

VETERAN HOMESTEAD, INC.

<input type="checkbox"/> Accepted
<input type="checkbox"/> Denied
Admission Date _____

Application for Admission

Date: _____ Completed By: _____ D.O.B _____ Age: _____
 Name: _____ Phone: _____
 Address: _____
 Sex: _____ Race: _____ Social Security #: _____

<u>In Case of Emergency Contact:</u>	
Name: _____	Address: _____
City: _____	State: _____ Phone: _____

Income Sources: _____ Amounts: _____

- Homelessness Verification Form signed
- Military Discharged Papers (DD-214)
- Signed medical records?

Medical Records:

- History & Physical, Summary of last hospital admission
- Allergies
- Last TB test and/or Chest X-Ray
- List of Medications
- Height & Weight
- What other agencies are involved with this veteran's care (visiting nurses etc.)?

Who is your Primary Care Physician? Name: _____ Address: _____
 Phone: _____

- Will this physician follow the veteran after their admission to the hospice? _____
- Have you been diagnosed with a terminal illness?

When: _____ What: _____

Where: _____ By Whom: _____

Do you had/have any...

Substance Abuse/Psych History? _____ Pending legal issues? _____

- What is your length of sobriety? _____

<u>Health Insurance:</u>	
<i>Health Care Plan</i>	<i>Plan Number</i>
1. _____	_____
2. _____	_____

Do you have any advanced directives?

- Living Will
- Health Care Proxy
- DNR (Do not resuscitate)
- Durable Power of Attorney

Signature: _____ Date: _____ Witness: _____