

Kansas Soldiers' Home
714 Sheridan – Unit 128
Fort Dodge KS 67843
(620) 682-7554
Fax: (620) 225-6331

Kansas Veterans' Home
1220 World War II Memorial Drive
Winfield KS 67156
(620) 221-9479
Fax: (620) 221-1718

APPLICATION FOR ADMISSION

Application for: Kansas Soldiers' Home Kansas Veterans' Home First Available
Level of Care: Long Term Care Assisted Living/Domiciliary Undetermined

Name of Applicant: _____
Last First Middle

Date of Birth: _____ Last 4 of SS#: _____ Gender: _____

Home Address: _____ Telephone No. _____
Street

Marital Status: Single Married Widowed Separated Divorced
City State County Zip Code

Name of Spouse: _____
Last First Middle

Present Location of Applicant (If other than home): _____

Address: _____
Street City State Zip Code

Medicare No. _____ Part A Part B Part D Effective Date: _____

Medicaid No. _____ Effective Date: _____

Pending Application/Date Submitted: _____

Medical Insurance Name and No. _____

Prescription Insurance Name and No. _____

Attending Physician: _____ Telephone No. _____

Address: _____
Street City State Zip Code

Please Supply Copies of ALL Insurance Cards

Check all that apply: POW Veteran Veteran's Spouse Veteran's Widow/er Gold Star Parent

Do you have a service-connected disability rated by the VA? Yes No

If yes: Disability: _____ Percent: _____

Have you been convicted of a felony? Yes No (If yes, completion of an additional form is required)

Power of Attorney/Guardian/Conservator/Designated Representative

(Attach copies of Power of Attorney, Guardianship and Conservatorship Court Orders)

Name: _____ Phone No. _____

Address: _____
Street City State Zip Code

Email Address: _____ Relationship: _____

Power of Attorney/Guardian/Conservator/Designated Representative

Name: _____ Phone No. _____

Address: _____
Street City State Zip Code

Email Address: _____ Relationship: _____

Do you desire to have a Veteran Service Representative review your financials to determine if you meet the qualifications for financial benefits? Yes No

You may choose to submit your application without disclosing your financial information to the facility by checking the box below.

I do not wish to disclose my financial information and agree to pay the full rate.

Applicant Resources:

	Applicant	Spouse
Salary	\$ _____ /Month	\$ _____ /Month
Social Security	\$ _____ /Month	\$ _____ /Month
Retirement Pension	\$ _____ /Month	\$ _____ /Month
Veteran's Pension	\$ _____ /Month	\$ _____ /Month
Railroad Pension	\$ _____ /Month	\$ _____ /Month
Supplementary Security Income	\$ _____ /Month	\$ _____ /Month
Other Monthly Income	\$ _____ /Month	\$ _____ /Month

Do you have a pre-paid funeral arrangements? Please select Yes No
(If yes, please provide a copy)

Assets:

Name of Investment/Broker Accts. _____ Present Value _____

Address of Investment/Broker Accts. _____

Checking Account: Bank _____ Account No. _____ Amount _____

Bank _____ Account No. _____ Amount _____

Saving Account: Bank _____ Account No. _____ Amount _____

Bank _____ Account No. _____ Amount _____

Name/Address of Trusts _____ Date Trust Established _____

Beneficiaries _____ Amount _____

Other Assets/Investments _____

Liabilities:

Mortgage _____ \$ _____ /Month

Credit Card Institution(s) _____ \$ _____ /Month

Other: Specify _____ \$ _____ /Month

Please initial the following statements of understanding:

___ I understand that payment for the first month's room and board is due on the day of admission and that I am responsible for the monthly financial obligation as determined by the facility.

___ If it is determined that I will pay less than the full rate, I understand that as a condition for continued residency, I must apply for Medicaid benefits.

___ If it is determined that I will pay less than the full rate and I am a wartime veteran or a surviving spouse of a wartime veteran, I must apply for monetary pension benefits from the United States Department of Veterans Affairs. I must inform the Kansas Veterans' Home when benefits are awarded.

___ If it is determined that I will pay less than the full rate, I understand that any retroactive receipt (back payment) of income needs to be reported to the Business Office and that income will be applied to my monthly fee as an adjustment backdated to the effective date of the award.

___ I understand that no alcoholic beverages are allowed on the facility grounds. I understand that tobacco use (smoking or chewing) is not allowed within the facility buildings.

By signing this application, I agree that the information provided in this application is true to the best of my knowledge. I, therefore, authorize the facility to verify with banks, employers, veteran's administration, social security, Medicaid, insurance and/or other institutions accuracy of information that I have disclosed.

Signature: _____
(Applicant/Legal Representative)

Date: _____

For Official Use Only:

Comments: _____	
<input type="checkbox"/> SC <input type="checkbox"/> PP <input type="checkbox"/> MCA <input type="checkbox"/> MCD <input type="checkbox"/> MCP <input type="checkbox"/> RR <input type="checkbox"/> LTCI <input type="checkbox"/> Other (Specify): _____	
_____ Signature	_____ Date

Basic Care Information

Name of Applicant: _____

Please answer to the best of your ability the following:

Dressing

- Independent
- Needs Assistance
- Total Dependence

Eating

- Independent
- Needs Assistance
- Total Dependence
- Special Diet: _____

Bathing

- Independent
- Needs Assistance
- Total Dependence

Transfers

- Independent
- Needs Assistance
- Total Dependence

Toileting

- Independent
- Needs Assistance
- Total Dependence
- Other (Specify) _____

Bowel and Bladder Management

- Continent of Bowel and Bladder
- Incontinent of Bladder
- Incontinent of Bowel

Ambulation

- Independent
- Needs Assistance
- Total Dependence

Assistive Device with Ambulation

- None
- Walker
- Wheelchair
- Other (Specify) _____

Any other information you feel we need to know to care for you or your loved one:

The above information was provided by:

- Applicant
- Other (Specify): _____

Additional medical information may be required to fully process your application. Please be sure and include required medical release forms. This will enable us to obtain the additional medical information.
