Application for Admission to an Illinois Veterans' Home

Anna Veterans' Home	LaSalle Veterans' Home	Chicago Veterans' Home	Manteno Veterans' Home	Quincy Veterans' Home
792 N. Main Street	1015 O'Conor Avenue	4250 N. Oak Park Ave.	One Veterans Drive	1707 N. 12th Street
Anna, IL 62906	LaSalle, IL 61301	Chicago, IL 60634	Manteno, IL 60950	Quincy, IL 62301
(618) 833-5394	(815) 410-8375	(773) 794-3763	(815) 468-6581, x226	(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: _____

CURRENT ADDRESS: _____

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

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

EMAIL ADDRESS: _____

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 #: _____

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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.

FULL NAME	RELATIONSHIP	DOB	ADDRESS	PHONE

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:_____

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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	$	$
VA PENSION BENEFITS	$	$
ANNUITY	$	$
RENTAL PROPERTY (NET)	$	$
OTHER PENSION or INCOME	$	$
TOTAL MONTHLY INCOME	$	$

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

FINANCIALLY RESPONSIBLE PERSON

FULL NAME | RELATIONSHIP | DOB | 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)**

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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.

Signature of the Adjutant Date _____

Applicant medically (eligible) / (ineligible)

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 _____

ILLINOIS DEPARTMENT OF VETERANS AFFAIRS

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Health Questionnaire

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:_____

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

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					

Health Questionnaire

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 RECREATIONAL DRUGS _____

DATE COMPLETED RECREATIONAL DRUG PROGRAM _____

EXPLANATION: _____

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

PSYCHIATRIC TREATMENT ❍ YES ❍ NO

CHEMICAL ABUSE ❍ YES ❍ NO

ALCOHOLISM ❍ YES ❍ NO

DEPRESSION ❍ YES ❍ NO

PTSD ❍ YES ❍ NO

SUICIDAL ❍ YES ❍ NO

VERBALLY / PHYSICALLY COMBATIVE ❍ YES ❍ NO

RESISTIVE TO CARE ❍ YES ❍ NO

"SUNDOWN" SYNDROME ❍ YES ❍ NO

ELOPEMENT RISK ❍ YES ❍ NO

INVOLUNTARY DISCHARGE FROM HEALTHCARE FACILITY ❍ YES ❍ NO

EXPLANATION: _____

Health Questionnaire

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

GET DRESSED ○ YES ○ NO ○ PARTIALLY
TOILET SELF ○ YES ○ NO ○ PARTIALLY
CONTINENT OF BOWEL ○ YES ○ NO ○ PARTIALLY
CONTINENT OF BLADDER ○ YES ○ NO ○ PARTIALLY
BATHE ○ YES ○ NO ○ PARTIALLY
ORAL HYGIENE ○ YES ○ NO ○ PARTIALLY
TRANSFER SELF ○ YES ○ NO ○ PARTIALLY
MAKE NEEDS KNOWN ○ YES ○ NO ○ PARTIALLY
PREPARE & TAKE MEDICATION ○ YES ○ NO ○ PARTIALLY

USE STAIRS SAFELY ○ YES ○ NO ○ PARTIALLY
REPOSITION IN BED ○ YES ○ NO ○ PARTIALLY
OPERATE WHEELCHAIR ○ YES ○ NO ○ PARTIALLY
OPERATE MEDICAL EQUIPMENT ○ YES ○ NO ○ PARTIALLY
FEED SELF ○ YES ○ NO ○ PARTIALLY
AMBULATE SELF ○ YES ○ NO ○ PARTIALLY
MENTALLY COMPETENT ○ YES ○ NO ○ PARTIALLY
ABLE TO CLEARLY SPEAK ○ YES ○ NO ○ PARTIALLY
ABLE TO UNDERSTAND SPEECH ○ YES ○ NO ○ PARTIALLY

EXPLANATION: _____

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

OXYGEN ○ YES ○ NO
NEBULIZER TX ○ YES ○ NO
INHALER ○ YES ○ NO
TRACH CARE ○ YES ○ NO
DYSPNEA ○ YES ○ NO
ACCU CHECKS ○ YES ○ NO

NOCOMPLETE BED CARE ○ YES ○ NO
APHASIC ○ YES ○ NO
EPILEPSY ○ YES ○ NO
CARDIAC PATIENT ○ YES ○ NO
PACEMAKER / DEFIB ○ YES ○ NO
FOLEY CATHETER ○ YES ○ NO

NOCOLOSTOMY ○ YES ○ NO
STOMA ○ YES ○ NO
DEAF ○ YES ○ NO
BLIND ○ YES ○ NO
PRESSURE INJURY ○ YES ○ NO
SPECIAL DIET ○ YES ○ NO

EXPLANATION: _____

14. DURABLE MEDICAL EQUIPMENT

GLASSES ○ YES ○ NO
DENTURES ○ YES ○ NO
HEARING AIDS ○ YES ○ NO

CONTACTS ○ YES ○ NO
WALKER ○ YES ○ NO
CANE ○ YES ○ NO

WHEELCHAIR ○ YES ○ NO
CRUTCHES ○ YES ○ NO
BRACE ○ YES ○ NO

COMMENTS: _____

15. FALLS

RECENT FALLS? ○ YES ○ NO DATE: _____ INJURIES? _____

COMMENTS: _____

Health Questionnaire

ADDITIONAL COMMENTS / OTHER RELEVANT NOTES

NOTICE TO EXAMINING CLINICIAN: History, symptoms, and physical findings must be recorded in sufficient detail to clearly support the diagnoses. Include recent history of current diagnosis of infectious disease with pertinent pathology information. PURSUANT TO 210 ILCS 45/2-213 a facility shall administer or arrange for administration of a pneumococcal vaccination to each resident, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, who has not received this immunization prior to or upon admission to the facility, unless the resident refuses the offer for vaccination or the vaccination is medically contraindicated. A facility shall document in each resident's medical record that a vaccination against pneumococcal pneumonia was offered and administered, arranged, refused, or medically contraindicated

Based on the applicant's current medical status, placement for the following care levels is appropriate:

INDEPENDENT LIVING: ❍ YES ❍ NO
SKILLED NURSING CARE: ❍ YES ❍ NO

Signed: _____ Name: _____
Examining Clinician — Printed / Typed

Address: _____

City: _____ State: _____ Zip: _____

Date: _____ Phone: _____

This State Agency is requesting disclosure of information necessary to accomplish the statutory purpose pursuant to 20 ILCS 2805, et. seq., Department of Veterans Affairs Act. Inasmuch as this information is VOLUNTARY, failure to provide the information may prevent admission to an Illinois Veterans' Home.

ILLINOIS DEPARTMENT OF VETERANS AFFAIRS

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