Admission Form

Colorado State Veterans Nursing Homes

Fitzsimons	Florence	Homelake/Monte Vista	**Rifle**	Walsenburg
1919 Quentin Street	903 Moore Drive	P.O. Box 97	**851 East 5th Street**	23500 US Hwy 160
Aurora, CO 80045	Florence, CO 81226	Homelake, CO 81135	**Rifle, CO 81650**	Walsenburg, CO 81089
720-857-6406	719-784-6331	719-852-5118	**970-625-0842**	719-738-5100

Applicant's name: _____ Sex _____
Last First Middle

Address: _____
Street City County State Zip

Phone number(s): _____ Religion: _____

Date of birth: _____ Place of birth: _____
City County State Country

Marital status: Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Never married ☐

Applicant is a: Veteran ☐ Veteran's spouse ☐ Veteran's widow ☐ Gold-Star Parent ☐

Military information

Branch of service: _____ Service number: _____
Date entered: _____ Date discharged: _____
Does the applicant have a service-connected disability rated by the VA? Yes ☐ No ☐
If yes, please list disability: _____ Percent disability: _____

Medical and health insurance information

Applicant's Social Security Number: _____ Medicare number: _____
Does applicant have: Medicare Part A? Yes ☐ No ☐ Medicare Part B? Yes ☐ No ☐
Does an HMO manage the applicant's Medicare? Yes ☐ No ☐
Secondary/supplemental insurance: _____ Insurance ID number: _____
Medicare Part D/other prescription coverage: _____ Insurance ID number: _____
Does applicant have Medicaid? Yes ☐ No ☐ If yes, provide Medicaid ID number: _____
Has applicant received medical care from the VA? Yes ☐ No ☐ VA claim #: _____
If yes, where, when and for what did the applicant receive treatment? _____
_____
Does applicant have any of the following?:
Medical Power of Attorney (POA): ☐ General POA: ☐ Living Will: ☐ Guardian/Conservator: ☐

Spouse information

Spouse's name: _____ Maiden name (if any): _____
Last First Middle

Spouse's address: _____ Phone #: (_____)_____
Street City State Zip

Spouse's Social Security Number: _____ Spouse's date of birth: _____

Emergency notification:

1) Name: _____ Relationship: _____
   Address: _____
   Street City County State Zip
   Phone number(s): _____

2) Name: _____ Relationship: _____
   Address: _____
   Street City County State Zip
   Phone number(s): _____

3) Name: _____ Relationship: _____
   Address: _____
   Street City County State Zip
   Phone number(s): _____

If admitted to the Colorado State Veterans Home, who will handle your financial affairs? *(Provide name and phone):*

_____

Financial information:

The following financial information is required to determine eligibility for benefits and ability to pay. Please state gross monthly amounts before any deductions.

Monthly income	**Applicant**	**Spouse**
Social Security:	$ _____	$ _____
Civil Service:	$ _____	$ _____
Railroad retirement:	$ _____	$ _____
Military retirement (not VA):	$ _____	$ _____
VA service-connected disability compensation:	$ _____	$ _____
VA pension:	$ _____	$ _____
Other pensions (specify): _____	$ _____	$ _____
Gross wages (employment):	$ _____	$ _____
Total monthly income:	**$ _____**	**$ _____**

Assets	**Applicant**	**Spouse**
Cash/checking account/savings:	$ _____	$ _____
Investments:	$ _____	$ _____
Trusts:	$ _____	$ _____
Real estate (other than your residence):	$ _____	$ _____
Other:	$ _____	$ _____

Please attach copies of the following:

- Military separation orders or discharge papers (DD214 or similar document)
- Service-Connected Disability Award Letter from the VA, if applicable
- Front and back of all insurance cards
- Medical POA, General POA, guardian/conservatorship documents and living will, if available

I understand that it may be necessary for me to provide copies of bank statements periodically to verify my financial position, and that I must keep my account current.

If I am admitted, I agree to abide by the rules and regulations of the Colorado State Veterans Nursing Home. I realize that the facility is operated in full compliance with the Civil Rights Act of 1964, and the Americans With Disabilities Act of 1990, and that I am to cooperate with the nursing home in maintaining full compliance.

I authorize the State Veterans Home to verify any and all information provided on this form. The information I have provided is true and complete to the best of my knowledge and belief.

Signature: _____ Date: _____
(Applicant or POA)