SOUTHERN NEVADA STATE VETERANS HOME

APPLICATION FOR ADMISSION

APPLICANT'S INFORMATION

Applicant is a: ☐ Veteran ☐ Spouse of Veteran ☐ Gold Star Parent

_____ _____ _____ _____
Last Name *First Name* *Middle Name* *Alias/Nickname*

_____ _____ _____/____/_____
Date of Birth *Place of Birth* *Social Security Number*

Gender: ☐ Male ☐ Female _____
Religious Preference

Home Address: _____

_____

Phone Numbers: (_____)_____ (_____)_____ (_____)_____
Home *Cell* *Other*

Current Location: ☐ Home ☐ Assisted Living ☐ Nursing Home ☐ Hospital ☐ Other

Have you recently traveled outside of the U.S. or been in the presence of anyone who has recently traveled outside of the U.S.? ☐ Yes ☐ No **If Yes, please identify whom & location visited:** _____

Have you ever been a resident at the Southern Nevada State Veterans Home?

Yes ☐ **No** ☐ **Date:** _____

Have you ever applied to be a resident at the Southern Nevada State Veterans Home?

Yes ☐ **No** ☐ **Date:** _____

Smoking/Tobacco Use Status: ☐ Current Smoker ☐ Non-Smoker

Marital Status: ☐ Married ☐ Widowed ☐ Single ☐ Divorced ☐ Other

_____ _____
Spouse's Last Name *Spouse's First Name*

_____ _____/_____/_____ _____
Spouse's Date of Birth *Spouse's Social Security #* *Date of Marriage*

_____ _____
Initial Date

APPLICANT'S OR SPOUSE'S MILITARY SERVICE INFORMATION

Branch of Service: _____ **Service Number:** _____

Entry Date: _____ **Discharge Date:** _____ **Type of Discharge:** _____

Were you a POW? ☐ **Yes** ☐ **No** **Retired from Military?** ☐ **Yes** ☐ **No**

Do you have a Service-Connected Disability? ☐ **No** ☐ **Yes**
If Yes: _____% and Reason(s) for disability

_____

_____

We must have copies of your rating decision and disability award letters.

EMERGENCY CONTACT INFORMATION

Primary Contact:

First & Last Name: _____

Relationship to Applicant: _____

Home Address: _____

Phone Number: (_____)_____ (_____)_____
Home *Cell/Other*

E-Mail Address: _____

Secondary Contact:

First & Last Name: _____

Relationship to Applicant: _____

Home Address: _____

Phone Number: (_____)_____ (_____)_____
Home *Cell/Other*

E-Mail Address: _____

ADDITIONAL INFORMATION

Do you/does the applicant have:

Medicare:	☐ **No**	☐ **Yes,**	***Medicare #:*** _____
Medicare Part D or Other Drug Plan	☐ **No**	☐ **Yes,**	***Provider & #:*** _____
Other Insurance:	☐ **No**	☐ **Yes,**	***Provider & #:*** _____
Dental Insurance:	☐ **No**	☐ **Yes,**	***Provider & #:*** _____
Prepaid Burial Plan:	☐ **No**	☐ **Yes,**	***Name:*** _____
Financial Power of Attorney:	☐ **No**	☐ **Yes,**	***Name:*** _____

_____ _____
Initial **Date**

Health Power of Attorney: ☐ No ☐ Yes, *Name:* _____

Advanced Directive/Living Will: ☐ No ☐ Yes

Court Ordered Guardian: ☐ No ☐ Yes, *Name:* _____

Revocable/Irrevocable Trust: ☐ No ☐ Yes

FINANCIAL INFORMATION

PLEASE PROVIDE SUPPORTING DOCUMENTATION FOR ALL INCOME AND ASSETS

MONTHLY INCOME:	*APPLICANT*	*SPOUSE*
Income from Farm/Ranch/Business:	$	$
Social Security Retirement/Disability:	$	$
Non Service-Connected VA Pension/A&A:	$	$
Service-Connected Disability Compensation:	$	$
Military Retirement Pay:	$	$
Retirement Income from Employer:	$	$
Civil Service Retirement Income:	$	$
U.S. Railroad Retirement Income:	$	$
Interest/Dividend (i.e. interest or standard dividend income from non tax deferred annuities):	$	$
Rental Income from Rental Property:	$	$
Real Estate Contract Held for Property Sold:	$	$
Other Income:	$	$
TOTAL MONTHLY INCOME:	$	$

TYPE OF ASSET:	*APPLICANT*	*SPOUSE*
Interest Bearing Checking/Savings Accounts:	$	$
Non-Interest Bearing Savings Account:	$	$
Life Insurance:	$	$
Interest in a Trust Fund:	$	$
Mutual Funds:	$	$
Stocks and Bonds:	$	$
Certificates of Deposits (CDs):	$	$
IRAs/Keoghs/401Ks:	$	$

Initial _____ Date _____

Real Estate/Real Estate Contracts:	**$**	**$**
Other Assets:	**$**	**$**
TOTAL ASSETS:	**$**	**$**

Has the applicant sold, transferred ownership, or gifted any property or financial assets in the last five (5) years? ☐ **No** ☐ **Yes**

Are you/is the applicant:

Capable of making informed decisions relative to their healthcare? ☐ **No** ☐ **Yes**

Capable of making informed decisions relative to their finances? ☐ **No** ☐ **Yes**

COMMENTS

_____

_____

_____

_____

_____

WITH MY SIGNATURE BELOW, I CERTIFY THE INFORMATION PROVIDED HEREIN IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF:

_____ _____

Signature **Printed Name**

_____ _____

Date **Relationship to Applicant**

_____ _____

Initial **Date**