



## The Commonwealth of Massachusetts

Executive Office of Veteran Services  
Massachusetts Veterans Home at Holyoke  
110 Cherry Street  
Holyoke, MA 01040-2829  
TEL: (413) 532-9475 FAX: (413) 538-7968  
[www.mass.gov/hly/](http://www.mass.gov/hly/)

MAURA T. HEALEY  
Governor

KIMBERLEY DRISCOLL  
Lieutenant Governor

JON SANTIAGO  
Secretary, DVS

MICHAEL LAZO  
Executive Director

### MASSACHUSETTS VETERANS HOME AT HOLYOKE LONG TERM CARE ADMISSION APPLICATION

Thank you for your interest in the Veterans Home at Holyoke. At the Veterans Home at Holyoke, our mission is to provide 'Care with Honor, Dignity, and Respect' in the best possible health care environment for eligible veterans who reside in the Commonwealth of Massachusetts. In order to be eligible to apply for admission, a veteran must be a resident of the Commonwealth and be able to provide proof of an honorable discharge from the armed forces, as well as demonstrate a need for long term care placement.

The first step in the process is to complete this application for admission. The application must be filled out in its entirety, with the most accurate information possible. It must be signed at the end of the application by the veteran applicant or by one of the following individuals: Legal Guardian or Invoked Health Care Proxy. If this application is filled out by either of these, we require a copy of the invoked health care proxy or guardianship papers.

Once completed and signed, please return the application along with the following required documents:

- ☐ Copy of the veteran's military separation papers – known as DD Form 214
- ☐ Copy of Health Care Proxy
- ☐ Proof of veteran's residency. Examples include valid Massachusetts driver's license; official Mass ID card; registered voter status letter; utility bill or other bill from veteran's current residence; Massachusetts income tax return.
- ☐ Completed veteran medical information (form enclosed) and all requested medical documents
- ☐ Enclosed receipt of HIPAA policy
- ☐ A copy (front and back) of all health insurance and prescription cards (this includes Medicare).
- ☐ Signed Primary Care Provider's Order for Long-Term Care
- ☐ Medicare Secondary Payer Questionnaire: Enclosed - **Please complete the entire form to the best of your ability**
- ☐ Completed Financial Worksheet

**You may return completed application and required documents by:**

Fax:	413-552-4757 Attn: Admitting
U.S. Mail:	Veterans Home at Holyoke 110 Cherry Street, Holyoke, MA 01040
In person:	Admitting Office

We are happy to assist you in the process.

If, at any time, you have any questions about this process, please do not hesitate to contact us directly at 413-552-4764.

# VETERANS HOME AT HOLYOKE LONG TERM CARE ADMISSION APPLICATION

Veteran Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

SS#: \_\_\_\_\_ Gender: \_\_\_\_\_ Religion: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Preferred language, if other than English: \_\_\_\_\_

Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Never Married ☐ Separated

No individual will be denied admission, care, or any other benefit provided by the Commonwealth of Massachusetts on the grounds of race, color, creed, age, sex, differently abled, national origin or ability to pay.

## Best contact person regarding this application

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

Relationship: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

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

How do you prefer to communicate? ☐ Telephone ☐ U.S. Mail ☐ Email

Does the veteran have any industrial or automobile accident litigation pending or activity involving insurance and liability of another, i.e. Workers' Comp? ☐ Yes ☐ No

Does the veteran have a service-connected disability rating from the VA? ☐ Yes ☐ No

*If YES, please provide a document from the VA indicating the percentage.* \_\_\_\_\_

Where is the veteran currently residing?

☐ In own residence with adult companion

☐ Home alone

☐ In a long-term care facility/hospital

Name of Facility: \_\_\_\_\_

How long has the veteran resided there? \_\_\_\_\_

On which type of unit does the veteran reside? (secure, etc.) \_\_\_\_\_

☐ Other \_\_\_\_\_

## COMMUNICATION & CONTACT INFORMATION

I, \_\_\_\_\_ give my permission for the Veterans Home at Holyoke to discuss my application with the following people:

**Contact Person:**

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

Relationship: \_\_\_\_\_

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

City, State, Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address Required: \_\_\_\_\_

Preferred communication? ☐ Telephone ☐ U.S. Mail ☐ Email ☐ Text

**Contact Person:**

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

Relationship: \_\_\_\_\_

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

City, State, Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address Required: \_\_\_\_\_

Preferred communication? ☐ Telephone ☐ U.S. Mail ☐ Email ☐ Text

**Financially Responsible Person:**

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

Relationship: \_\_\_\_\_

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

City, State, Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address Required: \_\_\_\_\_

Preferred communication? ☐ Telephone ☐ U.S. Mail ☐ Email ☐ Text

## FUNERAL ARRANGEMENTS

Name of Funeral Home: \_\_\_\_\_

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

Phone Number: \_\_\_\_\_

In compliance with the eligibility requirement, I do hereby apply for admission to the Veterans Home at Holyoke, a long-term care facility for veterans, and I declare the following statement to be true: I, the undersigned, am a resident of the State of Massachusetts in accordance with M.G.L. c. 4, sec.7, cl. 43<sup>rd</sup> as amended by the Acts of 2005, ch.130.

Pursuant to the Federal Privacy Act of 1974, you are hereby notified that disclosure of your social security number is mandatory. Disclosure of the social security number is required pursuant to 38 CFR §1.575(b), 108 CMR 4.03, and M.G.L. Chapter 115, § 4. The social security number is used to verify your identity.

All information gathered in this form is considered protected health information and will only be used as outlined in the Health Insurance Portability and Accountability Act (HIPAA) Privacy Notice enclosed with this application and is yours to keep.

Please sign the enclosed Acknowledgement of Receipt of HIPAA and return with the application and supporting documents.

This application is true and complete to the best of my knowledge.

\_\_\_\_\_  
Signature

Printed Name

Date

Signed by:

☐ Veteran

☐ Invoked Health Care Proxy

☐ Legal Guardian

**A reminder: All documents must be signed by the veteran, unless the veteran's Health Care Proxy has been invoked, or if the veteran has a court appointed legal guardian.**

**If a health care provider has determined the veteran lacks the capacity to make medical decisions, a signed order from the provider must be submitted with this application. The Health Care Proxy will be responsible for signing appropriate documents.**

# VETERANS HOME AT HOLYOKE - MEDICARE SECONDARY PAYER QUESTIONNAIRE

Veteran's Name: \_\_\_\_\_

Veterans' Home Number (if known): \_\_\_\_\_

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

<b>1. Are you entitled to Medicare based on:</b>	<input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End-Stage Renal Disease (ESRD)
<b>2. Are you currently employed?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, employer name and address:	
If NO, date of retirement:	
If NO, never employed:	
<b>3. Do you have employer group health plan coverage?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, insurer name and address:	
Policy #:	
Group #:	
Does employer have 20 or more employees?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does employer have 100 or more employees?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>4. Is your spouse employed?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, spouse's name:	
Spouse's employer name and address:	
If NO, date of retirement, if applicable:	
If NO, "Never Employed"	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>5. Are you covered under your spouse's EGHP?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, insurer name and address:	
Policy #:	
Group#:	
Does employer have 20 or more employees?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does employer have 100 or more employees?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>6. Are you receiving Black Lung (BL) Benefits?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>7. Are services to be paid by a Government Research program?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>8. Has the Dept. of Veterans Affairs (VA) authorized and agreed to pay for care?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>9. Is injury / illness a work-related accident / condition?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

If YES, name and address of workers' compensation:	
Policy or ID#:	
Accident date:	
Employer's name and address:	
<b>10. Is injury / illness due to a non-work-related accident?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Accident date:	
If YES, name and address of no-fault insurer:	
Name and address of policy holder:	
Insurance claim #:	
Is liability insurance available?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name and address of Liability Insurer:	
Name and address of Responsible party:	
Insurance claim #:	
<b>11. Do you have End Stage Renal Disease or kidney transplant?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, date of transplant:	
<b>12. Have you received maintenance dialysis treatments?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, date dialysis began:	
<b>13. Have you participated in a self-dialysis training program?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, date training began:	
<b>14. Are you within the 30-month coordination period?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is patient entitled to Medicare solely based on ESRD?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please contact our Billing Department with questions about this document. 413-552-4709

## THE VETERANS HOME AT HOLYOKE STANDARDS FOR VETERANS' ROOMS

- Ceilings must be free of hanging objects
- Room doors, including handles both inside and outside, must be free of all objects.
- Personal items such as cards and knick-knacks are limited to the shelving provided.
- A shelf and bulletin board are provided for personal pictures and other items.
- Potted plants are not allowed in veteran rooms.
- Bird food or bird feeders are not allowed.
- Pets, reptiles, fish, and small animal pets are not authorized.
- Perishable food from food trays must be kept in the units' refrigerator and labeled with name, date, time. Food must be discarded within 24 hours.
- One airtight shoe boxed sized storage container may be kept in the room for non-perishable food items. The storage box is provided by the Veterans Home.
- Clothing must be limited to the available storage space for personal clothing and appropriate for the season.
- Floors are not to be used for storage of any kind. Floors and furniture are to be kept clear of any clutter.
- The Veterans Home provides veteran rooms with a television.
- Small personal computers (laptops) are permitted. iPads are provided to veterans according to availability.
- Electric devices must be approved by the Administrator or designee prior to installation and use. All electrical devices must be inspected by the Veterans Home prior to being used.
- Only Mylar balloons are allowed in the Veterans Home. Mylar balloons must be anchored or tied down to prevent them from coming into contact with sprinkler heads.
- Furniture must not be moved into or out of rooms without the permission of the charge nurse.
- Due to strict fire and safety codes, all mattresses, pillows, bed linens and window treatments are provided and will be selected by the Veterans Home. A small, washable, lap blanket, throw or other like item appropriate for either winter or summer may be brought in for personal use. Item must be able to be washed at 160 degrees.
- Each veteran will receive a Veterans Home personal photo album to keep in their room. We strongly encourage that photos be copies and not original photos.
- **The Veterans Home at Holyoke is a smoke-free facility. No veteran resident, visitor or staff of the VHH may engage in tobacco use on the VHH grounds.**



## ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I \_\_\_\_\_, veteran/veteran's representative, do hereby acknowledge receipt of the Notice of Privacy Practices as established by the Veterans Home at Holyoke.

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Veteran Signature	Veteran Printed Name	Date
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OR

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Invoked Health Care Agent Signature	Health Care Agent Printed Name	Date
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OR

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Guardian Signature	Guardian Printed Name	Date
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# HIPAA PRIVACY NOTICE

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## **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION**

*Please retain this document for your records*

This notice describes the Veterans Home at Holyoke practices and those of:

- Any health care professional authorized to enter information into your medical chart.
- All departments of the Veterans Home at Holyoke.
- Any member of a volunteer group we allow to help you while you are at the Veterans Home at Holyoke.
- All employees, staff and other personnel.

### **OUR PLEDGE REGARDING MEDICAL INFORMATION**

The Veterans Home at Holyoke understands that medical information about you and your health is personal. We will continue our commitment to protect your medical information. We create a record of the care and service you receive at the Veterans Home at Holyoke. This record is required to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Veterans Home at Holyoke, whether made by our personnel or your personal physician. Any physician outside the Veterans Home at Holyoke may have different policies or notices regarding his/her use of your medical information created at his/her office.

This notice will tell you about the ways in which the Veterans Home at Holyoke may use and disclose the medical information it has about you. We will also describe your rights and obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal obligations and privacy practices with respect to medical information about you; and
- Abide by the terms of this notice or any modifications to it.

### **HOW THE VETERANS HOME AT HOLYOKE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU**

The following categories describe the different ways that the Veterans Home at Holyoke uses and discloses medical information. For each category of use or disclosure, we will explain what is meant and try to give an example. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

**For Treatment:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to physicians, nurses, technicians, or other personnel of the Veterans Home at Holyoke or contracted personnel of the Veterans Home at Holyoke who are involved in taking care of you either as an inpatient or outpatient. For example, the physician treating you for a heart condition may need to know if you have diabetes because of the effects diabetes may have on you. In addition, the physician may need to tell the dietician that you are diabetic in order that your meals as an inpatient may be arranged. Different departments of the Veterans Home at Holyoke may also share medical information about you in order to coordinate the different services you may need, such as prescriptions, lab work, x-rays and therapy. We may also disclose medical information about you to people

outside the Veterans Home at Holyoke who may be involved in your medical care such as family members, health care proxy, or others we use to provide services that are part of your care.

**For Payment:** We may use and disclose medical information about you so that the treatment and services you receive at the Veterans Home at Holyoke may be billed and payment may be collected from you, your insurance carrier or a third party. For example, we may need to give your health plan information about services you received at the Veterans Home at Holyoke so that your health plan will pay us or reimburse you. The Veterans Home at Holyoke may also tell your health plan about a treatment you are going to receive in order to obtain prior approval and to determine whether your plan will cover the treatment.

**For Health Care Operations:** The Veterans Home at Holyoke may use and disclose information about you for our own operations. These uses and disclosures are necessary to run the Veterans Home at Holyoke and make sure that all our veterans receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many of our veterans in order to decide what additional services the Veterans Home at Holyoke should offer, what services may not be needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians and other personnel for review. We may also combine the medical information we have with medical information from other state Veterans Homes or VA Hospitals in order to compare how we are doing and to ascertain where we can make improvements in the care and services we provide. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific veteran may be.

**Appointment Reminders:** The Veterans Home at Holyoke will not use or disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the Veterans Home at Holyoke unless you have specifically authorized us, in writing, to do so.

**Patient Directory:** We may include certain limited information about you in the directory while you are an inpatient at the Veterans Home at Holyoke. This information may include your name, location within the Veterans Home, your general condition and your religious affiliation. This information, excluding your religious affiliation, may also be released to a person who asks for you by name. Your religious affiliation may be given to a member of the clergy such as a priest, minister or rabbi, even if they don't ask for you by name. You have a right to further limit this information and if your request is in writing, we will abide by your request until such time as we are otherwise notified.

**Individuals Involved in Your Care or Payment for Your Care:** We may release medical information about you to a friend or family member whom you have designated as your health care proxy or you have authorized us to release medical information. We may also tell your family or friends your general condition and your location in the Veterans Home at Holyoke. We may also disclose medical information about you to an entity assisting in disaster relief efforts, so that your family can be notified about your condition, status and location.

**As Required by Law:** The Veterans Home at Holyoke will disclose medical information about you when required to do by federal, state or local law.

**To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health, and safety or the health and safety of the public or another person. Any disclosure, however, would be to someone able to help prevent the threat.

## **SPECIAL SITUATIONS**

**Organ and Tissue Donation:** If you are an organ donor, we may release medical information to organizations that handle organ procurement on organ, eye or tissue transplantation or to an organ donation bank, as is necessary to facilitate the organ or tissue donation and transplantation.

**Military and veterans:** If you are or were a member of the armed forces, we may release medical information about you as may be required by the Department of Veterans Affairs. This disclosure is necessary for the Department of Veterans Affairs to determine if you are eligible for certain benefits.

**Public Health Risks:** The Veterans Home at Holyoke may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability.
- to report deaths;
- to report abuse or neglect;
- to report reactions to medications or problems with products;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; or
- to notify the appropriate governmental authority if we believe a veteran has been the victim of abuse, neglect or domestic violence. We will only make this disclosure when it is required or authorized by law.

**Health Oversight Activities:** The Veterans Home at Holyoke may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections and licensure. The Veterans Home at Holyoke is inspected from time to time by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); the Department of Veterans Affairs (VA) and the Department of Public Health (DPH). These entities are a few but not all the entities, which may provide inspections or licensure. These investigations, audits, and inspections are necessary for the federal and state government to monitor the health care system, governmental programs and compliance with civil rights laws.

**Lawsuits and Disputes:** The Veterans Home at Holyoke may disclose medical information about you in response to a lawsuit or a dispute only if required by a court or administrative order. We may disclose medical information about you in response to a subpoena, discovery request or other lawful process made by someone else involved in the dispute but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement:** The Veterans Home at Holyoke may release medical information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death which is believed may be the result of criminal conduct;
- about criminal conduct at the Veterans Home at Holyoke;
- to identify or locate a suspect, fugitive, material witness, or missing person; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

**Coroners, Medical Examiners and Funeral Directors:** The Veterans Home at Holyoke may release medical information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release medical information about patients of the Veterans Home at Holyoke to funeral directors as necessary to carry out their duties, if we are so authorized by you.

**National Security and Intelligence Activities:** The Veterans Home at Holyoke may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

**Protective Services for the President and Others:** The Veterans Home at Holyoke may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

## YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

**Right to Inspect and Copy:** You have a right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records but does not include psychotherapy notes.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Medical Record Department. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

**Right to Amend:** In the event, you feel that the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Veterans Home at Holyoke.

To request an amendment, your request must be made in writing and submitted to the HIPAA Privacy Officer. Your request must be supported by a reason for the amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the medical information kept by or for the hospital;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

**Right to an Accounting or Disclosures:** You have the right to request an “account of disclosures.” This is a list of the disclosures we made of medical information about you.

To request this list of accounting of disclosures, you must submit your request in writing to the HIPAA Privacy Officer. Your request must state a time period, which may not be longer than six (6) years and may not include dates before April 16, 2003. Your request should indicate in what form you want the list (for example, paper, electronically). The first list you request within a twelve (12) month period will be provided free of charge. For any additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery or procedure you had.

**We are not Required to Agree with Your Request:** If the Veterans Home at Holyoke does not agree, we will comply with the request unless the information is needed to provide you with emergency treatment.

To request restrictions, you must make your request in writing to the HIPAA Privacy Officer. In your request you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse or family.

**Right to Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the HIPAA Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**Right to a Copy of this Notice:** You have a right to a copy of this notice. You may ask us to give you a copy of this notice at any time. Upon signing this notice, a copy will automatically be given to you.

## **CHANGES TO THIS NOTICE**

We reserve the right to change this notice. We reserve the right to make the revisions or changes effective for medical information we already have about you as well as any information we receive in the future. A copy of any current notice will be posted in the Veterans Home at Holyoke in each care center and other conspicuous places. The notice so posted will contain on the first page, lower left-hand corner, the effective date. In addition, each time you register as an outpatient for treatment or health care services, we will offer you a copy of the current notice in effect.

## **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with the Veterans Home at Holyoke or with the Secretary of the Department of Health and Human Services.

To file a complaint with the Veterans Home at Holyoke, contact General Counsel, at 413-552-4704. All complaints must be submitted in writing. You may also contact Region I (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont) Boston Office of Civil Rights to lodge a complaint.

Their contact information is:

Regional Manager  
Government Center  
J.F.K. Federal Building - Room 1875  
Boston, MA 02203  
Telephone: 617-565-1340  
Fax: 617-565-3809  
TDD: 617-565-1343  
Web site: [www.hhs.gov/ocr/hipaa/](http://www.hhs.gov/ocr/hipaa/)

**This notice became effective on April 14, 2003**

**You will not be penalized for filing a complaint.**

## **OTHER USES OF MEDICAL INFORMATION**

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you give us permission to use or disclose medical information about you, you may revoke that permission at any time. Your revocation must be in writing. If you revoke your permission, we will immediately cease to use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are not able to take back any disclosures we have already made with your permission, and that our obligation to retain your record of the care that has been provided to you will be maintained.



**THE COMMONWEALTH OF MASSACHUSETTS  
EXECUTIVE OFFICE OF VETERANS SERVICES**

Massachusetts Veterans Home at Holyoke

110 Cherry Street, Holyoke, MA 01040

TEL: (413) 532-9475 FAX: (413) 538-7968

[www.mass.gov/hly](http://www.mass.gov/hly) • [www.mass.gov/veterans](http://www.mass.gov/veterans)

**MAURA T. HEALEY**  
GOVERNOR

**KIMBERLEY DRISCOLL**  
LIEUTENANT GOVERNOR

**JON SANTIAGO, MD, MPH**  
SECRETARY, EOVS

**MICHAEL LAZO**  
EXECUTIVE DIRECTOR

**Primary Care Provider's Order for Long-Term Care**

Name and Address of Primary Care Provider:

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

The patient whose name is listed below is medically and socially appropriate for residing in the Veterans Home at Holyoke, a Long-Term Care facility.

As of the date annotated above, I am the Primary Care Provider for:

\_\_\_\_\_  
*Full name of Veteran*

Respectfully,

\_\_\_\_\_  
*Signature of Provider*

ADM-040

## VETERANS HOME AT HOLYOKE – FINANCIAL INFORMATION WORKSHEET

**GROSS INCOME FROM ALL SOURCES:** Proof of ALL income must be provided – (Copy of most recent Federal Income Tax Return, copies of all bank, retirement, Social Security, VA - within last 60 days).

INCOME SOURCE	MONTHLY INCOME	
	VETERAN	Spouse/Other
VA AWARD - Provide Pension Award Letter and copy of VA check/amount deposited in account		
<b>VA Service Connected or Non-Service Pension or Housebound Aid &amp; Attendance</b>		
SOCIAL SECURITY BENEFITS - Provide Copy of Benefit Statement(s)		
Social security (not SSI)		
Social Security Disability		
RETIREMENT PENSION- Provide 1099-R		
ANNUITY INCOME - Provide 1099 and/or End of Year Statement		
IRA DISTRIBUTIONS - Provide 1099-R and/or End of Year Statement		
INTEREST INCOME - Provide 1099-INT		
DIVIDEND INCOME-Provide 1099R/1099INT		
WAGES OR SALARY- Provide W-2		
UNEMPLOYMENT BENEFITS		
SAVINGS ACCOUNT BALANCE		
CHECKING ACCOUNT BALANCE		
Other (please list & describe)		

**Marital Status:** ☐ Married    ☐ Divorced    ☐ Widowed    ☐ Never Married    ☐ Separated

*To the best of my knowledge, the information provided herein is complete and accurate. I understand that providing erroneous, inaccurate or incomplete information could result in room and board charges being retroactively applied to my account.*

\_\_\_\_\_  
Signature of Veteran, or person authorized to sign for Veteran

\_\_\_\_\_  
Date

### **Part 10 – Eligibility Requirement**

In compliance with the eligibility requirement, I do hereby apply for admission to the Veterans Home at Holyoke, veterans' long-term care facility and declare the following statements and information to be true.

### **Residence Certificate for State of Massachusetts**

I, the undersigned, am a resident of the State of Massachusetts in accordance with M.G.L. c. 4, sec.7, cl. 43<sup>rd</sup> as amended by the Acts of 2005, ch.130.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date



## VETERANS HOME AT HOLYOKE VETERAN MEDICAL INFORMATION UPDATE REQUEST

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Has the veteran had COVID-19? ☐ Yes, when? \_\_\_\_\_ ☐ No

Please provide current vaccination dates: \_\_\_\_\_

Does the veteran have a history of falls? ☐ Yes ☐ No \_\_\_\_\_

Has the veteran had a recent fall? ☐ Yes ☐ No When was the last fall? \_\_\_\_\_

Does veteran currently of have history of wandering outside of residence, gets lost or exit seeks?

☐ Yes ☐ No If yes, of what nature? \_\_\_\_\_

Does the veteran have a history of cognitive deficits? (Impaired judgment, impulsivity, forgetfulness)

☐ Yes ☐ No If yes, please describe: \_\_\_\_\_

Is the veteran combative with care? ☐ Yes ☐ No If yes, please describe: \_\_\_\_\_

Does the veteran have a mental health diagnosis? (Suicidality, depression, PTSD, anxiety, hallucinations)

☐ Yes ☐ No If yes, of what nature? \_\_\_\_\_

Have these issues been treated? ☐ Yes ☐ No

Does the veteran have a history of substance abuse issues? ☐ Yes ☐ No

If yes, of what nature? \_\_\_\_\_

Are these issues active? ☐ Yes ☐ No

Have these issues been treated? ☐ Yes ☐ No

How often does the veteran drink alcohol? \_\_\_\_\_

Does the veteran smoke or consume marijuana? ☐ Yes ☐ No

Does the veteran smoke cigarettes?

☐ Yes ☐ No

- **The Veterans Home at Holyoke is a smoke-free facility. No veteran resident, visitor or staff of the VHH may engage in tobacco use on the VHH grounds.**

Does the veteran have a history of aggression or assault? ☐ Yes ☐ No

If yes, of what nature? \_\_\_\_\_

Are there any other unique or special circumstances or needs you feel we should be aware of such as: equipment for mobility or personal care, medical supplies, adaptive equipment, daily rituals, etc.

Require Medical Treatments: ☐ oxygen ☐ CPAP ☐ nebulizer ☐ dialysis ☐ wound care ☐ catheter

☐ ostomy ☐ feeding tube ☐ Other: \_\_\_\_\_

Use Equipment: ☐ cane ☐ walker ☐ wheelchair ☐ prosthesis ☐ hearing aids ☐ eyeglasses ☐ dentures

Others: \_\_\_\_\_

Required Therapies: ☐ occupational ☐ physical ☐ speech ☐ nutritional Other: \_\_\_\_\_

Dietary Needs: (swallowing issues/restrictions/intolerance/special needs/ground/puree):

☐ Yes

☐ No

☐ Unknown

If yes, list: \_\_\_\_\_

\_\_\_\_\_

Does veteran have problems with memory? ☐ Yes ☐ No ☐ Unknown

Does veteran have a Rogers Order ☐ Yes ☐ No ☐ Unknown

Any Safety Concerns: \_\_\_\_\_

\_\_\_\_\_

Please describe the veteran's level of function and/or assistance required in the following areas:

1. Ambulation: ☐ Independent ☐ Supervision ☐ Hands on assistance
2. Assistive devices needed for ambulation: ☐ Cane ☐ Walker ☐ Wheelchair
3. Bathing: ☐ Independent ☐ Supervision ☐ Hands on assistance
4. Dressing/Undressing: ☐ Independent ☐ Supervision ☐ Hands on assistance
5. Toileting: ☐ Independent ☐ Supervision ☐ Hands on assistance
6. Eating: ☐ Independent ☐ Supervision ☐ Hands on assistance
7. Mobility outside of residence: ☐ Independent ☐ Supervision ☐ Hands on assistance

**You must provide us with the following updated medical information from your medical provider & care facility for this application:**

1. Current medication list ☐
2. Current Diagnosis list ☐
3. Most recent physical exam ☐
4. Most recent progress note ☐
5. Immunization Record to include COVID-19 & boosters ☐
6. Clinical Specialists Consults ☐

- |                                   |                          |
|-----------------------------------|--------------------------|
| 7. Psychiatric/Behavioral Consult | <input type="checkbox"/> |
| 8. Most Recent Nurses Notes       | <input type="checkbox"/> |
| 9. Fall Risk & Number of Falls    | <input type="checkbox"/> |
| 10. Elopement Risk                | <input type="checkbox"/> |

**The above documents can be:**

**Faxed to:**

- **413.552.4757**

**Emailed to:**

- [Magaly.King@mass.gov](mailto:Magaly.King@mass.gov) (Admissions) or,
- [David.DesLauriers@mass.gov](mailto:David.DesLauriers@mass.gov) (RN Clinical Coordinator)

**Mailed to:**

- **Veterans Home at Holyoke**  
**110 Cherry Street**  
**Holyoke, MA, 01040**  
**Attn: Admissions**

**If assistance is needed, please feel free to call 413.532.9475 and ask to speak with the Admissions Department.**