Veteran
Application For Admission
To The Iowa Veterans Home

1301 Summit Street - Marshalltown, Iowa 50158-5485
Telephone (641) 753-4325 or 800-645-4591

THIS APPLICATION MUST BE THOROUGHLY COMPLETED OR THE ADMISSION PROCESS MAY BE DELAYED. SUBMIT WITH APPLICATION A COPY OF YOUR HONORABLE DISCHARGE OR DD-214.

A COPY OF A COMPLETE HISTORY AND PHYSICAL IS REQUIRED. THIS HISTORY AND PHYSICAL MUST BE DATED WITHIN THREE MONTHS FROM THE DATE THE IVH APPLICATION IS RECEIVED. YOUR HEALTH CARE PROVIDER MUST ALSO SUBMIT LAB WORK, IMMUNIZATIONS, YOUR HISTORY OF TESTING AND RESULTS OF RESISTANT ORGANISIMS (MRSA OR VRE), AND PPD (TB TESTING).

DATE/MONTH OF REQUESTED ADMISSION _____
The requested date will be accommodated, if possible. Please do not choose a date more than two months out from the date of application.

1. Applicant's name in full _____ (First / Middle / Last / Maiden)
2. Legal Residence _____ (Address / City / State / Zip Code)

   County of legal residence _____ Applicant Phone Number _____

   Present Address _____ (If at facility skip to next line) (Address / City / State / Zip Code)

   Current Facility _____ (Name) Phone Number _____ Admission Date _____

   _____ (Address / City / State / Zip Code)
3. Date of Birth _____ Birthplace _____ (County / City / State)
4. Social Security Number _____ Spouse's Social Security Number _____
5. Are you a U.S. citizen? Yes ☐ No ☐ Naturalized? Yes ☐ No ☐ If yes, please provide a copy of naturalization papers.
6. Father's Name _____ (First / Middle / Last) Birthplace _____ (County/City / State)
7. Mother's *Maiden* Name _____ (First / Middle / Last) Birthplace _____ (County/City / State)

8. **MARRIAGE(S): Provide the following information for your MOST RECENT marriage. Copies of all marriage, divorce and/or death certificates will be required.**

   Circle one of the following: Married Widowed Divorced Separated Never Married

   Spouse's full name _____ (First / Middle / Last ***(Maiden)***) Birthplace _____ (County/City / State)

   Date of Birth _____ (Month/Day/Year) Date of Marriage _____ (Month/Day/Year) Place _____ (County/City / State)

   How marriage ended _____ (If applicable) When _____ (Month/Day/Year) Where _____ (County/City / State)

9. **CHILDREN:** Applicant _____

Please indicate approval to contact children regarding the application process by circling yes or no before each name.

YES/NO _____
Name Address City State Zip Code

_____
Age Relationship Main Phone Alternate Phone Number (Work, Cell, Other)

YES/NO _____
Name Address City State Zip Code

_____
Age Relationship Main Phone Alternate Phone Number (Work, Cell, Other)

YES/NO _____
Name Address City State Zip Code

_____
Age Relationship Main Phone Alternate Phone Number (Work, Cell, Other)

Attach separate sheet for additional children. List all living children, regardless of age. If they are minors, please furnish a copy of the birth certificates.

10. Your usual occupation _____ Kind of business or industry _____
Do NOT write retired

Spouse's usual occupation _____ Kind of business or industry _____
Do NOT write retired

11. Date you retired or became disabled _____ Date spouse retired or became disabled _____

If you receive Social Security, is it from your work? Yes ☐ No ☐ Spouse's work? Yes ☐ No ☐

Your Civil Service Annuity Number _____ Railroad Retirement Number _____

Spouse's Civil Service Annuity Number _____ Railroad Retirement Number _____

Do you have Medicare? **Part A:** Yes ☐ No ☐ **Part B:** Yes ☐ No ☐ **Part D:** Yes ☐ No ☐

Medicare Number _____ Are you on Medicaid? Yes ☐ No ☐ Number _____

Do you have other health insurance? Yes ☐ No ☐ Name of company _____

Do you have Nursing Home insurance? Yes ☐ No ☐ Name of company _____

PROVIDE COPY OF THE FRONT AND BACK OF MEDICARE, MEDICAID AND HEALTH INSURANCE CARDS

12. **EDUCATION:** (Circle highest level of completion)

Elementary: 1, 2, 3, 4, 5, 6, 7, 8 High School: 9, 10, 11, 12, GED College: 1, 2, 3, 4 AA, BA, BS, MA, MS, Doctorate

13. **CIRCLE BRANCH OF SERVICE:** Army Navy Air Force Marines Coast Guard Merchant Marines
WACS WAVES WAAF WMC SPARS Nurse Corps

Date of your enlistment _____ Place of entry _____

Do you have a service-connected disability? Yes ☐ No ☐ Percentage of disability? _____

Combat Veteran? Yes ☐ No ☐ Prisoner of War? Yes☐ No ☐ Purple Heart Recipient? Yes ☐ No ☐

14. Unit number and name _____ Rank at discharge _____

Date of discharge _____ Place of discharge _____

15. Your Armed Services Number _____ Your DVA Claim or File Number _____

16. Number of years residence in Iowa? _____

17. **LEGAL DECISION MAKERS: (Continued on page 3)**

a. Court-appointed Conservatorship _____
(Please provide a copy of the court order and letter of appointment) Name Main Phone Number

_____
Address City State Zip Code

b. Court-appointed Guardianship _____
(Please provide a copy of the court order and letter of appointment) Name Main Phone Number

_____
Address City State Zip Code

Applicant _____

c. Financial Power of Attorney _____
(Please provide a copy) Name Main Phone Number

_____
Address City State Zip Code

d. Healthcare Power of Attorney _____
(Please provide a copy) Name Main Phone Number

_____
Address City State Zip Code

18. Your religious preference (optional) _____
Denomination

19. Person to be notified in an emergency _____
(Attach a separate sheet if more than one.) Name

_____
Address City State Zip Code

_____
Relationship Main Phone Number Alternate Phone Number (Work, Cell, Other)

20. Have you ever been a member of the Iowa Veterans Home? _____ Have you ever been a member of any State Institution, Department of Veterans Affairs Hospital or other State Veterans Home? _____ If so, where? _____

When were you discharged? _____ Why were you discharged? _____

21. I desire to be buried in _____ Cemetery _____
Telephone Number

_____
Address City State Zip Code

22. My funeral home of preference is _____
Name Telephone Number

_____
Address City State Zip Code

23. Is there a prefunded funeral contract or burial trust? _____ **(Please provide copy of contract or trust.)**

APPLICANT OR LEGAL REPRESENTATIVE TO READ THE FOLLOWING AND SIGN:

I am applying for admission to the Iowa Veterans Home. I am a resident of the state of Iowa. All of the statements on this application are true and complete to the best of my knowledge. I hereby give permission to the Iowa Veterans Home to do a background check. ***If admitted, I understand that all income and assets, regardless of source, will be considered in the determination of my cost of care.*** I understand that all personal expenses and/or prior existing debts are my responsibility.

_____
Signature of Applicant or Legal Representative

CERTIFICATE OF COUNTY COMMISSION OF VETERANS AFFAIRS

We hereby certify that _____ has been a resident of _____ County, State of Iowa, prior to date of this application as provided for by Chapter 35D of the Code of Iowa, and that we are members of the County Commission of Veteran Affairs of said county.

STATE OF IOWA
COUNTY OF _____

COUNTY COMMISSION OF VETERANS AFFAIRS

Signed or attested before me on this day

1. _____

_____ _____ _____
Month Day Year

2. _____

By _____ and _____

_____
Notary Public in and for State of Iowa

Decision Making to be filled out by MD, DO, PA-C, or ARNP

Is He/She able to make Healthcare Decisions? ☐ Yes or ☐ No

If answered no, who is their designated decision maker? _____

Is He/She able to make Financial Decisions? ☐ Yes or ☐ No

If answered no, who is their designated decision maker? _____

Is He/She court committed? ☐ Yes or ☐ No

(Attach copy of recent H&P to this form)

Print or Type Name of Care Provider: _____ Date: _____

_____ Date: _____
Care Provider Signature (MD, DO, PA-C, ARNP)

Provider Address: _____

_____

Phone Number: _____

Fax Number: _____