

# SOUTHWEST MONTANA VETERANS' HOME

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

PHONE: (406) 723-3225

65 VETERANS CIRCLE  
BUTTE, MT 59701

## ADMISSION APPLICATION

*Please send applications to*

*Executive Director Brenna Anderson*

*Copper Ridge Health and Rehab, 3251 Nettie Street, Butte, MT 59701*

I am applying for admission to the Southwest 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 Southwest 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: <input type="checkbox"/> Nursing home care		Do you agree to conform to SWMVH's rules and regulations? <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? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, what is the percent of your disability? % For what condition?		
Are you receiving Aid & Attendance from the VA? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, eff. date Part A                      eff. date Part B		
Do you have other health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, give name and address of insurance company and insurance #s.		
Do you have Medicare Part D? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, give name and address of insurance company and insurance #s.		
Income sources: VA        \$ SS        \$ Other     \$ Other     \$	Who will pay your bills? <input type="checkbox"/> Self <input type="checkbox"/> Other – Name, address and phone number:	
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 Southwest 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 <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, where located:		
I have made the following funeral arrangements:		
I have a prepaid funeral plan <input type="checkbox"/> Yes <input type="checkbox"/> No		
Previous occupation		

Additional information:

**All services and benefits are provided by the Southwest Montana Veterans 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 \_\_\_\_\_