
☐	☐	Social Security Card
☐	☐	Driver's license or ID Card
☐	☐	Current vehicle insurance card (if you have a current driver's license)
☐	☐	Burial Trusts / Arrangement Note: If you do not have a burial plan, please list the name and phone number of your preferred funeral home: _____
☐	☐	Healthcare Power of Attorney
☐	☐	Financial Power of Attorney

MICHAEL J. FITZMAURICE SOUTH DAKOTA VETERANS HOME

As of January 4, 2022

APPLICANT INFORMATION

Applicant's Name:

Date of birth: SSN: Phone:

Physical address:

City: State: Zip:

Mailing address:

City: State: Zip:

Married ☐ Single ☐ Divorced ☐ Widow/Widower ☐ Never Married ☐ Separated ☐

Spouse Name:

Date of Birth: SSN:

IN CASE OF EMERGENCY CONTACT INFORMATION

Name:

Relationship:

Address:

Home Phone: Cell Phone:

LEVEL OF CARE/MEDICAL INFORMATION

Level of Care Sought (select one): ☐ Residential Living (Independent) ☐ Nursing Care

Criteria for Residential Living:

- General health status is stable and does not require frequent medical Interventions for a Physician, Physician Assistant, or Certified Nurse Practitioner
- Free of communicable disease
- Residential living requires that potential residents have total independence with personal care needs; such as, bathing, dressing, eating, ambulating (walking), toileting, transferring, etc.
- Applicants who have a diagnosis of alcohol or substance abuse must have twelve months of documented sobriety before being accepted to the SDVH

Criteria for Nursing Care:

- The applicant requires nursing care 24 hours per day.
- The applicant requires nursing staff to manage, observe, and evaluate care.
- The applicant requires supervision or monitoring to ensure his or her safety.
- The applicant may require nursing restorative services and / or therapy rehabilitation services.
- Applicants who have a diagnosis of alcohol or substance abuse must have twelve months of documented sobriety before being accepted to the SDVH.
- PASRR (Pre-Admission Screening and Resident Review) Required

List all major medical conditions:

Cost of Care for the Michael J. Fitzmaurice South Dakota Veterans Home

Residential Living (Independent)	**Nursing Care**
Assets above $50,000 rate is $203.75 per day (**Approximate Cost: $6,197.40 per month based on Calendar Year 2022 rates)**	$360.00 per day (**Approximate Cost: $10,950.00 per month based on Calendar Year 2022 rates)**
Assets below $50,000 is 50% of total income (single) 55% of total income (couple)	

MICHAEL J. FITZMAURICE SOUTH DAKOTA VETERANS HOME

APPLICANT INFORMATION

Applicant's Name:	Preferred Name:
Mother's Maiden Name:	
Birth Sex: ☐ Male ☐ Female	
Are you Hispanic or Latino: ☐ Yes ☐ No	
What is your race? (You may check more than one): ☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American ☐ White ☐ Native Hawaiian or other Pacific Islander	
Birth City:	Religion:

MILITARY SERVICE INFORMATION

Last branch of service	Last Entry Date	Last Discharge Date
Discharge Type	Military Service # if known	

Military History (select those that apply):

- ☐ Are you a Purple Heart Recipient?
- ☐ Are you a former prisoner of war?
- ☐ Did you serve in a combat theater of operations after 11/11/98?
- ☐ Were you discharged or retired from military for a disability incurred in the line of duty?
- ☐ Are you receiving disability retirement pay instead of VA compensation?
- ☐ Did you serve in SW Asia during the Gulf War between August 2, 1990 and November 11, 1998?
- ☐ Do you have a VA Service-Connected Rating? If yes, what percentage? _____%
- ☐ Did you serve in Vietnam between January 9, 1962 and May 7, 1975?
- ☐ Were you exposed to radiation while in the military?
- ☐ Did you receive nose and throat radium treatments while in the military?
- ☐ Did you serve on active duty at least 30 days at Camp Lejeune from August 1, 1953 through December 31, 1987?

Signatures

I certify that the information contained above is true and correct to the best of my knowledge. My signature, or the signature of my representative, signifies my interest in admission to the Michael J. Fitzmaurice South Dakota Veterans Home. I agree to cooperate fully with providing additional admissions documentation that is necessary prior to admission to the Michael J. Fitzmaurice South Dakota State Veterans Home.

Signature of Applicant or Representative (required):	Date:
Signature of Spouse (if applicable):	Date:

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY AND FRIENDS

Name _____ Date of Birth _____

I hereby authorize the *Michael J. Fitzmaurice South Dakota Veterans Home* at *2500 Minnekahta Ave., Hot Springs, SD 57747* to release my Protected Health Information as described below:

Name (please print)	Relationship to Resident	Phone Number	Mailing Address	Email address (if applicable)

Information to be released (check each requested item):

☐ History and Physical ☐ Progress Notes ☐ Social Worker Notes
☐ Laboratory Reports ☐ Radiology Reports ☐ Other (see below)
Other is specified as: _____

The following information will not be released unless you specifically authorize it by checking the relevant box(es) below:
☐ I specifically authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment.
☐ I specifically authorize the release of information pertaining to mental health diagnosis or treatment.

The purpose of this release is (check one or more):
☐ Continuity of care or discharge planning
☐ At the request of the resident / resident's representative
☐ Other (state reason) _____

Expiration of Authorization: Unless otherwise revoked, in writing, this authorization expires at the time I am on longer a resident at the Michael J. Fitzmaurice South Dakota Veterans Home.

_____ _____
Signature of Resident or Resident Representative Date

_____ _____
Printed Name Resident Representative Relationship

NOTICE: The Michael J. Fitzmaurice South Dakota Veterans Home (MJFSDVH) and many other organizations and individuals, such as physicians, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, state or federal confidentiality laws may no longer protect it.

MY RIGHTS:

- I understand this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for 1) conducting research-related treatment, 2) obtaining information in connection with eligibility or enrollment in a health plan, 3) determining an entity's obligation to pay a claim, or 4) creating health information to provide to a third party. Under no circumstances, however, am I required to authorize the release of mental health records.
- I may revoke this authorization at any time, provided that I do so in writing and submit it to the MJFSDVH at 2500 Minnekahta Avenue, Hot Springs, SD 57747. The revocation will take effect when the MJFSDVH receives it, except to the extent that the MJFSDVH or others have already relied on it.
- I am entitled to receive a copy of this Authorization.

AUTHORIZATION FOR FINANCIAL VERIFICATION

I HEREBY AUTHORIZE THE VETERANS ADMINISTRATION AND ANY BANK, SAVINGS AND LOAN OR OTHER FINANCIAL INSTITUTION TO RELEASE TO ANY AGENT OR REPRESENTATIVE OF THE MICHAEL J. FITZMAURICE SOUTH DAKOTA VETERANS HOME A FINANCIAL STATEMENT OR OTHER FINANCIAL INFORMATION REGARDING ALL ASSETS, INCLUDING PROPERTY, ACCOUNTS, LOANS, AND INVESTMENTS, IN WHICH I OR MY SPOUSE HAVE AN INTEREST.

- **SUCH AUTHORIZATION IS CONTINUING AND WITHOUT LIMITATION FROM THIS DATE.**

DATED THIS _____ DAY OF _____ 20 ___

_____
(APPLICANT SIGNATURE)

_____
(NOTARY PUBLIC SIGNATURE)

SEAL COMMISSION EXPIRES_____

The following summary is provided to help you understand the laws that refer to disposition of assets while residing at the South Dakota Veterans Home.

- There often is a difference between what you will pay as your monthly maintenance rent and the actual full cost of care. South Dakota Codified Laws provide for a claim against your estate up to the amount of that difference.
- The specific laws are reprinted below. We recommend that you share a copy of this information with your next of kin.
- If you have any questions, please feel free to contact the Veterans Home Business Office at (605) 745-5127.

SDCL 33A-4-16. Distribution of assets of deceased member. If any member of the State Veterans' Home dies without legal dependents, the member's property shall be distributed to the South Dakota State Veterans' Home as sole heir for the sole use and benefit of the home. The member may, by will, dispose of the member's estate subject to the preferred claim provided in §§ 33A-4-17 to 33A-4-20, inclusive. A spouse residing at the home is considered as a legal dependent for the purpose of this section.

SDCL 33A-4-17. Authority to turn deceased member's property over to department--Subsequent claim for property. If a member of the State Veterans' Home dies, leaving at the home cash or other personal property of value, the superintendent of the home may turn over the cash, property, or its proceeds to the Department of Veterans Affairs for the sole use and benefit of the home, without administration. The cash, property, and proceeds are subject to refund within three years to any creditor, legal dependent, or heir, if the deceased member left a will, and if the creditor, legal dependent, or heir establishes a right to the cash, property, or proceeds or any portion of the cash, property, or proceeds. The attorney general, upon being satisfied that a claim out of the cash, property, or proceeds is legal and valid, may certify the claim to the secretary of veterans affairs, and the secretary of veterans affairs shall satisfy the claim.

SDCL 33A-4-18. Claim for maintenance of deceased member--Disposition of funds. If an estate is left by a deceased member of the State Veterans' Home leaving no surviving spouse or dependent, the state home shall file a claim against the estate of the 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. However, the credits may not include any allowances of the state government. Any such money received from the deceased member shall go to a capital fund of the state home for repairs, equipment, improvements, or construction.

SDCL 33A-4-19. Claim against estate of deceased spouse or dependent. If a deceased member of the State Veterans' Home leaves a spouse, or other dependent, the member's estate is payable to the spouse, or other dependent. Upon the death of the spouse or other dependent, the state home shall file a claim against the estate of the deceased spouse or other dependent for any claim against the estate of both the deceased husband and wife as provided in § 33A-4-18. The claim is a preferred claim against the estates.

SDCL 33A-4-20. Transfers to avoid state's claim. Any transfer of property to avoid the payment of a claim of the State Veterans' Home shall be voidable.

SDCL 29A-6-107 Payment to surviving party from multiple-party account -- Liability for debts and expenses of administration -- Procedure -- Liability of financial institution. No multiple-party account is effective against an estate of a deceased party to transfer to a survivor sums needed to pay debts, taxes, and expenses of administration, including statutory allowances to the surviving spouse, minor children and dependent children, if other assets of the estate are insufficient. A surviving party, P.O.D. payee or beneficiary who receives payment from a multiple-party account after the death of a deceased party shall be liable to account to his personal representative for amounts the decedent owned beneficially immediately before his death to the extent necessary to discharge the claims and charges mentioned above remaining unpaid after application of the decedent's estate. No proceeding to assert this liability may be commenced unless the personal representative has received a written demand by a surviving spouse, a creditor or one acting for a minor or dependent child of the decedent, and no proceeding shall be commenced later than two years following the death of the decedent. Sums recovered by the personal representative shall be administered as part of the decedent's estate. This section does not affect the right of a financial institution to make payment on multiple-party accounts according to the terms thereof or make it liable to the estate of a deceased party unless before payment the institution has been served with process in a proceeding by the personal representative.

I hereby acknowledge that I have received a copy and understand the provisions of SDCL 33A-4-16, 33A-4-17, 33A-4-18, 33A-4-19, 33A-4-20 and SDCL 29A-6-107 regarding the state's preferred claim for maintenance payments of deceased members.

_____ _____

Applicant's Signature Date

_____ _____

Signature of Next of Kin/Witness Date

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

Spouse's Name	Birth date	Sex	SSN

2. INFORMATION ON DEPENDENTS:

Dependents Name(s)	Birthdate(s)

3. LIVING ARRANGEMENTS: Check the box that describes current living conditions

Self: ☐ Own Home	☐ Renting	☐ In someone else's Home	Other (describe)	
Spouse: ☐ Own Home	☐ Renting	☐ In someone else's Home	Other (describe)	

4. 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	☐ Part A	☐ Part B	☐ Part D	Effective date(s)	Medicare ID Number
Does your spouse have Medicare? ☐ Yes ☐ No	☐ Part A	☐ Part B	☐ Part D	Effective date(s)	Medicare ID Number

5. INFORMATION ON MEDICAID:

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

Do you have Medicaid? ☐ Yes ☐ No	Medical ☐	Long Term Care ☐	Effective date(s)	Medicaid ID Number
Does your spouse have Medicaid? ☐ Yes ☐ No	Medical ☐	Long Term Care ☐	Effective date(s)	Medicaid ID Number

6. INFORMATION ON ALL OTHER INSURANCE: If you have other insurance, please complete the following information and provide copies. This includes health, long term care, and prescription medication coverage. Attach another sheet if more room is needed.

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

7. 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	*Social Security Income	*Wages/Self Employment	*Annuities
*Railroad/Retirement Benefits	*Veterans Benefits	*Trust or Annuity Payments	*Long Term Care Benefits
*Pension/Retirement Benefits	*Rental Income	*Oil Royalties/Mineral Rights	*Disability Income

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

8. ALL ASSETS:

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? ☐ Yes ☐ No
If Yes, please complete the following information about each vehicle

Owner(s)	Year	Make	Model	Value	Amount Owed

9. ALL ASSETS:

List all types of 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 arrang
* Burial Plots
* Stocks and Bonds
* Certificates of Deposit
* Cash on hand
* Safety Deposit boxes
* Retirement Funds
* Other Income, Resources
* Annuities
* Life Insurance

Attach additional pages if needed.

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

10. 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 assets:

Value of the property or assets: _____

Amount received: _____

Disposition of the proceeds:

11. 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.

12. OPTION TO PAY FULL COST OF CARE: 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.

13. 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.

14. MEDICARE PART B & D: If I do not have Medicare part B and D upon admission, I agree to apply for both during the next open enrollment period.

15. MEDICAL RECORDS: Medical records will be obtained via the attached medical records Release of Information (ROI) forms on pages 11-13. If your received records do not contain a History & Physical or annual exam within the last 60 days proceeding the date of the application you may be required to schedule an appointment with your primary care provider for a History & Physical or annual exam.

_____ _____

Signature of Applicant or Representative (REQUIRED) Date

_____ _____

Signature of Applicant's Spouse Date

The MJF S.D. Veterans Home Nursing Care Units and Special Care Units operate under Medicaid Guidelines. The Independent Living Households operate 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 MJF S.D. Veterans Home and changes in administrative rules. Initial maintenance rent will be based on current income (and assets), or an adjusted gross income from your prior year's federal income tax return (and assets), whichever is greater. Annual updates to your financial statement may be required.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION ***Please do not use this form for VA Medical Records. It is only for providers, clinics, hospitals outside of the VA***

Name _____ Date of Birth _____

Medical Record Number _____ SSN _____

I hereby authorize (name of person or facility sending information) _____

_____

to release my health information to the *Michael J. Fitzmaurice South Dakota Veterans Home* at *2500 Minnekahta Ave., Hot Springs, SD 57747*.

Information to be released (check each requested item):

☐ History and Physical ☐ Progress Notes ☐ Social Worker Notes
☐ Laboratory Reports ☐ Radiology Reports ☐ Entire Record
Other (please specify): _____

The following information will not be released unless you specifically authorize it by checking the relevant box(es) below:
☐ I specifically authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment.
☐ I specifically authorize the release of information pertaining to mental health diagnosis or treatment.

The purpose of this release is (check one or more):
☐ Continuity of care; Assessment for admission; Treatment; Discharge planning
☐ At the request of the resident / resident's legal representative
☐ Other (state reason) _____

Expiration of Authorization: Unless otherwise revoked, in writing, this authorization expires at the time I am on longer a resident at the Michael J. Fitzmaurice South Dakota Veterans Home.

_____ _____
Signature of Resident or Legal Representative Date

_____ _____
Printed Name Legal Representative Relationship

_____ _____
Witness Date

NOTICE: The Michael J. Fitzmaurice South Dakota Veterans Home (MJFSDVH) and many other organizations and individuals, such as physicians, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, state or federal confidentiality laws may no longer protect it.

MY RIGHTS:

- I understand this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for 1) conducting research-related treatment, 2) obtaining information in connection with eligibility or enrollment in a health plan, 3) determining an entity's obligation to pay a claim, or 4) creating health information to provide to a third party. Under no circumstances, however, am I required to authorize the release of mental health records.
- I may revoke this authorization at any time, provided that I do so in writing and submit it to the MJFSDVH at 2500 Minnekahta Avenue, Hot Springs, SD 57747. Any information disclosed prior to receipt of written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this authorization is as effective as the original. Unless otherwise agreed in writing, information be disclosed under authorization in any form or medium including oral, written, or electronic transmission.
- I am entitled to receive a copy of this Authorization.

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPER WORK 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 is 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 Address of VA Health Care Facility)*

VA Black Hills HCS
500 N. 5th Str.
Hot Springs,SD 57747
Fax: 612-725-1329

Sioux Falls VA HCS OR
2501 W. 22nd Str.
Sioux Falls SD 57105
Fax: 612-725-1355

Please indicate VA facility you received care at:

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

Michael J. Fitzmaurice South Dakota Veterans Home
2500 Minnekahta Ave.
Hot Springs, SD 57747
Medical Records contact: 605-745-5127 Ext. 1500115- Medical Records Fax: 605-745-5507

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

☒ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ EMPLOYMENT ☒ OTHER *(Please specify)* Admission Assessment

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

☒ HEALTH SUMMARY *(Prior 2 Years)*

☒ INPATIENT DISCHARGE SUMMARY *(Dates)*: Last 2 and last 2 H&P and last 2 annual exams

☒ PROGRESS NOTES:

- ☒ SPECIFIC CLINICS *(Name & Date Range)*: All Clinics to include mental health providers (MPH)
- ☒ SPECIFIC PROVIDERS *(Name & Date Range)*: All providers to include mental health providers
- ☒ DATE RANGE: Six months all providers & clinics;One year all mental health providers

☒ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: Last 2

☒ LAB RESULTS:

- ☒ SPECIFIC TESTS *(Name & Date)*: All
- ☒ DATE RANGE: Last six

☒ RADIOLOGY REPORTS *(Name & Date)*: Last 3

☒ LIST OF ACTIVE MEDICATIONS: Please include any allergies to medications

☒ FLU VACCINATION *(Dose, Lot Number, Date & Location)*: Please include all immunizations in my record
If Covid vaccinated please include type of vaccine, Moderna, Pfizer, etc.

☒ OTHER *(Describe)*: My signature authorizes MJFS.D.Vet.Home to request additional records

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): Upon written revocation or discharge from the Michael J. Fitzmaurice South Dakota Veterans Home

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:

This form allows our staff to contact Medicaid in the event you are applying for Medicaid or need to apply for Medicaid in the future.

Section K

Authorization to Release Information is optional. This is used when you want us to communicate with others about your application or case.

Signing up to vote - Optional

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you are not registered to vote where you live now, would you like to apply to register to vote?

☐ **Yes** ☐ **No**

If you checked yes, the Department of Social Services will send you a voter registration form. Return the completed registration card to the County Auditor in your county of residence or to your local Department of Social Services office, Department of Human Services office, WIC office or military recruitment office. **The deadline for registration is 15 days before any election.**

If you did not check either box, you will be considered to have decided not to register to vote at this time.

Please note that the information and office to which application was made will remain confidential and be used for voter registration purposes. If you would like help filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application in private.

If you believe that someone has interfered with your right to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the:

South Dakota Secretary of State, 500 E Capitol, Pierre SD 57501, (605) 773-3537

EA Authorization to Release Information

I, _____, authorize the Department of Social Services (DSS), Division of Economic Assistance (EA) to disclose my protected health information to the following individual/facility. My date of birth is _____

Individual/Facility and Name of Facility Person to Receive Information: South Dakota Veterans Home/Business Office Personnel
Address: 2500 Minnekahta Ave. Hot Springs, SD 57747
Phone Number: (605)745-5127 Fax Number: (605)745-5547

This authorization is for the time period from: _____ to _____. If left blank, this authorization shall expire 1 year from the date of execution.

I allow DSS-EA to release only the following checked information to the above strategy: (check all that apply)

- [x] Copy of Application/Renewal Form Dated: Month(s) ____ Year(s) ____ ☐ Address on File
- [ ] Copy of Notices from DSS-EA Relating to Application/Renewal Form Dated: Month(s) _____ Year(s) _____
- [x] Copy of Verification Checklist Form (EA-300) Dated: Month(s) _____ Year(s) _____

Purpose of this disclosure: _____.

I understand if this information is released to a third part, the information may be released by the person or entity that receives that information may no longer be protected by federal or other applicable privacy regulations.

I understand that I may revoke this authorization, except to the extent that staff has already taken action upon it, by sending written notice to the Department of Social Services, Division of Economic Assistance, 700 Governors Drive, Pierre, SD 57501.

I understand that I am under no obligation to sign this authorization. If the information requested is necessary to determine if I am eligible to enroll in benefits available through the South Dakota Department of Social Services or to determine if another medical program can pay for my health care, I understand that if I choose not to authorize the disclosure and use of this information, I may not be able to show that I qualify.

_____	_____	_____
Signature	Printed Name	Date
_____	_____	_____
Address of Individual Signing	City/State/Zip	Phone

If signed by someone other than Applicant/Recipient indicate relationship (check appropriate box)

☐ Spouse ☐ Parent (if for child under 18) ☐ Power of Attorney ☐ Legal Guardian