North Florida/South Georgia Veterans Health System

Applying for Veterans Health Care:

Please read the instructions within this **Application for Health Benefits Form, 10-10EZ**. Complete all information that applies to you and your dependents.

If you have a copy of your DD214, please include it in the 10-10EZ application packet.

Use the attached self-addressed envelope to return your completed application to:

VA Medical Center
1601 SW Archer Road – 136A
Gainesville, FL 32608

Or return your completed form to your local VA health care facility.

~Failure to complete the entire packet could cause a delay in processing~

VA HEALTH CARE | Defining EXCELLENCE in the 21st Century

Department of Veterans Affairs
Quick Facts - Did You Know?

Did You Know?
The "VA" is comprised of three separate and distinct branches:
1. The Veterans Health Administration (VHA) – offers health care benefits.
2. The Veterans Benefits Administration (VBA) – offers compensation benefits.
3. National Cemetery Administration (NCA).

Did You Know?
VA offers eligible Veterans a comprehensive health care plan, known as VA's Medical Benefits Package. Once enrolled, Veterans who qualify for VA's health care plan will be categorized as either co-pay exempt or co-pay required, based on their individual eligibility status.

Veterans may apply for enrollment on-line, to determine if they qualify.
http://www.northflorida.va.gov/ (Click on – "Become a Patient")

Did You Know?
VA health care facilities vary in size and the type of services available.

1. VA Medical Centers (VAMCs). Offer the widest array of services, which includes outpatient care (primary care and specialty care), Emergency Department care and hospital (inpatient) care.

2. Outpatient clinics (OPCs). Offer outpatient care (primary care and specialty care) and urgent care.

3. Community-based outpatient clinics (CBOCs). Offer primary care and limited specialty care.

4. Rural health clinics (RHCs). Focus on providing primary care.

Did You Know?
A Veteran can choose his/her preferred facility, where they will be assigned a primary care provider. They may choose from 13 facilities in the North Florida/South Georgia Veterans Health System:

1. Malcom Randall (Gainesville) VA Medical Center
2. Lake City VA Medical Center
3. Jacksonville VA OPC
4. Tallahassee VA OPC
5. The Villages VA OPC
6. Lecanto VA CBOC
7. St. Augustine VA CBOC
8. Valdosta VA CBOC (Georgia)
9. Ocala CBOC
10. Marianna VA CBOC
11. St. Marys VA CBOC (Georgia)
12. Palatka VA CBOC
13. Waycross VA Rural Health Clinic (Georgia)

Department of Veterans Affairs

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. MOTHER'S MAIDEN NAME	3 GENDER ☐ MALE ☐ FEMALE

4. ARE YOU SPANISH, HISPANIC, OR LATINO?	5. WHAT IS YOUR RACE? *(You may check more than one. Information is required for statistical purposes only.)*
☐ YES	☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN
☐ NO	☐ ASIAN ☐ WHITE ☐ NATIVE AMERICAN OR OTHER PACIFIC ISLANDER

6. SOCIAL SECURITY NUMBER	7. DATE OF BIRTH *(mm/dd/yyyy)*	7A. PLACE OF BIRTH *(City and State)*

8. PERMANENT ADDRESS *(Street)*	8A. CITY	8B. STATE	8C. ZIP CODE

8D. COUNTY	8E. HOME TELEPHONE NUMBER *(Include area code)*	8F. MOBILE TELEPHONE NUMBER *(Include area code)*

8G. E-MAIL ADDRESS	9. CURRENT MARTIAL STATUS ☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED

10. I AM ENROLLING TO OBTAIN MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT	11. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? *(for listing of facilities visit www.va.gov/directory)*	12. WOULD YOU LIKE FOR VA TO CONTACT YOU TO SCHEDULE YOUR FIRST APPOINTMENT?
☐ YES ☐ NO		☐ YES ☐ NO

SECTION II - MILITARY SERVICE INFORMATION

1 LAST BRANCH OF SERVICE	1A. LAST ENTRY DATE	1B. LAST DISCHARGE DATE	1C. DISCHARGE TYPE

2 MILITARY HISTORY *(Check yes or no)*	YES	NO		YES	NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?	☐	☐	E DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998?	☐	☐
B. ARE YOU A FORMER PRISONER OF WAR?	☐	☐	F DID YOU SERVE IN VIETNAM BETWEEN JANUARY 9, 1962 AND MAY 7, 1975?	☐	☐
C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?	☐	☐	G WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?	☐	☐
D. WERE YOU DISCHARGED OR RETIRED FROM MILITARY FOR A DISABILITY INCURRED IN THE LINE OF DUTY?	☐	☐	H. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	☐	☐
			I DID YOU SERVE ON ACTIVE DUTY AT LEAST 30 DAYS AT CAMP LEJEUNE FROM AUGUST 1, 1953 THROUGH DECEMBER 31, 1987?	☐	☐

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

1. ENTER YOUR HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER *(include coverage through spouse or other person)*

2. NAME OF POLICY HOLDER	3. POLICY NUMBER	4 GROUP CODE	5. ARE YOU ELIGIBLE FOR MEDICAID?	6. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A?
			☐ YES ☐ NO	☐ YES ☐ NO 6A. EFFECTIVE DATE *(mm/dd/yyyy)*

APPLICATION FOR HEALTH BENEFITS, Continued

VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

SECTION IV - DEPENDENT INFORMATION *(Use a separate sheet for additional dependents)*

1. SPOUSE'S NAME *(Last, First, Middle Name)*

1A. SPOUSE'S SOCIAL SECURITY NUMBER

1B. SPOUSE'S DATE OF BIRTH *(mm dd yyyy)*

1C. DATE OF MARRIAGE *(mm dd yyyy)*

1D. SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP - if different from Veteran's)*

3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT?

☐ YES ☐ NO

2. CHILD'S NAME *(Last, First, Middle Name)*

2A. CHILD'S DATE OF BIRTH *(mm dd yyyy)*

2B. CHILD'S SOCIAL SECURITY NUMBER

2C. DATE CHILD BECAME YOUR DEPENDENT *(mm dd yyyy)*

2D. CHILD'S RELATIONSHIP TO YOU *(Check one)*

☐ SON ☐ DAUGHTER ☐ STEPSON ☐ STEPDAUGHTER

2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18?

☐ YES ☐ NO

2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR?

☐ YES ☐ NO

2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(e.g., tuition, books, materials)*

SECTION V - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN *(Use a separate sheet for additional dependents)*

	VETERAN	SPOUSE	CHILD 1
1. GROSS ANNUAL INCOME FROM EMPLOYMENT *(wages, bonuses, tips, etc.)* EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
3. LIST OTHER INCOME AMOUNTS *(e.g., Social Security, compensation, pension interest, dividends)* EXCLUDING WELFARE	$	$	$

SECTION VI - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE *(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home) VA will calculate a deductible and the net medical expenses you may claim.*	$
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES (INCLUDING PREPAID BURIAL EXPENSES) FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD *(Also enter spouse or child's information in Section VI.)*	$
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES *(e.g., tuition, books, fees, materials)* *DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES*	$

SECTION VII - CONSENT TO COPAYS AND TO RECEIVE COMMUNICATIONS

By submitting this application you are agreeing to pay the applicable VA copays for treatment or services of your NSC conditions as required by law. You also agree to receive communications from VA to your supplied email or mobile number.

ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section 1729 and 42 U.S.C. 2651, the Department of Veterans Affairs (VA) is authorized to recover or collect from my health plan (HP) or any other legally responsible third party 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 payment of the charges for my medical care, including benefits otherwise payable to me or my spouse. Furthermore, I hereby assign to the VA any claim I may have against any person or entity who is or may be legally responsible for the payment of the cost of medical services provided to me by the VA. I understand that this assignment shall not limit or prejudice my right to recover for my own benefit any amount in excess of the cost of medical services provided to me by the VA or any other amount to which I may be entitled. I hereby appoint the Attorney General of the United States and the Secretary of Veterans' Affairs and their designees as my Attorneys-in-fact to take all necessary and appropriate actions in order to recover and receive all or part of the amount herein assigned. I hereby authorize the VA to disclose, to my attorney and to any third party or administrative agency who may be responsible for payment of the cost of medical services provided to me, information from my medical records as necessary to verify my claim. Further, I hereby authorize any such third party or administrative agency to disclose to the VA any information regarding my claim.

ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS WHICH DEFINE WHO CAN SIGN ON BEHALF OF THE VETERAN.

SIGNATURE OF APPLICANT ______________________ DATE ______________

INSTRUCTIONS FOR COMPLETING ENROLLMENT APPLICATION FOR HEALTH BENEFITS

Please Read Before You Start . . . What is VA Form 10-10EZ used for?

For Veterans to apply for enrollment in the VA health care system. The information provided on this form will be used by VA to determine your eligibility for medical benefits and on average will take 30 minutes to complete. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Where can I get help filling out the form and if I have questions?

You may use ANY of the following to request assistance:

- Ask VA to help you fill out the form by calling us at 1-877-222-VETS (8387).
- Access VA's website at http://www.va.gov and select "Contact the VA."
- Contact the Enrollment Coordinator at your local VA health care facility.
- Contact a National or State Veterans Service Organization.

Definitions of terms used on this form:

SERVICE-CONNECTED (SC): A VA determination that an illness or injury was incurred or aggravated in the line of duty, in the active military, naval or air service.
COMPENSABLE: A VA determination that a service-connected disability is severe enough to warrant monetary compensation.
NONCOMPENSABLE: A VA determination that a service-connected disability is not severe enough to warrant monetary compensation.
NONSERVICE-CONNECTED (NSC): A Veteran who does not have a VA determined service-related condition.

Getting Started:

ALL VETERANS MUST COMPLETE SECTIONS I - III.

Directions for Sections I - III:

Section I - General Information: Answer all questions.

Section II - Military Service Information: If you are not currently receiving benefits from VA, you may attach a copy of your discharge or separation papers from the military (such as DD-214 or, for WWII Veterans, a "WD" Form), with your signed application to expedite processing of your application. If you are currently receiving benefits from VA, we will cross-reference your information with VA data.

Section III - Insurance Information: Include information for all health insurance companies that cover you, this includes coverage provided through a spouse or significant other. Bring your insurance cards, Medicare and/or Medicaid card with you to each health care appointment.

Directions for Sections IV-VI:

Financial Disclosure: ONLY NSC AND 0% NONCOMPENSABLE SC VETERANS MUST COMPLETE THIS SECTION TO DETERMINE ELIGIBILITY AND COPAY RESPONSIBILITY FOR VA HEALTH CARE ENROLLMENT AND/OR CARE OR SERVICES.

Financial Disclosure Requirements Do Not Apply To:

- a former Prisoner of War; or
- those in receipt of a Purple Heart; or
- a recently discharged Combat Veteran; or
- those discharged for a disability incurred or aggravated in the line of duty; or
- those receiving VA SC disability compensation; or
- those receiving VA pension; or
- those in receipt of Medicaid benefits; or
- those who served in Vietnam between January 9, 1962 and May 7, 1975; or
- those who served in SW Asia during the Gulf War between August 2, 1990 and November 11, 1998; or
- those who served at least 30 days at Camp Lejeune between August 1, 1953 and December 31, 1987.

You are not required to disclose your financial information; however, VA is not currently enrolling new applicants who decline to provide their financial information unless they have other qualifying eligibility factors. If a financial assessment is not used to determine your priority for enrollment you may choose not to disclose your information. However, if a financial assessment is used to determine your eligibility for cost-free medication, travel assistance or waiver of the travel deductible, and you do not disclose your financial information, you will not be eligible for these benefits.

Continued ...

Section IV - Dependent Information: Include the following:

- Your spouse even if you did not live together, as long as you contributed support last calendar year.
- Your biological children, adopted children, and stepchildren who are unmarried and under the age of 18, or at least 18 but under 23 and attending high school, college or vocational school (full or part-time), or became permanently unable to support themselves before age 18.
- Child support contributions. Contributions can include tuition or clothing payments or payments of medical bills.

Section V - Previous Calendar Year Gross Annual Income of Veteran, Spouse and Dependent Children.

Report:

- Gross annual income from employment, except for income from your farm, ranch, property or business. Include your wages, bonuses, tips, severance pay and other accrued benefits and your child's income information if it could have been used to pay your household expenses.
- Net income from your farm, ranch, property, or business.
- Other income amounts, including retirement and pension income, Social Security Retirement and Social Security Disability income, compensation benefits such as VA disability, unemployment, Workers and black lung, cash gifts, interest and dividends, including tax exempt earnings and distributions from Individual Retirement Accounts (IRAs) or annuities.

Do Not Report:

Donations from public or private relief, welfare or charitable organizations; Supplemental Security Income (SSI)and need-based payments from a government agency; profit from the occasional sale of property; income tax refunds, reinvested interest on Individual Retirement Accounts (IRAs); scholarships and grants for school attendance; disaster relief payments; reimbursement for casualty loss; loans; Radiation Compensation Exposure Act payments; Agent Orange settlement payments; Alaska Native Claims Settlement Acts Income, payments to foster parent; amounts in joint accounts in banks and similar institutions acquired by reason of death of the other joint owner; Japanese ancestry restitution under Public Law 100-383; cash surrender value of life insurance; lump-sum proceeds of life insurance policy on a Veteran; and payments received under the Medicare transitional assistance program.

Section VI - Previous Calendar Year Deductible Expenses.

Report non-reimbursed medical expenses paid by you or your spouse. Include expenses for medical and dental care, drugs, eyeglasses, Medicare, medical insurance premiums and other health care expenses paid by you for dependents and persons for whom you have a legal or moral obligation to support. Do not list expenses if you expect to receive reimbursement from insurance or other sources. Report last illness and burial expenses, e.g., prepaid burial, paid by the Veteran for spouse or dependent(s).

Section VII - Submitting your application.

1. Read Paperwork Reduction and Privacy Act Information, Section VIII Consent to Copays and Assignment of Benefits.
2. In Section VIII, you or an individual to whom you have delegated your Power of Attorney must sign and date the form. If you sign with an "X", 2 people you know must witness you as you sign. They must sign the form and print their names. If the form is not signed and dated appropriately, VA will return it for you to complete.
3. Attach any continuation sheets, a copy of supporting materials and your Power of Attorney documents to your application.

Where do I send my application?

Mail the original application and supporting materials to the Health Eligibility Center, 2957 Clairmont Road, Suite 200 Atlanta, GA 30329.

PAPERWORK REDUCTION ACT AND PRIVACY 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 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 30 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

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 your eligibility for medical benefits. Information you supply may be verified from initial submission forward through a computer-matching program. 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 systems of records notices and in accordance with the VHA Notice of Privacy Practices. Providing the requested information is voluntary, but if any or all of the requested information is not provided, it may delay or result in denial of your request for health care benefits. Failure to furnish the information will not have any effect 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 their records, and for other purposes authorized or required by law.

VISN 8
VA SUNSHINE
HEALTHCARE NETWORK

SUPPLEMENT TO VA FORM 10-10EZ

Instructions: Please complete this form in addition to the 10-10EZ application and return to your VA office.

Veterans Name (Last, First Middle): ______________________________

SSN: ____________________ **Father's Name:** ______________________________

Mother's Name: ____________________ **Mother's Maiden Name:** ____________________

Place of Birth (City & State): ______________________________

Divorced? YES / NO Date: ____________ **Widowed? YES / NO Date:** ____________

Employer: ____________________ **Address:** ______________________________

City: ____________ **State:** ____ **Phone: (   )____-______** **Occupation:** ____________

*****MULTIPLE BIRTH INDICATOR***** **( ) YES** **( ) NO**

If you live part time in another state, complete this section. If not, please go to the next section.

Street Address: ______________________________

City: ____________________ **State:** ____________ **Zip code:** ____________

County: ____________________ **Date of Arrival:** ____________________

Date of Departure: ______________________________

Please be sure to bring your insurance card(s) with you if applying in person. If mailing your application, include a copy of both sides of the current cards with your 10-10EZ form.

Have you ever received care at the VA? ( ) YES ( ) NO

If "yes", name the most recent VA hospital or clinic: ______________________________

Location (City & State): ______________________________

The most recent date of care: ______________________________

Spouse's Employer: ____________________ **Address:** ______________________________

City: ____________ **State:** ____ **Phone: (   )____-______** **Occupation:** ____________

The office of the Surgeon General requested that the VA collect the race and ethnicity information from all of our patients. Please check the space that applies to you.

Ethnicities (Check One)

_______ Spanish, Hispanic or Latino

_______ No, Not Spanish, Hispanic or Latino

Race (Check One)

_______ American Indian or Alaska Native

_______ Black or African American

_______ White

_______ Native Hawaiian or other Pacific Islander

COMBAT DATES

	From:	To:
OEF/OIF	_______	_______
Vietnam	_______	_______
Other	_______	_______

PURPLE HEART YES_____ NO_____

Privacy Act Information: VA is asking you to provide the information on this form under 38 U.S.C. Sections 1710, 1712 and 1722 in order for the VA to determine your eligibility for medical Benefits. The information is collected at the request of the Surgeon General and will help us track diseases that are more common in certain races and ethnicities. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure for civil or criminal law enforcement, congressional communications, and epidemiological research studies. The collection of money owed to the United States, litigation in which the United States is a party or has and interest, the administration of VA programs and delivery of VA benefits, verification of identity and status and personnel administration. Providing the requested information is voluntary, but if any or all of the requested information is not provided, it may delay or result in denial of your request for health care benefits. Failure to furnish the information will not have any effect 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 their records, and for other purposes authorized or required by law.

Supplemental Dependent Child Data

Child's Name (Last, First MI)	Child's Date of Birth	Child's SSN	Child's relationship to you	Date Child became your Dependent	Financial Data (see note 1)	Expenses (see note 2)	Disabled (see note 3)	School (see note 4)

Note:

1. If this child did not live with you last year, enter the amount you contributed to his/her support.
2. Expenses paid by your dependent child for college, vocational rehabilitation of training (tuition, books, materials, etc.)
3. Was child permanently and totally disabled before the age of 18?
4. If child is between 18-23, did child attend school during the last calendar year?

Signature of Veteran:_______________________________ Date:_________________