DEPARTMENT OF VETERANS' AFFAIRS
APPLICATION FOR ADMISSION
TO THE ILLINOIS VETERANS' HOMES

Quincy Veterans' Home	Manteno Veterans' Home	LaSalle Veterans' Home	Anna Veterans' Home
1707 North 12th Street	One Veterans Drive	1015 O'Conor Avenue	792 North Main Street
Quincy, IL 62301	Manteno, IL 60950	LaSalle, IL 61301	Anna, IL 62906
(217) 222-8641, Ext. 209	(815) 468-6581, Ext. 226	(815) 223-0303, Ext. 261	(618) 833-6302, Ext. 123

READ INSTRUCTIONS BEFORE COMPLETING APPLICATION:

Print in black ink or type. Answer all questions. Assistance in completing this application can be obtained from any Department of Veterans' Affairs Field Service Office, call 800-437-9824 to find the nearest location. The information that you provide as part of this application will be used to determine the eligibility and appropriate level of care and to do preliminary planning for care and treatment. The financial section is needed to determine the appropriate charges based on the charge statement. This application can only be signed by the applicant or their legal representative.

SOC. SEC #: _____

APPLICANT'S FULL NAME: _____
(FIRST) (MIDDLE) (LAST)

MAILING ADDRESS: _____ COUNTY: _____

CITY: _____ STATE: _____ ZIP CODE: _____ PH. # (____) _____

SERVICE #: _____ V.A. CLAIM #: C-_____ RELIGION: _____

TYPE OF DISCHARGE: _____ WERE YOU A P.O.W.? _____ YES _____ NO

BRANCH OF MILITARY SERVICE: _____ ARMY _____ NAVY _____ MARINE _____ AIR FORCE _____
_____ COAST GUARD _____ MERCHANT MARINE

SERVED DURING: _____ WORLD WAR II _____ KOREAN _____ VIETNAM _____ GULF WAR-OEF/OIF _____ OTHER

DATE ENTERED ACTIVE SERVICE: _____ PLACE ENLISTED: _____

DATE OF DISCHARGE: _____ PLACE DISCHARGED: _____

RANK AT DISCHARGE: _____ UNIT NO. AND NAME: _____

OTHER SIGNIFICANT MILITARY INFORMATION: _____

DATE OF BIRTH: _____ BIRTHPLACE: _____ AGE: _____ SEX _____

MARITAL STATUS: _____ MARRIED _____ WIDOWED _____ DIVORCED _____ SEPARATED _____ SINGLE

NUMBER OF DEPENDENTS: _____ FORMER OCCUPATION OF VETERAN: _____

HAVE YOU PREVIOUSLY RESIDED AT OR APPLIED FOR MEMBERSHIP AT THIS HOME OR ANOTHER ILLINOIS VETERANS' HOME?

_____ YES _____ NO IF YES, WHICH HOME? _____

ARE YOU PRESENTLY ON A WAITING LIST AT ANOTHER ILLINOIS VETERANS' HOME?

_____ YES _____ NO IF YES, WHICH HOME? _____

I (HAVE / HAVE NOT) LIVED IN THE STATE OF ILLINOIS CONTINUOUSLY FOR THE PAST ONE YEAR.

RESIDENCE FOR LAST ONE YEAR: _____ FROM: _____ TO: _____

SOCIAL INFORMATION

LIST ALL INFORMATION ON SPOUSE (INCLUDE MAIDEN NAME IF FEMALE) AND ALL CHILDREN BORN OR LEGALLY ADOPTED OF THIS UNION. LIST CHILDREN BORN OF PREVIOUS MARRIAGE (S). USE ADDITIONAL SHEET IF NECESSARY.

	FULL NAME	RELATIONSHIP	BIRTH DATE	ADDRESS
1.				
2.				
3.				
4.				
5.				

PLEASE LIST PERSONS TO NOTIFY IN CASE OF EMERGENCY, OR IF ADDITIONAL INFROMATION IS NEEDED.

#1 PERSON _____ RELATIONSHIP: _____

ADDRESS _____ PHONE #: _____

CITY _____ STATE: _____ ZIP: _____ WORK #: _____

#2 PERSON _____ RELATIONSHIP: _____

ADDRESS _____ PHONE #: _____

CITY _____ STATE: _____ ZIP: _____ WORK #: _____

#3 PERSON _____ RELATIONSHIP: _____

ADDRESS _____ PHONE #: _____

CITY _____ STATE: _____ ZIP: _____ WORK #: _____

(PLEASE LIST ANY ADDITIONAL PERSONS ON A SEPARATE SHEET.)

FINANCIAL INFORMATION

The applicant is charged a Monthly Maintenance Charge to live at an Illinois Veterans' Home. The following financial information is needed for both the veteran and spouse to properly advise an applicant and spouse about V.A. Benefits.

	Name of Bank or Savings & Loan	Amount	Type of Account	Location
1.		$		
2.		$		
3.		$		
4.		$		
5.		$		

MONTHLY INCOME AMOUNTS

BRING SUPPORTING DOCUMENTATION AT ADMISSION	VETERAN	SPOUSE
MILITARY RETIREMENT, VETERAN'S PENSION OR SERVICE	MONTHLY AMOUNT	MONTHLY AMOUNT

CONNECTED COMPENSATION (DISABILITY%?_____)	$ _____	$ _____
SOCIAL SECURITY	$ _____	$ _____
MONTHLY INTEREST / DIVIDENDS	$ _____	$ _____
PENSION BENEFITS	$ _____	$ _____
ANNUITY	$ _____	$ _____
RENTAL PROPERTY (NET)	$ _____	$ _____
OTHER	$ _____	$ _____
TOTAL MONTHLY INCOME	$ _____	$ _____

IF ABOVE INCOME GOES TO A REPRESENTATIVE PAYEE, PLEASE PROVIDE THEIR NAME, ADDRESS, AND PHONE #:

_____

_____

_____

FINANCIALLY RESPONSIBLE PERSON

FULL NAME **RELATIONSHIP** **BIRTHDATE** **STREET ADDRESS, CITY STATE AND ZIP**

_____

INSURANCE POLICIES

HEALTH INSURANCE (NON-MEDICARE) YES _____ NO _____ MONTHLY PREMIUM COST: _____

COMPANY: _____ POLICY NO: _____

PLEASE PROVIDE A COPY OF INSURANCE CARD (FRONT AND BACK)

MEDICARE PARTICIPATION IS MANDATORY (IF NOT CURRENTLY PARTICIPATING, RESIDENT WILL BE SIGNED UP AT ADMISSION)

MEDICARE: PART A (HOSPITALIZATION) YES _____ NO _____ EFFECTIVE DATE _____

MEDICARE: PART B (MEDICAL COVERAGE) YES _____ NO _____ EFFECTIVE DATE _____

PRE-PAID FUNERAL ARRANGEMENTS YES _____ NO_____ **PROVIDE COPY.**

ADVANCE DIRECTIVES AND LEGAL AUTHORITY

DO YOU HAVE ANY OF THE FOLLOWING ADVANCE DIRECTIVES OR LEGAL APPOINTMENTS:

LIVING WILL _____ YES _____NO CONSERVATOR _____ YES _____ NO

LEGAL GUARDIANSHIP _____ YES _____NO

POWER OF ATTORNEY _____ YES _____NO WHAT TYPE _____

NOTE: IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS REGARDING ADVANCE DIRECTIVES OR LEGAL AUTHORITY YOU MUST PROVIDE A COPY OF THOSE DOCUMENTS BEFORE OR UPON ADMISSION.

I agree to abide by and obey the rules and regulations governing the Illinois Veterans' Homes and to accept transfer to another hospital, special treatment center, or Home if in the opinion of the Medical Staff, such transfer is deemed advisable. I/We understand that should I/We receive additional income or be eligible for any additional income at any future date, from any sources, that it is mandatory that it be reported to the Home, and that failure to do so shall be cause for discharge.

This authorizes the Administrator of the Home or his/her representative to verify any facts relative to my/our financial status or income.

I have read or have had read to me all questions and answers on this form and the answers are true and complete to the best of my knowledge and belief. I also understand that any falsification regarding the aforementioned information will be reason for discharge from the Home.

SIGNED: _____

DATE: _____

IMPORTANT NOTICE: This application must be fully completed in all portions and accompanied by a Photostatic copy of your HONORABLE DISCHARGE (DD 214), and the DEPARTMENT OF VETERANS' AFFAIRS HEALTH QUESTIONNAIRE. If this form is signed by anyone other than the applicant, a copy of their legal authority must accompany the application.

TO BE COMPLETED BY DEPARTMENT PERSONNEL

Applicant (meets) (does not meet) Veterans' eligibility criteria.

_____
Signature of Adjutant

Applicant medically (eligible) (ineligible)

_____
Signature of Medical Officer

This application has been carefully investigated and it is recommended that the Applicant (be admitted) (not be admitted) to reside in the Illinois Veterans' Home.

This State Agency is requesting disclosure of information necessary to accomplish the statutory purpose of P.A. 79-1384, Paragraph 5. Inasmuch as this information is VOLUNTARY, failure to provide same may prevent admission to the Veterans' Home.

_____ _____
DATE SIGNATURE OF ADMINSTRATOR

HEALTH QUESTIONNAIRE
DEPARTMENT OF VETERANS' AFFAIRS
ILLINOIS VETERANS' HOMES

APPLICATION WILL NOT BE REVIEWED UNLESS THIS FORM IS COMPLETED AND A COPY OF THE LAST OR MOST RECENT HISTORY AND PHYSICAL OR DISCHARGE SUMMARY IS ATTACHED.
(TO BE COMPLETED BY LICENSED PHYSICIAN)

APPLICANT NAME: _____ DATE: _____

Current residence: Acute hospital _____ Nursing home _____ Home _____

_____
Name, Address and Phone Number of Hospital or Nursing Home

If at home, number of inhabitants _____

HEIGHT :_____ WEIGHT:_____

CURRENT DIAGNOSIS(SES):

_____ _____ _____

_____ _____ _____

_____ _____ _____

Present medications taken (Type, strength, dosage)

_____ _____

_____ _____

_____ _____

_____ _____

Allergies and Allergic Reactions

_____

PLEASE CHECK EACH OF THE FOLLOWING:
(Space provided on page 4 for additional comments or attach additional sheets.)

		YES	NO	PARTIALLY
1.	Can applicant do the following:			
	a. Dress and use lavatory?	____	____	_____
	b. Bathe?	____	____	_____
	c. Oral hygiene?	____	____	_____
	d. Reposition in bed?	____	____	_____
	e. Ascend and descend steps?	____	____	
	f. Feed self?	____	____	_____
	g. Operate wheelchair, if needed, without aid?	____	____	_____

		YES	NO	PARTIALLY
2.	Is applicant:			
	a. Aphasic?	____	____	_____
	b. Deaf?	____	____	_____
	c. Blind?	____	____	_____
	d. Cardiac Patient?	____	____	
	e. Using oxygen?	____	____	
	f. Continent of bowel?	____	____	_____
	g. Continent of bladder?	____	____	_____
	h. Mentally competent?	____	____	
	i. Able to walk 1 block?	____	____	

3. Does applicant require sensory aid? _____ Specify: _____

		YES	NO
4.	Does applicant have decubiti (bedsores)?	____	____
	If yes, describe: _____		
5. **	Is any infection present?	____	____
**	Is there a history of MRSA, VRE or any other anti-biotic resistant infection?	____	____
6. **	Is applicant undergoing Cancer/Dialysis treatment?	____	____
**	Is there a past history of Cancer/Dialysis?	____	____
7. **	Is applicant ambulatory without assistance?	____	____
	a. Require crutches, walker, wheelchair?	____	____
	b. Require complete bed care?	____	____
8. **	Does applicant require prosthesis?	____	____

** If answer to questions 5, 6, 7, or 8 is YES, please give brief explanation:

_____

_____

		YES	NO
9.	Is applicant mentally capable of managing personal needs or self-administering oral medications without supervision? (Explain on page 4)	____	____
10.	Does applicant have a history of: (Explain YES answers on page 4)		
	a. Alcoholism? (Treatment program; see #15)	____	____
	b. Epilepsy?	____	____
	c. Dyspnea?	____	____
	d. Psychiatric treatment? (When, where; see #15)	____	____
	e. Chemical abuse? (Include prescription meds)	____	____
	f. Depression?	____	____
	g. Verbally combative? (Give examples on Page 4)	____	____
	h. Physically combative? (Give examples on Page 4)	____	____

	YES	NO
11. Does applicant require:		
a. Observation to make his/her wants known?	____	____
b. Spoon-feeding?	____	____
c. Tube feeding?	____	____
d. Tracheostomy suctioning?	____	____
e. Colostomy / Urostomy care?	____	____
f. Special Diet? Specify: _____		
g. Appetite? Specify: _____		
h. Is applicant a cigarette smoker?	____	____
Use of other tobacco products? Specify: _____		
i. Does applicant have Foley catheter?	____	____

12. Will applicant require supervision to prevent wandering from assigned unit? If YES, please give a brief explanation: _____

_____

_____

13. Most recent date applicant had the following vaccine/tests:

Pneumonia ..... _____

Influenza ..... _____

Tetanus/Diphtheria (DT) ..... _____

Mantoux . . . If positive - Millimeter of Induration _____

Treatment received: _____

14. Has applicant been hospitalized or received outpatient treatment for any of the following reasons?

	Hospital	City	Date
Psychiatric treatment			
Surgery			
Alcohol/Substance Abuse			

Please give brief explanation: _____

_____

_____

_____

NOTICE TO EXAMINING PHYSICIAN - History, symptoms and physical findings must be recorded in sufficient detail to clearly support the diagnoses. Include recent history or current diagnosis of infectious disease with pertinent pathology information.

PUBLIC ACT 90-366 REQUIRES THAT BEFORE A PROSPECTIVE RESIDENT'S ADMISSION TO A FACILITY, THE FACILITY SHALL ADVISE THE PROSPECTIVE RESIDENT TO CONSULT A PHYSICIAN TO DETERMINE WHETHER THE PROSPECTIVE RESIDENT SHOULD OBTAIN A VACCINATION AGAINST PNEUMOCOCCAL PNEUMONIA.

PLEASE ADD COPIES OF PATIENT'S LAST HOSPITALIZATION (H & P) OR MOST RECENT DISCHARGE SUMMARY AND MOST RECENT NINETY DAYS OF NURSING NOTES IF CURRENTLY IN A NURSING HOME

- - - - - - - - - - - - - -

ADDITIONAL COMMENTS
(Please attach additional sheets if necessary)

- - - - - - - - - - - - - -

Based on the applicant's current medical status, placement for nursing home care is appropriate.

YES _____ NO _____

Signed: _____
Examining Physician

Date: _____

Name: _____
Printed / Typed

Address: _____

City, State
Zip Code _____

Phone: (_____) _____
Area Code Phone Number

IMPORTANT NOTICE: This State Agency is requesting disclosure of information necessary to accomplish the statutory purposes of ILCS Chapter 20, Act 2805. Inasmuch as this information is VOLUNTARY, failure to provide it may prevent admission to the Veterans Home. This form has been approved by the Forms Management Center.

APPLICATION WILL NOT BE REVIEWED UNLESS THIS FORM IS COMPLETED AND A COPY OF THE LAST OR MOST RECENT HISTORY AND PHYSICAL OR DISCHARGE SUMMARY IS ATTACHED.