APPLICATION FOR ADMISSION
TO THE WISCONSIN VETERANS HOME

THIS APPLICATION IS FOR (PLEASE CHECK ONE):

☐ **WVH–Chippewa Falls**
2175 E. Park Ave.
Chippewa Falls, WI 54729
(715) 720-6775
Toll-free Fax (888) 966-8821

☐ **WVH–King**
N2665 County Rd. QQ
King, WI 54946-0600
(715) 258-5586
Toll-free Fax (888) 966-8819

☐ **WVH–Union Grove**
21425 G Spring St.
Union Grove, WI 53182
(262) 878-6702
Toll-free Fax (888) 966-8816

UNION GROVE APPLICANTS
Applying for: Assisted Living ☐
-or- Skilled Nursing Home ☐

The information requested on this form is authorized for collection by Ch. 45, Wis. Stats., ss. VA 6.01, Wis. Adm. Code. The information collected is used to determine eligibility for programs administered by the department. Contact Facility Admissions for other eligibility requirements. Completion of this form is voluntary; however, failure to furnish the requested information may result in denial of eligibility for programs.

This department does not discriminate on the basis of race, color, national origin, sex, religion, age, or disability in employment or provision of services. Title II of the American Disabilities Act signed January 26, 1992.

Seeking Admission: ☐ Immediate Future ☐ Next 6 Months ☐ Other

Applicant is a: ☐ Veteran ☐ Veteran's Spouse ☐ Surviving Spouse ☐ Gold-Star Parent

If Spouse or Parent, Veteran's Name: ____________ DOB: ________ SS#: ________

Applicant's Name: ______________________ Sex: ______
(Last) (First) (Middle)

Address: ______________________________________
(Number and Street) (City) (County) (State) (Zip)

Phone Numbers: ____________________

Currently at: ☐Home ☐Nursing Home - Location: ____________
☐Hospital - Location: ____________

Date of Birth: ____________ Place of Birth: ____________________
(City) (County) (State) (Country)

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

Have You Ever Been Convicted of a Felony? ☐ Yes ☐ No If Yes, List Date & State: ____________

Nature of Felony: ______________________

Military Information

Does the applicant have a service-connected disability rated by the VA? ☐ Yes ☐ No

If yes, please list disability: ____________ Percent disability: ________

Medical and Health Insurance Information

Primary Care Provider: ____________ Phone Number: ____________

Applicant's Social Security Number: ____________ Medicare Number: ____________

Does Applicant Have: Medicare Part A? ☐ Yes ☐ No Medicare Part B? ☐ Yes ☐ No

Does an HMO manage the applicant's Medicare? ☐ Yes ☐ No

Secondary/Supplemental Insurance: ____________ Insurance ID Number: ________

Medicare Part D/Other Prescription Coverage: ____________ Insurance ID Number: ________

Does Applicant Have Medicaid? ☐ Yes ☐ No If yes, provide Medicaid ID Number: ________

Has Applicant received medical care from the VA? ☐ Yes ☐ No VA Claim Number: ________

If yes, where, when and for what did the applicant receive treatment? ____________

Does Applicant Have Any of the Following? ☐ Health Care Power of Attorney (POA) ☐ Financial or Durable POA ☐ Living Will ☐ Conservator ☐ Guardian ☐ Protective Placement

Spouse Information

Spouses Name: ______________________ Maiden Name (if any): ____________
(Last) (First) (Middle)

Spouse's Address: ______________________________________
(Number and Street) (City) (County) (State) (Zip)

Spouse's Social Security Number: ____________ Spouse's Date of Birth: ____________

You can access the most recent version of this form from the WDVA website at *www.WisVets.com/Forms.*

Point of Contact – Person Assisting Applicant With Application

Name: ______________________ Relationship: ______________

Address: ____

(Number and Street) (City) (County) (State) (Zip)

Phone Number: ______________________

County Veteran Service Officer/Veteran Service Organization That Has Been Assisting You

Name: ______________________

Address: ____

(Number and Street) (City) (County) (State) (Zip)

Phone Number: ______________________

Financial Information

(For **Assisted Living**, applicant must have sufficient income and assets to fund 4 years of residency.)

The following financial information is required to determine eligibility for benefits and ability to pay. Please state gross monthly amounts before any deductions.

Monthly Income	**Applicant**	**Spouse**
Social Security:	$	$
Military Retirement (not VA):	$	$
VA Service-Connected Disability Compensation:	$	$
VA Pension:	$	$
Other Income:	$	$
Gross Wages (Employment):	$	$
Total Monthly Income:	$	$

Assets	**Applicant**	**Spouse**
Cash/Checking Account/Savings:	$	$
Investments/CDs/Stocks/Bonds/Securities:	$	$
Trusts:	$	$
Real Estate: ☐ Residence ☐ Other Property	$	$
Other:	$	$

Have you sold, transferred, or created a joint tenancy (ownership) in any property within the last 60 months? (This includes cash and bank accounts.)

Applicant ☐ Yes ☐ No Spouse ☐ Yes ☐ No

Please attach copies of the following, or submit as soon as possible:

- Military separation orders or discharge papers (DD214 or similar document). If you do not have these papers, please call the Home listed on the front page so we can check our database for you.
- Service-Connected Disability Award Letter from the VA if applicable.
- Front and back of all health insurance cards.
- Healthcare POA (and Activation if applicable), Financial or Durable POA, Conservatorship/Guardianship/Protective Placement documents, and Living Will if available.
- Certified copy of Marriage Certificate if Spouse/Surviving Spouse.
- Certified copy of Death Certificate of Veteran if Surviving Spouse.
- Bank statements for last 2 months if Assisted Living.

I understand that it may be necessary for me to provide copies of bank statements periodically to verify my financial position, and that I must keep my account current.

If I am admitted, I agree to abide by the rules and regulations of the Wisconsin Veterans Homes.

I authorize the Wisconsin Veterans Homes to verify any and all information provided on this form. The information I have provided is true and complete to the best of my knowledge and belief.

Signature: ______________________ Date: ____________

(Applicant or Legal Representative)

Signature: ______________________ Date: ____________

(Commandant's Approval)