

Gold Star Parent Application For Admission To The Iowa Veterans Home

1301 Summit Street, Marshalltown, IA 50158-5485
Telephone (641) 753-4325

THIS APPLICATION MUST BE THOROUGHLY COMPLETED OR THE ADMISSION PROCESS MAY BE DELAYED. SUBMIT WITH APPLICATION A COPY OF YOUR CHILD'S HONORABLE DISCHARGE OR DD-214, BIRTH CERTIFICATE AND CERTIFICATION OF CHILD'S DEATH WHILE SERVING IN THE ARMED FORCES.

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 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 _____ Phone Number _____ Admission Date _____
Name Address
_____ 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 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 _____ 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 application process by circling yes or no before each name.

YES/NO _____
Name _____ Address, City, State, Zip Code _____

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

YES/NO _____
Name _____ Address, City, State, Zip Code _____

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

Attach a separate sheet for additional children. List all living children, regardless of age. If any are minors, please furnish a copy of 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 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 A 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 CHILD'S BRANCH OF SERVICE:** Army Navy Air Force Marines Coast Guard Merchant Marines

Date of child's entry _____ Place of entry _____

Date of child's discharge _____ Place of discharge _____

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

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

Was your child a: Combat veteran? Yes No Prisoner of War? Yes No Purple Heart Recipient? Yes No

Rank at discharge _____ Job held in service? _____

14. Number of years of your residency 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 _____

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

Address _____ City _____ State _____ Zip Code _____

Applicant _____

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

Address City State Zip Code

d. Financial Power of Attorney _____
 (Please provide 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 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 _____
 Telephone Number

Address City State Zip Code

Is there a prefunded 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 the 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 VETERAN AFFAIRS

Signed or attested before me on this date _____

 Month Day Year

1. _____
 2. _____

By _____ and _____

 Notary Public in and for the 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: _____