

Veteran Name: _____ **Telephone Number:** _____

Address: _____

SSN: _____ **Claim No.** _____

POA: _____ **Telephone Number:** _____

Date/Action

--

SUBJ: **VISN 11 Request for Enrollment and/or VA Healthcare**

(Name) Last, First, MI

Please check all that apply:

(SSN)

_____ Please open a file for me at your hospital/clinic. I will call for an appointment when I need care.

_____ Schedule an appointment for me in your Primary Care Clinic.

Please make the appointment for:

_____ Early Morning

_____ Late Morning

_____ Early Afternoon

_____ Late Afternoon

The best days for me are:

_____ Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday _____ Saturday

_____ **Please enroll me in the VA Healthcare System. My preferred VA Healthcare facility is:**

_____ Ann Arbor VA Medical Center

_____ Manteno VA Community Based Outpatient Clinic

_____ Battle Creek VA Medical Center

VA Northern Indiana Healthcare System

_____ Danville VA Medical Center

_____ Ft. Wayne Campus

_____ Decatur VA Community Based
Outpatient Clinic

_____ Marion Campus

_____ Detroit VA Medical Center

_____ Peoria VA Community Based Outpatient Clinic

_____ Gaylord VA Community Based
Outpatient Clinic

_____ Saginaw VA Medical Center

_____ Grand Rapids VA Community
Based Outpatient Clinic

_____ Toledo VA Community Based
Outpatient Clinic

_____ Indianapolis VA Medical Center

Additional Comments _____

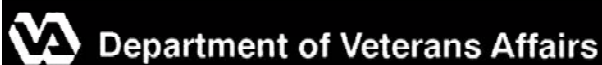
_____ Phone number where I can be reached during the day:

Signature

VISN 11

February 1998

Application Package Page 1



APPLICATION FOR HEALTH BENEFITS

SECTION I - GENERAL INFORMATION

Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)

1. VETERAN'S NAME (Last, First, Middle Name)		2. OTHER NAMES USED		3. MOTHER'S MAIDEN NAME		4. GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
5. ARE YOU SPANISH, HISPANIC, OR LATINO? <input type="checkbox"/> YES <input type="checkbox"/> NO		6. WHAT IS YOUR RACE? (You may check more than one.) (Information is required for statistical purposes only.) <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> ASIAN <input type="checkbox"/> WHITE <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER					
7. SOCIAL SECURITY NUMBER		9. DATE OF BIRTH (mm/dd/yyyy)			10. RELIGION		
8. CLAIM NUMBER		9A. PLACE OF BIRTH (City and State)					
11. PERMANENT ADDRESS (Street)			11A. CITY		11B. STATE	11C. ZIP CODE	
11D. COUNTY		11E. HOME TELEPHONE NUMBER (Include area code)			11F. E-MAIL ADDRESS		
12. TYPE OF BENEFIT(S) APPLIED FOR (You may check more than one) <input type="checkbox"/> HEALTH SERVICES <input type="checkbox"/> NURSING HOME <input type="checkbox"/> DOMICILIARY <input type="checkbox"/> DENTAL							
13. IF APPLYING FOR HEALTH SERVICES OR ENROLLMENT, WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER?							
14. DO YOU WANT AN APPOINTMENT WITH A VA DOCTOR OR PROVIDER AS SOON AS ONE BECOMES AVAILABLE? <input type="checkbox"/> YES <input type="checkbox"/> NO I am only enrolling in case I need care in the future.				15. HAVE YOU BEEN SEEN AT A VA HEALTH CARE FACILITY? <input type="checkbox"/> YES. LOCATION: <input type="checkbox"/> NO			
16. CURRENT MARITAL STATUS (Check one) <input type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> UNKNOWN							
17. NAME, ADDRESS AND RELATIONSHIP OF NEXT OF KIN				17A. NEXT OF KIN'S HOME TELEPHONE NUMBER (Include area code)			
				17B. NEXT OF KIN'S WORK TELEPHONE NUMBER (Include area code)			
18. NAME, ADDRESS AND RELATIONSHIP OF EMERGENCY CONTACT				18A. EMERGENCY CONTACT'S HOME TELEPHONE NUMBER (Include area code)			
				18B. EMERGENCY CONTACT'S WORK TELEPHONE NUMBER (Include area code)			
19. INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH. NOTE: THIS DOES NOT CONSTITUTE A WILL OR TRANSFER OF TITLE (Check One) <input type="checkbox"/> EMERGENCY CONTACT <input type="checkbox"/> NEXT OF KIN							

SECTION II - INSURANCE INFORMATION (Use a separate sheet for additional information)

1. ARE YOU COVERED BY HEALTH INSURANCE? (Including coverage through a spouse or another person) <input type="checkbox"/> YES <input type="checkbox"/> NO		2. HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER					
3. NAME OF POLICY HOLDER							
4. POLICY NUMBER							
		YES		NO			
6. ARE YOU ELIGIBLE FOR MEDICAID?		<input type="checkbox"/>		<input type="checkbox"/>			
7. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A?		<input type="checkbox"/>		<input type="checkbox"/>		7A. EFFECTIVE DATE (mm/dd/yyyy)	
8. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART B?		<input type="checkbox"/>		<input type="checkbox"/>		8A. EFFECTIVE DATE (mm/dd/yyyy)	
9. NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD				10. MEDICARE CLAIM NUMBER			
11. IS NEED FOR CARE DUE TO ON THE JOB INJURY? (Check One) <input type="checkbox"/> YES <input type="checkbox"/> NO				12. IS NEED FOR CARE DUE TO ACCIDENT? (Check One) <input type="checkbox"/> YES <input type="checkbox"/> NO			

APPLICATION FOR HEALTH BENEFITS, Continued		VETERAN'S NAME <i>(Last, First, Middle)</i>	SOCIAL SECURITY NUMBER
SECTION VIII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES			
1. NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE <i>(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home).</i>		\$	
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD <i>(Also enter spouse or child's information in Section VI.)</i>		\$	
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES <i>(e.g., tuition, books, fees, materials)</i> DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.		\$	
SECTION IX - PREVIOUS CALENDAR YEAR NET WORTH <i>(Use a separate sheet for additional dependent.)</i>			
	VETERAN	SPOUSE	CHILD 1
1. CASH, AMOUNT IN BANK ACCOUNTS <i>(e.g., checking and savings accounts, certificates of deposit, individual retirement accounts, stocks and bonds)</i>	\$	\$	\$
2. MARKET VALUE OF LAND AND BUILDINGS MINUS MORTGAGES AND LIENS. <i>(e.g., second homes and non-income producing property. Do not count your primary home.)</i>	\$	\$	\$
3. VALUE OF OTHER PROPERTY OR ASSETS <i>(e.g., art, rare coins, collectables)</i> MINUS THE AMOUNT YOU OWE ON THESE ITEMS. <i>Exclude household effects and family vehicles.</i>	\$	\$	\$
SECTION X - CONSENT TO COPAYMENTS			
<p>If you are a 0% service-connected veteran and do not receive VA monetary benefits or a nonservice-connected veteran (and you are not an Ex-POW, Purple Heart Recipient, WWI veteran or VA pensioner) and your household income (or combined income and net worth) exceeds established thresholds, application will be considered for enrollment, but only if you agree to pay VA copayments for treatment of your nonservice-connected conditions. If you are such a veteran by signing this application you are agreeing to pay the applicable VA copayment as required by law.</p>			
SECTION XI - PAPERWORK REDUCTION ACT AND PRIVACY ACT INFORMATION			
<p>The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3501 of the Paperwork Reduction Act of 1995. 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 10 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.</p> <p>Privacy Act Information: VA is asking you to provide the information on this form under 38 U.S.C. Sections 1705, 1710, 1712, and 1722 in order for VA to determine eligibility for medical benefits. Information you supply may be verified through a computer-matching program. VA may disclose the information that you provide on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA may be unable to process your request and meet your medical needs. Failure to furnish the information may have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and to maintain records, and for other purposes authorized or required by law.</p>			
SECTION XII - ASSIGNMENT OF BENEFITS			
<p>I understand that pursuant to 38 U.S.C. Section 1729, VA is authorized to recover or collect from my health plan (HP) for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for the charges for my medical care, including copayments, deductibles, and coinsurance, and for other purposes authorized or required by law.</p>			
ALL APPLICANTS MUST SIGN AND DATE THIS APPLICATION FOR HEALTH BENEFITS. REFER TO INSTRUCTIONS WHICH DEFINE WHO CAN SIGN ON BEHALF OF THE VETERAN.			
SIGNATURE OF APPLICANT			DATE

NAME: _____
SSN: _____

REGISTRATION ATTACHMENT

Please provide the information requested below to help make your first VA visit a little easier.

Place of Birth (city and state): _____

Father's Name: _____

Mother's Name: _____

Mother's Maiden Name: _____

Hair Color: _____

Eye Color: _____

Education: _____

Identifying Marks: _____

Race: _____

Do you have Advanced Directives or a Living Will?

_____ YES _____ NO

(If yes, please send a copy with your completed application)

Were you in combat? If yes, please fill out the information below for us:

Where _____

From: Month: _____ Day: _____ Year: _____ to

Month: _____ Day: _____ Year: _____

Private Physician's Name and address:

In Reply/Refer to: 610/10-10

Name:

Date of Birth:

SSN:

We would appreciate your cooperation in forwarding medical records or information to assist our medical staff in the examination and/or treatment of the patient named above:

_____ Final Summary or report of hospitalization or diagnosis treated.

_____ Brief report of examination or treatment within the last year.

_____ X-ray, EKG, and Procedures Reports within the last year.

_____ Current list of medications.

Sincerely,

Janice Taylor-Pulido, RHIA
Manager, Health Information Systems

I request and authorize you to release the medical information requested above to the Department of Veterans Affairs. I understand that the information to be released includes information regarding the following condition(s):

_____ Drug Abuse _____ Alcohol Abuse _____ HIV/AIDS _____ Sickle Cell Anemia

I understand that I may revoke this authorization at any time except to the extent action has already been taken to comply with it. Without my express revocation, this consent will automatically expire after the requested information has been supplied to the Department of Veterans Affairs.

Signature of Patient or Authorized Representative

Date

Note: This information requested on this form letter is solicited under Title 38, USC and will authorize the addressee to disclose the information you specify to the Department of Veterans Affairs. The information will be used to assist our medical staff in your examination and treatment. Your disclosure of the information requested is voluntary. However, your failure to give your consent may result in incomplete information on which to base your treatment.

VA NORTHERN INDIANA HEALTH CARE SYSTEM CO-MANAGED CARE – INFORMATION FOR PATIENTS

You have chosen to be seen by both a local (non-VA) provider and a VA provider for your primary medical care. This is called Co-Managed Care. The VA provider is responsible for coordinating this care with your community provider. This is critical, but the patient also has an important role in this process. The following information explains what must be done when a patient is seen by both VA and community providers and your responsibility in this process:

VA must have copies of your community provider's medical records. You will not receive medication through VA until we have received all the medical information we need from your community provider.

VA requires current information on your medication condition from your community provider. Every time you see this provider, you should make sure we receive copies of these records.

You must sign a Release of Information form to allow our staff to discuss your care and/or exchange information with your provider.

Your first appointment to see a VA provider will be scheduled after arrangements have been made to receive copies of your local records. The appointment will be scheduled within 90 days. You will be prescribed medication from VA at that time. Until then, you must continue to get medications from your community provider.

You must try to keep ALL scheduled appointments. Regularly scheduled VA care is required for continued prescription renewals.

Medications given to you by VA may be different from that prescribed by your community provider. Some medications may not be available on the VA Drug Formulary and substitutions may be made. Doses may be changed.

VA is not responsible for new prescriptions written by a community provider between scheduled visits. VA Pharmacy does not accept telephone requests to fill prescriptions from community providers. Be sure to bring the medical justification for the new prescription requests from your community provider to your next VA clinic visit.

IMPORTANT: Your community provider and VA provider must both know your medical condition. Make sure both providers are fully informed about your medical care.

**APPLICATION FOR
COLD WAR
RECOGNITION CERTIFICATE**

Cold War Recognition
Suite 400
4035 Ridge Top Road
Fairfax, VA 22030-7403

Please forward a Cold War Recognition Certificate to the following veteran:

Name: _____ SSN: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Period of Service: From: _____ To: _____

Enclosed is a source document (**copy of DD Form 214 or WD AGO 53-33 Enlisted Report & Record of Separation, Leave and Earning Statement (LES), copy of orders to active duty, etc.**), which verifies my service during the Cold War era. I understand that the enclosed source document will not be returned.

Submission of this request confirms my service. I further certify that my service was either honorable or general under honorable conditions.

(Signature)

(Date)