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|  | **APPLICATION FOR ADMISSION****TO THE WISCONSIN VETERANS HOME** |
| **THIS APPLICATION IS FOR (PLEASE CHECK ONE):** |
| **[ ]**  **WVH–Chippewa Falls** **2175 E. Park Ave.** **Chippewa Falls, WI 54729** **(715) 720-6775 Toll-free Fax (888) 966-8821** | **[ ]**  **WVH–King** **N2665 County Rd. QQ** **King, WI 54946-0600** **(715) 258-5586 Toll-free Fax (888) 966-8819** | **[ ]**  **WVH–Union Grove** **21425 G Spring St.** **Union Grove, WI 53182** **(262) 878-6702 Toll-free Fax (888) 966-8816** |

**The information requested on this form is authorized for collection by Ch. 45, Wis. Stats., ss. VA 6.01, Wis. Adm. Code. The information collected is used to determine eligibility for programs administered by the department. Contact Facility Admissions for other eligibility requirements. Completion of this form is voluntary; however, failure to furnish the requested information may result in denial of eligibility for programs.**

**This department does not discriminate on the basis of race, color, national origin, sex, religion, age, or disability in employment or**

**provision of services. Title II of the American Disabilities Act signed January 26, 1992.**

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| Please indicate your admission preference: |
| [ ]  Immediate Skilled Rehab [ ]  Immediate Long Term Care [ ]  Pre-Registration |
|  |
| [ ]  Veteran [ ]  Spouse of Veteran [ ]  Widowed Spouse of Veteran [ ]  Gold Star Parent |
| Applicant’s Name (last, first, middle initial) | Sex |
|       |       |
| Address (number and street, city, state, zip) | County |
|       |       |
| Phone numbers |
|       |
| Currently at | Location | Dates |
| [ ]  Home [ ]  Nursing Home: |       |       |
|  |  |  |
|  [ ]  Hospital: |       |       |
| Date of Birth | Place of Birth | Mother’s Maiden Name |
|       |       |       |
| Marital Status | Marriage Date | Marriage City/State |   |
| **[ ]** Married |       |       |  |
|  | Date of Death |  |
| [ ]  Divorced [ ]  Widowed |       | [ ]  Separated [ ]  Never Married |
| Religion | Race |
|       |       |
| Funeral Home (Name, address, city, state, zip) | Phone Number |
|       |       |
| Former Occupation | Highest Grade Completed |
|       |       |
| Have you ever been convicted of a felony?  | If yes, list dates and state |
| **[ ]** Yes [ ]  No |       |
| Nature of Felony |
|       |
|  |
| **Military Information** |
| Does the applicant have a service-connected disability rated by the VA? | If yes, please list disability | Percent disability |
| [ ]  Yes [ ]  No |       |       |
|   | Dates of Service | Branch of Service |
| **[ ]** Active Duty [ ]  Reserves |       |       |
|  |  |  |
| **[ ]** Purple Heart Recipient | [ ]  Former Prisoner of War | [ ]  Combat Veteran |
|  |
| **Spouse Information** |
| Spouse’s Name | Maiden Name (if any) |
|       |       |
| Spouse’s Address (number and street, city, state, zip) | County |
|       |       |
| Spouse’s Social Security Number | Spouse’s Date of Birth |
|       |       |

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| **[ ]  Primary Contact** **[ ]  Health Care POA/Health Care Guardian** **[ ]  Financial POA/Financial Guardian** |
| Name | Relationship |
|       |       |
| Address (number and street, city, state, zip) | County |
|       |       |
| Phone Numbers [ ]  Cell [ ]  Home [ ]  Work | E-mail |
|       |       |
|  |
| **[ ]  Second Contact [ ]  Health Care POA/Health Care Guardian [ ]  Financial POA/Financial Guardian**  |
| Name | Relationship |
|       |       |
| Address (number and street, city, state, zip) | County |
|       |       |
| Phone Numbers [ ]  Cell [ ]  Home [ ]  Work | E-mail |
|       |       |
|  |  |
| **Financial Information** |
| *The following financial information is required to determine eligibility for benefits and ability to pay.*  |
| **Monthly Income** | **Applicant** | **Spouse** |
| Social Security:…………………………………………………………… | $       | $       |
| Military Retirement (not VA):……………………………………………. | $       | $       |
| VA Service-Connected Disability Compensation:……………………….. | $       | $       |
| VA Pension:……………………………………………………………… | $       | $       |
| Other Income:…………………………………………………………….. | $       | $       |
| Gross Wages (Employment):…………………………………………….. | $       | $       |
| **Total Monthly Income:………………………………………………….** | $       | $       |
|  |
| **Assets** | **Applicant** | **Spouse** |
| Cash/Checking Account/Savings:………………………………………... | $       | $       |
| Investments/CDs/Stocks/Bonds/Securities:……………………………… | $       | $       |
| Trusts:…………………………………………………………………….. | $       | $       |
| Real Estate: [ ]  Residence [ ]  Other Property…………………….. | $       | $       |
| Other (i.e. life insurance & prepaid funeral costs) ………………………………... | $       | $       |
|  |
| **Have you sold, transferred, or created a joint tenancy (ownership) in any property within the last 60 months? (This includes cash and bank accounts.)** |
| **Applicant** **[ ]  Yes** **[ ]  No Spouse** **[ ]  Yes** **[ ]  No** |
|  |
| **Medical and Health Insurance Information** |
| Name of Facility where you receive primary care | Phone Number |
|       |       |
| Applicant’s Social Security Number | Medicare Number |
|       |       |
| Does Applicant Have: Medicare Part A? [ ]  Yes [ ]  No Medicare Part B? [ ]  Yes [ ]  No |
| Does an HMO manage the applicant’s Medicare? [ ]  Yes [ ]  No |
| Secondary/Supplemental Insurance | Insurance ID Number |
|       |       |
| Medicare Part D/Other Prescription Coverage | Insurance ID Number |
|       |       |
| Does Applicant Have Medicaid? [ ]  Yes Medicaid # |       |
| Has Applicant received medical care from the VA? [ ]  Yes [ ]  No | VA Claim Number: |       |
| If yes, where, when and for what did the applicant receive treatment? |       |
|       |
|  |
| I understand that it may be necessary for me to provide copies of bank statements periodically to verify my financial position, and that I must keep my account current.I authorize the Wisconsin Veterans Homes to verify any and all information provided on this form. The information I have provided is true and complete to the best of my knowledge and belief. |
|  |
| Signature: |  | Date: |       |
|  | *(Applicant or Legal Representative)* |  |  |
|  |  |  |  |
| Signature: |  | Date: |       |
|  | *(Commandant’s Approval)* |  |  |