



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.

Please indicate your admission preference:		
<input type="checkbox"/> Immediate Skilled Rehab	<input type="checkbox"/> Immediate Long Term Care	<input type="checkbox"/> Pre-Registration

<input type="checkbox"/> Veteran	<input type="checkbox"/> Spouse of Veteran	<input type="checkbox"/> Widowed Spouse of Veteran	<input type="checkbox"/> Gold Star Parent
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Applicant's Name (last, first, middle initial)	Sex
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Address (number and street, city, state, zip)	County
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Phone numbers

Currently at	Location	Dates
<input type="checkbox"/> Home		
<input type="checkbox"/> Nursing Home: <input type="checkbox"/> Hospital:		

Date of Birth	Place of Birth	Mother's Maiden Name
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Marital Status	Marriage Date	Marriage City/State
<input type="checkbox"/> Married		

<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	Date of Death	<input type="checkbox"/> Separated	<input type="checkbox"/> Never Married
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Religion	Race
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Funeral Home (Name, address, city, state, zip)	Phone Number
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Former Occupation	Highest Grade Completed
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Have you ever been convicted of a felony? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list dates and state
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Nature of Felony

Military Information

Does the applicant have a service-connected disability rated by the VA? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list disability	Percent disability
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<input type="checkbox"/> Active Duty	<input type="checkbox"/> Reserves	Dates of Service	Branch of Service
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<input type="checkbox"/> Purple Heart Recipient	<input type="checkbox"/> Former Prisoner of War	<input type="checkbox"/> Combat Veteran
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Spouse Information

Spouse's Name	Maiden Name (if any)
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Spouse's Address (number and street, city, state, zip)	County
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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 <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> 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 <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	E-mail

Financial Information

The following financial information is required to determine eligibility for benefits and ability to pay.

Monthly Income	<u>Applicant</u>	<u>Spouse</u>
Social Security:.....	\$	\$
Military Retirement (not VA):.....	\$	\$
VA Service-Connected Disability Compensation:.....	\$	\$
VA Pension:.....	\$	\$
Other Income:.....	\$	\$
Gross Wages (Employment):.....	\$	\$
Total Monthly Income:.....	\$	\$

Assets	<u>Applicant</u>	<u>Spouse</u>
Cash/Checking Account/Savings:.....	\$	\$
Investments/CDs/Stocks/Bonds/Securities:.....	\$	\$
Trusts:.....	\$	\$
Real Estate: <input type="checkbox"/> Residence <input type="checkbox"/> 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)