

# 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

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

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**

I 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 I am a member/employee of the County Veteran Affairs of said county.

STATE OF IOWA  
COUNTY OF \_\_\_\_\_

**COUNTY VETERANS AFFAIRS OFFICE**

Signed or attested before me on this day

\_\_\_\_\_  
Signature Director/Administrator/CVSO/Commissioner

\_\_\_\_\_  
Month Day Year

\_\_\_\_\_  
Printed Name Director/Administrator/CVSO/Commissioner

By \_\_\_\_\_

\_\_\_\_\_  
Notary Public in and for State of Iowa

Applicant \_\_\_\_\_

**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: \_\_\_\_\_

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

Provider Address: \_\_\_\_\_

\_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

# Iowa Veterans Home Application Information Checklist

## Items required to be submitted with Iowa Veterans Home application:

- Completed IVH Application for Admission (Veterans must use form 475-0409; Spouses and surviving spouses of veterans must use form 475-0410; Gold star parents must use form 475-2044)
- Signatures on the bottom of page three (3) to include applicant/legal representative; one (1) signature from Director/Administrator/Veteran Service Officer or a Commissioner of Veteran Affairs in the county of legal residence and a notary verifying the authentic signature of the County representative.
- Complete History and Physical dated and signed within three months of the receipt of application with current medication list and current immunization list from the medical provider. **(If currently at a hospital or other nursing care facility, also provide the following: MDS; MAR w/PRN's; PASRR; Facesheet.)**
- Signed "Consent to Release of Information" (Form 475-0859) for all current medical providers and facilities of residence, if applicable
- Completed Personal Functional Assessment (Form 475-0837)
- Copy of DD 214 (Honorable Discharge from the military: Spouses and Gold Star parents must supply Veteran's)
- Completed Financial Affidavit (Form 475-0839) and Supplement to Application (Form 475-0843)
- Copy of marriage certificate must be provided by all current and surviving spouses\*
- Copy of death certificate of spouse or child must be provided by all surviving spouses and gold star parents\*
- Copy of all Powers of Attorney for Healthcare and/or Finance and/or the Judge's Order and Letters of Appointment for Guardianship and/or Conservatorship, if these exist

## Items needed prior to the date of admission:

- Copy of birth certificate\*
- Copy of marriage certificate/divorce decree/legal separation/spouse's death certificate (Whichever is applicable for **all** marriages.)\*
- Verification of all income and assets including a copy of all pages of statements from all banking and other asset accounts for the most recent three (3) months
- Copy of previous calendar year's year end statements (W-2's & 1099's) from all incomes
- Total of previous calendar year's unreimbursed medical expenses, including insurance premiums
- Copies of Private medical insurance card, Medicare card, Prescription Drug card (Medicare Part D), Medicaid card (Title 19) and DVA card. Please provide front and back of cards)
- Copy of Social Security card and State-issued photo identification, if available
- Copies of facesheet for all life insurance policies, if applicable
- Copy of Long-Term Care (Nursing Home) insurance policy, if applicable
- Copy of prepaid burial, if applicable
- Copy of deed for burial lot(s), if applicable

*\*NOTE: You may need to provide certified copies of birth certificate; marriage certificate; divorce decree or legal separation (whichever is applicable) for all marriages. You will be notified if this is necessary.*

- ☆ **Please mail this information to: Jason Matteson, Admissions Coordinator, Iowa Veterans Home, 1301 Summit Street, Marshalltown, IA 50158. Information may be faxed to 641-844-6303, Attn: Jason Matteson or sent via email to [jason.matteson@ivh.state.ia.us](mailto:jason.matteson@ivh.state.ia.us).**
- ☆ **Contact Jason Matteson, Admissions Coordinator, at 641-753-4325 with any questions related to admission.**
- ☆ **Contact Kathy Kopsa, Admissions Supervisor, at 641-753-4514 with any questions related to financial information or cost of care. Verification of all incomes and assets must be submitted prior to the scheduling of an admission date to ensure accurate billing for care.**

**CONSENT TO RELEASE OF INFORMATION**

NAME \_\_\_\_\_ Date of Birth \_\_\_\_\_

SSN \_\_\_\_\_ Claim # \_\_\_\_\_ Service # \_\_\_\_\_

**I, THE UNDERSIGNED, HEREBY AUTHORIZE:**

(Name and address of organization or individual from whom information is to be released.)

**TO DISCLOSE AND/OR DELIVER TO:**

(Name and address of person, Institution or organization.)

Iowa Veterans Home  
1301 Summit St  
Marshalltown, IA 50158

(641)753-4325  
(641)844-6303 (fax)

Only the following specific information from the subject records: (specify dates of service rendered). **(See reverse side for specific consents for mental health, substance abuse and or HIV/AIDS information.)**

Progress notes; consultation reports; operative report(s); history and physical exam(s); social history(s); multidisciplinary summaries; Rehabilitation Medicine note(s)/evaluation(s); PT, OT, Corrective Therapy; Laboratory & Radiology Reports; Respiratory Therapy Report(s); Speech & Audiology Report(s); nutrition note(s); discharge summaries; immunization records; appointments

I understand that this information is to be used (Reason for release of information) \_\_\_\_\_  
Admission processing

I also understand that I may revoke this consent at any time by sending a written notice to the discloser of this information. I understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality. I understand I may review the disclosed information. This authorization will automatically expire one year from the date of signature, except as specified: \_\_\_\_\_  
At that time no express revocation shall be needed to terminate my consent.

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DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

**Specific Authorization For Release of:**

<b>Mental Health Information</b> (including neuropsychiatric testing).	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
			Date and Initial
<b>Substance Abuse Information</b> (including drug and alcohol abuse)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
			Date and Initial
<b>HIV/AIDS/ARC Information</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
			Date and Initial

I acknowledge that data to be released **MAY INCLUDE** information that is protected by Federal Law and that it is applicable to any one or all of the above. My signature authorizes release of all specified information.

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SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**IN ORDER FOR THE ABOVE INFORMATION TO BE RELEASED, YOU MUST SIGN HERE AND ON THE FRONT SIDE.**

**PERSONAL FUNCTIONAL ASSESSMENT**

**ALL INFORMATION REQUESTED ON THIS FORM IS REQUIRED except for sections titled other considerations and please comment.**

***IF YOU ARE CURRENTLY IN A FACILITY, PLEASE HAVE LICENSED CAREGIVER COMPLETE THIS FORM. IF CURRENTLY IN A LONG-TERM CARE FACILITY, ATTACH COPY OF CURRENT MDS; MAR w/ PRNs; PASRR AND FACESHEET.***

For each area of your functioning listed on the following pages, please mark the description which best describes your current ability. The word "assistance" means supervision, direction or personal assistance. For "Other Considerations", please note any additional information which you believe is pertinent and will assist the Admissions Committee in determining the correct level of care. Unless otherwise directed, mark the one box that is most representative of your abilities. Attach additional sheets as necessary.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Currently Living At: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone Number(s): \_\_\_\_\_

Name of Person Completing This Form: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_



**BATHING**

- No assistance needed. I get in and out of shower and/or tub by myself (if tub is the usual means of bathing).
- Cueing only. Can bathe self  
Assistance with set-up. Please explain set up required.
- \_\_\_\_\_  
\_\_\_\_\_
- Some assistance in bathing. *Please explain assistance required.*
- \_\_\_\_\_  
\_\_\_\_\_
- Total assistance in bathing.

Other considerations: \_\_\_\_\_  
\_\_\_\_\_

**DRESSING** - Getting clothes from closets and drawers, including underclothes, outer garments, and using fasteners (including braces, if worn).

- I get my clothes and get completely dressed without assistance.
- I get my clothes and get completely dressed with adaptive devices. *(Please explain below.)*
- I get completely dressed by myself once clothes are set out.  
I require cueing to complete dressing. Please explain cueing required.
- \_\_\_\_\_  
\_\_\_\_\_
- I receive some assistance in getting clothes and getting dressed. *(Please explain assistance needed below.)*
- I receive total assistance in getting clothes and getting dressed.

Other considerations: \_\_\_\_\_  
\_\_\_\_\_

**GROOMING: HAIR**

- I get out needed items and can comb/brush my hair myself.
- I can brush/comb my hair myself but need set-up.  
I need cueing to complete. Please explain cueing required.
- \_\_\_\_\_  
\_\_\_\_\_
- I need total assistance with brushing/combing my hair.

**SHAVING**

- I get out needed items and can shave myself.
- I can shave myself but need set-up.  
I need cueing to complete. Please explain cueing required
- \_\_\_\_\_  
\_\_\_\_\_
- I need total assistance with shaving.
- I typically use an electric razor.

**ORAL HYGIENE**

- I get out needed items and clean my teeth/dentures myself.
- I can clean my teeth/dentures myself but need set-up.  
I can clean my teeth/dentures myself but need cueing to complete.  
Please explain cueing required
- \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- I need total assistance with cleaning my teeth/dentures.

**TOILETING** - Going to the “bathroom” for bowel and urine elimination, cleaning self after elimination, and arranging clothes.

- I require no assistance in toileting.
- I require assistance in getting to and from the “bathroom” only.
- I require assistance getting to and from the “bathroom”, cleaning myself and/or in arranging clothes after elimination or in use of night bedpan or commode.

Other considerations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**CONTINENCE** (Choose all that apply)

- I control urination completely by myself.
- I control bowel movements completely by myself.
- I occasionally lose control of: (If checked, mark one of the following)
  - bowel       bladder       both
- I **cannot** control urination.
- I **cannot** control bowel movements.
- I use adult incontinent protection such as Attends, Depends, or other incontinent pads. (If checked, mark one of the following)
  - I care for them myself       I need assistance with changing
- I have a catheter. (If checked, mark one of the following)
  - indwelling       external       suprapubic
- I have a colostomy or ileostomy and can care for this myself.
- I have a colostomy or ileostomy and need assistance with this.

Other considerations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ORIENTATION (Choose all that apply)**

- Never confused or disoriented.
- Rarely confused or disoriented. Describe confusion.  
\_\_\_\_\_
- Sometimes confused, disoriented and forgetful. (To include functioning in familiar surroundings, but gets disoriented in new surroundings.) Describe confusion.  
\_\_\_\_\_
- Totally confused and disoriented. Describe confusion.  
\_\_\_\_\_
- I experience frequent periods of agitation such as yelling, hitting or throwing things. Explanation required: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please mark the appropriate answers below:**

1. Do you wander away and/or get lost?  Yes  No  
 If yes, how often? \_\_\_\_\_ Please explain the circumstances: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. Are you safe to be left alone at home *alone* for more than two hours?  Yes  No

3. Are you currently in a secure memory care area?  Yes  No

4. Do you wear a WanderGuard bracelet?  Yes  No

**\*\*If using a WanderGuard does the individual check doors or in some other way try to exit the facility?**  Yes  No

5. Are restraints currently being used?  Yes  No  
 If yes, state type and frequency: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**FOOD & NUTRITION SERVICES:**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs. My usual weight is: \_\_\_\_\_ lbs.

I have experienced significant changes in weight in the past 6 months:  Yes  No

If yes, describe: \_\_\_\_\_

I have a food allergy or intolerance:  Yes (list below)  No

Food allergies (if any): \_\_\_\_\_

Food intolerance (if any): \_\_\_\_\_

I have special dietary needs related to my religion, culture or ethnicity:  Yes  No

If yes, please describe: \_\_\_\_\_

*\*\*IMPORTANT NOTICE: IVH does not offer holistic and/or organic foods and drinks. Residents may purchase these at their own expense if they wish\*\**

My usual diet(s):

Regular  Heart Healthy

Diabetic (Small Portions diet available)

Renal/Dialysis (Modified Renal diet available)

Pureed  Thickened Liquids  Tube feeding: \_\_\_\_\_

I have difficulty swallowing and/or chewing?  Yes  No

My appetite is generally:  Good  Fair  Poor

I am able to feed myself food & drinks:  Always  Sometimes  Not usually or never

I use adaptive tools at meals (e.g. weighted silverware, plate guard, etc.)  Yes  No

If yes, list adaptive tools: \_\_\_\_\_

Other considerations: \_\_\_\_\_

**MEDICATIONS** (Choose all that apply)

- I take my own medications.
- I take my own medications after someone else sets them up.
- Need reminders to take medications. What mechanism is used to remind you to take medications?
- Someone else gives me my medications.
- I receive medications by injection.
- I receive my medications crushed.

Other considerations: \_\_\_\_\_  
\_\_\_\_\_

**OXYGEN**

- Occasional Liter flow? \_\_\_\_\_  
How often used? \_\_\_\_\_
- Continuous Liter Flow? \_\_\_\_\_
- Do not use
- CPAP/BiPAP
- Other

Please mark the appropriate response for oxygen use:  Receive at bedside  Portable

Are you compliant with your oxygen use?  Yes  No

Do you own your oxygen equipment?  Yes  No

If yes, who issued the equipment? Medicare  DVA  Personal Purchase

Other considerations: \_\_\_\_\_  
\_\_\_\_\_

**MOBILITY**

- I can walk two blocks with or without assistive devices independently.
- I require assistive devices to walk independently. (Mark all that apply)
  - cane       walker       crutches

Distance able to walk with the use of assistive devices? \_\_\_\_\_

- I use a manual wheelchair and can operate it independently. Distance able to wheel manual wheelchair without assist? \_\_\_\_\_
- I use a manual wheelchair and require assistance to operate it.
- I use a walker and need assistance of one person to ambulate.
- I use a walker and need assistance of more than one person to ambulate.
- I have a power mobility device (electric wheelchair or scooter) that I use.
- Please see supplement related to power mobility devices at the Iowa Veterans Home.

Other considerations: \_\_\_\_\_  
\_\_\_\_\_

**TRANSFERS**

- I get in and out of bed as well as in and out of a chair without assistance.
- I require assistance from one person to get in and out of bed or chair.
- I require assistance from more than one person to get in and out of bed or chair.
- I require a lift to get in and out of bed or chair. Type of lift needed:
  - Ceiling Lift    Stand Lift    Hoyer Lift
- I can turn from side to side when in bed without assistance.
- I need assistance to turn from side to side when in bed.

Other considerations: \_\_\_\_\_  
\_\_\_\_\_

**FALL HISTORY**

Have you had any recent falls?    Yes    No      If yes, please explain the circumstances surrounding each fall: \_\_\_\_\_  
\_\_\_\_\_

If yes, how many falls have you had in the last 3 months? \_\_\_\_\_

Are these falls a change in baseline behavior?    Yes    No

When was your last fall? \_\_\_\_\_

**PROSTHESIS**

If you use prosthesis, please state type: \_\_\_\_\_

Eyeglasses     Hearing aids     Dentures     Other \_\_\_\_\_

I can apply my own prosthesis:     Yes     No

Other considerations: \_\_\_\_\_

\_\_\_\_\_

**REHABILITATIVE SERVICES**

Have you previously received or are you receiving rehabilitation treatment for a current physical condition?     Yes     No

Type of therapy received: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

LOCATION

DATES

\_\_\_\_\_

\_\_\_\_\_

**MENTAL HEALTH**

Are you under a court commitment?     Yes     No

If yes, please mark appropriate type:     Inpatient     Outpatient

Have you ever been hospitalized or received care in relation to mental health problems?

Yes     No

If yes, list name of doctor or agency:    Date(s)    Length of Stay

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**ALCOHOL/CHEMICAL DEPENDENCE**

- I do not drink alcoholic beverages nor do I use other chemical substances and have no history of problems with these substances.
- I occasionally drink alcoholic beverages, but never to excess and have no history of problems with these substances.
- I have in the past, but not within the last year, and do not currently have problems with alcohol and/or chemical dependency.
- I currently have problems associated with alcohol and/or chemical dependency.

Have you consumed alcohol or chemical substances in the past 60 days?  Yes  No

If yes, what and how much? \_\_\_\_\_ How often? \_\_\_\_\_

Please list treatment programs attended/completed and date(s):

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Other considerations: \_\_\_\_\_

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**TOBACCO USE**

1) Do you smoke cigarettes, e-cigarettes, cigars or vape?  Yes  No

2) Do you chew tobacco or use snuff?  Yes  No

**OTHER HEALTH CONSIDERATIONS**

Presently I have:  Pressure Ulcers  Skin Rashes  Injuries

Please describe: \_\_\_\_\_

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Other considerations: \_\_\_\_\_

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Please provide the date of the most recent immunization below. If you have never received an immunization listed below, please indicate this. *Immunization records must be obtained prior to any potential admission.*

Tetanus (Td, Tdap)	Date: _____	Hepatitis B	Date: _____
Influenza	Date: _____	Zostavax	Date: _____
Pevnar 13	Date: _____	Shingrix 1	Date: _____
Pneumovax 23	Date: _____	Shingrix 2	Date: _____
Covid – 19	Date: _____		

List reaction(s) to any of the immunizations above \_\_\_\_\_

Please answer the following questions to the best of your ability: (Mark yes or no)  
If yes, please explain, including dates. Use available space on page 12, if needed.

1. Have you had a TB skin test?  Yes  No Date: \_\_\_\_\_
2. Did you have a reaction?  Yes  No
3. Do you presently have or have you had a history of infection(s) and/or communicable disease(s)?  Yes  No
4. Do you presently have or have you had a history of having MRSA or VRE or any other resistive disease?  Yes  No

If you answered yes to any question above, please explain, including dates:

Have you been diagnosed with the following illnesses?

Measles (Red Measles)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____
Mumps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____
Rubella (German Measles)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____
Pertussis (Whooping Cough)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____
Smallpox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____
Chicken Pox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____
Polio	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____

**THIS SPACE PROVIDED FOR ANY ADDITIONAL COMMENTS/INFORMATION YOU MAY HAVE:**

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**FINANCIAL AFFIDAVIT**

**Verification of ALL financial information is required for admission  
Use additional sheets as necessary**

Veteran's Name: \_\_\_\_\_

I (or as financial legal representative for applicant) hereby  
declare that my total income and assets are as follows:

**Per Month Incomes:**

**Veterans Affairs Compensation/Pension...** \$ \_\_\_\_\_

**Social Security/Railroad Retirement (Gross)** \$ \_\_\_\_\_

Medicare Part B Deduction..... \$ \_\_\_\_\_

Medicare Part D Deduction..... \$ \_\_\_\_\_

Medicare Part D Company: \_\_\_\_\_

Net..... \$ \_\_\_\_\_

**Military Retirement (Gross)**..... \$ \_\_\_\_\_

Any Deduction..... \$ \_\_\_\_\_

Net..... \$ \_\_\_\_\_

**IPERS (Gross)**..... \$ \_\_\_\_\_

Any Deduction..... \$ \_\_\_\_\_

Net..... \$ \_\_\_\_\_

**Civil Service Annuity (Gross)**..... \$ \_\_\_\_\_

Any Deduction..... \$ \_\_\_\_\_

Net..... \$ \_\_\_\_\_

**Company Retirement Pension(s)**..... \$ \_\_\_\_\_

Any Deduction..... \$ \_\_\_\_\_

Net..... \$ \_\_\_\_\_

Name of Pension: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Long-Term Care/Nursing Home Insurance**

Daily amount: \$ \_\_\_\_\_

Name of Company: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Sale/Rent of Real Estate**..... \$ \_\_\_\_\_

**Dividends/Interest/Annuities**..... \$ \_\_\_\_\_

**Wages, Farm and/or Other Business**

**Income**..... \$ \_\_\_\_\_

Please list source: \_\_\_\_\_

\_\_\_\_\_

**TOTAL**..... \$ \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

I (or as financial legal representative for spouse) hereby  
declare that my total income and assets are as follows:

**Per Month Incomes:**

**Veterans Affairs Compensation/Pension...** \$ \_\_\_\_\_

**Social Security/Railroad Retirement (Gross)** \$ \_\_\_\_\_

Medicare Part B Deduction..... \$ \_\_\_\_\_

Medicare Part D Deduction..... \$ \_\_\_\_\_

Medicare Part D Company: \_\_\_\_\_

Net..... \$ \_\_\_\_\_

**Military Retirement (Gross)**..... \$ \_\_\_\_\_

Any Deduction..... \$ \_\_\_\_\_

Net..... \$ \_\_\_\_\_

**IPERS (Gross)**..... \$ \_\_\_\_\_

Any Deduction..... \$ \_\_\_\_\_

Net..... \$ \_\_\_\_\_

**Civil Service Annuity (Gross)**..... \$ \_\_\_\_\_

Any Deduction..... \$ \_\_\_\_\_

Net..... \$ \_\_\_\_\_

**Company Retirement Pension(s)**..... \$ \_\_\_\_\_

Any Deduction..... \$ \_\_\_\_\_

Net..... \$ \_\_\_\_\_

Name of Pension: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Long-Term Care/Nursing Home Insurance**

Daily Amount: \$ \_\_\_\_\_

Name of Company: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Sale/Rent of Real Estate**..... \$ \_\_\_\_\_

**Dividends/Interest/Annuities**..... \$ \_\_\_\_\_

**Wages, Farm and/or Other Business**

**Income**..... \$ \_\_\_\_\_

Please list source: \_\_\_\_\_

\_\_\_\_\_

**TOTAL**..... \$ \_\_\_\_\_

Veteran's Name: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

**ASSETS**

**ASSETS**

**Do you own or have any interest in real estate?** \_\_\_\_\_

**Do you own or have any interest in real estate?** \_\_\_\_\_

Address of property(ies):  
\_\_\_\_\_  
\_\_\_\_\_

Address of property(ies):  
\_\_\_\_\_  
\_\_\_\_\_

Value: \$ \_\_\_\_\_

Value: \$ \_\_\_\_\_

Is this your homestead? \_\_\_\_\_

Is this your homestead? \_\_\_\_\_

**Cash on hand**..... \$ \_\_\_\_\_

**Cash on hand**..... \$ \_\_\_\_\_

**Cash in bank/savings & loan institutions/credit unions:**

**Cash in bank/savings & loan institutions/credit unions:**

Checking..... \$ \_\_\_\_\_

Checking..... \$ \_\_\_\_\_

Savings..... \$ \_\_\_\_\_

Savings..... \$ \_\_\_\_\_

CD's..... \$ \_\_\_\_\_

CD's..... \$ \_\_\_\_\_

Name(s) on account and bank name and address for all accounts:

Name(s) on account and bank name and address for all accounts:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Do you have a burial trust agreement?** \_\_\_\_\_  
If yes, please provide a copy.

**Do you have a burial trust agreement?** \_\_\_\_\_  
If yes, please provide a copy.

**How many cemetery plots do you own?** \_\_\_\_\_

**How many cemetery plots do you own?** \_\_\_\_\_

**IRA's/401K**..... \$ \_\_\_\_\_

**IRA's/401K**..... \$ \_\_\_\_\_

**Other assets (stocks, bonds, etc.)**..... \$ \_\_\_\_\_

**Other assets (stocks, bonds, etc.)**..... \$ \_\_\_\_\_

**Do you have interest in a trust fund?** \_\_\_\_\_

**Do you have interest in a trust fund?** \_\_\_\_\_

**Life Insurance**

**Life Insurance**

Face Value..... \$ \_\_\_\_\_

Face Value..... \$ \_\_\_\_\_

Cash Value..... \$ \_\_\_\_\_

Cash Value..... \$ \_\_\_\_\_

Company Name: \_\_\_\_\_

Company Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

*Attach additional sheets as necessary and list all assets owned individually and jointly, regardless of whose name the account(s) is titled in. If married, both veteran and spouse must provide the above financial information whether or not both are admitting. I understand that, by order of the Iowa Commission of Veterans Affairs, failure to disclose my full income and assets and those of my spouse may be cause for discharge from the Iowa Veterans Home.*

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of applicant or legal financial representative

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of spouse or legal financial representative

**SUPPLEMENT TO APPLICATION FOR ADMISSION  
TO THE IOWA VETERANS HOME**

Have you or your spouse sold or given away any property (land, cash [including bonds, stocks, Certificates of Deposit], home, etc.) in the last 60 months or placed assets into a trust within the last 60 months?

Yes \_\_\_\_\_ No \_\_\_\_\_

**If you answered YES to this question, please provide documentation of the property sold/given away and complete the following information for each circumstance. Use additional sheets as necessary.**

- a. Description of the property, which was sold, given away, or placed in a trust: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- b. What was the value of the property at the time you sold or gave it away? \_\_\_\_\_
- c. How much did you receive as compensation for the property? \_\_\_\_\_
- d. When did you sell or give the property away? \_\_\_\_\_
- e. Who did you sell or give the property to? \_\_\_\_\_
- f. What is your relationship to this person? \_\_\_\_\_
- g. If compensation received for the property was less than the value of the property, please explain your reasons for accepting less than the fair market value for the property: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- h. Did you attempt to sell the property at its fair market value? Yes \_\_\_\_\_ No \_\_\_\_\_

I understand I assume full responsibility for the accuracy of the statement on this form and I understand the Iowa Veterans Home will use this statement to determine charges for care and treatment.

I am aware that Iowa laws provide anyone who obtains, or attempts to obtain, or who aids or abets any person to obtain public assistance to which he or she is not entitled is guilty of violating the laws of the State of Iowa, including but not limited to Chapter 35D of the Code of Iowa.

I HEREBY CERTIFY THAT THE STATEMENTS MADE HEREIN ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

\_\_\_\_\_  
Signature or Mark of Applicant (or Financial Legal Representative) DATE

\_\_\_\_\_  
Applicant's Name (Please type or print) Social Security Number



# IOWA VETERANS HOME

1301 Summit Street  
Marshalltown, Iowa 50158-5485  
Ph: (641) 752-1501  
Fax: (641) 753-4278

Kim Reynolds, Governor  
Adam Gregg, Lt. Governor  
State of Iowa  
Matthew Peterson, Commandant

**For: All Iowa Veterans Home resident applicants**

**Subject: Important information for new residents**

## **Tobacco Free Campus**

The Iowa Veterans Home is committed to the health, safety and well-being of all of our residents. As a result, we have made a commitment to become a tobacco (smoke and smokeless) free campus. This is to notify you that those residents choosing to move to the Iowa Veterans Home after January 1, 2020, will not be allowed to use tobacco (smoke and smokeless) products.

Privileges for residents who use tobacco products that moved to the Iowa Veterans Home prior to January 1, 2020, are grandfathered in. This means that they will be allowed to use tobacco products in designated areas during designated times.

## **Power Mobility Device (PMD) usage**

Please be advised of the following Iowa Veterans Home (IVH) policies and procedures regarding Power Mobility Device usage.

1. Upon admission, the PMD will be sent to the IVH Wheelchair Clinic where a mechanical check will be completed to ensure that the device meets IVH safety standards.
2. Each PMD will be cleaned, labeled, and inventoried.
3. Unit staff will refer the resident to IVH Optometry for a vision exam. *If an eye exam was performed within the past 12 months, this may be provided.*
4. The IVH RCC Team will complete a capabilities assessment of medical necessity, physical and cognitive ability, and the optometrist's evaluation.
5. Each resident will be scheduled for a clinic face-to-face evaluation to assure medical necessity using the CMS/VA Power Mobility Guidelines.
6. If the criteria are met, a physician's order will be obtained, a Power Mobility Device Evaluation form completed and these will be sent to the IVH Wheelchair Clinic
7. Safety operational expectations and driving criteria are reviewed with each resident. If all criteria are met, a 2-3-day PMD training is completed. With successful completion of the training, the PMD is issued for use. *Note that this process could take anywhere from a few days up to 2 weeks.*
8. IVH staff monitors the environment for safe use of PMDs on an on-going basis. Any unsafe use is addressed, as indicated, and may result in periodic or permanent removal of the device to maintain the safety of all.
9. Repairs including batteries, parts and labor are the responsibility of the Department of Veteran Affairs (DVA) if issued by the DVA. Expenses associated with a privately purchased PMD are the responsibility of the resident or their representative.