Admission Form

Colorado State Veterans Nursing Homes

Colorado Department of Human Services
people who help people

Caring communities that honor America's heroes!

Fitzsimons	Florence	Homelake/Monte Vista	Rifle	Walsenburg
1919 Quentin Street	903 Moore Drive	P.O. Box 97	851 East 5th Street	23500 US Hwy 160
Aurora, CO 80045	Florence, CO 81226	Homelake, CO 81135	Rifle, CO 81650	Walsenburg, CO 81089
720-857-6406	719-784-6331	719-852-5118	970-625-0842	719-738-5100

Applicant's name: _____ Sex _____
Last First Middle

Address: _____
Street City County State Zip

Phone number(s): _____ Religion: _____

Date of birth: _____ Place of birth: _____
City County State Country

Marital status: Married _____ Divorced _____ Widowed _____ Separated _____ Never married _____

Applicant is a: Veteran _____ Veteran's spouse _____ Veteran's widow _____ Gold-Star Parent _____

Military information

Branch of service: _____ Service number: _____
Date entered: _____ Date discharged: _____
Does the applicant have a service-connected disability rated by the VA? Yes _____ No _____
If yes, please list disability: _____ Percent disability: _____

Medical and health insurance information

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 _____ No _____ If yes, provide Medicaid ID number: _____
Has applicant received medical care from the VA? Yes ____ No ____ VA claim #: _____
If yes, where, when and for what did the applicant receive treatment? _____
_____
Does applicant have any of the following?:
Medical Power of Attorney (POA): ___ General POA: ___ Living Will: ___ Guardian/Conservator: ___

Spouse information

Spouse's name: _____ Maiden name (if any): _____
Last First Middle

Spouse's address: _____ Phone #: (_____)_____
Street City State Zip

Spouse's Social Security Number: _____ Spouse's date of birth: _____

Emergency notification:

1) Name: _____ Relationship: _____
   Address: _____
   Street City County State Zip
   Phone number(s): _____

2) Name: _____ Relationship: _____
   Address: _____
   Street City County State Zip
   Phone number(s): _____

3) Name: _____ Relationship: _____
   Address: _____
   Street City County State Zip
   Phone number(s): _____

If admitted to the Colorado State Veterans Home, who will handle your financial affairs? *(Provide name and phone):*

_____

Financial information:

The following financial information is required to determine eligibility for benefits and ability to pay. Please state gross monthly amounts before any deductions.

Monthly income	**Applicant**	**Spouse**
Social Security:	$ _____	$ _____
Civil Service:	$ _____	$ _____
Railroad retirement:	$ _____	$ _____
Military retirement (not VA):	$ _____	$ _____
VA service-connected disability compensation:	$ _____	$ _____
VA pension:	$ _____	$ _____
Other pensions (specify): _____	$ _____	$ _____
Gross wages (employment):	$ _____	$ _____
Total monthly income:	**$ _____**	**$ _____**

Assets	**Applicant**	**Spouse**
Cash/checking account/savings:	$ _____	$ _____
Investments:	$ _____	$ _____
Trusts:	$ _____	$ _____
Real estate (other than your residence):	$ _____	$ _____
Other:	$ _____	$ _____

Please attach copies of the following:

- Military separation orders or discharge papers (DD214 or similar document)
- Service-Connected Disability Award Letter from the VA, if applicable
- Front and back of all insurance cards
- Medical POA, General POA, guardian/conservatorship documents and living will, if available

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.

If I am admitted, I agree to abide by the rules and regulations of the Colorado State Veterans Nursing Home. I realize that the facility is operated in full compliance with the Civil Rights Act of 1964, and the Americans With Disabilities Act of 1990, and that I am to cooperate with the nursing home in maintaining full compliance.

I authorize the State Veterans Home 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 POA)