THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF VETERANS SERVICES
Massachusetts Veterans Home at Chelsea
100 Summit Ave., Chelsea, MA 02150
TEL: (617) 884-5660 FAX: (617) 884-1162
www.mass.gov/che • www.mass.gov/veterans

MAURA T. HEALEY
GOVERNOR

JON SANTIAGO, MD, MPH
SECRETARY, EOVS

KIMBERLEY DRISCOLL
LIEUTENANT GOVERNOR

CHRISTINE BALDINI
SUPERINTENDENT

Thank you for your recent inquiry regarding admission to Residential/Independent Living at the Massachusetts Veterans at Chelsea. Enclosed is an application and forms that must be completed to start the admissions process. Eligibility for admission is based in part on state law. Applicant must be a Commonwealth of Massachusetts resident. To be a "veteran" under Massachusetts law a person is required to have either 180 days of regular active-duty service and a last discharge or release under honorable conditions or 90 days of active-duty service, one (1) day of which is during "wartime" and a last discharge or release under honorable conditions.

To process your application, it is imperative that the entire application and all forms be completed, and the following copies provided:

- **Veteran's DD214 (Honorable discharge or equivalent documentation of military service)**
- **All insurance cards.**
- **All financial award letters and proof of income (Employment, Social Security, Aid & Attendance, Veterans Administration, Retirement, one month of bank statements etc.)**
- **Proof of Massachusetts residency**
- **Government Issued Photographic Identification (i.e., Mass. Driver's License, etc.)**
- **All healthcare proxy, guardianship, Power of Attorney documents, if applicable**

You must include, if eligible, Medicare A, B and D or qualifying pharmacy plan. Also, under Massachusetts General Laws Chapter 115, veterans must apply for all financial and medical benefits that they are entitled to.

Please complete, sign, and return all forms and copies of the above to:

Massachusetts Veterans Home at Chelsea
Attention: Superintendent's Office
100 Summit Ave.
Chelsea, MA 02150

Upon receipt of the signed, completed forms and all required copies, your application will be processed and once this process is completed, you will be called for an interview.

Remember, the application and forms must be completed, and copies of all required documentation (listed above) must be provided or your application will not be processed and will be returned to you.

If you have any questions, please call the Admissions Office at 617-887-7146.

MASSACHUSETTS VETERANS HOME AT CHELSEA
100 SUMMIT AVE
CHELSEA, MA 02150
617-887-7146

PLEASE PRINT LEGIBLY

APPLICATION FOR: RESIDENTIAL/INDEPENDENT LIVING

1. **NAME**: _____ _____ _____
FIRST MIDDLE LAST

SOCIAL SECURITY NUMBER: _____

2. **DATE OF APPLICATION**

3. **CURRENT HOME ADDRESS**

STREET & NUMBER _____

CITY & STATE _____

ZIP CODE _____

HOME TELEPHONE NO. _____

CELL TELEPHONE NO. _____

EMAIL: _____

4A. **SEX** M ( ) F ( )

4B. **DATE OF BIRTH**

_____

4C. **RELIGION (OPTIONAL)**

_____

4D. **RACE (OPTIONAL)**

_____

5. BRANCH OF SERVICE	DATE ENTERED ACTIVE DUTY (DD/MM/YYYY)	DATE OF SEPARATION (DD/MM/YYYY)	RANK	TYPE OF DISCHARGE	6. OCCUPATION PRIOR TO RETIREMENT

7. **MARITAL STATUS** _____ SINGLE _____ MARRIED _____ SEPARATED _____ DIVORCED _____ WIDOWED

NUMBER OF CHILDREN UNDER 18 YEARS OF AGE _____

DO YOU CONTRIBUTE TO SUPPORT OF OTHERS? Yes ( ) No ( ) **IF YES, PLEASE SPECIFY:** _____

DO YOU USE A SERVICE ANIMAL? _____ **IF SO, FOR WHAT PURPOSE?** _____

8. **NAME AND ADDRESS OF NEXT OF KIN/EMERGENCY CONTACT**

NAME _____ RELATIONSHIP _____

ADDRESS _____

CITY & STATE _____ ZIP CODE _____

HOME NUMBER _____ CELL NUMBER _____

WORK NUMBER _____ EMAIL _____

LEGAL ISSUES

9. **DO YOU HAVE ANY ACTIVE RESTRAINING ORDERS ANYWHERE, EITHER AGAINST YOU OR AS AN ORDER OF PROTECTION FOR YOU? IF SO, PLEASE EXPLAIN** _____

_____

ARE YOU CURRENTLY ON PROBATION OR PAROLE? YES ( ) NO ( ) **IF YES, NAME OF COURT, PAROLE OFFICER AND CONTACT NUMBER:**

_____

_____

_____

WE ARE A SMOKE-FREE FACILITY

10. **REFERRED FROM:** **REFERRED BY:**

FACILITY: _____ **CASE WORKER/SOCIAL WORKER:**

ADDRESS: _____ **NAME:** _____

_____ **TELEPHONE:** _____

11. **PRE-ARRANGED FUNERAL INFORMATION**

NAME OF FUNERAL HOME _____

ADDRESS _____

CONTACT PERSON AND TELEPHONE NO. _____

12. **FINANCIAL INFORMATION**

SOURCE OF INCOME (**PLEASE MATCHUP SOURCE TO APPROPRIATE NUMBERED LINE**) GROSS **MONTHLY** AMOUNT

1. VETERANS ADMINISTRATION:
   - 1A. COMPENSATION (SERVICE CONNECTED) 1A._____
   - 1B. PENSION (NON-SERVICE CONNECTED) 1B._____
2. RETIREMENT PENSION 2. _____
3. SOCIAL SECURITY 3. _____
4. AID & ATTENDANCE/HOUSE BOUND 4. _____
5. CHAPTER 115 (MA VETERANS SERVICES) 5. _____
6. INCOME FROM OTHER SOURCES (DESCRIBE) _____ 6. _____
   (DIVIDENDS, ANNUITIES, INTEREST ON BANK ACCOUNTS, BONDS, SECURITIES, RENTS)
7. TOTAL **MONTHLY** INCOME FROM **ALL** SOURCES 7. _____

13. **HEALTH INSURANCE INFORMATION**

TYPE OF HEALTH INSURANCE: (CHECK ALL THAT APPLY)

MEDICARE PART A _____ MEDICARE PART B _____ MEDICARE PART D _____

MEDEX _____ BLUE CROSS _____ OTHER _____ NONE _____

MASSHEALTH _____

MEDICARE CERTIFICATE NUMBER _____ EFFECTIVE DATE PART A _____ PART B _____

MEDEX CERTIFICATE NUMBER _____ BLUE CROSS CERTIFICATE NUMBER _____

OTHER HEALTH INSURANCE:

SUBSCRIBER'S NAME _____

NAME OF PLAN _____

ADDRESS OF PLAN _____

POLICY NUMBER _____

CONTACT PERSON, PHONE NUMBER AND ADDRESS IF PRE-ADMISSION APPROVAL REQUIRED:

_____

_____

PLEASE ATTACH HEALTH CARE PROXY, POWER OF ATTORNEY, GUARDIANSHIP, AND/OR CONSERVATORSHIP, IF APPLICABLE

I HEREBY AUTHORIZE THE PHYSICIANS AND STAFF OF THE MASSACHUSETTS VETERANS HOME AT CHELSEA TO RENDER SUCH TREATMENT AS IS FOUND NECESSARY AND TO PERFORM ANY EXAMINATION THAT IS DEEMED ADVISABLE.

THE ANSWERS TO ALL QUESTIONS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____

SIGNATURE OF APPLICANT

SIGNATURE, TITLE AND TELEPHONE NUMBER OF PERSON COMPLETING APPLICATION ON BEHALF OF APPLICANT

WE ARE A SMOKE-FREE FACILITY

MASSACHUSETTS VETERANS HOME AT CHELSEA
DAILY CARE CHARGES

RESIDENTIAL/INDEPENDENT LIVING

Veterans pay $10.00 per day with a $300.00 personal exemption from monthly income. Income shall not include VA Aid and Attendance and/or VA Housebound, which shall be retained by the Home.

Please note that charges are billed monthly and timely payment to the Massachusetts Veterans Home at Chelsea is required. The Executive Director has the authority to terminate the stay of a resident for failure to pay the Daily Care Charge.

THE AMOUNT OF THE DAILY CARE CHARGE MAY CHANGE ON A PERIODIC BASIS WITHOUT NOTICE IN ACCORDANCE WITH COMMONWEALTH OF MASSACHUSETTS REGULATIONS.

MASSACHUSETTS VETERANS HOME AT CHELSEA

HEALTHCARE PROVIDER FORM

Please list all the healthcare providers who have provided care or treatment to you for the **past three years**. All private, public, state, military and VA hospitals, physicians, clinics, and nursing associations should also be included. Try to approximate the date(s) of care as closely as possible.

NAME OF HEALTH CARE PROVIDER/FACILITY	ADDRESS	TELEPHONE AND FAX	DATE(S) OF CARE

I agree to assist the Massachusetts Veterans Home at Chelsea in obtaining my full medical records.

_____ _____

Signature Date

Enclosed are medical record request forms to be completed and returned with this application. There should be a form for each facility/healthcare provider listed above. Please use these forms as follows:

- Department of Veteran Affairs Form 10-5345 to be used **only** for VA facilities (2 copies)
- Authorization for Release of Medical Information (Massachusetts Veterans Home at Chelsea form) for all other facilities (3 copies)

If you need additional copies of either the Department of Veteran Affairs Form 10-5345 or the Massachusetts Veterans Home at Chelsea Authorization for Release of Medical Information form, please contact the Admissions Office at 617-887-7146.

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT STATEMENT:

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 Location of the VA Health Care Facility)*

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

MASSACHUSETTS VETERANS HOME AT CHELSEA, 100 SUMMIT AVE., CHELSEA, MA 02150
ATTN: SUPERINTENDENT'S OFFICE

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

☐ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ EMPLOYMENT ☐ OTHER *(Please specify below):*

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

☐ HEALTH SUMMARY *(Prior 2 Years)*

☐ PATIENT MEDICAL RECORDS *(Dates)*: _____

☐ INPATIENT DISCHARGE SUMMARY *(Dates)*: _____

☐ PROGRESS NOTES:

- ☐ SPECIFIC CLINICS *(Name & Date Range)*: _____
- ☐ SPECIFIC PROVIDERS *(Name & Date Range)*: _____
- ☐ DATE RANGE: _____

☐ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: _____

☐ LAB RESULTS:

- ☐ SPECIFIC TESTS *(Name & Date)*: _____
- ☐ DATE RANGE: _____

☐ RADIOLOGY REPORTS *(Name & Date)*: _____

☐ LIST OF ACTIVE MEDICATIONS: _____

☐ VACCINATION *(Dose, Lot Number, Date & Location)*: _____

☐ ADMINISTRATIVE RECORDS: _____

☐ OTHER *(Describe)*: _____

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): _____

_____

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:

Department of Veterans Affairs

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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

MASSACHUSETTS VETERANS HOME AT CHELSEA, 100 SUMMIT AVE., CHELSEA, MA 02150
ATTN: SUPERINTENDENT'S OFFICE

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- ☐ DATE RANGE: _____

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☐ LIST OF ACTIVE MEDICATIONS: _____

☐ VACCINATION *(Dose, Lot Number, Date & Location)*: _____

☐ ADMINISTRATIVE RECORDS: _____

☐ OTHER *(Describe)*: _____

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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.

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☐ 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): _____

_____

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:

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF VETERANS SERVICES
Massachusetts Veterans Home at Chelsea
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SECRETARY, EOVS

CHRISTINE BALDINI
SUPERINTENDENT

PLEASE PRINT CLEARLY

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

YOUR NAME: _____

YOUR ADDRESS:_____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

I hereby authorize (name of facility) _____

_____

to release information from my medical record from the **past 3 years** to:

Massachusetts Veterans Home at Chelsea
Attn: Superintendent's Office
100 Summit Ave.
Chelsea, MA 02150

This authorization covers the following records:

( ) 1. Complete copy of medical record.

This authorization is for continuing care here at the Veterans' Home in Chelsea

- This authorization covers treatment for Alcohol Abuse, Drug Abuse, Psychiatric Treatment, HIV/Aids.
- The information released to the Massachusetts Veterans Home at Chelsea will not be re-disclosed unless: A. The patient signs another Authorization for Release, or B. in event of emergency.
- The patient may revoke the authorization in writing, which will be valid, unless action has already been taken on the authorization, and the written revocation will be sent to the Director of Health Information Management
- This authorization expires one (1) year from date signed.
- I understand that information used or disclosed pursuant to this authorization could be subject. to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting. its confidentiality.

Signature of Patient or Legal Representative: _____

Printed Name of Patient or Patient Representative _____ Date_____

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STATEMENT OF UNDERSTANDING
UPON ADMISSION TO
RESIDENTIAL/INDEPENDENT LIVING

This is to acknowledge that I have read, and I fully understand and accept the fact that my admission to Residential/Independent Living in no way carries the implication that I am guaranteed elevation to any other level of care at any time during my stay at the Massachusetts Veterans Home at Chelsea/Community Living Center.

I accept admission to Residential/Independent Living with the clear understanding and realization that my status as a resident does not entitle me to automatic admittance to the Community Living Center should my health condition change in the future.

I accept the fact that if my health condition does change in the future, I may be required to seek medical care/accommodations elsewhere.

_____ _____

Signature Date

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SUPERINTENDENT

CORI REQUEST FORM

The Executive Office of Health and Human Services has been certified by the Criminal History Systems Board for access to conviction and pending criminal case data. As a residential applicant, I understand that a criminal offender record information (CORI) check will be conducted for conviction and pending criminal case information only and that such information will not necessarily disqualify me. The information below is correct to the best of my knowledge.

_____
APPLICANT SIGNATURE (unless otherwise preempted by law)

RESIDENTIAL APPLICANT INFORMATION (PLEASE PRINT)

_____ _____ _____
LAST NAME FIRST NAME MIDDLE NAME

_____ _____
MAIDEN NAME OR ALIAS (IF APPLICABLE) PLACE OF BIRTH

_____ _____ - _____ - _____ _____
DATE OF BIRTH SOCIAL SECURITY NUMBER ID Theft Index PIN (if applicable)*

_____
MOTHER'S MAIDEN NAME

CURRENT AND FORMER ADDRESSES:

_____

_____

_____

SEX: _____ HEIGHT: _____ft. _____in. WEIGHT: _____ EYE COLOR:_____

STATE DRIVER'S LICENSE NUMBER: _____
(include state of issue)

THE ABOVE INFORMATION WAS VERIFIED BY REVIEWING THE FOLLOWING FORM OF GOVERNMENT ISSUED PHOTOGRAPHIC IDENTIFICATION: _____

REQUESTED BY: _____
SIGNATURE OF CORI AUTHORIZED EMPLOYEE

*The CHSB Identity Theft Index PIN Number is to be completed by those applicants that have been issued an identity Theft PIN Number by the CHSB. Certified agencies are required to provide all applicants the opportunity to include this information to ensure the accuracy of the CORI request process. **All CORI request forms that include this field are required to be submitted to the CHSB via mail or by fax to 617-660-4614.**

HAVE YOU EVER BEEN CONVICTED OF A FELONY? _____ YES _____ NO
IF YES, EXPLAIN:

HAVE YOU EVER BEEN CONVICTED OF ANY OTHER OFFENSE AGAINST THE LAW? (*See below before answering) _____ YES _____ NO
EXPLAIN:

DATE OF COURT OFFENSE: DISPOSITION:

DO YOU HAVE A PAROLE OR PROBATION OFFICER? _____ YES _____ NO
IF SO, NAME _____
NUMBER _____
COURT _____

*You are not required to furnish information on:

1. Any offense committed prior to your seventeenth (17) birthday, unless such offense was bound over for trial in superior court;

2. A first misdemeanor conviction for drunkenness, simple assault, speeding, minor traffic violations, affray, or disturbance of the peace;

3. A misdemeanor conviction which occurred more than five (5) years ago unless you have been convicted of any offense within the last five (5) years;

4. A misdemeanor conviction which resulted in a period of incarceration which ended more than five (5) years ago unless you have been convicted of any offense within the last five (5) years.

THE ANSWERS TO ALL QUESTIONS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____
Signature of Applicant

_____
Signature, Title, and Telephone Number of Person Completing Application on Behalf of Applicant

WE ARE A SMOKE-FREE FACILITY

FOR YOUR CONVENIENCE, WE HAVE PROVIDED THIS CHECKLIST TO ENSURE THAT YOU RETURN ALL REQUIRED DOCUMENTATION

COPIES	√
DD 214 (honorable discharge or equivalent documentation of military service)	
Insurance Cards	
Financial Award Letters and Proof of Income (Employment, Social Security, Aid & Attendance, Veterans Administration, Retirement, one month bank statement etc.)	
Proof of Massachusetts Residency (License, Utility bill, etc.)	
Government Issued Photographic Identification (i.e., Mass. Drivers License, etc.)	
Health Care Proxy, Power of Attorney, Guardianship (if applicable)	
MEDICATION	√
All applicants who are accepted for admission are required to have a minimum of a 2 week supply of all medication.	