

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) 966-88	N266 9 King (715)	N2665 County Rd. QQ 214 King, WI 54946-0600 Uni (715) 258-5586 (266 Toll-free Fax (888) 966-8819 Tol		21425 G Union G (262) 87	VH–Union Grove 125 G Spring St. ion Grove, WI 53182 2) 878-6702 Il-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.							
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 Home Nursing Home:	Location			Dates			
☐ Hospital:							
Date of Birth	Place of Birth Mother's Maiden Name						
Marital Status Marriage Date Married	Marriage City/State						
☐ Divorced ☐ Widowed	Date of Death Separated Ne			Never Married			
Religion	Race						
Funeral Home (Name, address, city, state, zip			Pho	one Number			
Former Occupation	Highest Grade	Highest Grade Completed					
Have you ever been convicted of a felony? Yes No	If yes, list dates and state						
Nature of Felony							
Military Information Does the applicant have a service-connected disability rated by the VA? If yes, please list disability Yes No No					Percent disability		
Active Duty Reserves	Dates of Service		Branch of Service				
☐ 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					County		
Spouse's Social Security Number	Spouse's Date of Birth						

☐ Primary Contact ☐ Health Care POA/Health Care Guardi	an 🔲 Fi		nancial Guardian			
Name	Relationship					
Address (number and street, city, state, zip)	County					
Phone Numbers	E-mail					
Second Contact Health Care POA/Health Care Guardi	an	Financial 1	POA/Financial Guardian			
Name	Relationship					
Address (number and street, city, state, zip)		County				
Phone Numbers		E-mail				
Financial Information	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					
The following financial information is required to determine eligibility for benefits a Monthly Income	nd ability to	pay. Applicant	Spouse			
Social Security:	\$	Applicant	\$			
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:	\$	присин	\$			
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 prope	rty within tl	ne last 60 months?	(This includes cash and bank			
accounts.)	_		(
	Yes \[\] N	lo				
Medical and Health Insurance Information	1					
Name of Facility where you receive primary care		one Number				
Applicant's Social Security Number	Medicare N	licare 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	rance ID Number				
Medicare Part D/Other Prescription Coverage	Insurance	surance ID Number				
Does Applicant Have Medicaid? Yes Medicaid#						
Has Applicant received medical care from the VA?						
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 states must keep my account current.	ments perio	dically to verify m	y financial position, and that I			
I authorize the Wisconsin Veterans Homes to verify any and all information true and complete to the best of my knowledge and belief.	provided o	n this form. The in	nformation I have provided is			
Signature:		Date:				
(Applicant or Legal Representative)						
G' 4-		D. A				
Signature:		Date:				
(Commandant's Approval)						