

**ILLINOIS DEPARTMENT OF VETERANS' AFFAIRS
APPLICATION FOR ADMISSION TO AN ILLINOIS VETERANS HOME**

Anna Veterans Home
792 N. Main Street
Anna, IL 62906
(618) 833-5394

LaSalle Veterans Home
1015 O'Conor Avenue
LaSalle, IL 61301
(815) 410-8375

Chicago Veterans Home
4250 N. Oak Park Ave.
Chicago, IL 60634
(773) 794-3763

Manteno Veterans Home
One Veterans Drive
Manteno, IL 60950
(815) 468-6581, x226

Quincy Veterans Home
1707 N. 12th Street
Quincy, IL 62301
(217) 222-8641, x02454

PLEASE READ INSTRUCTIONS BEFORE COMPLETING APPLICATION

Assistance in completing this application may be obtained from any of the above offices. All questions on this form must be answered. The information provided will be used to determine eligibility; appropriate level of care; and to allow preliminary planning for care and treatment. **This application can only be signed by the applicant or their legal representative.**

APPLICANT INFORMATION

APPLICANT'S FULL NAME: _____
(FIRST) (MIDDLE) (LAST)

CURRENT ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____ COUNTY: _____

PRIMARY PHONE NUMBER: (____) _____ ALTERNATE PHONE NUMBER: (____) _____

EMAIL ADDRESS: _____ SOCIAL SECURITY #: _____

DATE OF BIRTH: _____ BIRTHPLACE: _____ AGE: _____ SEX: _____

MARITAL STATUS: MARRIED WIDOWED SEPARATED DIVORCED NEVER MARRIED

NUMBER OF DEPENDENTS: _____ FORMER OCCUPATION OF VETERAN: _____

HAVE YOU EVER BEEN CONVICTED OF A FELONY? YES NO WHEN? _____

PERSON TO CONTACT IF DIFFERENT FROM APPLICANT

FULL NAME: _____

CURRENT ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____ COUNTY: _____

PRIMARY PHONE NUMBER: (____) _____ ALTERNATE PHONE NUMBER: (____) _____

EMAIL ADDRESS: _____ RELATIONSHIP: _____

MILITARY INFORMATION

STATUS: VETERAN NON-VETERAN GOLD STAR PARENT OTHER: _____

SERVICE BRANCH: ARMY NAVY MARINES AIR FORCE COAST GUARD MERCHANT MARINE

SERVED DURING: WORLD WAR II KOREA VIETNAM PERSIAN GULF/OEF/OIF OTHER: _____

DID YOU RECEIVE AN EXPEDITIONARY MEDAL? YES NO WERE YOU A P.O.W? YES NO

DATE ENTERED ACTIVE SERVICE: _____ PLACE ENLISTED: _____

DATE OF DISCHARGE: _____ PLACE DISCHARGED: _____

TYPE OF DISCHARGE: _____ SERVICE #: _____

DO YOU HAVE A VA CLAIM #? YES NO VA CLAIM # _____

DEMOGRAPHICS INFORMATION

HAVE YOU PREVIOUSLY LIVED IN OR APPLIED FOR ADMISSION AT AN ILLINOIS VETERANS' HOME? YES NO
IF YES, WHICH HOME? _____ WHEN? _____

ARE YOU PRESENTLY ON A WAITING LIST AT ONE OF THE ILLINOIS VETERANS' HOMES? YES NO
IF YES, WHICH HOME? _____ WHEN? _____

WHAT CARE LEVEL ARE YOU APPLYING FOR? SKILLED NURSING INDEPENDENT LIVING

I HAVE LIVED IN THE STATE OF ILLINOIS CONTINUOUSLY FOR THE PAST YEAR / 12 MONTHS. YES NO
RESIDENCE ADDRESS FOR LAST 12 MONTHS: _____ FROM: _____ TO: _____

NEXT OF KIN/FRIENDS INFORMATION

LIST ALL INFORMATION ON SPOUSE (INCLUDING MAIDEN NAME) 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>DOB</u>	<u>ADDRESS</u>	<u>PHONE</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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

#1 PERSON _____ RELATIONSHIP: _____
ADDRESS: _____ PRIMARY PHONE #: _____
CITY: _____ STATE: _____ ZIP: _____ ALTERNATE PHONE #: _____
EMAIL ADDRESS: _____

#2 PERSON _____ RELATIONSHIP: _____
ADDRESS: _____ PRIMARY PHONE #: _____
CITY: _____ STATE: _____ ZIP: _____ ALTERNATE PHONE #: _____
EMAIL ADDRESS: _____

#3 PERSON _____ RELATIONSHIP: _____
ADDRESS: _____ PRIMARY PHONE #: _____
CITY: _____ STATE: _____ ZIP: _____ ALTERNATE PHONE #: _____
EMAIL ADDRESS: _____

FINANCIAL INFORMATION – BANK ACCOUNTS

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 / Credit Union / Savings & Loan	Amount	Account Type	Location

FINANCIAL INFORMATION - MONTHLY INCOME AMOUNTS

(BRING SUPPORTING DOCUMENTATION AT ADMISSION)

VETERAN

SPOUSE

MILITARY RETIREMENT, VETERAN’S PENSION OR SERVICE
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

FULL NAME

RELATIONSHIP

BIRTH DATE

STREET ADDRESS, CITY, STATE, AND ZIP

INSURANCE POLICIES

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

COMPANY: _____ POLICY NO: _____

PLEASE BRING INSURANCE CARD ON ADMISSION. MEDICARE PARTICIPATION IS MANDATORY (IF NOT CURRENTLY PARTICIPATING, YOU WILL BE ENROLLED AT ADMISSION)

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

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

PRE-PAID FUNERAL ARRANGEMENTS YES NO **(PROVIDE COPY OF AGREEMENT)**

ADVANCE DIRECTIVES AND LEGAL AUTHORITY

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

LIVING WILL YES NO

LEGAL GUARDIANSHIP YES NO

POWER OF ATTORNEY – HEALTHCARE YES NO

POWER OF ATTORNEY – FINANCIAL/PROPERTY YES NO

NOTE: IF YOU ANSWERED YES TO ANY OF THESE 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 a 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 Home Administrator or designee 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 provided 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 copy of the applicant’s **Discharge Certificate or DD 214, and the ILLINOIS 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.

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 this information may prevent admission to a Veterans’ Home.

TO BE COMPLETED BY DEPARTMENT PERSONNEL

Applicant (meets) / (does not meet) Veterans’ eligibility criteria.

Applicant medically (eligible) / (ineligible)

Signature of the Adjutant Date

Signature of Medical Officer Date

This application has been investigated and it is recommended that the applicant (be admitted) / (not be admitted) to reside in the Illinois Veterans’ Homes.

Signature of the Administrator Date

**HEALTH QUESTIONNAIRE
ILLINOIS 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 COMPLETED BY A LICENSED PROVIDER IS ATTACHED. ALSO INCLUDE THE MOST RECENT 90 DAYS OF NURSING PROGRESS NOTES.

APPLICANT NAME: _____ DATE OF EXAM: _____

Current Residence?	Home:	Hospital:	Nursing Home:
Nursing Home/Hospital Name and Address:			

1. DIAGNOSIS:

2. CURRENT MEDICATIONS/SUPPLEMENTS: (Type; Strength; Dosage)

3. ALLERGIES:

4. HX OF INFECTIOUS DISEASES

DISEASE	DATE	SITE OF INFECTION
VRE		
ESBL		
C-DIFF		
HERPES ZOSTER		
COVID-19		
OTHER:		

5. VACCINATIONS

VACCINE	YES	NO	DATE	DATE	TB/MANTOUX RESULTS
TB TEST/MANTOUX					
PREVNAR					
PNEUMOVAX					
INFLUENZA					
TDAP					
SHINGLES / HERPES ZOSTER					
COVID-19 SERIES			#1-	#2-	

6. PAST SURGERIES (When and What)

7. PAST INJURIES (When and What)

8. PAST MAJOR DISEASES (When and What)

9. FAMILY MEDICAL HISTORY (When and What)

10. LIFESTYLE HISTORY

TOBACCO USER	YES / NO	AGE STARTED		TYPE	
AGE STOPPED USING TOBACCO					

ALCOHOL USER	YES / NO	AGE STARTED		TYPE	
AGE STOPPED USING ALCOHOL		DATE COMPLETED ALCOHOL PROGRAM			

RECREATIONAL DRUG USER	YES / NO	AGE STARTED		TYPE	
AGE STOPPED USING DRUGS		DATE COMPLETED DETOX PROGRAM			

EXPLANATION:

11. BEHAVIORAL HEALTH (Does applicant have a history of the following. Explain all "yes answers)

PSYCHIATRIC TREATMENT	YES / NO	VERBALLY / PHYSICALLY COMBATIVE	YES / NO
CHEMICAL ABUSE	YES / NO	RESISTIVE TO CARE	YES / NO
ALCOHOLISM	YES / NO	"SUNDOWN" SYNDROME	YES / NO
DEPRESSION	YES / NO	ELOPEMENT RISK	YES / NO
PTSD	YES / NO	INVOLUNTARY DISCHARGE FROM HEALTHCARE FACILITY	YES / NO
SUICIDAL	YES / NO		

EXPLANATION:

12. ACTIVITIES OF DAILY LIVING (Can applicant do the following by themselves)

GET DRESSED	YES / NO / PARTIALLY	USE STAIRS SAFELY	YES / NO / PARTIALLY
TOILET SELF	YES / NO / PARTIALLY	REPOSITION IN BED	YES / NO / PARTIALLY
CONTINENT OF BOWEL	YES / NO / PARTIALLY	OPERATE WHEELCHAIR	YES / NO / PARTIALLY
CONTINENT OF BLADDER	YES / NO / PARTIALLY	OPERATE MEDICAL EQUIPMENT	YES / NO / PARTIALLY
BATHE	YES / NO / PARTIALLY	FEED SELF	YES / NO / PARTIALLY
ORAL HYGIENE	YES / NO / PARTIALLY	AMBULATE SELF	YES / NO / PARTIALLY
TRANSFER SELF	YES / NO / PARTIALLY	MENTALLY COMPETENT	YES / NO / PARTIALLY
MAKE NEEDS KNOWN	YES / NO / PARTIALLY	ABLE TO CLEARLY SPEAK	YES / NO / PARTIALLY
PREPARE & TAKE MEDICATION	YES / NO / PARTIALLY	ABLE TO UNDERSTAND SPEECH	YES / NO / PARTIALLY

EXPLANATION:

13. SPECIAL NEEDS (Explain any "Yes" answers below)

OXYGEN	YES / NO	COMPLETE BED CARE	YES / NO	COLOSTOMY	YES / NO
NEBULIZER TX	YES / NO	APHASIC	YES / NO	STOMA	YES / NO
INHALER	YES / NO	EPILEPSY	YES / NO	DEAF	YES / NO
TRACH CARE	YES / NO	CARDIAC PATIENT	YES / NO	BLIND	YES / NO
DYSPNEA	YES / NO	PACEMAKER / DEFIB	YES / NO	PRESSURE INJURY	YES / NO
ACCU CHECKS	YES / NO	FOLEY CATHETER	YES / NO	SPECIAL DIET	YES / NO

EXPLANATION:

14. DURABLE MEDICAL EQUIPMENT

GLASSES	YES / NO	CONTACTS	YES / NO	WHEELCHAIR	YES / NO
DENTURES	YES / NO	WALKER	YES / NO	CRUTCHES	YES / NO
HEARING AIDS	YES / NO	CANE	YES / NO	BRACE	YES / NO

COMMENTS:

15. FALLS

RECENT FALLS?	YES / NO	DATE:		INJURIES?	
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COMMENTS:

