WISCONSIN DVA VETERANS FORWARD

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.

Seeking Admission:
☐ Immediate Future ☐ Rehab ☐ Next 6 Months ☐ Long Term Care ☐ Pre-Registration
☐ Assisted Living (UG Only)

☐ 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

You can access the most recent version of this form from the WDVA website at http://dva.state.wi.us/Pages/newsmedia/WDVAToolkit.aspx

☐ **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)