

# MONTANA STATE VETERANS' HOME

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

PHONE: (406) 892-3256  
 FAX: (406) 892-0256

400 VETERANS DRIVE  
 PO BOX 250  
 COLUMBIA FALLS MT 59912-0250

## ADMISSION APPLICATION

I am applying for admission to the Montana Veterans' Home under provisions of Montana Statute 10-2-403. It is my understanding that access to the information in this application will be used by the Montana Veterans' Home staff. No other use, not specifically authorized by law, will be made of this information requested by this form; however, my eligibility cannot be determined without my providing such information, the consequences of such a refusal would make me ineligible for admission.

Name (Last, first, middle initial)		Phone	
Address			
Where have you lived the past two years (city, county, state)			
Social Security #		Religion	
Date of birth	Place of birth (city, state)		Age
Marital status:			
<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated			
Name of spouse, if married		Address (street, city, state)	Phone
Branch of service		Dates of service	
		From: _____ To: _____	
Has a power of attorney been established? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, name, address and phone number	
Do you have a legal guardian <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, name, address and phone number	
Are you applying for:		Do you agree to conform to Home's rules and regulations?	
<input type="checkbox"/> Nursing home care <input type="checkbox"/> Domiciliary care		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of personal physician		Physician's address and phone number	
Date of last hospitalization	Name and address of hospital		

Are you currently receiving VA compensation for a service connected disability?  
 Yes     No    If yes, what is the percent of your disability? \_\_\_\_\_%  
 For what condition?

Are you receiving Aid & Attendance from the VA?  
 Yes     No

Are you eligible for Medicare?  
 Yes     No    If yes, eff. date Part A \_\_\_\_\_ eff. date Part B \_\_\_\_\_

Do you have other health insurance?  
 Yes     No    If yes, give name and address of insurance company and insurance #s.

Do you have Medicare Part D?  
 Yes     No    If yes, give name and address of insurance company and insurance #s.

Income sources: VA \$ _____ SS \$ _____ Other \$ _____ \$ _____	Who will pay your bills? <input type="checkbox"/> Self <input type="checkbox"/> Other, Name, address and phone number: _____ _____ _____
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Please notify the following in event of an emergency:

Name	Address and phone number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

I designate the following person(s), in order listed, to receive possession of all my personal property left on premises of the Montana Veterans' Home after leaving such place, or at time of my death (this designation does not constitute a will or transfer of title.

Name	Address and phone number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have a last will and testament  
 Yes     No    If yes, where located:

I have made the following funeral arrangements:

I have a prepaid funeral plan     Yes     No

Previous occupation

Additional information:

**All services and benefits are provided by the Home on a non-discriminatory basis as required by the Civil Rights Act and the regulations of the Department of Veterans Affairs on the grounds of race, color, national origin, age or gender.**

Signature of applicant or person responsible:

\_\_\_\_\_

Date: \_\_\_\_\_