ALL DOCUMENTS CAN BE FAXED BACK TO

1-844-375-1125

OR

Emailed to: veilrcf@gmail.com

Page 2 should be faxed back first, along with hospital / doctor's notes including a face sheet.

Pages 3,4,5 and 6 are for the doctor and or RN to complete and then faxed back.

The Veil can be reached @ 803-809-0003(O)

Thank You,

Novella Jackson 803-878-2478(C)

Intake Package

Date of Intake. _____

Date of Adm._____

Placement Name: _____

DOB_____Social Security#_____Race_____

Hgt_____Wgt_____Age_____Sex_____

Old Address_____

Old Address_____

Maiden Name_____Mother's Maiden Name_____

Place of Birth _____

Diagnosis_____

Family Contact _____

Resident Representatives/ Placing Agency

Name_____**Number**_____

Agency_____**Email**_____

Pay Source_____**Amount $**_____**Pic ID** _____**Bank Card**_____

Payee_____**Number**_____

Medicaid_____**Medicare**_____**Part D**_____

Do you own Land or house?_____
Do you own a car?_____
Do you Have Life Insurance or Burial Plot?_____

What is needed

1. Face sheet- Needed
2. PPD 1 & 2 step
3. Admission medical
4. prescriptions 30-day supply with 3 refills faxed to Pharmacy_____
5. Medication List
6. COVID Card or Negative test Results
7. Two months bank statement / direct express card statement

ALL LINES MUST BE COMPLETELY FILLED OUT- FAX 844-375-1125

ADMISSION/ANNUAL MEDICAL EXAMINATION

Name of Resident	**Age**	**Sex**	**Uses:** ( ) **Walker** ( ) **Cane** ( ) **Wheelchair** ( ) **None**
DOB:			

1. General Diagnosis: _____

_____

_____.

2. Any contagious or infectious disease? **Yes / No** If "Yes" please explain:

3. Any condition or habits which would adversely affect the well-being of others in the facility? **Yes / No** If "yes" please explain:

4. Is this person able to self-administer medications? **Yes / No**

5. Does this person have the physical ability to engage in light, specially designed, low-level, geriatric exercise? **Yes / No**

6. Is this person ambulatory; able to enter and exit the facility unassisted? **Yes / No**

7. Does this person require the daily care of a registered or licensed practical nurse? **Yes / No**

8. A Community Residential Care Facility ICRCF) provides room, board, and a degree of personal assistance in the activities of daily living. A community resident care facility by South Carolina law cannot provide daily nursing care or care to individuals in need of care appropriately provided by a nursing home or hospital.

Can this person be cared for in this type of facility? Yes / No

9 Diet: Regular Renal Diabetic

Physician' Signature:	Address:	Telephone#	Date: (Please Print Clearly)

TUBERCULOSIS SKIN TEST FORM 1st / 2nd

Healthcare Professional/Patient Name: _____

Testing Location: _____

Date Placed:_____Expiration Date: _____

Site: _Right _Left

Lot#:_____

Signature (administered by):_____

RN_ MD_ Other:_____

Date Read (within 48-72 hours from date placed):_____

__Induration (please note in mm) ---------- 'mm

PPD (Mantoux) Test Result: Negative Positive

Signature (results read/reported by):_____

RN_ MD_ Other:_____

PHYSICIAN'S/MEDICAL OFFICER'S STATEMENT OF PATIENT'S CAPABILITY TO MANAGE BENEFITS

TIME IT TAKES TO COMPLETE THIS FORM
We estimate that it will take you about 5 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts, and fill out the form. If you have comments or suggestions on this estimate, or on any other aspect of this form write to the Social Security Administration, ATTN: Reports Clearance Officer, 1-A-21 Operations Bldg., Baltimore, MD 21235-0001, And to the Office of Management and Budget, Paperwork Reduction Project (0960-0024), Washington, D.C. 20503. **Send only comments relating to our estimate or other aspects of this form to the offices listed above. All requests for Social Security cards and other claims-related information should be sent to your local social Security office, whose address is listed in your telephone directory under the Department of Health and Human Services.**

In Replying use this address:
SOCIAL SECURITY ADMINISTRATION

TELEPHONE NUMBER (Including Area Code)
( )

DATE

SSA CONTACT

This report is authorized by sections 205(a) and 205 (j) of the Social Security Act, as amended (42 U.S.C.) 405(a) and 405(j). While you are not required to respond, your cooperation will help us decide whether any Social Security benefits that may be due should be paid directly to the patient or to someone else on the patient's behalf. Your cooperation in completing and returning this statement will be appreciated.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it. These and other reasons why information your provide may be used or given out are explained in the Federal Register. If you want to learn more about this, contact any Social Security office.

IDENTIFYING INFORMATION (SSA or
If different from patient

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON

SOCIAL SECURITY NUMBER
_____ / _____ / _____

PATIENT'S NAME		PATIENT'S ADDRESS (Number and Street, City, State and ZIP Code)
PATIENT'S SOCIAL SECURITY NUMBER _____ / _____ / _____	PATIENT'S DATE OF BIRTH	

YOUR HELP IS NEEDED
The patient shown above has filed for or is receiving Social Security or Supplemental Security income payments. We need you to complete the back of this form and return it to us in the enclosed envelope to help us decide if we should pay this person directly or if he or she needs a representative payee to handle the funds. **Please Note:** This determination affects how benefits are paid and has no bearing on disability determinations. Thank you for your help.

WHO IS A REPRESENTATIVE PAYEE

A representative payee is someone who manages the patient's money to make sure the patient's needs are met. The payee has a strong and continuing interest in the patient's well-being and is usually a family member or close friend.

WHO NEEDS A REPRESENTATIVE PAYEE?

Some individuals age 18 and older who have mental or physical impairments are not capable of handling their funds or directing others how to handle them to meet their basic needs, so we select a representative payee to receive their payments. Examples of impairments which may cause incapability are senility, severe brain damage or chronic schizophrenia. However, even though a person may need some assistance with such things as bill paying, etc., does not necessarily mean he/she cannot make decisions concerning basic needs and is incapable of managing his/her own money.

PLEASE COMPLETE THE INFORMATION ON THE REVERSE OF THIS FORM

1. Date you last examined the patient_____

2. Do you believe the patient is capable of managing or directing the management of benefits in his or her own best interest?

By capable we mean the patient:

- is able to understand and act on the ordinary affairs of life, such as providing for own adequate food, housing, clothing, etc., and
- is able, in spite of physical impairments, to manage funds or direct others how to manage them.

☐ Yes

If "Yes", please omit question 3, but be sure to sigh and date the form.

☐ No

If "No", please provide a brief summary of the findings that led to this conclusion. Also, complete question 3.

☐ Unsure

If "Unsure", please explain.

3. Do you expect the patient to be able to manage funds in the future (for example, the patient is temporarily unconscious)?

☐ Yes ☐ No

If yes, please explain

HEREBY CERTIFY THAT THE ABOVE STATEMENTS AND ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE.

NAME OF PHYSICIAN/MEDICAL OFFICER *(Please print)*	TITLE
ADDRESS *(Number and street, City, State, And ZIP Code)*	TELEPHONE NUMBER *(Including Area Code)* ( )
NATURE OF PHYSICIAN/MEDICAL OFFICER	DATE

FORM SSA-787 (7-92)

*U.S. Government Printing Office: 1994 --300-948/00029

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Authorization for Release of Information and Appointment of Authorized Representative for Medicaid Applications/Reviews and Appeals

Name of Medicaid applicant/member	Social Security Number

Appointing an Authorized Representative

Would you like to allow someone to represent you on all matters related to your case?

You can give a trusted person or an organization permission to talk about your application with us, see your information, and act for you on matters related to your application, including getting information about your application and signing your application on your behalf. This person can also act for you on other matters, including reviews, appeals and managed care processes. This person is called an "authorized representative." The Medicaid eligibility worker can release any information regarding your application/review and status to your authorized representative. More than one person or organization can serve as your authorized representative.

You can appoint, withdraw or change an authorized representative at any time. If you ever need to change your authorized representative, contact Healthy Connections. If you are a legally appointed representative for someone on this application, you do not need to complete this section.

Full Name of Authorized Representative or Organization	☐ New ☐ Change ☐ Addition ☐ Remove this person or organization as my authorized representative

Point of Contact If Authorized Representative Is An Organization	Unit* (if applicable)	ID number (if applicable)

City	State	ZIP code

Authorized Representative's phone number	Other phone number

Authorized Representative's email address

Authorized Representative's address (Leave blank if you don't have one)	Apartment or suite number

*It is best to identify a specific unit for large organizations.

OR

Permission to Release Information

Is there anyone that you would like us to share information with about your application?

By completing this section, you can give permission for the following person to receive information about your application/case, but they won't have the ability to act on your behalf like an authorized representative. You also give SCDHHS permission to release information about this application to this additional person or organization.

Name of person/organization		Phone	
Address	City	State	ZIP
Unit (if applicable)	ID Number (if applicable)		

Medicaid applicant/member's signature	Date (mm/dd/yyyy)

If signing with an "X," please have two people sign below as witnesses.

Witness: _____ Witness: _____

☐ Member is incapacitated and unable to sign. SCDHHS reserves the right to verify member's inability to sign. Provide reason: _____

Mail your signed form to: SCDHHS – Central Mail, PO Box 100101, Columbia, SC 29202-3101 **Fax:** (888) 820-1204

NEED HELP WITH YOUR APPLICATION? Visit SCDHHS.gov or call us at **1-888-549-0820**. Para obtener una copia de este formulario en Español, llame **1-888-549-0820**. If you need help in a language other than English, call **1-888-549-0820** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-888-842-3620**.