*Inquiry* for Admission to Arkansas Veterans Home at N. Little Rock

Name: _____________________________________________________________

Current Address: _____________________________________________________

City: ___________________________ State: ______ Zip: ______________________

Phone Number: _____________________________________________________

Date of Birth: _______ / _____ / _______ Gender: Male Female

_______ I am a Veteran**

_______ I am the Spouse of a Veteran**

_______ I am a Gold Star Parent**

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 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): ________________________________

Who is your Primary Care Physician? _____________________________

When was your last visit to a doctor? _____________________________

Telephone Number: __________________________________________________________________

Medical Diagnosis(es):

________________________________________________________________________

Mental Health Diagnosis(es)

________________________________________________________________________
Do you see Mental Health therapist/Psychiatrist?  
YES \ NO

Who?  ______________________________________________________________

Have you recently been hospitalized?  YES  \ NO

If YES please answer:

When?
____________________________________________________________________

Where?
____________________________________________________________________

Why?
____________________________________________________________________

Are you: ______ ambulatory    ______ incontinent    or do you ________ need
assistance with feeding or self-care?

Email prescreening form to NLRVH@arkansas.gov or mail to the address at the
top of the form.

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