OKLAHOMA DEPARTMENT OF VETERANS AFFAIRS

(please print clearly or type all information)

APPLICATION FOR: Nursing Care ☐ Domiciliary Care ☐ Special Needs: Psychiatric related ☐ Alzheimer related ☐

PERSONAL INFORMATION

Veteran's Legal Name:

Last Name **Address**

First Name **City** **State** **Zip Code**

Middle **County**

Home Phone: **Work Phone:** **Other Phone:** **Email:**

Preferred First Name: **SSN:** **VA Claim #:** **Sex: Male:** ☐ **Female:** ☐

Race: **Marital Status:** **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed** ☐ **Never Married** ☐

Birthdate: **Birthplace (City & State):**

Religious Preference: **Previous Occupation:**

Education: **Graduate Degree** ☐ **Bachelors Degree** ☐ **Some College** ☐ **HS Diploma** ☐ **8th Grade/Less** ☐ **No School** ☐

MILITARY SERVICE INFORMATION

(If veteran served more than one stint of active duty, complete a section below for each stint)

FIRST STINT OF ACTIVE DUTY

Branch of Service: **Army** ☐ **Air Force** ☐ **Navy** ☐ **Marines Corps** ☐ **Coast Guard** ☐ **Service Number:** **Highest Rank Attained:**

Date of Enlistment: **Where Enlisted (City & State):**

Date of Discharge: **Where Discharged (City & State):**

Type of Discharge: **Wars Served (if any):**

Honors Received:

SECOND STINT OF ACTIVE DUTY

Branch of Service: **Army** ☐ **Air Force** ☐ **Navy** ☐ **Marines Corps** ☐ **Coast Guard** ☐ **Service Number:** **Highest Rank Attained:**

Date of Enlistment: **Where Enlisted (City & State):**

Date of Discharge: **Where Discharged (City & State):**

Type of Discharge: **Wars Served (if any):**

Honors Received:

(If veteran served more than two active duty stints in military service, attach an additional sheet with the same information as above for each additional stint.)

Is veteran an ex-POW? **YES** ☐ **NO** ☐

Does veteran have a service connected disability rating from the VA? **YES** ☐ **NO** ☐ **Disability rating percent:** %

AS PROOF OF THE VETERAN'S MILITARY INFORMATION PROVIDED ABOVE, THE FOLLOWING ARE REQUIRED:

1. VETERANS DISCHARGE PAPERS (FORM DD-214) OR OTHER SEPARATION DOCUMENTS FOR EACH STINT OF SERVICE.

2. VERIFICATION OF POW STATUS (IF YOU CHECKED "YES" FOR EX-POW).

3. VA DISABILITY RATING (IF YOU CHECKED "YES" FOR SERVICE CONNECTED DISABILITY RATING FROM VA).

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(please print clearly or type all information)

FAMILY INFORMATION (LIVING RELATIVES ONLY)

Be sure to list spouse & dependent children as applicable. List other family members as needed to supply three emergency contacts.
List others if needed to identify Primary Contact, Responsible Party or Legal Guardian. Attach additional sheets if needed.
(NOTE: If desired, only supply Soc. Sec. #'s for spouse, dependent children and responsible party)

Check only one box
☐ **SPOUSE** ☐ **Dependent Child** ☐ **Non-Dependent Child** **OTHER Relation?:** ______
This person is the veteran's : (check all that apply) ☐ Emergency Contact ☐ Primary Contact ☐ Responsible Party ☐ Legal Guardian
First Name: ______ Initial: ___ Last Name: ______ Soc Sec. #: ______
Home Phone: ______ Other Phone: ______ Birth date: ______ **Email:** ______
Street Address: ______ City: ______ State: ___ Zip Code: ______

Check only one box
☐ **SPOUSE** ☐ **Dependent Child** ☐ **Non-Dependent Child** **OTHER Relation?:** ______
This person is the veteran's : (check all that apply) ☐ Emergency Contact ☐ Primary Contact ☐ Responsible Party ☐ Legal Guardian
First Name: ______ Initial: ___ Last Name: ______ Soc Sec. #: ______
Home Phone: ______ Other Phone: ______ Birth date: ______ **Email:** ______
Street Address: ______ City: ______ State: ___ Zip Code: ______

Check only one box
☐ **SPOUSE** ☐ **Dependent Child** ☐ **Non-Dependent Child** **OTHER Relation?:** ______
This person is the veteran's : (check all that apply) ☐ Emergency Contact ☐ Primary Contact ☐ Responsible Party ☐ Legal Guardian
First Name: ______ Initial: ___ Last Name: ______ Soc Sec. #: ______
Home Phone: ______ Other Phone: ______ Birth date: ______ **Email:** ______
Street Address: ______ City: ______ State: ___ Zip Code: ______

Check only one box
☐ **SPOUSE** ☐ **Dependent Child** ☐ **Non-Dependent Child** **OTHER Relation?:** ______
This person is the veteran's : (check all that apply) ☐ Emergency Contact ☐ Primary Contact ☐ Responsible Party ☐ Legal Guardian
First Name: ______ Initial: ___ Last Name: ______ Soc Sec. #: ______
Home Phone: ______ Other Phone: ______ Birth date: ______ **Email:** ______
Street Address: ______ City: ______ State: ___ Zip Code: ______

Check only one box
☐ **SPOUSE** ☐ **Dependent Child** ☐ **Non-Dependent Child** **OTHER Relation?:** ______
This person is the veteran's : (check all that apply) ☐ Emergency Contact ☐ Primary Contact ☐ Responsible Party ☐ Legal Guardian
First Name: ______ Initial: ___ Last Name: ______ Soc Sec. #: ______
Home Phone: ______ Other Phone: ______ Birth date: ______ **Email:** ______
Street Address: ______ City: ______ State: ___ Zip Code: ______

Father's Name: ______ Birthplace: ______
Mother's Maiden Name: ______ Birthplace: ______

****** <u>REQUIRED DOCUMENTS:</u>***
**** A COPY OF THE LEGAL DOCUMENT FOR ANY OF THE ABOVE IDENTIFIED AS THE LEGAL GUARDIAN.***
**** IF VETERAN CONTRIBUTES REGULARY TO SUPPORT OF A SPOUSE, SUPPLY COPY OF THE MARRIAGE CERTIFICATE.***
**** IF VETERAN CONTRIBUTES REGULARY TO SUPPORT OF A DEPENDENT CHILD, SUPPLY COPY OF BIRTH CERTIFICATE FOR EACH.***

(please print clearly or type all information)

MEDICAL INFORMATION

FOR ADMISSION TO AN OKLAHOMA VETERANS CENTER, THE VETERAN MUST SUBMIT A ***CURRENT*** PHYSICIAN'S STATEMENT OR HOSPITAL SUMMARY CONTAINING DIAGNOSIS, PROGNOSIS, MEDICATIONS AND HISTORY.

Veteran's Physician:

Name: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

IF THE VETERAN IS NOW, OR HAS BEEN WITHIN THE LAST YEAR, IN A HOSPITAL, NURSING HOME OR OTHER FULL OR PARTIAL CARE FACILITY, PLEASE SUPPLY THE FOLLOWING INFORMATION FOR THAT FACILITY.

Name of Facility: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

TO ALLOW OUR CENTER TO BE BETTER PREPARED FOR THE VETERAN, PLEASE ANSWER THE FOLLOWING QUESTIONS

☐ **YES** ☐ **NO** **Does veteran use a Dialysis machine?**

☐ **YES** ☐ **NO** **Is veteran ambulatory?**

☐ **YES** ☐ **NO** **Does veteran have use to a** ☐ **wheelchair,** ☐ **walker,** ☐ **cane?**

☐ **YES** ☐ **NO** **Is veteran alert and can he/she answer questions correctly?**

☐ **YES** ☐ **NO** **Does veteran have a tendency to wander?**

☐ **YES** ☐ **NO** **Has veteran ever been hospitalized for any type of mental problems? If YES, name & location of institution:**

Institution Name: _____ **City:** _____ **State:** _____

☐ **YES** ☐ **NO** **Can veteran feed, dress and bathe himself/herself?**

LEGAL INFORMATION

☐ **YES** ☐ **NO** **Does veteran have a Living Will, Advance Directive or DNR? (If yes, attach copies of applicable documents.)**

☐ **YES** ☐ **NO** **Has veteran granted Durable Power of Attorney/ Health Care? (If yes, attach copies of applicable documents.)**

☐ **YES** ☐ **NO** **Has veteran granted Durable Power of Attorney/ Financial? (If yes, attach copies of applicable documents.)**

☐ **YES** ☐ **NO** **Does veteran have a Legal Guardian? (If yes, attach copies of applicable documents.)**

☐ **YES** ☐ **NO** **Does veteran have a legal Financial Custodian/ Fiduciary? (If yes, attach copies of applicable documents.)**

☐ **YES** ☐ **NO** **Does veteran have a will for distribution of assets? (if yes, please provide the specific location)** _____

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(please print clearly or type all information)

FINANCIAL INFORMATION

ACTUAL INCOME: Supply the GROSS MONTHLY amount for all income items and attach documentation which verifies those monthly income amounts. Attach additional sheet if needed.

SOURCE OF INCOME	VETERAN ACTUAL	ADDITIONAL ENTITLEMENT	SPOUSE	DEPENDENT CHILD	DEPENDENT CHILD	DEPENDENT CHILD
SOCIAL SECURITY						
US Civil Service						
VA Pension/ Compensation						
Military Retirement Pay						
Supplemental Security (SSI)						
Other Retirement						
Wages/ Salary						
Other Income						
Other Income						

PLEASE ENTER TOTAL # OF DEPENDENTS HERE : ____ (EXCLUDING THE VETERAN, ENTER 0 IF NONE)

ASSETS: (Attach additional sheet if needed.)
List all assets owned by the veteran, the veterans spouse and the veterans dependent children. Include homes, vehicles, land, bank accounts, savings accounts, CD's, stocks, bonds, mutual funds, IRA's, etc.

ASSET DESCRIPTION	ASSET LOCATION	MARKET VALUE	DEBT	NET VALUE

RESPONSIBLE PARTY: (Skip this part if you identified a family member on page 2 as the responsible party.)

☐ YES ☐ NO **Is the veteran financially responsible for his own affairs?**

If the answer above is no and you did not identify a family member on page 2 as the responsible party, please provide the following information about the financially responsible party:

First Name: _____ Initial: ____ Last Name: _____ Soc Sec #: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Street Address: _____ City: _____ State: ____ Zip Code: _____

FOR ODVA USE ONLY
FOR
PROJECTED
ENTITLEMENTS

_____ PROJECTED ENTITLEMENT SOURCE	$_____ PROJECTED AMOUNT	____/____/____ PROJECTED EFFECTIVE DATE
_____ PROJECTED ENTITLEMENT SOURCE	$_____ PROJECTED AMOUNT	____/____/____ PROJECTED EFFECTIVE DATE

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INSURANCE INFORMATION

☐ YES ☐ NO Does the veteran have Medicare Part A? ☐ YES ☐ NO Does the veteran have Medicare Part B?

PLEASE SUPPLY THE FOLLOWING INFORMATION AS APPLICABLE FOR ALL INSURANCE POLICIES INVOLVING THE VETERAN, THE VETERAN'S SPOUSE OR THE VETERAN'S DEPENDENT CHILDREN.

LIFE INSURANCE? ☐ YES ☐ NO

Name of Company: City: State:

Name of Insured: Name of Beneficiary:

Amount of Insurance: $ Amount/Frequency of Premium: $ Group Number: Policy Number:

(Attach additional sheets if needed)

HEALTH/HOSPITALIZATION INSURANCE? ☐ YES ☐ NO

Name of Company: City: State:

Name of Insured: Name of Beneficiary:

Amount of Insurance: $ Amount/Frequency of Premium: $ Group Number: Policy Number:

(Attach additional sheets if needed)

AMBULANCE POLICY? ☐ YES ☐ NO

Name of Company: City: State:

Name of Insured: Name of Beneficiary:

Amount of Insurance: $ Amount/Frequency of Premium: $ Group Number: Policy Number:

BURIAL POLICY? ☐ YES ☐ NO

Name of Company: City: State:

Name of Insured: Name of Beneficiary:

Amount of Insurance: $ Amount/Frequency of Premium: $ Group Number: Policy Number:

(☐ YES ☐ NO Is burial policy irrevocable?)

PLEASE PROVIDE COPIES OF MEDICARE CARD AND ANY OTHER HEALTH INSURANCE CARDS AS MAY BE APPLICABLE. PLEASE PROVIDE COPIES OF AMBULANCE AND BURIAL POLICIES IF APPLICABLE.

MISCELLANEOUS INFORMATION

IN CASE OF DEATH, PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT THE FUNERAL HOME OF PREFERENCE:

Name: Phone Number:

Address:

City: State: Zip Code:

(please print clearly or type all information)

SCOPE OF SERVICE STATEMENT

All Oklahoma Veterans Centers are by licensure long term nursing facilities. Specifically, the scope of care is that normally associated with a skilled nursing care operation. While the centers provide limited physician, physician's assistant and/or nurse practitioner, pharmaceutical, diagnostic laboratory and radiological services, either in house or on a contractual basis, there is no intent to represent that care beyond that associated with a skilled nursing care level will be provided. Patients with medical or psychological needs, which in the judgment of the center's administrative and professional staff are beyond those associated with the scope of services normally provided, will not be admitted or in cases where a patient's condition changes following admission to require services other than those we normally provide, such patient shall be discharged or transferred to an appropriate facility.

Discrimination on the basis of race, color, sex, age, handicap, religion, national origin, source of payment or economic condition is prohibited.

I certify that I have read and understand the information provided on this form and that the above answers are true and correct to the best of my knowledge and belief.

Date:_____ Signature of Applicant:_____
(or Guardian, Custodian or Relative if veteran is unable)

SUBMIT THIS COMPLETED APPLICATION AND THE REQUESTED SUPPORTING DOCUMENTS TO THE VETERANS CENTER BELOW WHERE YOU WISH TO APPLY

FOR ANY QUESTIONS, PLEASE FEEL FREE TO CALL THE ADMISSIONS OFFICER AT THE CENTER BELOW WHERE THE VETERAN WILL BE APPLYING.

Oklahoma Department of Veterans Affairs

Oklahoma Veterans Memorial Building
2311 N. Central / P.O. Box 53067
Oklahoma City, Oklahoma 73152
Ph: (405) 521-3684

ARDMORE Veterans Centers
1015 S. Commerce / P.O. Box 489
Ardmore, Oklahoma 73402
Ph: (580) 223-2266, Fax: (580) 221-5606

CLAREMORE Veterans Centers
3001 W. Blue Starr Drive / P.O. Box 988
Claremore, Oklahoma 74018
Ph: (918) 342-5432, Fax: (918) 342-0835

CLINTON Veterans Centers
¼ mile S. of I-40 on Hwy. 183 / P.O. Box 1209
Clinton, Oklahoma 73601
Ph: (580) 331-2200, Fax: (580) 323-4834

LAWTON/FT. SILL Veterans Centers
501 SE Flower Mound Road/P.O. Box 849
Lawton, Oklahoma 73502
Ph: (580)-351-6511/6524, Fax: (580) 351-6526

NORMAN Veterans Centers
1776 E. Robinson / P.O. Box 1668
Norman, Oklahoma 73070
Ph: (405) 360-5600, Fax:(405)321-3647

SULPHUR Veterans Centers
304 E. Fairlane
Sulphur, Oklahoma 73086
Ph: (580) 622-2144, Fax: (580) 622-5881

TALIHINA Veterans Centers
10014 SE 1138th Ave. / P.O. Box 1168
4 miles NW on HWY 63A
Talihina, Oklahoma 74571
Ph: (918) 567-2251, Fax: (918) 567-2950