

Application for Admission to Fayetteville Veterans Home

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<p>Name: _____</p> <p>Current Address: _____</p> <p>City: _____ State: _____ Zip: _____</p> <p>Phone Number: _____</p> <p>Religious Preference: _____</p> <p>Father's Name: _____</p> <p>Mother's Maiden Name: _____</p> <p>Funeral Home Choice: _____</p> <p>If you have a service connected disability, what percent? _____</p> <p>Do you receive Aid and Attendance? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Do you have a Living Will? <input type="checkbox"/> yes <input type="checkbox"/> no A P.O.A? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Do you have a power of attorney for health care decisions? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Who will we talk with about this admission?</p> <p>Name: _____</p> <p>Address: _____</p> <p>Relation to Veteran _____ Phone _____</p>	<p>Gender: <input type="checkbox"/> M <input type="checkbox"/> F</p> <p>Age: _____ DOB: _____</p> <p>Marital Status: _____</p> <p>_____</p> <p style="text-align: center;">Place of birth</p> <p>_____</p> <p style="text-align: center;">What was your occupation?</p> <p>I am a Veteran <input type="checkbox"/></p> <p>I am the Spouse of a Veteran <input type="checkbox"/></p> <p>_____</p> <p style="text-align: center;">Social Security #</p> <p>_____</p> <p style="text-align: center;">Medicare #</p> <p>_____</p> <p>_____</p> <p style="text-align: center;">Other Insurance Name</p> <p>_____</p> <p>Do you have your DD-214? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>_____</p> <p>Attach a copy of the front and back sides of the above cards along with the Veterans DD-214 or Discharge Papers and a copy of a marriage License if you are the Spouse of a Veteran</p>
<p>Last eye exam was _____ by _____</p> <p>Last dental visit was _____ by _____</p> <p>Last hearing test was _____ by _____</p>	
<p>Have you been admitted to a hospital in the last year? <input type="checkbox"/> yes <input type="checkbox"/> no Dates: _____</p> <p>Where? _____ why? _____</p>	
<p>Answer the following by checking all the boxes that apply to you:</p> <p><input type="checkbox"/> ostomy <input type="checkbox"/> trachostomy <input type="checkbox"/> catheter <input type="checkbox"/> cannot communicate needs <input type="checkbox"/> problem hearing</p> <p><input type="checkbox"/> can bath self <input type="checkbox"/> can get in/out of bed by self <input type="checkbox"/> need total help <input type="checkbox"/> can walk alone <input type="checkbox"/> cannot walk</p> <p><input type="checkbox"/> toilet myself <input type="checkbox"/> need help going to toilet <input type="checkbox"/> incontinent <input type="checkbox"/> dress myself</p> <p><input type="checkbox"/> someone has to dress me <input type="checkbox"/> limited vision <input type="checkbox"/> blind <input type="checkbox"/> confused <input type="checkbox"/> knows self <input type="checkbox"/> knows family</p> <p><input type="checkbox"/> knows date <input type="checkbox"/> knows time <input type="checkbox"/> knows where I am <input type="checkbox"/> agreeable <input type="checkbox"/> disruptive at times</p> <p><input type="checkbox"/> wanderer <input type="checkbox"/> wound/skin problem <input type="checkbox"/> special diet <input type="checkbox"/> use oxygen</p> <p>Other information you want to share (use wheelchair, cane, walker, trapeze bar, wound care explain , special diet explain, etc.): _____</p> <p>_____</p>	
<p>Have you lost or gained weight in the last 6 months? <input type="checkbox"/> yes <input type="checkbox"/> no</p>	
<p>We will need to send for medical records. Please supply the following information for that purpose.</p> <p>Your primary doctor is: VA team #: _____ OR Other Dr. _____</p>	

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Current living situation: ___ at home with no help ___ at home with help
 ___ in assisted living at _____
 ___ in a nursing home at _____,
 if you are in a nursing home do you pay: ___ as a private pay resident
 ___ as a medicaid resident
 ___ other, explain: _____

In this calendar year, have you lived in any other nursing facility? If so provide the name(s):
 Name of Facility: _____ Dates: _____
 Name of Facility: _____ Dates: _____

FINANCIAL INFORMATION: Please list the Gross monthly income.

	VA Benefits	Social Security	Military Ret Pay	Civil Service	Interest	Dividends	Wages	Railroad Ret	Other Income
Veteran									
Spouse									

___ I know I will be private pay. If so, you don't need to give any financial information.
 (Check if applicable)

Please list all assets (home, automobiles, bonds, CDs, saving /checking accounts), **in order to determine eligibility for VA benefits and assessment of charges.**

Description of Asset: _____ Location: _____
 Owner(s): _____ Present Value: _____

Description of Asset: _____ Location: _____
 Owner(s): _____ Present Value: _____

Description of Asset: _____ Location: _____
 Owner(s): _____ Present Value: _____

Description of Asset: _____ Location: _____
 Owner(s): _____ Present Value: _____

Return the required forms and requested copies to: **Fayetteville Veterans Home**
P O Box 9898
Fayetteville AR 72703 or bring to the facility

CHECK ONE: ___ I am **ready to move** to the nursing home now **OR** ___ I am just placing my name for the future

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

Applicant/Representative: _____ **Date:** _____

RELEASE OF INFORMATION FOR FAYETTEVILLE VETERANS HOME

This section to be completed by nursing home only:

To: _____ Phone: _____

(Name of hospital, physician, facility or other)

(Address of hospital, physician, facility, or other)

Medical Information to be used in considering applicant for placement

This section to be completed by applicant/power of attorney

Name: _____ SSN: _____ - _____ - _____

DOB _____ Sex: _____ M _____ F

I request authorize the release of medical information to include:

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

Send the requested information to: Fayetteville Veterans Home, P O Box 9898, Fayetteville AR 72703

Phone: 479-444-7001 Fax: 479-695-0184

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

Resident or Responsible Party _____
Date

For releasing agent use only

Content of material released

Date released: _____ Released by: _____

NOTE: This Form is only valid for a 90 day period from date of signature