



Arkansas Veterans Home at Fayetteville  
1179 N. College Avenue, Fayetteville, AR 72703  
Phone: (479) 444-7001 | Fax: (479) 695-0184



ADVAcates for Arkansas Veterans

**ASA HUTCHINSON**  
Governor

**NATHANIEL (NATE) TODD**  
Secretary

Dear Applicant or Family Member:

We appreciate your interest in placing yourself or loved one in the Arkansas Veterans Home at Fayetteville. Below is some general information.

Who can apply:

- Veteran with an Honorable or general discharge from the military
- Spouse of veteran
- Gold Star parents

**Cost of Services:**

1. If you have a Service Connected Disability rated through the VA at 60% and unemployable OR rated at 70% or higher, it is possible that the Veterans Administration will pay for your stay here. Please provide that rating letter to us when you send in the completed application packet.
2. The cost per day for a semi-private room is 85% of the current Medicaid rate. Private rooms incur a \$15 addition and for deluxe private rooms a \$25 addition.  
*Please contact for exact pricing.*
3. If you are not a service connected disabled veteran nor have the financial resources to pay, we can help you apply for long term care support under the Arkansas Medicaid Program.
4. We do accept long term care insurance policies. Please provide that with your application packet, if applicable.
5. Medicare Part A could also pay for short term rehabilitation, if you qualify

Medication:

Your medication will be billed separately to you.

Smoking:

The use of tobacco products are not allowed inside the facility. However, we do allow smoking in designated area outside on the ground floor.

**Call for more information on these criteria.**

*If you have any questions or need assistance, please call (479) 444-7001. You are welcome to come by for a tour during regular business hours, Monday - Friday, no appointment needed.*



Arkansas Veterans Home at Fayetteville  
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Phone: (479) 444-7001 | Fax: (479) 695-0184  
[FVH@arkansas.gov](mailto:FVH@arkansas.gov)



ADVAcates for Arkansas Veterans

**NATHANIEL (NATE) TODD**  
Secretary

**BUSTER MCCALL**  
Administrator

### Application Instructions:

Please provide the following documentation along with completed application. These are required for consideration for admission to the Veterans Home. Application packet is considered incomplete if items are missing or **not signed**.

- Complete, **date**, and **sign** ALL forms within the application.
- Submit a government issued DD-214 or separation records showing a **Honorable Discharge** with entry and separation dates. *If unable to locate, please contact us and we may be able to assist.*
- Submit Social Security card, Medicare, Medicaid, Veterans Administration and any other current insurance cards (copy of the front and back of all cards)
- Signed** copy for release of information (ROI) forms. There are **TWO** of them in the admission packet. One is the facility ROI, please sign and date it. The other is an ROI VA form. Please **sign** if you have medical records from the VA. *If applicant is unable to sign, the Healthcare Power of Attorney must sign the form.*
- Power of attorney documents or Guardianship documents. (*if applicable*)
- For spouses of veteran - please include a copy of your marriage license
- If you have a service connected disability rated through the VA, include written verification.
- Mail** or *fax* signed copy of VA release form 10-5245 to: 1179 N. College Avenue, Fayetteville, AR 72703 , (479) 695-0184



Application for Admission to the Arkansas Veterans Home at Fayetteville

1179 N. College Avenue, Fayetteville, AR 72703 | (479) 444-7001

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

I am a veteran  I am the spouse of a veteran  I am a Gold Star Parent of a veteran

Phone Number: \_\_\_\_\_ Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Permanent Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Place of Birth: \_\_\_\_\_ Primary Language: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Current Residence:  Nursing Home  Assisted Living Facility  Permanent Address

Name of facility: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Medicare#: \_\_\_\_\_ Other insurance: \_\_\_\_\_

Branch of Service: \_\_\_\_\_ Dates of service: \_\_\_\_\_ Do you have your DD214: Yes / No

If you have a service connected disability, what percent? \_\_\_\_\_ Do you receive Aid & Attendance? Yes / No

Do you wish to be contacted by a veteran services officer regarding services connected disability or VA pension to help pay for long term care?  YES  NO

Do you have a Power of Attorney?  YES  NO Do you have a guardian?  YES  NO

Who should we talk to about this admission (if applicant is unable)? Name: \_\_\_\_\_

POA  Guardian Relation: \_\_\_\_\_ Phone number: \_\_\_\_\_ Email: \_\_\_\_\_

Have you been admitted to the hospital in the past 6 months or currently in the hospital?  YES  NO

Dates: \_\_\_\_\_ Hospital name: \_\_\_\_\_ Location: \_\_\_\_\_

Reason: \_\_\_\_\_

Have you been seen by a primary care doctor in the last 30 days?  YES  NO

Doctors Name: \_\_\_\_\_ Location: \_\_\_\_\_

Funeral Home Choice: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How did you hear about us?

Referred by: \_\_\_\_\_  Facebook  [veterans.arkansas.gov](http://veterans.arkansas.gov)  Other: \_\_\_\_\_



**Financial Information for Admission to the Arkansas Veterans Home at Fayetteville**

1179 N. College Avenue, Fayetteville, AR 72703 | (479) 444-7001

\_\_\_\_\_ I know that I will be private pay/VA per diem. **If so, you do not need to give financial information below**

Please list the gross monthly income:

	VA Benefits	Social Security	Military Retired Pay	Civil Service	Interest	Dividends	Wages	R R Ret	Other: _____
<b>Veteran</b>	\$	\$	\$	\$	\$	\$	\$	\$	\$
<b>Spouse</b>	\$	\$	\$	\$	\$	\$	\$	\$	\$

Please list all assets (home, auto, bonds, CDs, savings/checking accounts, life insurance policies etc.) to determine eligibility for VA benefits and assessment of charges:

- Description of Asset: \_\_\_\_\_ Location: \_\_\_\_\_  
Owner: \_\_\_\_\_ Present Value: \_\_\_\_\_
  - Description of Asset: \_\_\_\_\_ Location: \_\_\_\_\_  
Owner: \_\_\_\_\_ Present Value: \_\_\_\_\_
  - Description of Asset: \_\_\_\_\_ Location: \_\_\_\_\_  
Owner: \_\_\_\_\_ Present Value: \_\_\_\_\_
  - Description of Asset: \_\_\_\_\_ Location: \_\_\_\_\_  
Owner: \_\_\_\_\_ Present Value: \_\_\_\_\_
- Other: \_\_\_\_\_

Return **signed** application, DD214, copy of ID, Medicare and insurance cards and releases of information to:

**Arkansas Veterans Home at Fayetteville  
1179 North College Ave  
Fayetteville AR 72703**

Or email to: [FVH@arkansas.gov](mailto:FVH@arkansas.gov)

Or fax to: **479-695-0184**

Please check one:  I am ready to move now **OR**  I want to move in: \_\_\_\_\_

I certify that have read and understand the Information provided on this form and that the above answer are true and correct to the best of my knowledge/belief.

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

Check one of the following:  I am the applicant  I am a representative for the applicant



**Criteria for Admission to the Arkansas Veterans Home at Fayetteville**

1179 N. College Avenue, Fayetteville, AR 72703 | (479) 444-7001

**SKILLED NURSING HOME LEVEL OF CARE**

Besides being an honorably discharged veteran, spouse, or Gold Star Parent, to be eligible for admission to the Arkansas Veterans Home at Fayetteville, you **MUST** meet the skilled care requirements of Medicaid/Medicare in **AT LEAST TWO** of the Katz Index listed below. You must answer **YES** to at least **TWO** of the following:

Katz Index of Independence in Activities of Daily Living

<b>Activity of Daily Living</b>	<b>Response</b>	<b>Dependence</b> <b>WITH</b> supervision, direction, personal assistance or total care.
Bathing	<input type="checkbox"/> YES <input type="checkbox"/> NO	Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing
Dressing	<input type="checkbox"/> YES <input type="checkbox"/> NO	Needs help with dressing self or needs to be completely dressed.
Toileting	<input type="checkbox"/> YES <input type="checkbox"/> NO	Needs help transferring to the toilet, cleaning self or uses bed an or commode.
Transferring	<input type="checkbox"/> YES <input type="checkbox"/> NO	Needs help in moving from bed to chair or requires a complete transfer.
Continence	<input type="checkbox"/> YES <input type="checkbox"/> NO	Is partially or totally incontinent of bowel or bladder
Feeding	<input type="checkbox"/> YES <input type="checkbox"/> NO	Needs partial or total help with feeding or requires parenteral feeding

Services provided by our skilled nursing facility include:

- services that are needed temporarily due to an injury or illness
- post-operative wound care, dispensing and monitoring intravenous medications
- physical therapy to help correct strength and balance issues
- speech therapy to assist residents in reclaiming their ability to communicate following a stroke
- occupational therapy to help residents to become independent again, particularly when it comes to dressing, personal hygiene and eating
- pharmaceutical, laboratory and radiology services
- social and educational activities



**Release of Information to the Arkansas Veterans Home at Fayetteville**

1179 N. College Avenue, Fayetteville, AR 72703 | (479) 444-7001

**This section to be completed by ASVH-Fayetteville only:**

To: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of hospital, facility or other

Physician

Address

City

State

Zip

**This section to be completed by applicant/power of attorney**

Medical Information to be used in considering applicant for placement:

Name \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

DOB: \_\_\_\_\_

Gender: \_\_\_\_\_

I authorize the release of medical information to include:

- Medication and therapies
- Advance directive, durable power of attorney, DNR, Living Will
- Last hospital discharge summary (If within the last six months)
- Outpatient treatment notes
- Drug screen/substance abuse
- Alcoholism or alcohol abuse
- T.B. skin test
- Medical history and diagnosis from last six months
- Nursing assessments for last six months
- Infection with human Immunodeficiency virus (HIV/AIDS)
- Current pharmacy profile
- MDS/Care Plans
- Other: \_\_\_\_\_

Send the requested information to: **Arkansas Veterans Home at Fayetteville, 1179 N. College, Fayetteville AR 72703**

Phone: **479-444-7001**

Fax: **479-695-0184**

Authorization: I certify that this request has been made freely, voluntarily, and without coercion. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken. Disclosure of my medical record by those receiving the above authorized information may not be accomplished without my further written consent.

\_\_\_\_\_  
Resident or Responsible Party

\_\_\_\_\_  
Date

For releasing agent use **only**  
Content of material released

Date released: \_\_\_\_\_ Released by: \_\_\_\_\_



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 it 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 the information including the last four of your Social Security Number (SSN) and Date of Birth (used 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 treatment, payment, enrollment or eligibility on signing the authorization. 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 24VA10P2 "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)

LAST NAME- FIRST NAME- MIDDLE INITIAL

LAST 4 SSN

DATE OF BIRTH

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Arkansas State Veterans Home Fayetteville
1179 N. College Ave. Fayetteville, AR 72703

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

- TREATMENT BENEFITS LEGAL EMPLOYMENT OTHER (Please specify)

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):
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:
FLU VACCINATION (Dose, Lot Number, Date & Location):
OTHER (Describe):

LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH
<p><b>SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.</b></p> <p>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.</p> <p><input type="checkbox"/> DRUG ABUSE      <input type="checkbox"/> ALCOHOLISM OR ALCOHOL ABUSE      <input type="checkbox"/> SICKLE CELL ANEMIA</p> <p><input type="checkbox"/> HUMAN IMMUNODEFICIENCY VIRUS (<i>HIV</i>)</p> <p>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 <u>unless</u> I indicate by checking the box below that I do not want this information released for this specific disclosure.</p> <p><input type="checkbox"/> <b>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.</b></p>		
<p><b>AUTHORIZATION:</b> 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.</p> <p>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.</p>		
<p><b>EXPIRATION:</b> Without my express revocation, the authorization will automatically expire.</p> <p><input type="checkbox"/> AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED</p> <p><input type="checkbox"/> ON _____ (<i>enter a future date other than date signed by patient</i>)</p> <p><input type="checkbox"/> UNDER THE FOLLOWING CONDITION(S): _____</p>		
PATIENT SIGNATURE ( <i>Sign in ink</i> )	DATE ( <i>mm/dd/yyyy</i> )	
LEGAL REPRESENTATIVE SIGNATURE ( <i>if applicable</i> ) ( <i>Sign in ink</i> )	DATE ( <i>mm/dd/yyyy</i> )	
PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT	
<b>FOR VA USE ONLY</b>		
TYPE AND EXTENT OF MATERIAL RELEASED		
DATE RELEASED	RELEASED BY:	