MJHS®
HOSPICE AND PALLIATIVE CARE

Cultural Assessment

Before you begin:

- Reflect on the patient's culture
- Prepare for a cultural assessment

Components of Cultural Assessment[1]

- Preferred Terms for Cultural Identity
  - *"What term would you like me to use when referring to your culture?"*
- Appropriate Degree of Formality
  - *The patient's correct title should be used unless he or she requests a more casual form of address.*
- Language and Literacy
  - *"What language do you feel most comfortable speaking?"*
  - *"Do you read and write in English? Or in another language?"*
- Respectful Nonverbal Communication
  - *Watch for body language cues.*
  - *When in doubt, adopt conservative body language.*
  - *Allow the patient's preference to establish the optimal distance.*
- Alert for Elephants in the Room
  - *Be alert for a lack of trust in the healthcare system or for a fear of medical interventions.*
- History of Traumatic Experiences
  - *Is the patient a refugee or survivor of violence or genocide?*

[1] Adapted from *Doorway Thoughts: Cross-Cultural Health Care for Older Adults.* (2004). Ethnogeriatrics Committee of the American Geriatrics Society. Sudbury, MA: Jones and Bartlett Publishers.

- History of Immigration or Migration
    - *Learning about this history provides insight into key life transitions and outlook.*
- Acculturation
    - *Approach with sensitivity: "Do you adhere to your culture's traditions?"*
- Importance of Traditions and Health Beliefs
    - *What does the patient believe causes illness?*
    - *What alternative methods of treatment does the patient use?*
- Use of American Health Services
    - *Be alert for signs of guardedness that signal an underlying lack of trust.*
- Approaches to Decision Making
    - *"Do you prefer to make your own health decisions or would you prefer to involve others in the decision-making process?"*
- Disclosure and Consent
    - *Investigate cultural beliefs regarding disclosure of health information.*
- Gender Issues
    - *Learn about the structures related to gender roles in a given culture.*
- End-of-Life Decision Making and Care Intensity
    - *Be aware of your own attitudes, so that you can respect the beliefs and preferences of a patient, especially when they differ from your own.*
- Use of Advance Directives
    - *Respect patients that avoid written directives and wish to have only verbal directives in place.*

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Cultural Diversity Resource Sheet

Cultural Dimensions that Improve the Clinician's Understanding of the Patient/Family

Chinese Culture

Immigrant Background:

- According to a report from the Asian American Federation, Asian non-Hispanics continue to be the fastest growing group in the city during the past decade. Asian population growth in Brooklyn (40%) was higher than any other borough, the Chinese community made up nearly half (47%) of all Asians in New York City.
- Religion, as commonly practiced among Chinese, blends religious beliefs and practices with philosophical systems. Primary religion is Buddhism.
- Primary philosophical influences on Chinese culture are Confucianism and Taoism

Family Dynamics Around Decision Making:

- Patients and caregivers may hesitate to ask questions or voice opinions out of fear of disrespect to the health care clinician
- Chinese patients tend to be polite, to smile and nod. However, nodding does not necessarily indicate agreement or understanding
- Elderly Chinese often avoid saying *no* in order to avoid offending others; they answer *yes* to all questions or they remain silent

Beliefs and Myths About Pain:

- Most Chinese patients do not understand using the numeric pain scale for pain measurement
- Chinese are stoical when in pain
- Chinese patients appear to have a high threshold and tolerance for pain
- Patients are afraid of becoming addicted to pain medicine
- Eastern/Traditional treatments and medicine practices may be used to manage pain
- There is uncertainty about pain relief
- Patients worry about becoming a burden to their families due to pain

Discussions About Advance Directives and Taboos About Death:

- Although death at an old age is considered a blessing in Buddhism, most critically ill Chinese patients are sent to the hospital, even if death is anticipated and no active resuscitation or life support is intended.
- The word "Death" is forbidden.

- Many Chinese may be reluctant to discuss issues surrounding death due to the belief that if you talk about something bad, it could occur (Karma).

Inclusion and Presence of Family During the Illness and Dying Process:

- Families of patients often expect that information be disclosed to the family rather than to the patient alone
- Interests of the family outweigh interests of the individual
- Decision-making structure is family-oriented: healthcare decisions made by family as a group, not by individual
- Usually the husband or the eldest son is the decision-maker and the women tend to be the caregivers
- Less emphasis is placed on individual rights, self expression and self-determination
- Qualities such as harmony, function, and responsibility are stressed more than individual rights

Other Concerns that May Arise:

- Loss of control
- Uncertainty about care plan and immigration law for non-US citizens

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Cultural Diversity Resource Sheet

Cultural Dimensions that Improve the Clinician's Understanding of the Patient/Family

Hispanic/Latino Culture

Immigrant Background:

- According to a 2007 article published by The National Institute of Health about 'the Pain Experience of Hispanic patients With Cancer in the U.S.," most Hispanic participants in this study were unable to adequately describe and manage their pain. Multiple reasons include language barriers, cultural values placing family at highest priority and financial difficulties.

Family Dynamics Around Decision Making:

- Traditionally gender roles governs how families make decisions.
- Husband or oldest male is usually the decision maker.
- The mother will identify when a family member requires medical care and functions as caregiver, but defers decision making to husband or oldest male.
- Puerto Ricans value friendly, polite encounters over therapeutic ones, as they build trust. The patient and family are more forthcoming with staff when viewed as trustworthy.
- Puerto Rican families prefer to have professionals speak to the entire family unit rather than just the patient.
- At times, families will request that information be omitted when the patient is elderly, in order to protect him/her.

Beliefs and Myths About Pain:

- Most Puerto Ricans are unable to explain pain through use of a numeric pain scale
- Puerto Ricans use words like pain, burning, irritation, discomfort and pressure interchangeably. It is therefore easier for them explain pain in terms of activities of daily living and self care.
- Puerto Ricans holds the values familism and paternalism as important. Patients will not report pain as they do not want the family to worry or be burdened.
- Among Puerto Ricans there is fear of addiction to pain medications, and fear of effects to pain medication such as altered mental status, hypersomnia…
- Puerto Rican who are devout Catholics may view enduring pain as a form of penance. Some believe that taking pain medication reflects a lack of faith.
- Individuals may prefer to engage in spiritual activity such as prayer to address pain.

- Patients may be more willing to go to a 'curandero' (traditional healer) instead of using Western medicine to address their symptoms.

Discussion About Advance Directives and Taboos About 'Death':

- Traditionally it is consider an honor to die at home of old age.
- Funeral planning is not a topic that is discussed. Family members would traditionally be given a funeral within 24 hours at home and on family land
- Advance Directives is a taboo topic to discuss. Devout Catholics believe that words have power and speaking words about death can bring death.
- Those who practice the traditional religions of their ancestors will often discuss death on a spiritual level with a "Curandero," but not with Western professionals.

Inclusion and Presence of Family During the Illness and Dying Process:

- There is emphasis on Family vs. Individual and therefore patient will not want to burden the family. Special attention is paid to protect children from matters that are too emotionally difficult for them to handle.
- Family unit is considered sacred. Elders are consulted for advice and young are shielded from knowing the diagnosis and prognosis of family members who are ill.
- It is common for the husband or eldest male to discuss important family matters with all family members, reserve the right as decision maker and function as the family representative or liaison to the medical professionals.
- Maintaining a sense of hope is a strongly held value. Suggesting that children come their home country to see their loved one can challenge the family's sense of hope. Giving voice to fear of death, as indicated in the previous section about taboos, is believed to bring about death.

Cultural Diversity Resource Sheet
Cultural Dimensions that Improve the Clinician's Understanding of the Patient/Family

Russian Speaking Immigrants

Immigrant Background:

- People who moved to America from the former Soviet Union include people from many countries. The common denominator is that they all speak the Russian language.
- Immigrants from the former Soviet Union do not all identify as Russian and 'may' be offended by identifying them as Russian. This attitude resulted from marginalization of their heritage by the Soviet government and having been forced to adopt the Russian language and culture. Therefore, the correct cultural term is 'Russian Speaking Immigrant.'
- Former Soviet Union and post-Soviet independent states: Russia, Armenia, Ukraine, Moldova, Georgia, Azerbaijan, Belarus, Usbekistan, Kyrgyzstan, Kazakhstan, Turkmenistan, Tajikistan, Lithuania, Latvia, Estonia.
- Ethnic-religious groups in these countries were: Soviet Jews, Soviet Armenians, Pentecostals, Evangelicals, Muslim, Russian Orthodox, Roman Catholic. Jews represent the largest minority and large immigration to the U.S. began in the 1970s when the US granted refugee status to religious and ethnic minorities being persecuted by the Soviet government.
- Because religious practice was outlawed in Russia for a number of years there is a large number of Russian-speaking immigrants that consider themselves Athiests.
- It is not uncommon for Russian-speaking immigrant families to have a wide range of religious affiliations and levels of observance (within the same family). This diversity can at times raise end of life and funeral planning challenges among family members and for clinicians.
- After dissolution of the Soviet Union in 1991, Russian-speaking immigrants were allowed to emigrate as non-refugees.
- Most Russian-speaking immigrants are highly educated and were professionals in their homeland. 1 in 6 was a scientist, engineer, or medical doctor.
- Large proportions of people emigrated with large extended families, bringing elderly members with them.

Communication Norms:

- Older Russian-speaking Americans have limited skill in spoken English – offer translation services if the clinician is not Russian speaking.
- Direct eye contact is recommended as it shows concern and interest.
- There is an expectation of direct in-person communication with the physician.
- Elders should be asked if they prefer to be addressed as 'Mr./Mrs.' or by their first name. Most will choose first name; Uncle or Aunt followed by first name is

reserved for relatives or close friends and should not be used in more formal situations.

- Tone of voice among older Russian-speaking Americans is often loud, even in pleasant conversations.
- Greetings include shaking hands. A kiss on the cheek is an informal way of greeting and is common among women and children, but not men, unless they are close relatives who share a warm relationship.
- Touch is an important part of non-verbal communication, especially among friends/family.
- Russian-speaking patients tend to come across as less friendly because smiling 'for no apparent reason' can be perceived as a sign of insincerity or 'fake.' Being direct and forceful is a culturally accepted norm.
- The American norm of maintaining personal space and distance from the person being spoken to, is not shared within the Russian-speaking immigrant community.
- Once a doctor or clinician has an established trusting relationship with the older Russian-speaking patient, the patient may prefer to be called by first name.

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Family Dynamics Around Decision Making, Advance Directives and Taboos About Death:

- Not accustomed to discussing issues related to terminal illness or death.
- Disclosure of diagnosis may be perceived as a death sentence and is taboo.
- Older Russian-speaking Americans and their families are not accustomed to making decisions about end-of-life or palliative care as planning can bring bad luck.
- Clinicians are advised to frame conversations about medical decision making with sensitivity and within the context of making decisions about 'quality of life' and 'relief of suffering' rather than end-of-life planning.
- DNR orders, living wills and health care proxies are rare among this population.
- There is strong belief among this population that the Western medical system is capable of curing disease so there is an expectation that aggressive measures will be taken even when facing advanced serious illness.
- Even with acculturated second and third generation Russian-speaking Americans, there is reluctance to discuss advance directives with parents due to cultural taboos. However, they tend to welcome education about advance directives, and many will execute a Health Care Proxy if a health care professional facilitates the discussion between patient and family.

Beliefs and Myths About Pain and Symptom Management:

- It is more culturally acceptable for Russian-speaking females to express pain openly than it is for males. (*Most elderly Russian women are WWII/Holocaust Survivors and tend to be resilient and stoic*).

- Some fear morphine as a pain medication for belief that it can lead to addiction as well as development of pneumonia.
- Health problems may be described in amplified terms in order to get attention and more aggressive medical intervention.
- Older Russian-speaking patients are accustomed to curative treatments that are holistic and may include reliance on herbal remedies, food, light exercise, relaxation therapies. Cupping may be used by some for treatment of bronchitis or pneumonia.
- Older Russian-speaking Americans are used to a paternalistic and authoritative medical system, and they will expect that the doctor will tell them what they need to know.
- Since nurses had little authority in Russia, the Russian patient will often request the doctor or specialist, believing that only a mature and seasoned physician can deliver adequate care.
- Russian-speaking immigrants will often seek physicians through word of mouth referrals from friends and family who have experience with the doctor, rather than other means of research.

Inclusion and Presence of Family During the Illness and Dying Process:[ii]

- Family members will protect the patient from hearing information that may cause them to believe they are dying.
- A family member will stay with the patient while in the hospital or make several visits throughout the day, to make sure they are not alone.
- Decision-making structure is family-oriented and decisions will be made by father, mother, eldest son or eldest daughter. Usually the most dominant personality will prevail.
- Emphasis is placed on seeking aggressive medical interventions.
- Funeral planning is not discussed as it is believed it can bring bad luck.

Rituals of Death and Dying:

- Ask the family about notifying a rabbi, priest or minister.
- Depending on religion, family members may want to wash the body and put special clothing on the deceased.
- It is important to determine if a specific religion was practiced by the deceased as that will inform the clinician of post-death practice. Since religious practice was illegal in Russia, once arriving in the U.S. many Russians took on their birth religion practices.[iii]

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[i] American Geriatrics Society, Jones and Bartlett Publishers, 2004; Doorway Thoughts, Cross Cultural Health Care for Older Adults, Vol. 2

[ii] Hosparus Inc., 2009; The Community Hospices of Louisville, Southern Indiana and Central Kentucky

[iii] Erickson D'Avanzo, Carolyn; Geissler, Elaine M.; Mosby, Inc. 1998; Cultural Health Assessment, third edition

I am your nurse. My name is...
Я Ваша медсестра/ Ваш медбрат. Меня зовут...

Да yes

Do you read?
Можете ли Вы читать?

Нет no

Can you hear/hearing aid?
Слышите ли Вы?/ Используете ли Вы слуховой аппарат?

Can you see/glasses/contacts?
Видите ли Вы?/ Носите ли Вы очки/ контактные линзы?

Do you wear dentures?
Пользуетесь ли Вы зубными протезами?

Do you have pain? Point to pain.
У Вас что-нибудь болит? Покажите, где.

This is your medicine for pain/fever/nausea/infection.
Это Ваше лекарство от боли/ высокой температуры/ тошноты/ инфекции.

Are you thirsty? Hungry? Cold? Nauseated?
Вы хотите пить? Вы голодны? Вам холодно? Вас тошнит?

Are you better now?
Вам сейчас лучше?

Is it hard to breathe?
Вам трудно дышать?

It is time to get suctioned.
Пора прочистить дыхательные пути.

Do you need to urinate?
Please save some of your urine in a cup, for a sample.
Надо ли Вам сходить по малой нужде?
Пожалуйста, наберите немного мочи в стаканчик для анализа.

Do you need to have a bowel movement (BM)/gas?
Надо ли Вам сходить по большой нужде (БН)? У Вас газы?

Would you like to bathe?
Хотите помыться?

Да yes

Нет no

Take deep breaths. Cough.
Дышите глубоко. Кашляните.

You need to get out of bed.
Вам нужно встать с кровати.

It is the time to change your position.
Время поменять положение.

I am going to take blood.
Я сейчас возьму у Вас кровь на анализ.

I need to start an IV.
Мне нужно поставить Вам капельницу.

Push this call light if you need help.
Если Вы нуждаетесь в помощи, нажмите на кнопку вызова.

I have to change this dressing.
Мне нужно сменить эту повязку.

You have to go to x-ray.
Вам нужно пойти на рентген.

Have you had food or fluid?
Вы что-нибудь уже ели или пили?

Да yes

It is the time to go for your surgery.
Вам пора идти на операцию.

Нет no

Are you feeling sad?
Вам грустно?

Did you sleep well last night?
Хорошо ли Вы спали прошлой ночью?

Do you feel safe here?
Чувствуете ли Вы себя здесь в безопасности?

Death and Dying: Religious Practices Wall Chart: A guide to general principles *Always check with family*

	As death approaches	When death is imminent	Immediately after death	Method of Disposal	Funeral Customs	Mourning Practices
Buddhism	Dying person needs peace and quite to allow for meditation. A monk or religious teacher should be invited to talk to the dying person and chant passages of scripture.	The ideal is to die in a fully conscious and calm state of mind. If a monk is not available, a fellow Buddhist may chant to encourage a peaceful state of mind.	No special requirements relating to the care of the body. Buddhists from different countries will have their own traditions regarding care of the body. If a monk or religious teacher is not present, inform the monks of the appropriate school.	Buddhists bury or cremate according to local traditions.	Usually within 3-7 days a service may take place in the house prior to going to the cemetery or crematorium. Monks may be invited to remind the mourners of the impermanence of life.	There is great variations according to country of origin, e.g. Sri Lanker Buddhist mourners may return to work in three or four days and place no religious restrictions on widows. Some Vietnamese have a series of rituals; mourning may last 100 days and mourning for a husband or father, three years.
Christianity	Some Christians may wish for prayers and anointing with oil by a minister or priest.	Where appropriate, a priest or minister might be notified. Many Christians will wish to receive Communion (which will include some form of repentance and forgiveness). Prayers of commendation may also be said	No special requirements	Either burial or cremation. Increasingly only close family are present at the burial of the body or the ashes	It is customary in some areas to hold a prayer service in the house of the dead person before the funeral. For Orthodox, Roman Catholics and some Anglicans the funeral involves a church service with a Mass or Communion. Sometimes the body is placed in the church the night before and in Orthodox funerals the casket remains open throughout the service. Protestants services are simpler and the body is usually not visible.	There is usually no official mourning period or mourning dress. There may be a service of memorial and thanksgiving some months after the funeral.
Islam	Other Muslims, usually family members, join the dying person in prayer and recite verses from the Qur'an. Dying person may wish to have face towards Mecca (south east)	The Declaration of Faith (Shahada) is said and, if possible the dying person responds 'I bear witness that there is no God but God and Muhammad is His Messenger'	Non-Muslim health workers should ask permission to touch the body, then use disposable gloves. The body must be kept covered. Soon after death, there is a ritual washing of the body by same-sex Muslims. Post-mortems are disliked.	Always burial	Ideally burial is within 24 hours of death. Women are not included at the burial. Male family members carry the coffin either to the mosque or directly to the cemetery where the funeral prayer is said. The body is buried in a deep grave facing Mecca. In bigger cities there are special areas for Muslim burials and in some they are allowed to bury the shrouded body without a coffin. In some instances the body is embalmed and taken back to the country of origin for burial	Islamic law requires friends and relatives to feed mourners for three days. After this the family should officially return to normal though unofficial mourning may continue until the 40th day. It is ended by Quranic readings and a meal.

	As death approaches	When death is imminent	Immediately after death	Method of Disposal	Funeral Customs	Mourning Practices
Judaism	A rabbi may be called to join the dying Jew in prayer and facilitate the recitation of the Confession on a Death Bed.	The dying person should not be left alone. Jews present should recite psalms and when death occurs, the Declaration of Faith (Shema)	Health workers should handle the body as little as possible and cover with a white sheet. The Jewish Burial Society will collect the body and perform a ritual wash before burial. Post-mortems are disliked.	Burial as soon as possible in simple coffins. Some non-orthodox Jewish communities permit cremation. Funerals do not take place on the Sabbath or holy days.	The service takes place in designated Jewish burial grounds. Prayers are said in a chapel and at the graveside. Although women now attend funerals, the male mourners recite the prayers and place the coffin in the grave.	After burial there are three periods of mourning throughout which designated mourners recite prayers thrice daily and refrain from certain activities. The first week (shiva) mourners remain at home; the 30 days (shloshim) concludes mourning for all but the children of the deceased who mourn for a year. When mourning is concluded the tombstone is consecrated with a ceremony at the cemetery.
Hinduism	Hindus may receive comfort from hymns and readings from the Hindu holy books. Some may wish to lie on the floor. The family should be present.	The family may wish to call a Hindu priest to perform holy rites. A dying Hindu should be given Ganges water and the sacred Tulsi leaf in the mouth by the relatives. A person should die with the name of God being recited. Hindus often wish to die at home.	The family will usually want to wash the body themselves. If no family is available health workers should wear disposable gloves, close the eyes and straighten the limbs. Jewellery and religious objects should not be removed.	Cremation as soon as possible with the exception of children under three who are buried.	Part of the service takes place at home. The pandit (priest) chants from scripture and the chief mourner (usually the eldest son) performs the rituals. Mourners walk around the coffin which is then closed and taken to the crematorium for further prayers.	Mourners and friends return to the deceased's house. In India the period of mourning and austerity (10-16 days) culminates in rituals enabling the dead person's soul to join the ancestors. In Britain these very important rituals occur soon after the funeral and involve gifts to priests or to charity. There may be further rituals at one, three, and 12 months.
Sikhism	A dying Sikh may receive comfort from reciting hymns from the Sikh holy book. A relative or any practising Sikh may do so instead.	A Sikh person should die with the name of God, Waheguru (Wonderful Lord) being recited. Some Sikhs may want to have Amrit, holy water, in the mouth.	Health workers should not trim hair or beard. The body should be covered by plain white cloth. The 5Ks should remain on the body. Family members may wish to bathe the body themselves.	Cremation as soon as possible.	Similar to Hindus but dressing the person in the 5Ks. After a short ceremony in the home the body is taken to the gurdwara (temple) for a service and then to the crematorium for further prayer.	Up to 10 days of readings from the scriptures attended by relatives and friends. At the conclusion the eldest son is given a turban as a sign that he is now head of the family.

Religion Data Sheet
CATHOLIC

A. Key Catholic Beliefs relating to Health or Illness

1. The central focus is to attain eternal life, after death, with God and loved ones in heaven.
2. Fundamental Catholic convictions regarding medical procedures for the sick:
   a) *Every person has dignity.* Each is unique, and called to human fulfillment and to eternal life. All persons are equal, and all human life, because it originates from God, is sacred.
   b) Health is to be understood holistically: it encompasses physiological, psychological, social and spiritual dimensions of the person.
   c) *Suffering can possess meaning.* Although suffering and pain are not to be considered goods in their own right, they can have meaning. They can be opportunities for spiritual growth. (See note regarding purgatory).
   d) *The Church recognizes the legitimacy of trying to eliminate or reduce pain and suffering.* The patient is not required to endure pain and suffering at any price. But painkillers should not be used to plunge the patient into unconsciousness, unless that is absolutely necessary.
   e) *Death is natural and is a transitional stage to eternal life with God.* Therefore, death should be accepted with responsibility and dignity.
   f) The Catholic Church believes that death has occurred when: the spontaneous cardiac and respiratory functions have definitely ceased; or an irreversible cessation of every brain function is verified.
   g) *Euthanasia* is not permitted.

B. Glossary of Terms relating to dying Catholic patients

1. *Praying.* Patient and family often pray the *Rosary* (beads used for repetitive prayers commemorating key events in the life of Jesus), or *litanies* (prayers to many saints asking them to intercede with God), laying on of hands with prayer (often done by evangelical Catholics)
2. *Confession* (also called Reconciliation): A priest hears the patient's confession of sins and offers God's forgiveness.
3. *Anointing* of the sick person. This is done by a priest; it is one of the seven sacraments of the Church. The anointing is done with blest oil and prayers. Anointing is offered to any Catholic who is experiencing illness or debilitation, in order to provide spiritual strength, and perhaps even some physical improvement. Family members and friends often like to gather around for the anointing. (Note: The final anointing of a dying person is sometimes called "extreme unction".)
4. *Communion* (also called Eucharist). A wafer or "host" of bread consecrated by a priest at mass is here offered to the patient as spiritual food. Catholics believe that a mass in a continuation of the Last Supper where Jesus changed bread and wine into his body and

blood, asking his followers to do the same in memory of him. Communion may be brought to the patient by a priest, nun, brother or other designated lay persons, (Note: communion given to a dying person is sometimes called "holy viaticum" – a lovely term meaning food for the journey out of this world into the next).

5. *Ordinary vs. extraordinary treatment of pain and suffering.*
   Catholics should use all available *ordinary* treatment in dealing with the dying person. But they are not obliged to use *extraordinary* means: that is, treatment that is more burdensome than beneficial to the patient, or that will not prolong a terminal life appreciably, and often is meaninglessly expensive. And there is no obligation to use a ventilator. Finally, family and friends should not feel guilty when extraordinary means are not used.

C. Aftercare Practices

1. The body is treated with respect.
2. There is usually a wake service, followed the next day by a funeral mass at the patient's parish church.
3. The body is usually buried. However, cremation is now permissible, with burial in sacred ground or in a mausoleum.
4. A Catholic who commits suicide is nowadays considered by the church to not have been in his/her right mind, and Catholic burial is permitted.

Note: Understanding Purgatory

It helps to know something about the Catholic teaching on *purgatory*. As human beings, we are all sinners. Sin warps us. So, even though forgiven by God, this character-warping remains and is only healed by gradual steps - to change attitudes and habits. A person dying with this residue is not immediately pure enough to be in God's presence. The purification process, according to Catholics, is called "purgatory", a state of purgation. [There is no definitive Catholic answer as to what this purification entails or how long it takes].

Pain and suffering while alive may well be part, or all, of this process of purification. Catholics will often say that a suffering person is doing his/her purgatory on earth.

Catholics also have a lovely doctrine called "the communion of saints', meaning the intercommunion between the saints in heaven, the "saints" in purgatory (saved, not yet fully purified) and the "saints" or good people here on earth still struggling through this life. This interconnectedness means that those in heaven can intercede for us and for those in purgatory, while we can pray for the quicker purification of our loved ones in purgatory - if they are there. Thus, masses and prayers are often offered for "the souls in purgatory." And Catholics (especially older ones) sometimes say they are "offering up" their troubles and/or sufferings for the" poor souls" in purgatory.

Potential Triggers for Holocaust Survivors			
Event or Trigger	**Potential Reaction**	**Reason**	**Response Tips**
Taking a shower	Refusal Unusual fear Crying, Screaming Withdrawal	In the concentration camps, The Nazis herded Jews into the gas chambers, telling them they were going to shower. They were stripped and pushed into rooms that looked like shower rooms. They were crammed in for maximum efficiency, the doors were locked and poisonous gas came out of the showerheads.	Be as reassuring as possible, and remind person that you are helping them to feel clean. Offer options of bath or bed bath where appropriate. Be very respectful of privacy and nudity. Be prepared to offer flexible schedule Check to see if family member's presence would help. Do not force the issue. Always identify yourself and explain the reason for your actions.
Taking a Bath	Refusal Unusual fear Crying Screaming Withdrawal	Nazi 'doctors and researchers' conducted horrific experiments with Jews immersed in tubs of water. They included electroshock, freezing and scalding. Many inmates were dipped into tubs of harsh chemicals for cleansing and delousing purposes.	Offer options of shower or bed bath where appropriate. Be very respectful of privacy and nudity Be prepared to offer flexible schedule Check to see if family member's presence would help Do not force the issue. Always identify yourself and explain the reason for your actions.
Fear of Public or Strange Toilets **Smell of Urine or Feces**	Refusal to use washrooms Incontinence or withholding Adverse reaction to strong smells	The Jews were transported to concentration camps on cattle cars, with no sanitary conditions, often for days at a time. Many died in transit. Strong smells were everywhere. In the camps there were no washrooms, just makeshift facilities and no privacy. Sanitary conditions in the camps were almost non-existent.	Emphasize immediate cleanup post toileting Maintain deodorized environment Make washroom as homelike as possible ie. pictures, coloured towels, familiar scents etc. Be respectful of nudity and inability to self-toilet Ensure there are no smells in the corridors and public bathrooms.

		The smell of waste may easily trigger the memory of those train rides.	
Lack of Privacy	Withdrawal Secrecy	Whether in a ghetto, concentration camp or in hiding, there was no privacy for the Jews, and at any given moment, the world as they knew it could be turned inside out. Being forced to be with others could be very frightening.	Allow for as much privacy as possible In shared rooms ensure a designated private space Accommodate unusual hoarding (ie. change of clothes under pillow)
Small spaces, crowded conditions, lack of personal space	Anxiety Withdrawal	During the war, Jews were either forced into ghettos or concentration camps or survived in hiding. All of these meant cramped, over-crowded and desperate living conditions. In the ghettos, six families were commonly assigned to one small apartment. In the camps, six individuals could be sleeping on the same wooden tiered shelf.	In shared rooms ensure a designated personal private space and make the resident aware that you understand and respect their need for privacy. Respect individual right not to join a group program and allow for individual time with staff and/or solitary time where desired. Establishing trust may encourage individuals to join groups. Where possible and preferable allow for individual room.
Medical History – taking or Personal Questions	Refusal to cooperate Upset or depression	Routine medical histories can be family mysteries for Survivors. They may not know family medical histories and sadly most relatives died prematurely and violently. Simple questions can raise complex memories.	Be empathic and respectful when listening to someone's story when they offer it to you. Revise standard medical history taking to accommodate lack of information. Have notations on forms to accommodate these changes. Be prepared to listen to Holocaust history when asking historical questions or any reference to family loss.
Requests to do Medical Procedures	Refusal Distrust Fear	Many Survivors underwent atrocious experimentation by 'doctors' and 'technicians' in the name of treatment or research. Many 'patients' died in the process, and the Survivors	Explain all treatment options cautiously according to cognitive abilities. Spend time with an individual to ensure understanding. Try to have family or trusted friend support on hand. Where

		were often left with life-long damage.	cognitively competent, respect individual right to refuse treatment.
Shaving, Hair Cuts and Personal Grooming	Refusal or anxiety re hair cuts or shaving Extreme anxiety re baldness	For camp inmates and in the ghettos, personal grooming and privacy were next to impossible. Upon arrival at the concentration camps, all men and women had their heads shaved, so that often individuals were unrecognizable. This was a further form of humiliation.	Spend time preparing individual and reminding of personal and aesthetic benefits Allow options regarding hair care, i.e. Preference of time, date, style etc. Where appropriate, wigs may be a therapeutic response to baldness.
Receiving injections	Refusal Fear Anger	Many Survivors were tattooed with numbers for identification. These were done without anesthetic with series of needles. Once tattooed, only numbers identified them. An injection could symbolize a further loss of personal identity.	Explain all treatment options thoroughly. Provide a rationale for the need and distinguish the present from the past. Normalize the procedure as part of the treatment plan. Try to have family or trusted friend support on hand.
Wristband Identifi-cation	Removal Refusal to wear	Wristbands could be reminders of being depersonalized during the War, known only by number or location.	Try to avoid or use only when essential (i.e. wanderer's bracelet). Where necessary use design that is as non-institutional and as attractive as possible.
Lining Up for Treatment or Service	Refusal of treatment Anxiety in line	In the camps, Jews lined up for food rations, 'toilets', roll call, deportations and even murder. Sometimes they were awakened in the middle of the night and made to stand at attention for hours—until guards felt like releasing them. Military order and lineups were the norm.	Avoid requiring individuals having to lineup for programs, services or treatment. Always try to individualize services or treatments.
Harsh, Strong or Unpleasant Smells	Strong physical or emotional reactions	Sanitation in the camp barracks and in the ghettos consisted of the dumping of harsh antiseptics. People were often placed in lye prior to medical experimentation, and these smells may	Where antiseptic smells are unavoidable, prepare patients ahead of time and explain why it is necessary, (i.e. cleaning, maintenance etc.) Continue reminding as necessary.

		have horrible associations.	
Illness and feeling unwell	Denial Attempts to disguise symptoms	In the concentration camps, the ill and the elderly were immediately sent to the gas chambers. If a person became ill, the safest route would be to keep it secret and remain out of sight.	Use a positive and proactive approach to wellness so that change in health status will be recognized promptly. Be aware of changes in health status and any possible attempts to disguise it. Do not over react to illness, providing as much explanation as possible. Don't over react to illness. Try to understand the symptoms and if they have any link t the past. Where possible discuss positive treatment management.
Secure areas, locks on doors, physical restraints, Limited access	Frantic trying to 'escape' Assuming they are trapped Panic	Survivors were forced into walled ghettos, barbed wire enclosed concentration camps, barred prisons etc. All personal freedom was removed and any chance of escape was very slim. No escape meant eventual death. Jews in hiding rarely showed their faces in public for fear of exposure. Today, any sense of limited movement of restraint can be very difficult.	Where possible avoid locked doors and accommodate wanderers with alternative options. (such as wandering alert bracelets etc) Where unavoidable, have internal wandering options available giving patients a sense of choice and control of environment. Avoid use of restraints.
Flashlights Examining lights or bright lights	Fear Anxiety Refusal to cooperate	Camps and ghettos were lit at night by bright searchlights to ensure everyone remained in place. Guards used flashlights to find people in hiding and round them up for deportation.	Where possible avoid flashlights on rounds and bright examining lights. Nightlights in patient rooms and corridors are preferable. Strong overhead lighting in exam rooms should be avoided and where necessary should be explained.
Family members or visitors saying goodbye, Staff	Inability to let go Depressive reaction	Throughout the War, Jews saw their children, parents, other relatives and friends being taken away or murdered in front of them. Most never saw each	When families leave a unit, staff should be present to provide reassurance, discuss visit and plan next one. Be cautious of promising

changes	Withdrawal	other again. After the War, Survivors went through series of discoveries as they realized the enormity of the losses. Separation is difficult and can be terrifying.	ongoing relationships when they are not truly feasible. Staffing consistency is important Staff changes should be announced ahead of time with adequate time for farewells.
Foreign languages or heavy accents	Distrust and fear	Rarely did the guards, soldiers and authorities of the roundups, camps and ghettos speak Yiddish, the first language of most Survivors. A foreign language or a strange accent usually meant trouble.	When a patient responds to a foreign accent, first connect on a personal basis. Once this is established spend time explaining where you come from and why you moved. A quality care can overcome these fears.
Loud voices and sounds	Distrust and fear	The guards and soldiers in the ghettos and camps were never quiet and gentle. Jews were yelled at, shoved and forced in all communications. Loudspeakers blared out demands for roll calls and lists of names for execution.	Maintain a quiet and confident tone of voice. Encourage colleagues not shout back and forth in the halls. Loudspeakers should be used only for emergencies.
Sounds of others crying or screaming	Fear or similar reaction	Survivors lived through many different and painful horrors. The sounds of grief and tears are ready reminders. The combination of loud noises, the anguish of others and the inability to respond may be very upsetting.	Spend time with people in pain and try to understand the parameters of their pain. If this is ineffective, try to give people in pain, crying and screaming their privacy. Where appropriate be reassuring to others that the individual is being cared for.
Dogs and other Animals	Unusual fear Revulsion	Dogs were used as guard dogs and attack dogs in rounding up Jews, imprisoning and intimidating them. Dogs were often used to discover hidden Jews. Nazi pets were generally given more and better food than inmates.	Be cautious about pet visitations for Survivors on units. Avoid large or noisy animals, but be aware that many people may also benefit from spending time with an animal. Check first.
Group organizing, directing	Refusal Moving	Upon arrival at the Concentration Camps, Jews would be "selected".	Avoid patient/resident lineups for program, services or treatment. They are

people to line up, or to the left or right	quickly away Fear	for life or death, and sent to the left or the right....either directly to the gas chambers or to the slave barracks. These 'selections' were often the last time that family members saw each other.	undignified at any time. Allow individuals to move according to their own pace.
Routines and schedules	Non-compliance Direct sabotage	The Nazi war-machine was an efficient and orderly attempt to annihilate all Jews. They were known for their efficiency and keeping on schedule.	Routines and schedules are unavoidable in institutions. Explain their presence to support resident quality of life and explain carefully to clients. Be prepared to be flexible and accommodate individual need.
Meal Time And Food Presen-tation	Refusal to eat Overeating Hoarding of Food Chronic unhappiness with food	Withholding of food, designated minimal portions, rough handling, and almost inedible foods were dished out to long lines in the camps. Many Jews starved to death. Thus, poor service, (perceived or real) small portions or new foods could be difficult.	Meals should arrive as consistently as possible and be as personalized as possible. Where meals are delayed, explanations should be prompt with clear time frames of when food will be available. Accommodate those residents who feel the need to wrap food up at meals to take back to their rooms.
Not enough food **Hunger pangs**	Food hoarding or hiding Eating too fast	Hunger was an ever-present feeling during the War years. Many people starved to death. Often trading, stealing or hoarding food could be punishable by death, so secrecy around food was common. Not feeling hungry and always having left-over food is often comforting to Survivors.	Establish an environment that there is always food available and it is 'safe' for individuals to request it. There should be clear communication and signs reinforcing this. Where there is hoarding, this should be accommodated in a manner that is safe for everyone rather than prohibited. (i.e. a fresh roll always on hand in a patient's room to provide reassurance)
Jewish Holidays	Anticipatory fear Not involved in festivities	During the War, the Nazis often raided Jewish communities, killing and rounding up Jews on Jewish holidays; knowing their targets would be	Staff should be aware of the Jewish calendar and upcoming holidays. They should not assume the impact of a particular holiday on a particular individual.

		either at home or in the synagogue. Many Jews were murdered while observing a Jewish holiday.	Find out how the individual observes a particular holiday and try and accommodate. Understanding and support should be given to individuals as required.
Christian symbols	Adverse reaction to jewelry, holiday decorations or seasonal music	Christian symbols such as the cross or Christmas decorations were part of the culture of the enemy. These symbols reflected that the camps were not representative or supportive of Jewish people. As such, these symbols today have the potential to trigger a difficult memory.	Staff needs to be aware of the sensitivity some people may have to Christian symbols and reactions may vary. Since reactions vary so much, it is impossible to generalize what may be problematic. Where there is an issue, remove the particular symbol until a personal trust is established.
Ambulance or Fire Sirens, alarms, bells, whistles	Extreme anxiety in an ambulance Adverse reactions	Sirens, whistles and bells were often the signals for people to be rounded up and deported. They were also used to define the times in the camps and preceded public announcements to prisoners.	These are unavoidable sounds. When they occur, staff should be available to reassure patients, explaining what is occurring and why the particular noise is happening.
Night-time or dark rooms	Extreme fear	The most dangerous time was at night; when in the darkness all type of atrocities could happen.	Staff needs to identify which residents are at risk at night. Patients who feel the need should have nightlights or some other illumination available at night.
Nightmares	Extreme disorientation	In the camps, sleep may not have offered much needed rest, as nightmares about the daytime would intrude. Nightmares about the past may be especially vivid for Survivors.	Be sensitive to Survivors who suffer nightmares. A nightlight may be helpful. Allowing flexibility with sleep schedules may accommodate fears of nightmares. Give comfort, empathy and a warm drink until the resident is settled.
Reminis-cence	Refusal to discuss relatives or family history	While many Survivors have the need to tell and re-tell their story, others cannot bear to recount their tragic past. Even simple questions regarding family or country of origin may be too difficult to	Learn about individual sensitivities regarding telling their 'story'. We can never know what we may provoke. Be prepared to listen where that is important and not to pry where the person is uncomfortable. We do not

		discuss.	have to know all the details in order to provide sensitive care. Always exert caution and discuss the past only where there is a safe connection established.
Certain recorded or live music	Anxiety Refusal to listen	Concentration camps often had loudspeakers, and camp personnel might play their favourite music. Such music would be reminders of those days. Also, some Yiddish music might bring back reminders of the people who once sang or played these songs and who are now gone.	Identify which music triggers negative reactions and avoid. . Be aware both of volume and choice of music. There is enough choice in both secular and Yiddish selections to support selections that bring pleasure.
Discussion of Financial Matters	Over reaction to discussion of costs Not revealing of financial status	Survivors were robbed of all their assets during the War and had to start over. Many are very cautious about revealing their financial status today and concerned that they always have secured "enough" money, in case someone attempts to rob them again. Also, some people managed to escape Europe before the War if they had enough money or valuables to buy their way out.	Be particularly sensitive when making financial enquiries. It may be necessary to involve children or other family to supplement costs if an individual refuses to pay full fee even if he can afford it. Be prepared to fully explain rationale for costs.
Relocation	Anxiety, fear of abandonment	Some of these feelings would be normal for all people facing relocation to a hospital or nursing home, but Survivors may have extreme reactions as they recall forced relocation, deportation to camps and never seeing loved ones again.	Ensure that as much preparation as possible takes place prior to moving in. ie. visits, meeting staff, personal effects in room etc. Family members should have free and ready access to the institution and be a valued part of the care team.

Advanced Planning, Making end of life directives	Refusal to discuss	Many Survivors have been so intent on their survival, that discussing end-of- life directives, funeral preferences, burial sites etc. may be too painful for them.	Be particularly sensitive when discussing end of life directives and burial plans. It may be necessary to involve children or other family to participate in the discursion or to make decisions if the individual will not discuss. Be prepared to fully explain rationale for costs.
Specific Clothing Items	Fear or similar reaction	A religious icon, a Star of David around an employees neck, high heels that resound on a hard floor or even a certain colour may remind a Survivor of a wartime incident	Where possible, remove the piece of clothing or the item until a trusting relationship can be established and the patient is focused on the individual rather than the item.
Consulting or Meeting Medical Personnel	Fear, anxiety or refusal to cooperate	Medical experimentations, selections by physicians and the indifference of health care providers during the War may explain a Survivor's generalized mistrust of all medical personnel and procedures	New personnel should introduce themselves and take a few minutes to personalize the visit. All examination and treatment procedures should be explained fully in advance, and ceased if the patient becomes too anxious or upset.
Dentist and Oral Pain	Fear, anxiety Refusing to acknowledge pain or accept treatment	In the camps, gold fillings were forcibly removed and teeth were extracted. Subsequently starvation and lack of proper hygiene caused many dental problems. The use of dental "gas" or even the mention of this term by dentists may bring back memories of death by gas. The bright light aimed at the dental chair may also cause adverse reactions.	Explain all routines and procedures at least 2X using different language to ensure understanding. Proper oral hygiene should be maintained to ensure as little intrusive care as possible. Use high-speed suction and selected room deodorizers to eliminate odour.

Military History Checklist

"Identify, Honor, Serve"

Veterans may have experiences from their military service that present unique needs at the end of life. Because the unique needs of Veterans may require specific interventions, the first step to addressing these issues is to identify them as Veterans. The ***Military History Checklist*** is available to identify who is a Veteran, evaluate the impact of the experience and determine if there are benefits to which the Veteran and surviving dependents may be entitled.

What is the Military History Checklist?

- A short and simple one page form that can be used by hospice and palliative care staff and easily implemented within your organization.
- A tool which enables hospice staff to identify additional information about patients who are Veterans including branch of service, time of service, combat experience and possible VA benefits.

Why take the time to ask about military service?

- Identifying your patients as Veterans is the first step to honoring them for their service.
- Veterans may have issues related to their military service which their plan of care should address.
- Veterans may be entitled to benefits through VA.
- Hospice Volunteers who are Veterans may be able to provide valuable support to Veterans and their families.

Best Practices

- Use this tool as a ***conversation guide*** rather than a mandated checklist.
- Ask patients if they have served in the military rather than asking them if they are Veterans.
- Thank patients who have been identified as Veterans for their service with an honoring ceremony.

Successes

- "*Implementation of the military checklist, has given us a great understanding of how to care for the unique needs of our Veterans and their families.*" - Hospice Professional
- "*He was deeply touched when the staff commented on his military history. The recognition and appreciation of his service meant a great deal to him.*" - Family Member
- "*We obtained benefits for a patient who did not know he was eligible for VA benefits.*" - Hospice Professional

Military History Checklist Resources

- Military History Checklist form
  - One page questionnaire to be added to admission packets or EMRs
- Military History Checklist Guide
  - Summary of Military History Checklist questions and their implications
- Military History Checklist Pocket Card for Clinicians
  - Pocket-sized resource to help health care providers initiate conversations with Veterans
- *We Honor Veterans* PowerPoint Presentations
  - *Service-related Diseases, Illnesses and Conditions*
  - *Veteran Benefits*
  - *Homeless Veterans*

For more information, visit www.WeHonorVeterans.org or contact Veterans@nhpco.org.

MILITARY HISTORY CHECKLIST

PATIENT DATA	Completed By:	
Patient's Name:	Date:	
Address:	Hospice Medical Record #:	Last 4 SSN:

VETERAN STATUS INFORMATION

1. Did you (or your spouse or family member) serve in the military?

1a. Patient ☐Yes ☐No	Did you serve on active duty?	☐Yes ☐No
	Did your service include combat, dangerous or traumatic assignments?	☐Yes ☐No
	Do you have a copy of your DD214 discharge papers?	☐Yes ☐No

1b. Did your spouse serve on active duty? ☐Yes ☐No
Comments:

1c. Do you have any immediate family members that served or are serving in the military? ☐Yes ☐No
Comments:

MILITARY BACKGROUND

2. In which branch of the military did you serve?

☐Army	☐Marines	☐Merchant Marines during WWII
☐Navy	☐Coast Guard	☐Other _____
☐Air Force	☐Reservist or National Guard member	

3. In which war era or period of service did you serve?

☐WWI (4/6/17 to 11/11/18)	☐Vietnam (8/5/64 to 5/7/75 and 2/28/61 for Veterans who served "in country" (in Vietnam) before 8/5/64)	☐Peace Time
☐WWII (12/7/41 to 12/31/46)		☐Afghanistan/Iraq (OEF/OIF)
☐Korea (6/27/50 to 1/31/55)	☐Gulf War (8/2/90 through a date to be set by law or presidential proclamation)	☐Other
☐Cold War		Note: after 9/7/80, must have completed 24 months continuous active service, or the full period for which they were called or ordered to active duty.

4. Overall, how do you view your experience in the military?

5. If available would you like your hospice staff/volunteer to have military experience? ☐Yes ☐No

VA BENEFITS INFORMATION

6. Are you enrolled in VA? ☐Yes ☐No

6a. Do you receive any VA benefits? ☐Yes ☐No

6b. Do you have a service-connected condition? ☐Yes ☐No

6c. Do you get your medications from VA? ☐Yes ☐No

6d. What is the name of your VA hospital or clinic?

6e. What is the name and contact information of your VA physician or Primary Care Provider?

6f. Would you like to talk with someone about benefits you or your family might be eligible to receive? ☐Yes ☐No

Department of Veterans Affairs

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. 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.
2. 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.

OMB Approved No. 2900-0091
Estimated Burden Avg. 30 min.

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)

1A. VETERAN'S NAME *(Last, First, Middle Name)*	1B. PREFERRED NAME	2. MOTHER'S MAIDEN NAME

3A. BIRTH SEX	3B. SELF-IDENTIFIED GENDER IDENTITY	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.)*	6. SOCIAL SECURITY NO.
☐ MALE ☐ FEMALE	☐ MALE ☐ FEMALE	☐ YES ☐ NO	☐ ASIAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ WHITE ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	

7. VA CLAIM NUMBER	8A. DATE OF BIRTH *(mm/dd/yyyy)*	8B. PLACE OF BIRTH *(City and State)*	9. RELIGION

10A. PERMANENT ADDRESS *(Street)*	10B. CITY	10C. STATE	10D. ZIP CODE	10E.COUNTY

10F. HOME TELEPHONE NO. *(Include area code)*	10G. MOBILE TELEPHONE NO. *(Include area code)*	10H. E-MAIL ADDRESS

11A. RESIDENTIAL ADDRESS *(Street)*	11B. CITY	11C. STATE	11D. ZIP CODE	11E.COUNTY

12. TYPE OF BENEFIT(S) APPLYING FOR *(You may check more than one)*	13. CURRENT MARTIAL STATUS
☐ ENROLLMENT/HEALTH SERVICES ☐ DENTAL	☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED

14A. NEXT OF KIN NAME	14B. NEXT OF KIN ADDRESS	14C. NEXT OF KIN RELATIONSHIP

14D. NEXT OF KIN TELEPHONE NO. *(Include Area Code)*	14E. NEXT OF KIN WORK TELEPHONE NO. *(Include Area Code)*	15. DESIGNEE - INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH *(Note: This does not constitute a will or transfer of title)*

16. I AM ENROLLING TO OBTAIN MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT	17. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? *(for listing of facilities visit www.va.gov/directory)*	18. WOULD YOU LIKE FOR VA TO CONTACT YOU TO SCHEDULE YOUR FIRST APPOINTMENT?
☐ YES ☐ NO		☐ YES ☐ NO

SECTION II - MILITARY SERVICE INFORMATION

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

1E. DISCHARGE TYPE	1F. MILITARY SERVICE NUMBER

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

APPLICATION FOR HEALTH BENEFITS
Continued

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

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? ☐ YES ☐ NO	6A. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A? ☐ YES ☐ NO 6B. EFFECTIVE DATE *(mm/dd/yyyy)*

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

1. SPOUSE'S NAME *(Last, First, Middle Name)*		2. CHILD'S NAME *(Last, First, Middle Name)*	
1A. SPOUSE'S SOCIAL SECURITY NUMBER		2A. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)*	2B. CHILD'S SOCIAL SECURITY NO.
1B. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)*	1C. SPOUSE SELF-IDENTIFIED GENDER IDENTITY ☐ MALE ☐ FEMALE	2C. DATE CHILD BECAME YOUR DEPENDENT *(mm/dd/yyyy)*	
1D. DATE OF MARRIAGE *(mm/dd/yyyy)*		2D. CHILD'S RELATIONSHIP TO YOU *(Check one)* ☐ SON ☐ DAUGHTER ☐ STEPSON ☐ STEPDAUGHTER	
1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP if different from Veteran's)*		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	
3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT? ☐ YES ☐ NO		2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(e.g., tuition, books, materials)*	

SECTION V - EMPLOYMENT INFORMATION

1A. VETERAN'S EMPLOYMENT STATUS *(Check one)*. ☐ FULL TIME ☐ PART TIME ☐ NOT EMPLOYED ☐ RETIRED	1B. DATE OF RETIREMENT	
1C. COMPANY NAME. *(Complete if employed or retired)*	1D. COMPANY ADDRESS *(Complete if employed or retired -Street, City, State, ZIP)*	1E. COMPANY PHONE NUMBER *(Complete if employed or retired) (Include area code)*

SECTION VI - 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 VII - 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.*	$

APPLICATION FOR HEALTH BENEFITS *Continued*	VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

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 *(Sign in ink)* _____ **DATE** _____

Military Health History

POCKET CARD FOR HEALTH PROFESSIONS TRAINEES & CLINICIANS

"Help me understand my medical condition."

"I had some unique experiences while serving our country, many that civilians would never have. Some of those experiences may be affecting my health, and that is why I am here at VA."

"Help me understand my medical condition, and please be patient with me. Some of my memories may be painful or difficult to discuss."

Asking the questions on this card will be helpful in understanding my medical problems and concerns.

Office of Academic Affiliations
www.va.gov/oaa/pocketcard/

Post-Deployment Health Services
www.publichealth.va.gov/about/postdeploymenthealth/

Veterans Health Initiative Independent Study Courses
www.publichealth.va.gov/healthinitiative/

War-Related Illness and Injury Study Center
www.warrelatedillness.va.gov

Information for Veterans: Compensation & Pension Benefits
www.benefits.va.gov/compensation/

VA HEALTH CARE | Defining EXCELLENCE in the 21st Century

General Questions

Would it be ok if I talked with you about your military experience?
When and where did you/do you serve and in what branch?
What type of work did you/do you do while in the service?
Did you have **any** illnesses or injuries while in the service?

If your patient answers "Yes" to any of the following questions, ask:

"Can you tell me more about that?"

- Did you ever become ill while you were in the service?
- Were you or a buddy wounded, injured, or hospitalized?
- Did you have a head injury with loss of consciousness, loss of memory, *"seeing stars"* or being temporarily disoriented?
- Did you see combat, enemy fire, or casualties?
- Were you a prisoner of war?

Compensation & Benefits

Do you have a service-connected condition?
Would you like assistance in filing for compensation for injuries/illnesses related to your service?

Call VA at 1-800-827-1000 or 844-MyVA311 (698-2311)

Living Situation

Would it be ok to talk about your living situation?
Where do you live and who do you live with? Is your housing safe?
Are you in any danger of losing your housing?
Do you need assistance in caring for yourself and/or dependents?

Sexual Harassment, Assault, and Trauma

Would it be ok to talk about sexual harassment or trauma that you might have experienced?
Have you ever experienced physical, emotional, or sexual harassment or trauma?
Is this past experience causing you problems now?
Would you like a referral for some help with that?
Many people find it helpful to get some support.

IB 10-463, P96532
APRIL 2017

Veterans Health Administration
Office of Academic Affiliations

Ask all military service members and all Veterans

Exposure Concerns

Would it be okay if I asked about some things you may have been exposed to during your service?

What... were you exposed to?

- ***Chemical*** *(pollution, solvents, weapons, etc.)*
- ***Biological*** *(infectious diseases, weapons)*
- ***Psychological*** *(mental or emotional abuse, moral injury)*
- ***Physical***

Blast or explosion	***Radiation***	***Vehicular crash***
Munitions or bullet wound	***Shell fragment***	***Noise/Vibration***
	Heat	***Other injury***

What... precautions were taken? *(Avoidance, PPE, Treatment)*
How... long was the exposure?
How... concerned are you about the exposure?
Where... were you exposed?
When... were you exposed?
Who... else may have been affected? Unit name, etc.

Behavior

Would it be okay if we talked about emotional responses during your service?

PTSD: Have you been concerned that you might suffer from Post-Traumatic Stress Disorder? Symptoms can include numbing, re-experiencing symptoms, hyperarousal/being on guard, and/or avoiding situations that remind(s) you of the trauma.

Depression: Have you been experiencing sadness, feelings of hopelessness/helplessness, lack of energy, difficulty concentrating, and/or poor sleep?

Risk Assessment: Have you had thoughts of harming yourself or others?

Veterans Crisis Line 1-800-273-8255 (Press 1)
or 1-844-MyVA311 (698-2311)

Blood Borne Viruses (Hepatitis & HIV)

- Do you have tattoos? Have you ever injected or snorted drugs, such as heroin, cocaine, or methamphetamine?
- Have you ever been screened for Hepatitis C or HIV? If not, would you like to be screened for these?

Common Service-Related Exposure Concerns

Military Environmental Exposures (Any Era)

Burn Pit Smoke
Cold Injuries
Contaminated Water (benzene, trichloroethylene, vinyl chloride)
Endemic Diseases
Heat Stroke/Exhaustion
Hexavalent Chromium
Mustard Gas
Nerve Agents
Pesticides
Radiation (Ionizing & Non-Ionizing)
Sand, Dust, Smoke, and Particulates
TCDD, herbicides, other dioxins

Occupational Hazards: Asbestos, Industrial Solvents, Lead, Radiation, Fuels, PCBs, Noise/Vibration, Chemical Agent Resistant Coating (CARC)

Gulf War/Southwest Asia (Afghanistan, Kuwait, Iraq)

Animal Bites/Rabies
Blunt Trauma
Burn Injuries (Blast Injuries)
Chemical or Biological Agents
Chemical Munitions Demolition
Combined Penetrating Injuries
Depleted Uranium (DU)
Dermatologic Issues
Embedded Fragments (shrapnel)
Malaria Prevention: Mefloquine – Lariam
Mental Health Issues
Multi-Drug Resistant Acinetobacter
Oil Well Fires
Reproductive Health Issues
Spinal Cord Injury
Traumatic Amputation
Traumatic Brain Injury
Vision Loss

Immunizations: Anthrax, Botulinum Toxoid, Smallpox, Yellow Fever, Typhoid, Cholera, Hepatitis B, Meningitis, Whooping Cough, Polio, Tetanus

Infectious Diseases: Malaria, Brucellosis, Campylobacter jejuni, Coxiella burnetii, Mycobacterium tuberculosis, nontyphoid Salmonella, Shigella, visceral Leishmaniasis, West Nile Virus

Vietnam, Korean DMZ & Thailand

Agent Orange Exposure
Cold Injuries
Hepatitis C Risks

Cold War

Chemical Warfare Agent Experiments
Nuclear Weapons Testing or Cleanup

WWII & Korean War

Chemical Warfare Agent Experiments
Cold Injuries
Nuclear Weapons Testing or Cleanup
Biological Warfare Agents

Tell your patient about VA's
www.myhealth.va.gov
My healthevet Gateway to Veteran Health Benefits and Services

Find out more about military exposures
www.publichealth.va.gov/exposures/