Veteran
Application For Admission
To The Iowa Veterans Home

1301 Summit Street - Marshalltown, Iowa 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 HONORABLE DISCHARGE OR DD-214.

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 State 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 _____ Phone Number _____ Admission Date _____
   Name

   _____
   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 _____ Birthplace _____
   First Middle Last County/City State

7. Mother's *Maiden* Name _____ Birthplace _____
   First Middle Last 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 _____ Birthplace _____
   First Middle Last ***(Maiden)*** County/City State

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

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

Attach separate sheet providing above information for all previous marriages

9. **CHILDREN:** Applicant _____

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

YES/NO _____
Name Address City State Zip Code

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

YES/NO _____
Name Address City State Zip Code

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

Attach separate sheet for additional children. List all living children, regardless of age. If any are minors, please furnish a copy of the 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 for 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 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 BRANCH OF SERVICE:** Army Navy Air Force Marines Coast Guard Merchant Marines
WACS WAVES WAAF WMC SPARS Nurse Corps

Date of entry _____ Place of entry _____

Date of discharge _____ Place of discharge _____

Your Armed Services Number _____ Your DVA Claim or File Number _____

Do you have a service-connected disability? Yes ☐ No ☐ Percentage of disability? _____

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 a copy) Name Main Phone Number

_____
Address City State Zip Code

d. Financial Power of Attorney _____
(Please provide a 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 a 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 _____
Name 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 VETERANS AFFAIRS

We hereby certify that _____ has been a resident of _____ County, State of Iowa, prior to 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: _____