

# Spouse Application For Admission To The Iowa Veterans Home

1301 Summit Street - Marshalltown, Iowa 50158-5485  
Telephone (641) 753-4325 or 800-645-4591

**THIS APPLICATION MUST BE THOROUGHLY COMPLETED OR THE ADMISSION PROCESS MAY BE DELAYED. SUBMIT WITH APPLICATION A COPY OF YOUR SPOUSE'S HONORABLE DISCHARGE OR DD-214, MARRIAGE CERTIFICATE, AND DEATH CERTIFICATE (IF APPLICABLE).**

**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's Phone Number \_\_\_\_\_

Present Address \_\_\_\_\_  
(If at facility skip to next line) Address City State Zip Code

Current facility \_\_\_\_\_  
Name 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 \_\_\_\_\_ 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 MOST RECENT marriage. If applying under previous spouse, submit marriage information on that marriage and all subsequent marriages. Copies of all marriage, divorce and/or death certificates will be required.**

Circle one of the following: Married Widowed Divorced Separated

Spouse's full name \_\_\_\_\_ Birthplace \_\_\_\_\_  
First Middle Last 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, 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 SPOUSE'S BRANCH OF SERVICE: Army Navy Marines Air Force Coast Guard Merchant Marines

WACS WAVES WAAF WMC SPARS Nurse Corps

Date of spouse's entry \_\_\_\_\_ Place of entry \_\_\_\_\_

Date of spouse's discharge \_\_\_\_\_ Place of discharge \_\_\_\_\_

Spouse's Armed Services Number \_\_\_\_\_ Spouse's DVA Claim or File Number \_\_\_\_\_

Did your spouse have a service-connected disability? Yes  No  Percentage of disability? \_\_\_\_\_

Was your spouse a: Combat Veteran? Yes  No  Prisoner of War? Yes  No  Purple Heart Recipient? Yes  No

Rank at discharge \_\_\_\_\_ Job held in service? \_\_\_\_\_

14. Years of residence 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 Conservatorship \_\_\_\_\_  
(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

s. 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
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Relationship	Main Phone Number	Alternate Phone Number (Work, Cell, Other)
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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
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20. My funeral home of preference is \_\_\_\_\_  
 Name Telephone Number

Address	City	State	Zip Code
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Is there a pre-funded 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**

I 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 I am a member/employee of the County Veteran Affairs of said county.

STATE OF IOWA  
 COUNTY OF \_\_\_\_\_

**COUNTY VETERANS AFFAIRS OFFICE**

Signed or attested before me on this day

\_\_\_\_\_  
 Signature Director/Administrator/CVSO/Commissioner

\_\_\_\_\_  
 Month Day Year

\_\_\_\_\_  
 Printed Name Director/Administrator/CVSO/Commissioner

By \_\_\_\_\_

\_\_\_\_\_  
 Notary Public in and for State of Iowa

Applicant \_\_\_\_\_

**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: \_\_\_\_\_