New Mexico Veterans Home

Application for Admission

Today's Date: _____

Applicant's Name: _____ DOB: _____

AGE: _____

SEX: ( ) Male
( ) Female
( ) Other

Applicant is: ( ) Honorably Discharged Vet
( ) Spouse of Honorably Discharged Vet
( ) Gold Star Parent

Permanent address: _____
(street) (City) (State) (Zip code)

Home phone: _____ Cell: _____

Present location: ( ) Home (address listed above)
( ) Hospital: _____
( ) Nursing Facility: _____
( ) Behavioral Health Fac: _____
( ) Other: _____

Copies of following documents due ***at time of application submittal***:

Soc Sec #: _____
Medicare #: _____
VA Claim # : _____
Marriage Certificate (if spouse of veteran)
Veterans DD214
Veteran's Service-Connected Letter
Insurance Cards for all medical, eye, dental and pharmacy coverage.
Plus all financial information identified below in the financial section and
Copies of POA/Legal Guardianship/Living wills/advanced directives

Incomplete applications, missing information, or documentation cannot be approved for admissions, and will greatly delay the application process. The facility cannot hold any bed for incomplete applications. Only completed applications that meet eligibility criteria will be admitted or placed on a wait list. Wait listed applications will be admitted on the following basis: veterans, then spouses and gold star parents. The facility by VA regulations may only admit up to 25% of all beds to spouse and Gold Star parents.

Section A. FINANCIAL INFORMATION:

Primary Financial Responsible Party: *(party who handles applicants financial and/or medical affairs)*

Name: _____

Address: _____

_____

Email address: _____

home phone: _____

cell phone: _____

work phone: _____

Legal Relationship to Veteran: ( ) Self ( ) POA ( ) Guardian

Secondary Financial Responsible Party: *(party who handles applicants financial and/or medical affairs)*

Name: _____

Address: _____

_____

Email address: _____

home phone: _____

cell phone: _____

work phone: _____

Legal Relationship to Veteran: ( ) Self ( ) POA ( ) Guardian

MEDICARE INFORMATION:

Do you have Medicare Part A? ( ) Yes ( ) No #_____

Do you have Medicare Part B? ( ) Yes ( ) No #_____

Do you have Medicare Part D? ( ) Yes ( ) No

Do you have Pharmacy Coverage? ( ) Yes ( ) No

BANK INFORMATION:

*Please provide the last 3 months bank statements for all checking, savings, CD's, money market accounts in your name, whether independently held or joint accounts.

INSURANCE INFORMATION: *(LIST ALL PRIMARY AND SUPPLEMENTAL INSURANCES)*

Indicate if this is Primary ( ) or Supplemental ( ) coverage

Carrier Name	
Address:	
Phone #	
Fax #	
Policy #	
Group #	

Indicate if this is Primary ( ) or Supplemental ( ) coverage

Carrier Name	
Address:	
Phone #	
Fax #	
Policy #	
Group #	

* Provide copies of insurance cards with application

INCOME INFORMATION: *(failure to provide all income sources may result in termination of agreement)*

Social Security _____ per month **Military retirement**: _____ per month

Private Pension_____ per month **Workers Compensation** _____ per month

Spousal Support _____per month **SSI Disability** _____per month

Railroad Retirement _____per month

Other Source(s) Income _____ per month from _____
Other Source(s) Income _____ per month from _____

Is there *any* income that is being collected by or paid **to** a family member, friend, trust, or other person(s) but that can be attributed as income for you? ( ) Yes ( ) No

Are there *any* money, stock, retirement, insurance, checking, savings, real estate holdings, or any other kind of accounts that are held in your name and jointly or in common, with a family member, friend, trust, agency, or other person(s) that have not been reported here?
( ) Yes ( ) No

IF APPLICANT IS RECEIVING VA INCOME BENEFITS:

Service Connected Disability Pension: $ _____ per month

Service Connected Disability Rating by VA % _____

Non-Service Connected (NSC) Pension $ _____ per month

Aid and Attendance $ _____ per month

House Board $ _____ per month

***** Please provide copies of all service connected letters, ratings, pensions and aid

REAL ESTATE INFORMATION

Do you hold in part, interest or entirety any real estate holdings or rights including but not limited to: land, home(s), tracts, mining, mineral rights, water rights, etc. ( ) Yes ( ) No

If yes, please complete the following:

Address: _____ _____
(street) (City) (State) (Zip)

Address: _____ _____
(street) (City) (State) (Zip)

Parcel (legal description) _____

Parcel (legal description) _____

Total current value of real estate owned $ _____

Total current value of Rights owned $ _____

STOCKS:

List stocks held soley, jointly, held in trust, _____ $_____
(name of stock) (Current Value)

List stocks held soley, jointly, held in trust, _____ $_____
(name of stock) (Current Value)

List stocks held soley, jointly, held in trust, _____ $_____
(name of stock) (Current Value)

TRUSTS:

Do you have any trusts in your name, either revokable or irrevocable ( ) Yes ( ) No

Are you Trustee for any trust in which you are an heir or named? ( ) Yes ( ) No

ANNUITIES/RETIREMENT/IRAs:

Do you own any Annuities or have a pension or retirement? ( ) Yes ( ) No
If yes, please provide details:

_____	_____	_____
(Policy/Account #)	(Company)	(Monthly distribution)
_____	_____	_____
(Policy/Account #)	(Company)	(Monthly distribution)

* Please provide copies of most recent account statements

CD's/MONEY MARKET ACCOUNT

Do you have any CD's or Money Market Accounts ( ) Yes ( ) No
If yes, please provide details:

_____	_____	_____
(account #)	(Institution where account held)	(current value)
_____	_____	_____
(account #)	(Institution where account held)	(current value)

* Please provide copies of most recent account statements

LIFE INSURANCE POLICIES:

Do you have any life insurance policies with a cash value? ( ) Yes ( ) No
If yes, please provide details:

_____	_____	_____
(Policy #)	(Insurance Carrier)	(Cash Value of Policy)
_____	_____	_____
(Policy #)	(Insurance Carrier)	(Cash Value of Policy)

MEDICAID ELIGIBILITY QUESTIONS

Have you (or your family) disposed of any assets in the past five (5) years? ( ) Yes ( ) No
Have you (or your family) moved or transferred any assets in the past 5 years? ( ) Yes ( ) No
Do any of your family members receive any of your entitled payments, disbursements, social security benefits, retirement benefits, etc.? ( ) Yes ( ) No

SECTION B - MEDICAL INFORMATION

If applicant is living at home, he/she must provide or have the physician's office provide to NMVH (via fax or you can deliver to the facility), the applicants most updated medical records including, but not limited to:

1. Current History and Physical (must be within last 6 months)
2. Current list of diagnosis and conditions
3. Current medication list
4. Orders for admission to a long term care facility (if applicant meets eligibility)

If applicant is in the hospital, the facility will collect all the data needed for review of eligibility directly. However, applicant must give hospital signed consent for facility to access his/her information.

If applicant is located at another long-term care facility or behavioral facility, the facility will collect all data from the facility directly. However, signed consent by applicant may be necessary in order for NMVH to receive these documents.

Failure to obtain necessary medical documentation will result in the application being denied.

VETERAN SERVICE INFORMATION:

Branch of Service: _____ Rank: _____

Date entered Service:_____ State/Entry_____

Date Discharged: _____ Discharge Location_____

_____ _____

(Signature of Applicant) (Date)

_____ _____

(Signature of (Guardian or if applicant unable to sign – the POA) (Date)

_____ _____

(Signature of NMVH representative) (Date)