

SOCIAL INFORMATION

LIST ALL INFORMATION ON SPOUSE (INCLUDE MAIDEN NAME IF FEMALE) AND ALL CHILDREN BORN OR LEGALLY ADOPTED OF THIS UNION. LIST CHILDREN BORN OF PREVIOUS MARRIAGE (S). USE ADDITIONAL SHEET IF NECESSARY.

	<u>FULL NAME</u>	<u>RELATIONSHIP</u>	<u>BIRTH DATE</u>	<u>ADDRESS</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

PLEASE LIST PERSONS TO NOTIFY IN CASE OF EMERGENCY, OR IF ADDITIONAL INFORMATION IS NEEDED.

#1 PERSON	_____	RELATIONSHIP:	_____
ADDRESS	_____	PHONE #:	_____
CITY	_____	STATE:	_____
ZIP:	_____	WORK #:	_____
#2 PERSON	_____	RELATIONSHIP:	_____
ADDRESS	_____	PHONE #:	_____
CITY	_____	STATE:	_____
ZIP:	_____	WORK #:	_____
#3 PERSON	_____	RELATIONSHIP:	_____
ADDRESS	_____	PHONE #:	_____
CITY	_____	STATE:	_____
ZIP:	_____	WORK #:	_____

(PLEASE LIST ANY ADDITIONAL PERSONS ON A SEPARATE SHEET.)

FINANCIAL INFORMATION

The applicant is charged a Monthly Maintenance Charge to live at an Illinois Veterans' Home. The following financial information is needed for both the veteran and spouse to properly advise an applicant and spouse about V.A. Benefits.

	Name of Bank or Savings & Loan	Amount	Type of Account	Location
1.	_____	\$ _____	_____	_____
2.	_____	\$ _____	_____	_____
3.	_____	\$ _____	_____	_____
4.	_____	\$ _____	_____	_____
5.	_____	\$ _____	_____	_____

MONTHLY INCOME AMOUNTS

BRING SUPPORTING DOCUMENTATION AT ADMISSION	VETERAN	SPOUSE
MILITARY RETIREMENT, VETERAN'S PENSION OR SERVICE	MONTHLY AMOUNT	MONTHLY AMOUNT
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CONNECTED COMPENSATION (DISABILITY%? _____)	\$ _____	\$ _____
SOCIAL SECURITY	\$ _____	\$ _____
MONTHLY INTEREST / DIVIDENDS	\$ _____	\$ _____
PENSION BENEFITS	\$ _____	\$ _____
ANNUITY	\$ _____	\$ _____
RENTAL PROPERTY (NET)	\$ _____	\$ _____
OTHER	\$ _____	\$ _____
TOTAL MONTHLY INCOME	\$ _____	\$ _____

IF ABOVE INCOME GOES TO A REPRESENTATIVE PAYEE, PLEASE PROVIDE THEIR NAME, ADDRESS, AND PHONE #:

FINANCIALLY RESPONSIBLE PERSON

<u>FULL NAME</u>	<u>RELATIONSHIP</u>	<u>BIRTHDATE</u>	<u>STREET ADDRESS, CITY STATE AND ZIP</u>
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INSURANCE POLICIES

HEALTH INSURANCE (NON-MEDICARE) YES _____ NO _____ MONTHLY PREMIUM COST: _____

COMPANY: _____ POLICY NO: _____

PLEASE PROVIDE A COPY OF INSURANCE CARD (FRONT AND BACK)

MEDICARE PARTICIPATION IS MANDATORY (IF NOT CURRENTLY PARTICIPATING, RESIDENT WILL BE SIGNED UP AT ADMISSION)

MEDICARE: PART A (HOSPITALIZATION) YES _____ NO _____ EFFECTIVE DATE _____

MEDICARE: PART B (MEDICAL COVERAGE) YES _____ NO _____ EFFECTIVE DATE _____

PREPAID FUNERAL ARRANGEMENTS YES _____ NO _____ **PROVIDE COPY.**

ADVANCE DIRECTIVES AND LEGAL AUTHORITY

DO YOU HAVE ANY OF THE FOLLOWING ADVANCE DIRECTIVES OR LEGAL APPOINTMENTS:

LIVING WILL _____ YES _____ NO _____ CONSERVATOR _____ YES _____ NO _____

LEGAL GUARDIANSHIP _____ YES _____ NO _____

POWER OF ATTORNEY _____ YES _____ NO _____ WHAT TYPE _____

NOTE: IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS REGARDING ADVANCE DIRECTIVES OR LEGAL AUTHORITY YOU MUST PROVIDE A COPY OF THOSE DOCUMENTS BEFORE OR UPON ADMISSION.

I agree to abide by and obey the rules and regulations governing the Illinois Veterans' Homes and to accept transfer to another hospital, special treatment center, or Home if in the opinion of the Medical Staff, such transfer is deemed advisable. I/We understand that should I/We receive additional income or be eligible for any additional income at any future date, from any sources, that it is mandatory that it be reported to the Home, and that failure to do so shall be cause for discharge.

This authorizes the Administrator of the Home or his/her representative to verify any facts relative to my/our financial status or income.

I have read or have had read to me all questions and answers on this form and the answers are true and complete to the best of my knowledge and belief. I also understand that any falsification regarding the aforementioned information will be reason for discharge from the Home.

SIGNED: _____

DATE: _____

IMPORTANT NOTICE: This application must be fully completed in all portions and accompanied by a Photostatic copy of your HONORABLE DISCHARGE (DD 214), and the DEPARTMENT OF VETERANS' AFFAIRS HEALTH QUESTIONNAIRE. If this form is signed by anyone other than the applicant, a copy of their legal authority must accompany the application.

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TO BE COMPLETED BY DEPARTMENT PERSONNEL

Applicant (meets) (does not meet) Veterans' eligibility criteria.

Signature of Adjutant

Applicant medically (eligible) (ineligible)

Signature of Medical Officer

This application has been carefully investigated and it is recommended that the Applicant (be admitted) (not be admitted) to reside in the Illinois Veterans' Home.

This State Agency is requesting disclosure of information necessary to accomplish the statutory purpose of P.A. 79-1384, Paragraph 5. Inasmuch as this information is VOLUNTARY, failure to provide same may prevent admission to the Veterans' Home.

DATE

SIGNATURE OF ADMINSTRATOR

**HEALTH QUESTIONNAIRE
DEPARTMENT OF VETERANS' AFFAIRS
ILLINOIS VETERANS' HOMES**

**APPLICATION WILL NOT BE REVIEWED UNLESS THIS FORM IS COMPLETED AND A COPY OF THE
LAST OR MOST RECENT HISTORY AND PHYSICAL OR DISCHARGE SUMMARY IS ATTACHED.
(TO BE COMPLETED BY LICENSED PHYSICIAN)**

APPLICANT NAME: _____ DATE: _____

Current residence: Acute hospital _____ Nursing home _____ Home _____

Name, Address and Phone Number of Hospital or Nursing Home

If at home, number of inhabitants _____

HEIGHT : _____ WEIGHT: _____

CURRENT DIAGNOSIS(SES):

Present medications taken (Type, strength, dosage)

Allergies and Allergic Reactions

PLEASE CHECK EACH OF THE FOLLOWING:

(Space provided on page 4 for additional comments or attach additional sheets.)

	YES	NO	PARTIALLY
1. <u>Can applicant do the following:</u>			
a. Dress and use lavatory?	_____	_____	_____
b. Bathe?	_____	_____	_____
c. Oral hygiene?	_____	_____	_____
d. Reposition in bed?	_____	_____	_____
e. Ascend and descend steps?	_____	_____	_____
f. Feed self?	_____	_____	_____
g. Operate wheelchair, if needed, without aid?	_____	_____	_____

		YES	NO	PARTIALLY
2.	Is applicant:			
	a. Aphasic?	_____	_____	_____
	b. Deaf?.....	_____	_____	_____
	c. Blind?.....	_____	_____	_____
	d. Cardiac Patient?.....	_____	_____	_____
	e. Using oxygen?	_____	_____	_____
	f. Continent of bowel?.....	_____	_____	_____
	g. Continent of bladder?.....	_____	_____	_____
	h. Mentally competent?.....	_____	_____	_____
	i. Able to walk 1 block?	_____	_____	_____

3. Does applicant require sensory aid? _____ Specify: _____

		YES	NO
4.	Does applicant have decubiti (bedsores)?	_____	_____

If yes, describe: _____

5. **	Is any infection present?	_____	_____
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**	Is there a history of MRSA, VRE or any other anti-biotic resistant infection?.....	_____	_____
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6. **	Is applicant undergoing Cancer/Dialysis treatment?	_____	_____
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**	Is there a past history of Cancer/Dialysis?	_____	_____
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7. **	Is applicant ambulatory without assistance?	_____	_____
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a.	Require crutches, walker, wheelchair?	_____	_____
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b.	Require complete bed care?	_____	_____
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8. **	Does applicant require prosthesis?	_____	_____
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** If answer to questions 5, 6, 7, or 8 is YES, please give brief explanation:

		YES	NO
9.	Is applicant mentally capable of managing personal needs or self-administering oral medications without supervision? (Explain on page 4).....	_____	_____

10. **Does applicant have a history of: (Explain YES answers on page 4)**

a.	Alcoholism? (Treatment program; see #15)	_____	_____
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b.	Epilepsy?	_____	_____
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c.	Dyspnea?	_____	_____
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d.	Psychiatric treatment? (When, where; see #15).....	_____	_____
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e.	Chemical abuse? (Include prescription meds).....	_____	_____
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f.	Depression?.....	_____	_____
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g.	Verbally combative? (Give examples on Page 4).....	_____	_____
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h.	Physically combative? (Give examples on Page 4).....	_____	_____
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YES NO

11. Does applicant require:
- a. Observation to make his/her wants known? _____
 - b. Spoon-feeding? _____
 - c. Tube feeding? _____
 - d. Tracheostomy suctioning? _____
 - e. Colostomy / Urostomy care?..... _____
 - f. Special Diet? Specify: _____
 - g. Appetite? Specify: _____
 - h. Is applicant a cigarette smoker? _____
Use of other tobacco products? Specify: _____
 - i. Does applicant have Foley catheter? _____

12. Will applicant require supervision to prevent wandering from assigned unit? If YES, please give a brief explanation: _____

13. Most recent date applicant had the following vaccine/tests:
- Pneumonia _____
 - Influenza _____
 - Tetanus/Diphtheria (DT) _____
 - Mantoux . . . If positive - Millimeter of Induration _____
 - Treatment received: _____

14. Has applicant been hospitalized or received outpatient treatment for any of the following reasons?

	Hospital	City	Date
Psychiatric treatment	_____		
Surgery	_____		
Alcohol/Substance Abuse	_____		
Please give brief explanation:	_____		

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NOTICE TO EXAMINING PHYSICIAN - History, symptoms and physical findings must be recorded in sufficient detail to clearly support the diagnoses. Include recent history or current diagnosis of infectious disease with pertinent pathology information.

PUBLIC ACT 90-366 REQUIRES THAT BEFORE A PROSPECTIVE RESIDENT'S ADMISSION TO A FACILITY, THE FACILITY SHALL ADVISE THE PROSPECTIVE RESIDENT TO CONSULT A PHYSICIAN TO DETERMINE WHETHER THE PROSPECTIVE RESIDENT SHOULD OBTAIN A VACCINATION AGAINST PNEUMOCOCCAL PNEUMONIA.

PLEASE ADD COPIES OF PATIENT'S LAST HOSPITALIZATION (H & P) OR MOST RECENT DISCHARGE SUMMARY AND MOST RECENT NINETY DAYS OF NURSING NOTES IF CURRENTLY IN A NURSING HOME

ADDITIONAL COMMENTS
(Please attach additional sheets if necessary)

Based on the applicant's current medical status, placement for nursing home care is appropriate.

YES _____ NO _____

Signed: _____
Examining Physician

Address: _____

Date: _____

City, State
Zip Code _____

Name: _____
Printed / Typed

Phone: (_____) _____
Area Code Phone Number

IMPORTANT NOTICE: This State Agency is requesting disclosure of information necessary to accomplish the statutory purposes of ILCS Chapter 20, Act 2805. Inasmuch as this information is VOLUNTARY, failure to provide it may prevent admission to the Veterans Home. This form has been approved by the Forms Management Center.

APPLICATION WILL NOT BE REVIEWED UNLESS THIS FORM IS COMPLETED AND A COPY OF THE LAST OR MOST RECENT HISTORY AND PHYSICAL OR DISCHARGE SUMMARY IS ATTACHED.