

MONTANA STATE VETERANS' HOME

Department of Public Health and Human Services

400 VETERANS DRIVE

PO BOX 250

COLUMBIA FALLS MT 59912-0250

PHONE: (406) 892-3256

FAX: (406) 892-0256

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: _____ Age: _____

Place of birth (city, state): _____

Marital status: Married Single Widowed Divorced Separated

Name of spouse, if married _____ Phone _____

Spouse's Address (street, city, state) _____

Branch of service _____

Dates of service: From: _____ To: _____

Has a power of attorney been established? Yes No (Please provide a copy)

If yes, name, address and phone number _____

Do you have a legal guardian? Yes No (Please provide a copy)

If yes, name, address and phone number _____

Are you applying for Nursing home care Domiciliary care?

Do you agree to conform to Home's rules and regulations? Yes 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, effective date Part A: _____ effective 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? Self Other – Name, address and phone number:

Please notify the following in event of an emergency:

Name _____ Relationship _____

Address and Phone Number _____

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 _____ Relationship _____

Address and Phone Number _____

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 _____

NOTE: To secure placement on the admission waiting list, provide this completed form, a copy of any power of attorney or guardianship documents (if applicable), and any DD-214 forms (Certificate of Release or Discharge from Active Duty) from the veteran's military service. Please call (406) 892-3256, Extension 261 with any questions or to inquire about waiting list status.