West Virginia Veterans Nursing Facility
Application for Admission

No individual will, on the grounds of race, color, handicap, HIV status or national origin, be denied admission, care or any other benefit provided by the WVVNF. Also, you have the right to file a complaint with the State Survey and Certification agency concerning resident abuse, neglect and misappropriation of resident property in the facility.

INSTRUCTIONS: Application must be **TYPE WRITTEN or PRINTED IN INK.**

ADMISSIONS CRITERIA:

1. The following veterans shall be eligible for admission to the WVVNF:

   a. Veterans who have served on active duty or performed active service in a reserve component of the armed forces for a period of at least 12 consecutive months; *or who have been medically discharged for a service connected injury prior to 12 months service.*
   b. Veterans whose discharge status from military service is under honorable conditions.
   c. Veterans who have continuously been a citizen of the state of West Virginia for one (1) year immediately prior to application to the WVVNF, or who was a resident of West Virginia at the time they initially entered active military service.
   d. Veterans who are physically unable to maintain themselves in their own home by reason of age, disability or disease and meet the criteria for intermediate or skilled nursing care under Medicare and Medicaid regulations.
   e. Non-veteran spouses may be considered for admission ONLY when the veteran's nursing facility capacity is greater than 75% of the total licensed beds and when there are no veterans awaiting admission on the interest list.

2. The WVVNF shall not admit any applicant who requires treatment primarily for mental retardation, mental illness, or substance abuse, or who has a documented history of physical violence and/or disciplinary problems, or whose needs cannot be met by the facility. As a matter of clarity, prospective residents with Alzheimer disease or dementia are eligible for consideration.

3. "The West Virginia Veterans State Nursing Home is a SMOKE-FREE facility. All veterans must agree not to smoke anywhere on facility grounds."

COUNTY OF RESIDENCE:	**DATE:**
In compliance with the eligibility requirements, I do hereby apply for admission to the WVVNF and declare the following statements and information to be true:	
NAME	**SOCIAL SECURITY NUMBER**
ADDRESS (STREET OR RFD)	**TELEPHONE NUMBER**
CITY, COUNTY, ZIP CODE	

DATE OF BIRTH	**SEX**	**AGE**
PLACE OF BIRTH		**RELIGION**

MARITAL STATUS ☐ **MARRIED** ☐ **SINGLE** ☐ **DIVORCED (PLEASE PROVIDE COPY OF DIVORCE)**

☐ **WIDOWED (PLEASE PROVIDE COPY OF DEATH CERTIFICATE OF SPOUSE)**

☐ **LEGAL SEPARATION (PLEASE PROVIDE COPY OF DECREE)**

NAME OF SPOUSE

SPOUSE'S ADDRESS

MILITARY SERVICE INFORMATION (Please provide copy of DD 214/Discharge

BRANCH AND SERVICE NUMBER	DATE AND PLACE OF ENLISTMENT	DATE AND PLACE OF DISCHARGE	TYPE OF DISCHARGE

IF YOU HAVE EVER BEEN A RESIDENT OF THE WVVNF OR OTHER STATE OR FEDERAL LONG TERM CARE FACILITY, PLEASE COMPLETE THE FOLLOWING:

DATE OF DISCHARGE	FACILITY	REASON

INCOME

YOU HAVE TWO OPTIONS FOR PAYMENT:

1. I DO NOT WISH TO PROVIDE MY DETAILED INCOME INFORMATION. I UNDERSTAND THAT I WILL BE ASSESSED THE MAXIMUM AMOUNT FOR EXTENDED CARE SERVICES AND AGREE TO PAY THE MAXIMUM CHARGE.

SIGNATURE: **DATE:**

2. YOUR SECOND OPTION IS TO DISCLOSE YOUR INCOME AND YOU WILL BE CHARGED BASED ON YOUR INCOME. IF YOU ELECT THIS OPTION, PLEASE PROVIDE THE INFORMATION REQUESTED BELOW:

SIGNATURE: **DATE:**

LIST GROSS AMOUNTS OF MONTHLY INCOME:	**VETERAN**
Wages	$
VA Pension	$
VA Compensation: Percent of Compensation_____	$
Social Security	$
Medicare	$
Retirement Income	$
Pension Income	$
Other Retirement Income	$
Interest	$
Dividends	$
Income from rental properties	$
Other Income	$
TOTAL INCOME	$

PERSONS TO BE NOTIFIED IN ANY EMERGENCY. List two. If applicant has a guardian, conservator, or power of attorney, copies of the legal documents establishing such authority must be attached).

NAME	RELATIONSHIP
ADDRESS	HOME PHONE
CITY, STATE, ZIP CODE	WORK PHONE
NAME	RELATIONSHIP
ADDRESS	HOME PHONE
CITY, STATE, ZIP CODE	WORK PHONE

BURIAL ARRANGEMENTS

Name of Funeral Home to be called
Address of Funeral Home
Desired Location of Burial
Name of person taking care of arrangements, if any:

DO YOU HAVE MEDICARE? ☐ YES ☐ NO

PART A_____ PART B_____

EFFECTIVE DATES:_____
MEDICARE NUMBER_____
(Provide Copy)

DO YOU HAVE ANY OTHER HEALTH/MEDICAL INSURANCE? ☐ YES ☐ NO

COMPANY_____

NUMBER_____
(Provide copy & verification of premium due)

CERTIFICATION

I _____, do solemnly affirm that I fully understand requirements that must be met, and all qualifications that must be possessed by an applicant for admission to the West Virginia Veterans Nursing Facility (WVVNF). I fully understand all questions asked on this application and that all statements made by me on this application are true. I am a resident of the State of West Virginia and affirm that because of physical disability, I am unable to continue living in my home. I further agree to accept transfer to any other health care facility, or to my home, if in the opinion of the professional staff such transfer is necessary. This application is my free and voluntary act.

I also certify that I have provided all requested information regarding my assets, indebtedness and income (including that related to my spouse) and that such information is complete and correct. I also agree to provide required proof of all income, assets, and indebtedness upon request. I understand that my admission and continued stay in the WVVNF is subjected to a true and accurate reporting of my financial status. Misrepresentation of my financial status may result in my immediate discharge from the WVVNF.

I also understand that the professional staff at the facility shall have the right to deny admission, if, in their opinion, my needs cannot be adequately met at the facility.

I hereby authorize the WVVNF to apply for any financial benefits to which I may be entitled.

I understand that a non-medical leave of absence from the facility in excess of 96 hours (4 days) will result in a charge per day equal to the current VA Per Diem rate in effect at the time. This charge will be retroactive to the first day of absence from the facility and will cover the entire period of absence.

I understand the monthly charges by the facility and agree to pay in full any charges within ten days of receipt.

Signature of Applicant Date:

(or Legal Representative)