APPLICATION FOR ADMISSION

Applicant Information:

Last Name:_____ First Name:_____ Middle:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone #:(____)_____ Social Security #:_____-_____-_____

Sex (circle one): *Male Female*

Race:_____ DOB:_____ Birth Place:_____

Marital Status (circle one): *Single Married Widow(er) Divorced*

Religion:_____ Prior Occupation:_____

Father's Name:_____ Mother's Maiden Name:_____

Current Placement (name of nursing home, hospital, home, etc.):_____

Military Service Information:

Branch of Service (circle one): *ARMY AIR FORCE NAVY MARINE CORPS COAST GUARD*

Date of Enlistment:_____ Date of Discharge:_____

Highest Rank:_____ Honorable Discharge (circle one): *YES NO*

Does Veteran have a service-connected rating from the VA? *YES NO Disability rating:*____%

Family Information:

Primary Contact:

Last Name:_____ First Name:_____ Middle:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone #:(____)_____ Cell #:(_____)_____ Relationship:_____

If spouse, Social Security #:_____

Other Contact:

Last Name:_____ First Name:_____ Middle:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone #:(____)_____ Cell #:(_____)_____ Relation:_____

Medical Information:

****Note - For admission to NMVH, a current physician statement or hospital summary containing diagnosis, prognosis, medications, and history is required.***

Physician:_____ Phone #:(_____)_____

Address:_____ City:_____ State:_____ Zip:_____

****Note - If within the last year, the applicant has been in a hospital, nursing home, or other full/partial care facility, please provide the following information for the facilities.***

Name of Facility:_____ Phone #:(_____)_____

Address:_____ City:_____ State:_____ Zip:_____

Name of Facility:_____ Phone #:(_____)_____

Address:_____ City:_____ State:_____ Zip:_____

To better serve the Veteran, please answer the following questions

☐YES ☐NO Does the Veteran use a dialysis machine? ☐YES ☐NO Is Veteran ambulatory?
☐YES ☐NO Is Veteran alert & able to answer questions? ☐YES ☐NO Does Veteran have tendency to wander?
☐YES ☐NO Can Veteran feed, dress, and bath independently? ☐YES ☐NO Does Veteran use a CPAP or BiPAP?
☐YES ☐NO Does Veteran use wheelchair, walker, or cane?
☐YES ☐NO Does Veteran exhibit inappropriate sexual behaviors?
☐YES ☐NO Has Veteran ever been hospitalized for any type of mental problems? If ***YES***, provide name & location of institution below:
Institution Name:_____ City:_____ State:_____

Legal Information:

☐YES ☐NO Does Veteran have a ☐Living Will, ☐Advanced Directive, or ☐DNR? (check all that apply)
☐YES ☐NO Has Veteran granted Durable Power of Attorney for Health Care?
☐YES ☐NO Has Veteran granted Durable Power of Attorney for Financial?
☐YES ☐NO Does Veteran have a legal Guardian?
☐YES ☐NO Does Veteran have a legal Financial Custodian/Fiduciary?
☐YES ☐NO Does Veteran have a Will? Location:_____

Required Documentation

Please provide supporting documentation if you selected ***YES*** to any of the questions above.

Responsible Party Information:

☐YES ☐NO **Is the Veteran financially responsible for his own affairs?**

If the answer is ***NO***, please provide the following information about the financially responsible person.

Last Name:_____ First Name:_____ Middle:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone #:(____)_____ Cell #:(____)_____ Relationship:_____

Email:_____

Financial Information:

****Note – Provide gross monthly amount for all incomes sources and documentation to verify the amounts. Please provide prior year's income tax documents, if applicable. Attach additional sheet if needed.***

Source of Income	Veteran	Spouse	Dependent Child
Social Security			
US Civil Service			
Retirement			
VA Benefit			
Military Retirement			
Supp. Social Security			
Distributions			
Wages/Salary			
Interest			
Other Income			

Assets:
****Note – List all assets owned by the Veteran, the Veteran's spouse and/or dependent children. Include homes, vehicles, land, banking account, CD's, stocks, bonds, mutual funds, IRA's, etc. Provide documents to verify asset value.***

Asset Description	Asset Location	Market Value	Debt	Net Value

Insurance Information:

Does the Veteran have Medicare? ☐None ☐Part A only ☐Part A&B

Does the Veteran have Life Insurance? ☐YES ☐NO (if ***YES***, provide information)

Name of Company:_____ Name of Insured:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone #:(____)_____ Name of Beneficiary:_____

Amount of Policy:$_____ Is policy irrevocable? ☐YES ☐NO

Burial Policy:

Funeral Home:_____ Phone #:(____)_____

Address:_____ City:_____ State:_____ Zip:_____

Name of Burial Company:_____ Name of Insured:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone #:(____)_____ Name of Beneficiary:_____

Amount of Policy:$_____ Is policy irrevocable? ☐YES ☐NO

SCOPE OF SERVICE STATEMENT

New Mexico State Veterans Home is a licensed long term nursing facility. Specifically, the scope of care is that normally associated with a skilled nursing care operation. While the facility provides limited physician, and/or nurse, pharmaceutical, and diagnostic laboratory, either in house or on a contractual basis, there is no intent to represent that care beyond that associated with a skilled nursing care level will be provided. Patients with medical or psychological needs, which in the judgment of the facility's administrative and professional staff are beyond those associated with the scope of services normally provided, will not be admitted or in cases where a patient's condition changes following admission to require services other than those normally provided, such patient shall be discharged or transferred to an appropriate facility.

Discrimination on the basis of race, color, sex, age, handicap, religion, or national origin is prohibited.

I certify that I have read and understand the information provided on this form and that the above answers are true and correct to the best of my knowledge and belief.

Date:_____ Signature of Veteran:_____
(or Guardian, Custodian or Relative of Veteran)

SUBMIT COMPLETED APPLICATION AND THE REQUESTED DOCUMENTS TO NMVH ADMISSIONS. PLEASE CALL (575) 894-4200 WITH ANY QUESTIONS.