Gold Star Parent
Application For Admission
To The Iowa Veterans Home

1301 Summit Street, Marshalltown, IA 50158-5485
Telephone (641) 753-4325 or 800-645-4591
https://dva.iowa.gov

THIS APPLICATION MUST BE THOROUGHLY COMPLETED OR THE ADMISSION PROCESS MAY BE DELAYED. SUBMIT WITH APPLICATION A COPY OF YOUR CHILD'S HONORABLE DISCHARGE OR DD-214, BIRTH CERTIFICATE AND CERTIFICATION OF CHILD'S DEATH WHILE SERVING IN THE ARMED FORCES.

A COPY OF A COMPLETE HISTORY AND PHYSICAL IS REQUIRED. THIS HISTORY AND PHYSICAL MUST BE DATED WITHIN THREE MONTHS FROM THE DATE THE IVH APPLICATION IS RECEIVED. YOUR HEALTH CARE PROVIDER MUST ALSO SUBMIT LAB WORK, IMMUNIZATIONS, YOUR HISTORY OF TESTING AND RESULTS OF RESISTANT ORGANISIMS (MRSA OR VRE), AND PPD (TB TESTING).

1. Applicant's name in full _____ (First / Middle / Last / Maiden)
2. Legal Residence _____ (Address / City / Zip Code)

   County of legal residence _____ Applicant Phone Number _____

   Present Address _____ (If at facility, skip to next line) (Address / City / State / Zip Code)

   Current Facility _____ (Name / Address) Phone Number _____ Admission Date _____

   _____ (Address / City / State / Zip Code)
3. Date of Birth _____ Birthplace _____ (County / City / State)
4. Social Security Number _____ Spouse's Social Security Number _____
5. Are you a U.S. citizen? Yes ☐ No ☐ Naturalized? Yes ☐ No ☐ If yes, please provide a copy of naturalization papers.
6. Father's Name _____ (First / Middle / Last) Birthplace _____ (County/City / State)
7. Mother's *Maiden* Name _____ (First / Middle / Last) Birthplace _____ (County/City / State)
8. **MARRIAGE(S): Provide the following information for your MOST RECENT marriage. Copies of all marriage, divorce and/or death certificates will be required.**

Circle one of the following: Married Widowed Divorced Separated Never Married

Spouse's full name _____ (First / Middle / Last) Birthplace _____ (County/City / State)

Date of Birth _____ (Month/Day/Year) Date of Marriage _____ (Month/Day/Year) Place _____ (County/City / State)

How marriage ended _____ (If applicable) When _____ (Month/Day/Year) Where _____ (County/City / State)

Attach separate sheet providing above information for all previous marriages

9. **CHILDREN:** Applicant _____

Please indicate approval to contact children regarding application process by circling yes or no before each name.

YES/NO _____
Name Address, City, Sate, Zip Code

_____
Age Relationship Main Phone Number Alternate Phone Number (Work, Cell, Other)

YES/NO _____
Name Address, City, Sate, Zip Code

_____
Age Relationship Main Phone Number Alternate Phone Number (Work, Cell, Other)

Attach a separate sheet for additional children. List all living children, regardless of age. If any are minors, please furnish a copy of birth certificate(s).

10. Your usual occupation _____ Kind of business or industry _____
Do NOT write retired

Spouse's usual occupation _____ Kind of business or industry _____
Do NOT write retired

11. Date you retired or became disabled _____ Date spouse retired or became disabled _____

Do you receive Social Security? Yes ☐ No ☐

If yes, what type of benefit do you receive? (Please circle one) Retirement Disability (SSDI) Low Income (SSI)

Do you have Medicare? **Part A**: Yes ☐ No ☐ **Part B**: Yes ☐ No ☐ Start Date(s) _____

Medicare or MBI Number _____ Monthly Premium: _____

Part D: Yes ☐ No☐ Company Name _____

Member identification number _____ Monthly Premium: _____

Have you ever applied or are you currently receiving Medicaid? Yes ☐ No ☐ SID Number _____

Do you have other health insurance? Yes ☐ No ☐ Name of company _____

Member identification number _____ Monthly Premium _____

Do you have Nursing Home insurance? Yes ☐ No ☐ Name of company _____

PROVIDE A COPY OF THE FRONT AND BACK OF ALL INSURANCE CARDS LISTED ABOVE

12. **EDUCATION:** (Circle highest level of completion.)

Elementary: 1, 2, 3, 4, 5, 6, 7, 8 High School: 9, 10, 11, 12, GED College: 1, 2, 3, 4 AA, BA, BS, MA, MS, Doctorate

13. **CIRCLE CHILD'S BRANCH OF SERVICE:** Army Navy Air Force Marines Coast Guard Merchant Marines

Date of child's entry _____ Place of entry _____

Date of child's discharge _____ Place of discharge _____

Child's Armed Services Number _____ Child's DVA Claim or File Number _____

Did your child have a service-connected disability? Yes ☐ No ☐ Percentage of disability? _____

Was your child a: Combat veteran? Yes ☐ No ☐ Prisoner of War? Yes ☐ No ☐ Purple Heart Recipient? Yes ☐ No ☐

Rank at discharge _____ Job held in service? _____

14. Number of years of your residency in Iowa? _____

15. **LEGAL DECISION MAKERS (Continued on page 3)**

a. Court-appointed Guardian? _____
(Please provide a copy of the court order and letter of appointment) Name Main Phone Number

_____
Address City State Zip Code

b. Court-appointed Conservator? _____
(Please provide a copy of the court order and letter of appointment) Name Main Phone Number

_____
Address City State Zip Code

Applicant _____

c. Healthcare Power of Attorney _____
(Please provide copy) Name Main Phone Number

_____
Address City State Zip Code

d. Financial Power of Attorney _____
(Please provide copy) Name Main Phone Number

_____
Address City State Zip Code

16. Your religious preference (optional) _____
Denomination

17. Person to be notified in an emergency _____
(Attach separate sheet if more than one.) Name

_____
Address City State Zip Code

_____
Relationship Main Phone Number Alternate Phone Number (Work, Cell, Other)

18. Have you ever been a resident of the Iowa Veterans Home? _____ If so, when? _____

19. I desire to be buried in _____ Cemetery _____
Telephone Number

_____
Address City State Zip Code

20. My funeral home of preference is _____
Telephone Number

_____
Address City State Zip Code

Is there a prefunded funeral contract or burial trust? Yes ☐ No ☐ **(If yes, please provide copy of contract or trust.)**

21. Did you file an income tax return for the previous tax year? Yes ☐ No ☐ **(If yes, please provide a copy of all pages.)**

APPLICANT OR LEGAL REPRESENTATIVE TO READ THE FOLLOWING AND SIGN:

I am applying for admission to the Iowa Veterans Home. I am a resident of the state of Iowa. All of the statements on this application are true and complete to the best of my knowledge. I hereby give permission to the Iowa Veterans Home to do a background check. ***If admitted, I understand that all income and assets, regardless of source, will be considered in the determination of my cost of care.*** I understand that all personal expenses and/or prior existing debts are my responsibility.

_____
Signature of Applicant or Legal Representative

CERTIFICATE OF COUNTY COMMISSION OF VETERAN AFFAIRS

We hereby certify that _____ has been a resident of _____ County, State of Iowa, prior to the date of this application as provided for by Chapter 35D of the Code of Iowa, and that we are members of the County Veteran Affairs of said County.

COUNTY VETERANS AFFAIRS REPRESENTATIVE

_____
Signature Director/Administrator/CVSO

_____
Printed Name Director/Administrator/CVSO

Decision Making must be filled out by MD, DO, PA-C, or ARNP

Is He/She able to make Healthcare Decisions? ☐ Yes or ☐ No

If answered no, who is their designated decision maker? _____

Is He/She able to make Financial Decisions? ☐ Yes or ☐ No

If answered no, who is their designated decision maker? _____

Is He/She court committed? ☐ Yes or ☐ No

(Attach copy of recent H&P to this form)

Printed Name of Care Provider: _____ Date: _____

_____ Date: _____
Care Provider Signature (MD, DO, PA-C, ARNP)

Provider Address: _____

_____

Phone Number: _____

Fax Number: _____

Iowa Veterans Home Application/Admission Information Checklist

Items required to be submitted with Iowa Veterans Home application:

- ☐ Completed IVH Application for Admission (Veterans must use form 475-0409; Spouses and surviving spouses of veterans must use form 475-0410; Gold star parents must use form 475-2044)
- ☐ Signatures on the bottom of page three (3) to include applicant/legal representative; signature from Director/Administrator/Veteran Service Officer or a Commissioner of Veteran Affairs in the county of legal residence.
- ☐ Complete History and Physical dated and signed within three months of the receipt of application with current medication list and current immunization list from the medical provider. *(**If currently at a hospital or other nursing care facility**, also provide the following: MDS; MAR w/PRN's; PASRR; Facesheet.)*
- ☐ Signed "Consent to Release of Information" (Form 475-0859) for all current medical providers and facilities of residence, if applicable
- ☐ Completed Personal Functional Assessment (Form 475-0837)
- ☐ Copy of DD 214 (Honorable Discharge from the military: Spouses and Gold Star parents must supply Veteran's)
- ☐ Completed Financial Affidavit (Form 475-0839) and Supplement to Application (Form 475-0843)
- ☐ Copy of marriage certificate must be provided by all current and surviving spouses*
- ☐ Copy of death certificate of spouse or child must be provided by all surviving spouses and gold star parents*
- ☐ Copy of all Powers of Attorney for Healthcare and/or Finance and/or the Judge's Order and Letters of Appointment for Guardianship and/or Conservatorship, if these exist

Items needed once accepted for admission:

- ☐ Copy of birth certificate*
- ☐ Copy of marriage certificate/divorce decree/legal separation/spouse's death certificate (Whichever is applicable for **all** marriages.) *
- ☐ Verification of all income and assets including a copy of all pages of statements from all banking and other asset accounts for the most recent three (3) months
- ☐ Copy of previous calendar year's year end statements (W-2's & 1099's) from all incomes
- ☐ Total of previous calendar year's unreimbursed medical expenses, including insurance premiums
- ☐ Copies of Private medical insurance card, Medicare card, Prescription Drug card (Medicare Part D), Medicaid card (Title 19) and DVA card. Please provide front and back of cards)
- ☐ Copy of Social Security card and State-issued photo identification, if available
- ☐ Copies of facesheet for all life insurance policies, if applicable
- ☐ Copy of Long-Term Care (Nursing Home) insurance policy, if applicable
- ☐ Copy of prepaid burial, if applicable
- ☐ Copy of deed for burial lot(s), if applicable

***NOTE:** *You may need to provide certified copies of birth certificate; marriage certificate; divorce decree or legal separation (whichever is applicable) for all marriages. You will be notified if this is necessary.*

- ☆ **Please mail this information to: Jason Matteson, Admissions Coordinator, Iowa Veterans Home, 1301 Summit Street, Marshalltown, IA 50158. Information may be faxed to 641-844-6303, Attn: Jason Matteson or sent via email to jason.matteson@ivh.state.ia.us or kathy.kopsa@ivh.state.ia.us.**

- ☆ **Contact Jason Matteson, Admissions Coordinator, at 641-753-4325 with any questions related to admission.**

- ☆ **Contact Kathy Kopsa, Admissions Supervisor, at 641-753-4514 with any questions related to financial information or cost of care.**

- ☆ **Note: The items needed once accepted must be provided in order to move forward with the admission process. The applicant will not be considered for placement until these items are submitted. Please contact Kathy Kopsa with any questions.**

Iowa Veterans Home
Marshalltown, Iowa 50158
(641) 752-1501

CONSENT TO RELEASE OF INFORMATION

NAME _____ Date of Birth _____

SSN _____Claim # _____Service # _____

I, THE UNDERSIGNED, HEREBY AUTHORIZE:

(Name and address of organization or individual from whom information is to be released.)

TO DISCLOSE AND/OR DELIVER TO:

(Name and address of person, Institution or organization.)

Iowa Veterans Home
1301 Summit St
Marshalltown, IA 50158

(641)753-4325
(641)844-6303 (fax)

Only the following specific information from the subject records: (specify dates of service rendered). **(See reverse side for specific consents for mental health, substance abuse and or HIV/AIDS information.)**

Progress notes; consultation reports; operative report(s); history and physical exam(s); social history(s); multidisciplinary summaries; Rehabilitation Medicine note(s)/evaluation(s); PT, OT, Corrective Therapy; Laboratory & Radiology Reports; Respiratory Therapy Report(s); Speech & Audiology Report(s); nutrition note(s); discharge summaries; immunization records; appointments

I understand that this information is to be used (Reason for release of information)_____
_____**Admission processing**_____

I also understand that I may revoke this consent at any time by sending a written notice to the discloser of this information. I understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality. I understand I may review the disclosed information. This authorization will automatically expire one year from the date of signature, except as specified: _____
At that time no express revocation shall be needed to terminate my consent.

DATE _____ SIGNATURE _____

RELATIONSHIP _____

 (SEE REVERSE SIDE)

Specific Authorization For Release of:

Mental Health Information (including neuropsychiatric testing).	☐ YES	☐ NO	_____ Date and Initial
Substance Abuse Information (including drug and alcohol abuse)	☐ YES	☐ NO	_____ Date and Initial
HIV/AIDS/ARC Information	☐ YES	☐ NO	_____ Date and Initial

I acknowledge that data to be released **MAY INCLUDE** information that is protected by Federal Law and that it is applicable to any one or all of the above. My signature authorizes release of all specified information.

SIGNATURE DATE

IN ORDER FOR THE ABOVE INFORMATION TO BE RELEASED, YOU MUST SIGN HERE AND ON THE FRONT SIDE.

Iowa Veterans Home
1301 Summit Street
Marshalltown, Iowa 50158

PERSONAL FUNCTIONAL ASSESSMENT

ALL INFORMATION REQUESTED ON THIS FORM IS REQUIRED except for sections titled other considerations and please comment.

IF YOUR ARE CURRENTLY IN A FACILITY, PLEASE HAVE LICENSED CAREGIVER COMPLETE THIS FORM. IF CURRENTLY IN A LONG-TERM CARE FACILITY, ATTACH COPY OF CURRENT MDS; MAR w/ PRNs; PASRR AND FACESHEET.

For each area of your functioning listed on the following pages, please mark the description which best describes your current ability. The word "assistance" means supervision, direction or personal assistance. For "Other Considerations", please note any additional information which you believe is pertinent and will assist the Admissions Committee in determining the correct level of care. Unless otherwise directed, mark the one box that is most representative of your abilities. Attach additional sheets as necessary.

Name:_____ Date: _____

Currently Living At:_____

Address:_____

_____

Telephone Number(s):_____

Name of Person Completing This Form: _____

Relationship to Applicant:_____

BATHING

☐ No assistance needed. I get in and out of shower and/or tub by myself (if tub is the usual means of bathing).

☐ Cueing only. Can bathe self

Assistance with set-up. Please explain set up required.

☐ _____

_____

Some assistance in bathing. *Please explain assistance required.*

☐ _____

_____

☐ Total assistance in bathing.

Other considerations: _____

_____

DRESSING - Getting clothes from closets and drawers, including underclothes, outer garments, and using fasteners (including braces, if worn).

☐ I get my clothes and get completely dressed without assistance.

☐ I get my clothes and get completely dressed with adaptive devices. (*Please explain below.)*

☐ I get completely dressed by myself once clothes are set out.

I require cueing to complete dressing. Please explain cueing required.

☐ _____

_____

☐ I receive some assistance in getting clothes and getting dressed. (*Please explain assistance needed below.)*

☐ I receive total assistance in getting clothes and getting dressed.

Other considerations: _____

_____

GROOMING: HAIR

- ☐ I get out needed items and can comb/brush my hair myself.
- ☐ I can brush/comb my hair myself but need set-up.
  I need cueing to complete. Please explain cueing required.
- ☐ _____
  _____
- ☐ I need total assistance with brushing/combing my hair.

SHAVING

- ☐ I get out needed items and can shave myself.
- ☐ I can shave myself but need set-up.
  I need cueing to complete. Please explain cueing required
- ☐ _____
  _____
- ☐ I need total assistance with shaving.
- ☐ I typically use an electric razor.

ORAL HYGIENE

- ☐ I get out needed items and clean my teeth/dentures myself.
- ☐ I can clean my teeth/dentures myself but need set-up.
  I can clean my teeth/dentures myself but need cueing to complete.
  Please explain cueing required
- ☐ _____
  _____
  _____
- ☐ I need total assistance with cleaning my teeth/dentures.

TOILETING - Going to the "bathroom" for bowel and urine elimination, cleaning self after elimination, and arranging clothes.

- ☐ I require no assistance in toileting.
- ☐ I require assistance in getting to and from the "bathroom" only.
- ☐ I require assistance getting to and from the "bathroom", cleaning myself and/or in arranging clothes after elimination or in use of night bedpan or commode.

Other considerations: _____

_____

_____

_____

_____

CONTINENCE (Choose all that apply)

- ☐ I control urination completely by myself.
- ☐ I control bowel movements completely by myself.
- ☐ I occasionally lose control of: (If checked, mark one of the following)
  - ☐ bowel ☐ bladder ☐ both
- ☐ I **cannot** control urination.
- ☐ I **cannot** control bowel movements.
- ☐ I use adult incontinent protection such as Attends, Depends, or other incontinent pads. (If checked, mark one of the following)
  - ☐ I care for them myself ☐ I need assistance with changing
- ☐ I have a catheter. (If checked, mark one of the following)
  - ☐ indwelling ☐ external ☐ suprapubic
- ☐ I have a colostomy or ileostomy and can care for this myself.
- ☐ I have a colostomy or ileostomy and need assistance with this.

Other considerations: _____

_____

_____

COMMUNICATION/MEMORY:

- ☐ I have trouble communicating thoughts and/or I forget my words.
- ☐ People say they have trouble hearing or understanding me when I speak.
- ☐ I forget the topic of conversation or get confused during a conversation.
- ☐ I forget answers or instructions that were provided.
- ☐ I become frustrated and/or confused with too much information or too many steps.
- ☐ I have trouble keeping track of time or appointments.
- ☐ I don't function well in situations that are noisy or where many people are speaking at once.

I am hard of hearing. ☐ Yes ☐ No

☐ I wear hearing aids ☐ I do not wear hearings ☐ I have hearing aids, but do not wear them

I have trouble reading because:

☐ My vision is poor ☐ I need new glasses ☐ Words do not make sense

ORIENTATION (**Choose all that apply)**

☐ Never confused or disoriented.

☐ Rarely confused or disoriented. Please describe. _____

☐ Sometimes confused, disoriented and forgetful. (To include functioning in familiar surroundings, but gets disoriented in new surroundings.) Please describe. _____

☐ Totally confused and disoriented. Please describe. _____

☐ I experience frequent periods of agitation such as yelling, hitting or throwing things. Explanation required: _____

_____

_____

_____

_____

Please mark the appropriate answers below:

1. Do you wander away and/or get lost? ☐ Yes ☐ No
   If yes, how often? _____ Please explain the circumstances: _____
   _____
   _____
2. Are you safe to be left alone at home *alone* for more than two hours? ☐ Yes ☐ No
3. Are you currently in a secure memory care area? ☐ Yes ☐ No
4. Do you wear a Wander Guard bracelet? ☐ Yes ☐ No
   ****If using a Wander Guard does the individual check doors or in some other way try to exit the facility? ☐ Yes ☐ No**
5. Are restraints currently being used? ☐ Yes ☐ No
   If yes, state type and frequency: _____
   _____
   _____
   _____
   _____
   _____

FOOD & NUTRITION SERVICES:

Height: _____ Weight: _____lbs. My usual weight is: _____lbs.

I have experienced significant changes in weight in the past 6 months: ☐ Yes ☐ No

If yes, describe: _____

_____

I have a food allergy or intolerance: ☐ Yes (list below) ☐ No

Food allergies (if any): _____

Food intolerance (if any): _____

I have special dietary needs related to my religion, culture or ethnicity: ☐ Yes ☐ No

If yes, please describe: _____

_____

IMPORTANT NOTICE: IVH does not offer holistic and/or organic foods and drinks. Residents may purchase these at their own expense if they wish

My appetite is generally: ☐ Good ☐ Fair ☐ Poor

My usual diet(s):

☐ Regular ☐ Heart Healthy

☐ Diabetic (Small portions diet available) ☐ Tube feeding: _____

☐ Renal/Dialysis (Modified Renal diet available)

I have difficulty chewing or swallowing: ☐ Foods ☐ Liquids ☐ Pills

Sometimes food or liquid goes down the wrong way (into my windpipe) and makes me cough or choke. ☐ Yes ☐ No

I have dental problems. ☐ Missing teeth ☐ Poor fitting dentures

I eat food or liquids with special textures: ☐ Yes ☐ No

If so, I eat foods prepared as follows:

☐ Soft foods ☐ Diced foods ☐ Pureed foods ☐ Thickened Liquids

FOOD & NUTRITION SERVICES Continued:

I avoid these problematic foods: _____

_____

I have problems with my esophagus: ☐ Yes ☐ No

I swallow okay, but then it gets tuck or won't go all the way down.

☐ Food/pills get stuck ☐ Esophageal stricture

☐ Heart burn/Acid Reflux ☐ Hiatal hernia

At meal time:

☐ I am independent at meal time. I can feed myself food and drinks.

☐ I need some help cutting food and/or opening containers, but can otherwise feed myself.

☐ I require some help to eat bites or to get a drink. Sometimes I need to be fed.

☐ I always need help in order to eat and drink.

☐ I get tired or lose interest in the meal before I am finished.

☐ I use adaptive tools at meals (e.g. weighted silverware, plate guard, etc.) ☐ Yes ☐ No

If yes, list adaptive tools: _____

Other considerations: _____

_____

MEDICATIONS (Choose all that apply)

☐ I take my own medications.

☐ I take my own medications after someone else sets them up.

☐ Need reminders to take medications. What mechanism is used to remind you to take medications?

☐ Someone else gives me my medications.

☐ I receive medications by injection.

☐ I receive my medications crushed.

Other considerations: _____

_____

OXYGEN

☐ Occasional Liter flow? _____ How often used? _____ ☐ Continuous Liter Flow? _____ ☐ Do not use

☐ CPAP/BiPAP ☐ Other

Please mark the appropriate response for oxygen use: ☐ Receive at bedside ☐ Portable

Are you compliant with your oxygen use? ☐ Yes ☐ No

Do you own your oxygen equipment? ☐ Yes ☐ No

If yes, who issued the equipment? Medicare ☐ DVA ☐ Personal Purchase ☐

Other considerations: _____

_____

MOBILITY

☐ I can walk two blocks with or without assistive devices independently.

☐ I require assistive devices to walk independently. (Mark all that apply)

☐ cane ☐ walker ☐ crutches

Distance able to walk with the use of assistive devices? _____

☐ I use a manual wheelchair and can operate it independently. Distance able to wheel manual wheelchair without assist? _____

☐ I use a manual wheelchair and require assistance to operate it.

☐ I use a walker and need assistance of one person to ambulate.

☐ I use a walker and need assistance of more than one person to ambulate.

☐ I have a power mobility device (electric wheelchair or scooter) that I use. Please see supplement related to power mobility devices at the Iowa Veterans Home.

Other considerations: _____

_____

TRANSFERS

☐ I get in and out of bed as well as in and out of a chair without assistance.

☐ I require assistance from one person to get in and out of bed or chair.

☐ I require assistance from more than one person to get in and out of bed or chair.

☐ I require a lift to get in and out of bed or chair. Type of lift needed:
Ceiling Lift ☐ Stand Lift ☐ Hoyer Lift ☐

☐ I can turn from side to side when in bed without assistance.

☐ I need assistance to turn from side to side when in bed.

Other considerations: _____

_____

FALL HISTORY

Have you had any recent falls? ☐ Yes ☐ No If yes, please explain the circumstances surrounding each fall: _____

_____

_____

If yes, how many falls have you had in the last 3 months? _____

Are these falls a change in baseline behavior? ☐ Yes ☐ No

When was your last fall? _____

PROSTHESIS

If you use prosthesis, please state type: _____

☐ Eyeglasses ☐ Hearing aids ☐ Dentures ☐ Other _____

I can apply my own prosthesis: ☐ Yes ☐ No

Other considerations: _____

_____

REHABILITATIVE SERVICES

Have you previously received or are you receiving rehabilitation treatment for a current physical condition? ☐ Yes ☐ No

Type of therapy received: _____

_____

_____

LOCATION DATES

_____

_____

MENTAL HEALTH

Are you under a court commitment? ☐ Yes ☐ No

If yes, please mark appropriate type: ☐ Inpatient ☐ Outpatient

Have you ever been hospitalized or received care in relation to mental health problems?

☐ Yes ☐ No

If yes, list name of doctor or agency: Date(s) Length of Stay

_____

_____

_____

_____

_____

_____

ALCOHOL/CHEMICAL DEPENDENCE

- ☐ I do not drink alcoholic beverages nor do I use other chemical substances and have no history of problems with these substances.
- ☐ I occasionally drink alcoholic beverages, but never to excess and have no history of problems with these substances.
- ☐ I have in the past, but not within the last year, and do not currently have problems with alcohol and/or chemical dependency.
- ☐ I currently have problems associated with alcohol and/or chemical dependency.

Have you consumed alcohol or chemical substances in the past 60 days? ☐ Yes ☐ No

If yes, what and how much?_____ How often?_____

Please list treatment programs attended/completed and date(s):

_____

_____

Other considerations: _____

_____

TOBACCO USE

1) Do you smoke cigarettes, e-cigarettes, cigars or vape? ☐ Yes ☐ No

2) Do you chew tobacco or use snuff? ☐ Yes ☐ No

OTHER HEALTH CONSIDERATIONS

Presently I have: ☐ Pressure Ulcers ☐ Skin Rashes ☐ Injuries

Please describe: _____

_____

_____

Other considerations: _____

_____

Please provide the date of the most recent immunization below. If you have never received an immunization listed below, please indicate this. *Immunization records must be obtained prior to any potential admission.*

Tetanus (Td, Tdap)	Date: _____	Hepatitis B	Date: _____
Influenza	Date: _____	Zostavax	Date: _____
Prevnar 13	Date: _____	Shingrix 1	Date: _____
Pneumovax 23	Date: _____	Shingrix 2	Date: _____
Covid – 19	Date: _____		

List reaction(s) to any of the immunizations above _____

_____

Please answer the following questions to the best of your ability: (Mark yes or no)
If yes, please explain, including dates. Use available space on page 12, if needed.

1.	Have you had a TB skin test?	☐ Yes	☐ No	Date: _____
2.	Did you have a reaction?	☐ Yes	☐ No	
3.	Do you presently have or have you had a history of infection(s) and/or communicable disease(s)?	☐ Yes	☐ No	
4.	Do you presently have or have you had a history of having MRSA or VRE or any other resistive disease?	☐ Yes	☐ No	

If you answered yes to any question above, please explain, including dates:

_____

_____

Have you been diagnosed with the following illnesses?

Measles (Red Measles)	☐ Yes	☐ No	Date: _____
Mumps	☐ Yes	☐ No	Date: _____
Rubella (German Measles)	☐ Yes	☐ No	Date: _____
Pertussis (Whooping Cough)	☐ Yes	☐ No	Date: _____
Smallpox	☐ Yes	☐ No	Date: _____
Chicken Pox	☐ Yes	☐ No	Date: _____
Polio	☐ Yes	☐ No	Date: _____

THIS SPACE PROVIDED FOR ANY ADDITIONAL COMMENTS/INFORMATION YOU MAY HAVE:

Name: _____

For: **All Iowa Veterans Home resident applicants**

Subject: **Important information for potential residents**

Tobacco Free Campus

The Iowa Veterans Home is committed to the health, safety and well-being of all of our residents. As a result, we have made a commitment to become a tobacco (smoke and smokeless) free campus. This is to inform you that you will receive advanced notification of the date when the facility will become entirely tobacco free. Currently, IVH residents are allowed to use tobacco products on campus during designated times and in designated areas with the appropriate supervision.

Power Mobility Device (PMD) usage

Please be advised of the following Iowa Veterans Home (IVH) policies and procedures regarding Power Mobility Device usage.

1. Upon admission, the PMD will be sent to the IVH Wheelchair Clinic where a mechanical check will be completed to ensure that the device meets IVH safety standards.
2. Each PMD will be cleaned, labeled, and inventoried.
3. Unit staff will refer the resident to IVH Optometry for a vision exam. *If an eye exam was performed with in the past 12 months, this may be provided.*
4. The IVH RCC Team will complete a capabilities assessment of medical necessity, physical and cognitive ability, and the optometrist's evaluation.
5. Each resident will be scheduled for a clinic face-to-face evaluation to assure medical necessity using the CMS/VA Power Mobility Guidelines.
6. If the criteria are met, a physician's order will be obtained, a Power Mobility Device Evaluation form completed and these will be sent to the IVH Wheelchair Clinic
7. Safety operational expectations and driving criteria are reviewed with each resident. If all criteria are met, a 2-3-day PMD training is completed. With successful completion of the training, the PMD is issued for use. *Note that this process could take anywhere from a few days up to 2 weeks.*
8. IVH staff monitors the environment for safe use of PMDs on an on-going basis. Any unsafe use is addressed, as indicated, and may result in periodic or permanent removal of the device to maintain the safety of all.
9. Repairs including batteries, parts and labor are the responsibility of the Department of Veteran Affairs (DVA) if issued by the DVA. Expenses associated with a privately purchased PMD are the responsibility of the resident or their representative.

Driving Safety for Nursing Care Residents

Please be advised of the following Iowa Veterans Home (IVH) policies and procedures regarding operating a motor vehicle while being a nursing care resident of the Iowa Veterans Home.

1. Nursing care resident will not be able to drive until after an evaluation has been completed to ensure they are safe to operate a motor vehicle.
2. This evaluation will include:
    a. a vision screening
    b. a SLUM's screening that is indicative of normal cognitive functioning
    c. Medical clearance by the IVH Primary Care provider
    d. An evaluation by IVH Physical Therapy to insure ability to safely enter and exit the vehicle
    e. A driving evaluation completed by one of the following:
        i. Des Moines VA Medical Center
        ii. Iowa Department of Transportation
        iii. Younker Rehab – 515-263-5143
        iv. On With Life Ankeny – 515-289-9600 ext. 2
        v. On With Life Coralville – 319-259-6224
        vi. Des Moines VA Medical Center

    Any cost associated with this evaluation is the responsibility of the resident.
3. Anyone wishing to drive must maintain a vailid driver's license and provide proof of insurance.
4. All vehicles must be maintained in accordance with Administrative Policy 025A: Parking and Motor Vehicle Operation.