

Spouse 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 SPOUSE'S HONORABLE DISCHARGE OR DD-214, MARRIAGE CERTIFICATE, AND DEATH CERTIFICATE (IF APPLICABLE).

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).

1. Applicant's name in full _____
First Middle Last Maiden

2. Legal Residence _____
Address City State Zip Code

County of legal residence _____ Applicant's 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 _____ Birthplace _____
First Middle Last County/City State

7. Mother's Maiden Name _____ Birthplace _____
First Middle Last County/City State

8. MARRIAGE(S): Provide the following information for MOST RECENT marriage. If applying under previous spouse, submit marriage information on that marriage and all subsequent marriages. Copies of all marriage, divorce and/or death certificates will be required.

Circle one of the following: Married Widowed Divorced Separated

Spouse's full name _____ Birthplace _____
First Middle Last County/City State

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

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

Attach separate sheet providing above information for all previous marriages

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)	

Attach separate sheet for additional children. List all living children, regardless of age. If any are minors, furnish a copy of the birth certificate(s).

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 _____

Do you receive Social Security? Yes No

If yes, what type of benefit do you receive? (Please circle one) Retirement Disability (SSDI) Low Income (SSI)

Do you have Medicare? Part A: Yes No Part B: Yes No Start Date(s) _____

Medicare or MBI Number _____ Monthly Premium: _____

Part D: Yes No Company Name _____

Member identification number _____ Monthly Premium: _____

Have you ever applied for or are you currently receiving Medicaid? Yes No SID Number _____

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

Member identification number _____ Monthly Premium: _____

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

PROVIDE COPY OF THE FRONT AND BACK OF ALL INSURANCE CARDS LISTED ABOVE

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 SPOUSE'S BRANCH OF SERVICE: Army Navy Marines Air Force Coast Guard Merchant Marines

WACS WAVES WAAF WMC SPARS Nurse Corps

Date of spouse's entry _____ Place of entry _____

Date of spouse's discharge _____ Place of discharge _____

Spouse's Armed Services Number _____ Spouse's DVA Claim or File Number _____

Did your spouse have a service-connected disability? Yes No Percentage of disability? _____

Was your spouse a: Combat Veteran? Yes No Prisoner of War? Yes No Purple Heart Recipient? Yes No

Rank at discharge _____ Job held in service? _____

14. Years of residence in Iowa? _____

15. LEGAL DECISION MAKERS: (Continued on page 3)

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

Address	City	State	Zip Code
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b. Court appointed Conservatorship _____
(Please provide a copy of the court order and letter of appointment) Name Main Phone Number

Address	City	State	Zip Code
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Applicant _____

c. Healthcare Power of Attorney _____
(Please provide a copy) Name _____ Main Phone Number _____
Address _____ City _____ State _____ Zip Code _____

s. Financial Power of Attorney _____
(Please provide a copy) Name _____ Main Phone Number _____
Address _____ City _____ State _____ Zip code _____

16. Your religious preference (optional) _____
Denomination _____

17. 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) _____

18. Have you ever been a resident of the Iowa Veterans Home? _____ If so, when? _____

19. I desire to be buried in _____ Cemetery _____ Telephone Number _____
Address _____ City _____ State _____ Zip Code _____

20. My funeral home of preference is _____ Name _____ Telephone Number _____
Address _____ City _____ State _____ Zip Code _____

Is there a pre-funded funeral contract or burial trust? Yes No (If yes, please provide copy of contract or trust.)

21. Did you file an income tax return for the previous tax year? Yes No (If yes, please provide a copy of all pages.)

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 VETERAN 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 must 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)

Printed Name of Care Provider: _____ Date: _____

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

Provider Address: _____

Phone Number: _____

Fax Number: _____