

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'Connor 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: _____

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 _____

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					

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 TOBACCO _____

DATE COMPLETED ALCOHOL PROGRAM _____

RECREATIONAL DRUG USER YES NO AGE STARTED _____ TYPE _____ AGE STOPPED USING TOBACCO _____

DATE COMPLETED ALCOHOL 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: _____



Health Questionnaire

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

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

EXPLANATION: _____

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

- | | | |
|---|--|--|
| OXYGEN <input type="radio"/> YES <input type="radio"/> NO | NOCOMPLETE BED CARE <input type="radio"/> YES <input type="radio"/> NO | NOCOLOSTOMY <input type="radio"/> YES <input type="radio"/> NO |
| NEBULIZER TX <input type="radio"/> YES <input type="radio"/> NO | APHASIC <input type="radio"/> YES <input type="radio"/> NO | STOMA <input type="radio"/> YES <input type="radio"/> NO |
| INHALER <input type="radio"/> YES <input type="radio"/> NO | EPILEPSY <input type="radio"/> YES <input type="radio"/> NO | DEAF <input type="radio"/> YES <input type="radio"/> NO |
| TRACH CARE <input type="radio"/> YES <input type="radio"/> NO | CARDIAC PATIENT <input type="radio"/> YES <input type="radio"/> NO | BLIND <input type="radio"/> YES <input type="radio"/> NO |
| DYSPNEA <input type="radio"/> YES <input type="radio"/> NO | PACEMAKER / DEFIB <input type="radio"/> YES <input type="radio"/> NO | PRESSURE INJURY <input type="radio"/> YES <input type="radio"/> NO |
| ACCU CHECKS <input type="radio"/> YES <input type="radio"/> NO | FOLEY CATHETER <input type="radio"/> YES <input type="radio"/> NO | SPECIAL DIET <input type="radio"/> YES <input type="radio"/> NO |

EXPLANATION: _____

14. DURABLE MEDICAL EQUIPMENT

- | | | |
|---|---|---|
| GLASSES <input type="radio"/> YES <input type="radio"/> NO | CONTACTS <input type="radio"/> YES <input type="radio"/> NO | WHEELCHAIR <input type="radio"/> YES <input type="radio"/> NO |
| DENTURES <input type="radio"/> YES <input type="radio"/> NO | WALKER <input type="radio"/> YES <input type="radio"/> NO | CRUTCHES <input type="radio"/> YES <input type="radio"/> NO |
| HEARING AIDS <input type="radio"/> YES <input type="radio"/> NO | CANE <input type="radio"/> YES <input type="radio"/> NO | BRACE <input type="radio"/> YES <input type="radio"/> NO |

COMMENTS: _____

15. FALLS

RECENT FALLS? YES NO DATE: _____ INJURIES? _____

COMMENTS: _____

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.