Arkansas State Veterans Home at
North Little Rock
2401 John Ashley Drive
North Little Rock, AR 72114-1825
Telephone: (501) 683-2382

ARKANSAS DEPARTMENT OF VETERANS AFFAIRS

Inquiry* about Admission to Arkansas Veterans Home at North Little Rock

Name:_____
Current Address:_____
City:_____State:_____Zip:_____
Phone Number:_____
Date of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female
Place of Birth: _____
Gender: ☐ Male ☐ Female
Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed
Religious Preference:_____
What was your Occupation:_____
If you have a service connected disability, what percent?_____
Do you receive Aid and Attendance? ☐ Yes ☐ No
Do you have Medicare? ☐ Part A ☐ Part B ☐ Both Part A & B
How do you expect to pay for your care, if admitted?
☐ Private Pay ☐ Medicare ☐ Medicaid ☐ VA Per Diem (60% or less) ☐ VA Per Diem (60% or more - Unemployable) ☐ Private Insurance
Do you have a Living Will? ☐ Yes ☐ No Do you have a Power of Attorney for health care? ☐ Yes ☐ No
Do you have a Power of Attorney for financial decisions? ☐ Yes ☐ No
Next-of-kin or Contact:
Name:_____
Address:_____
_____
Relation to Veteran_____Phone _____
Email address(optional):_____

☐ I am a Veteran**
☐ I am the Spouse of a Veteran**
☐ I am a Gold Star Parent**

_____
Social Security #

_____
Medicare #

_____
Other Insurance

Do you have your DD-214?
☐ Yes ☐ No

Branch of Service:

_____

Dates of Service:

_____

If accepted for admission a copy of your DD214, marriage license (for spouses) and for Gold Star parents a copy of your child's birth certificate and DD1300 will be needed.

Where do you receive your primary care follow-up?
☐ VA ☐ UAMS ☐ Private Physician ☐ Other

Name of physician or Clinic: _____

Telephone Number: _____

What Pharmacy do you currently use?
☐ VA ☐ Other Include name & telephone number, if not VA

_____

Medical Diagnosis(es): _____

Mental Diagnosis(es) _____

Do you see Mental Health/Psychiatrist? ☐ Yes ☐ No
Who? _____

	Does the individual:	
1.	Need help with bathing or washing parts of your body	☐ Yes ☐ No
2.	Need help with dressing self or needs to be completely dressed	☐ Yes ☐ No
3.	Need help transferring to the toilet, cleaning self or do you use the bedpan or bedside commode	☐ Yes ☐ No
4.	Need help in moving from bed to chair or requires a complete transfer	☐ Yes ☐ No
5.	Is the person partially or totally incontinent of bowel or bladder	☐ Yes ☐ No
6.	Need help partial or total help with feeding or requires parental	☐ Yes ☐ No
7.	Is the person confused	☐ Yes ☐ No
8.	Have a diagnosis of Dementia or Alzheimer's Disease	☐ Yes ☐ No
9.	Wander	☐ Yes ☐ No
10.	Use a	
	a. Walker	☐ Yes ☐ No
	b. Cane	☐ Yes ☐ No
	c. Wheelchair	☐ Yes ☐ No
	d. Motorized Wheelchair	☐ Yes ☐ No
	e. Scooter or Hover-round	☐ Yes ☐ No
	f. Prosthesis Where? _____	☐ Yes ☐ No
11.	Have a wound, decubitus ulcer or skin tear	☐ Yes ☐ No
12.	On oxygen	☐ Yes ☐ No
13.	On a special or modified diet	☐ Yes ☐ No
	If yes, list diet _____	
	Do you use special utensils to assist with eating	☐ Yes ☐ No
	List_____	
14.	Have difficulty hearing	☐ Yes ☐ No
15.	Have difficulty in communicating	☐ Yes ☐ No
16.	Have a catheter	☐ Yes ☐ No
17.	Have an ostomy	☐ Yes ☐ No
18.	Have a tracheostomy	☐ Yes ☐ No
19.	Have low vision or blindness	☐ Yes ☐ No
20.	Display disruptive or violent behaviors	☐ Yes ☐ No
21	Are you on Dialysis	☐ Yes ☐ No
	Hemodialysis: Where _____	
	Time: _____ Days: _____	
	Peritoneal: How Often_____	
	Where do you get supplies_____	
22.	Are you on Radiation	☐ Yes ☐ No
23.	Are you on Chemotherapy	☐ Yes ☐ No
24.	Are you on/use CPap or BiPap?	☐ Yes ☐ No
25.	Use Ventilator or Trilogy? Which one? _____	☐ Yes ☐ No

** This form is ONLY an inquiry form and is not considered an application for admission to the facility.*

Email form to Patricia.Gray@arkansas.gov or mail to the address at the top of the form.