NEW YORK STATE DEPARTMENT OF HEALTH
New York State Veterans Homes at Batavia, Montrose, Oxford and St. Albans

APPLICATION FOR ADMISSION

Date Application Received	Date Admitted	Registration Number:

Pursuant to the Provisions of Title VI of the Civil Rights Act of 1964, and the Regulations issued hereunder, it is the policy of the New York State Veterans Homes to admit and treat all patients without regard to race, creed, color, national origin, sex, sponsor, or handicap.

NYS Public Health Law limits eligibility for admission to the New York State Veterans Homes to Veterans and their qualified dependents. To be eligible for admission to the Home, certain criteria must be met.

VETERAN ELIGIBILITY

- ❑ The veteran must have entered active duty from the State of New York or be a New York State resident for one year prior to the date of application for admission.
- ❑ The veteran must have had an honorable discharge from the United States Armed Forces.
- ❑ The veteran must have had at least 30 days of active service.
- ❑ Veterans accompanied by their spouses (both whom require skilled nursing care) will receive the highest priority for admission followed by wartime veterans, non-wartime veterans, and then other qualified applicants such as spouses, un-remarried surviving spouses, and Gold Star mothers and fathers. Special rules apply for admitting non-veterans. The Veterans Homes must maintain 75% or greater veteran occupancy before a non-veteran is eligible for admission. Please call the Admission Department with specific questions. *(See the following page for specific applicant designations.)*

DOCUMENTS REQUIRED FOR ADMISSION

A. Completed application form provided by the New York State Department of Health (Department).
B. Medical History Report and Certification by a physician on form provided by the Department.
C. Veteran's Military Discharge, original or certified copy (DD-214).
D. Documentation of monthly income and assets (see enclosed **Financial Report**).
E. Veteran's Marriage Certificate (if applicant is the spouse or widow of an eligible veteran).
F. Veteran's Birth Certificate (if applicant is the mother or father of an eligible veteran).
G. Birth Certificate or proof of age.
H. Completed funeral plans and means for paying anticipated costs.
I. Patient Review Instrument & Screen completed by Public Health Nurse or health care facility.
J. Copies of Social Security card, Medicare card, and all other insurance cards.
K. Copy of Power of Attorney, Conservatorship, etc., papers, if applicable.

PRIVACY LAW STATEMENT

The authority to request this information is contained in §206 of the New York State Public Health Law. The principal purpose of the information is to assist the Department of Health in determining your eligibility for admission to the New York State Veterans Home. Failure to provide the requested data will result in your not being admitted to the Veterans Home. This data will be maintained in the patient history systems of records by the Administrator, New York State Veterans Home.

MEDICAL ELIGIBILITY

Each applicant admitted to the Veterans Home must require skilled nursing care. Each application is reviewed and a pre-admission interview is conducted to determine the applicant's need for care.

INSTRUCTIONS

1. Read the eligibility section and determine whether you qualify for admission.
2. If you qualify, fill out each question on the application form in **Part I** (Veteran Identification). Complete **Part II** only if a dependent is applying for admission.
3. Have your physician examine you and fill out the Medical History Form and forward to the NYS Veterans Home if you are applying from home. If you are in a Veterans Affairs (VA) or private hospital, have the facility forward your Admission History and Physical. An assessment called the Patient Review Instrument (PRI) Form is to be completed by a nurse at the hospital or a certified PRI nurse in the community and forwarded to the Veterans Home.
4. Read and sign the bottom of page 2.
5. Send the application form and other necessary information to the Veterans Home. The following page contains the contact information for each Veterans Home.

VETERAN ELIGIBILITY: SPECIFIC APPLICANT DESIGNATIONS

The admission criteria for the Department of Health operated Veterans Homes is established in New York State Public Health Law §2632. The statute specifies "wartime" veteran as a veteran who served in the United States military during any one of the following time frames:

Spanish American War	April 21, 1898 - April 11, 1899
Philippine Insurrection	April 11, 1899 - July 4, 1902
World War I	April 6, 1917 - November 11, 1918
World War II	December 7, 1941 - December 31, 1946 (*) *(Special Rules Apply For WWII. Please Call The Admissions Department.)*
Korean Conflict	June 27, 1950 - January 31, 1955
Vietnam Conflict	February 28, 1961 - May 7, 1975
Lebanon [1]	June 1, 1983 - December 1, 1987
Grenada [1]	October 23, 1983 - November 21, 1983
Panama [1]	December 20, 1989 - January 31, 1990
Persian Gulf [2]	August 2, 1990 - End of Conflict
Bosnia and Herzgegovina [3]	November 21, 1995 - November 1, 2007

1. If recipient of Armed Forces, Navy, or Marine Corps expeditionary medal for participation in Lebanon, Grenada and/or Panama.
2. Persian Gulf conflict includes military service in Operation Enduring Freedom, Operation Iraqi Freedom, Operation New Dawn or Operation Inherent Resolve and was the recipient of the global war on terrorism expeditionary medal or the Iraq campaign medal or the Afghanistan campaign medal.
3. Participation in conflict or a recipient of the Kosovo campaign medal.

Public Health Law also includes the following veteran eligibility:

- ❑ Veterans who were exposed to radiation during military service in a "radiation-risk activity" defined as participation in the Occupation of Hiroshima or Nagasaki, Japan from August 6, 1945 - July 1, 1946.
- ❑ Veterans who were prisoners of war in Japan during World War II.
- ❑ Veterans with onsite participation in a test involving the atmospheric detonation of a nuclear device, whether or not the testing nation was the United States.

A dependent of a veteran is defined as:

- ❑ The spouse of a qualified veteran, unless legally separated, and married to that qualified veteran for a least one (1) year prior to the date of application for admission.
- ❑ The un-remarried surviving spouse of a qualified veteran, and married to that qualified veteran for a least one (1) year prior to the date of application for admission.
- ❑ The un-remarried surviving spouse, mother, or father of any member of the United States Armed Forces who died while on active duty.

CONTACT INFORMATION

Batavia
Admissions Coordinator
New York State Veterans Home at Batavia
220 Richmond Avenue
Batavia, NY 14020
585-345-2049
fax: 585-345-9030

Montrose
Admissions Coordinator
New York State Veterans Home at Montrose
2090 Albany Post Road
Montrose, NY 10548
914-788-6144
fax: 914-788-6134

Oxford
Admissions Coordinator
New York State Veterans Home at Oxford
4207 State Highway 220
Oxford, NY 13830
607-843-3121
fax: 607-843-3174

St. Albans
Admissions Coordinator
New York State Veterans Home at St. Albans
178-50 Linden Boulevard
Jamaica, NY 11434
718-990-0353
fax: 718-481-6994

PART 1 VETERAN IDENTIFICATION Please Print

1. Name: Last First Middle		2. Social Security Number
3a. Legal Address Street City State Zip County	b. How long at this address? ___ Yrs. ___ Mos.	4. Telephone Home ( ) Business ( )
5a. Date of Birth	b. Place of Birth	
6. Marital Status ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed		
7. Dependents Name		Age

8. War in which Service was rendered, if applicable	9. Date of Entry	10. Date of Discharge	11. Type of Discharge
12a. State of Residency at the Time of Entry		b. U.S. Citizen ☐ Yes ☐ No	
13. Service Serial Number		If Veteran is deceased, what is the date of death	

PART II SPOUSE, WIDOW, MOTHER OR FATHER IDENTIFICATION

1. Name: Last First Middle		2. Social Security No.
Legal Address Street City State Zip County	How Long at this address? ___ Yrs. ___ Mos.	Telephone Number Home ( ) Business ( )
Date of Birth	Place of Birth	
Marital Status ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed		
Dependents : Name:		Age:
Relationship ☐ Spouse ☐ Widow ☐ Mother ☐ Father		
Date of Marriage	US Citizen ☐ Yes ☐ No	

1. If admitted, I agree to furnish upon request certification as to my property, income and sources of income from time to time, but not more often than intervals of twelve (12) months.
2. I agree to pay for my cost of care from my income and assets according to current rates set by the State of New York as long as I am a resident. When my funds are not enough I agree to comply with Medicaid eligibility requirements and will apply for assistance through my county of legal residence.
3. I agree to provide a completed burial plan and means for paying the anticipated costs.
4. I agree not to transfer any property or assets without notice to the Fiscal Office.

A person of whom an oath is required by law, who willfully swears falsely in regard to any matter or thing respecting which such oath is required shall be guilty of perjury and shall be prosecuted to the full extent of the law. I understand all the questions and answers on this form, and the printed provision. To the best of my knowledge and belief, the answers to all questions are true, correct, and complete, as required by law.

_____

Applicant Signature Date

_____

Name and Address of Witness (if signed by mark)

Sworn before me this _____ day of _____ 20____

_____

Notary Public

NEW YORK STATE VETERANS' HOME FINANCIAL REPORT

NAME _____ **DATE** _____

MONTHLY INCOME:	**Patient**	**Spouse**
Social Security	_____	_____
Veteran's Pension	_____	_____
Retirement Pension	_____	_____
Company Name: _____		
Railroad Pension	_____	_____
Compensation/Disability	_____	_____
Wages/Employment	_____	_____
Mortgage/Rental	_____	_____
Trust/Lawsuit Settlement	_____	_____
Business/Farm/Other	_____	_____

CASH ASSETS:

Bank _____ Location _____

Checking Acct. # _____ Saving Acct. # _____

Balance in Account _____ Balance in Account _____

CD/Money Market/IRA Yes __ No __ If yes, approximate amount _____

Annuity/Keogh/401K Yes __ No __ If yes, approximate amount _____

Safe Deposit Box? Yes __ No __ If yes, bank location _____

OTHER ASSETS:

Burial Fund Yes ___ No ___

If yes, Bank _____ Amount _____

Real Estate – Own Home Yes ___ No ____ Outstanding Mortgage _____

Other Real Estate (i.e. camps/rentals/businesses)

Yes ___ No ___ Outstanding Mortgage _____

Life Insurance Policies _____

Vehicle Yes ___ No ___ Year/Make/Model _____

INVESTMENTS:

Stock _____

Bonds _____

Mutual Funds _____

Other _____

OUTSTANDING DEBTS:

Bank Loans _____

Charge Cards _____

Medical Bills _____

FOR VETERANS ONLY:

Funeral or burial expenses paid last calendar year for yourself, spouse or dependent child?

If yes, amount _____

Medical expenses not paid by Medicare, Medicaid, Insurance last calendar year for you or your spouse?

If yes, amount _____

Were you exposed to Agent Orange/radiation while in military? Yes ___ No ___

Do you have a military dental/spinal cord injury? Yes ___ No ___

Are you retired from military? Yes ___ No ___

Was retirement result of disability? Yes ___ No ___

Receives VA Pension? Yes ___ No ___

VA Service-Connected Pension ? Yes ___ No ___ If yes, percentage ____

Receives Medication from VA? Yes ___ No ___

Prisoner of War? Yes ___ No ___

Purple Heart? Yes ___ No ___

PRESCRIPTION DRUG COVERAGE: ____Yes ____No

If Yes, is it a Medicare Part D Plan? ____Yes ____No

Name of coverage: _____ Cost of Premium: _____

Through employer? ____Yes ____No If yes, employer name: _____

If No drug coverage, do you want us to set up a plan? ____Yes ____No

Medicare Part B Premium Amount: _____

MISCELLANEOUS:

Who handles income: _____

Does resident have Social Security Rep Payee: _____

Filed taxes in last five years? Yes ___ No ___

X _____

Signature

**Admission Interview will not be scheduled without submission of this form*

NEW YORK STATE VETERANS' HOME AT OXFORD
STATE OF NEW YORK DEPARTMENT OF HEALTH
4207 STATE HIGHWAY 220
OXFORD, NEW YORK 13830-4305

NAME OF APPLICANT **DATE**

MEDICAL HISTORY

(To Be Completed By Physician or Designee)

Last hospitalization: Adm. Date: _____ Disc. Date: _____
Reason for hospitalization: _____
Problem List:
Primary Diagnosis: _____
_____
_____
_____
_____
_____

Secondary Diagnosis: _____
_____
_____
_____
_____
_____

DISEASE DIAGNOSES/HEALTH CONDITIONS:
Check only those diseases present that have a relationship to the applicant's current Activities of Daily Living Status, cognitive status, behavioral status, medical treatments, or risk of death (do not check old/inactive diagnoses).

1. DISEASES

HEART/CIRCULATION
_____ Arteriosclerotic heart Disease (ASHD)
_____ Cardiac Dysrhythmia
_____ Congestive heart failure
_____ Hypertension
_____ Hypotension
_____ Peripheral vascular disease
_____ Other cardiovascular disease

NEUROLOGICAL
_____ Alzheimer's
_____ Dementia other than Alzheimers
_____ Aphasia
_____ Cerebrovascular Accident (stroke)
_____ Multiple Sclerosis
_____ Parkinson's disease

PULMONARY
_____ Emphysema/Asthma/ COPD
_____ Pneumonia

PSYCHIATRIC/MOOD
_____ Anxiety disorder
_____ Depression
_____ Manic depressive (bipolar disease)

SENSORY
_____ Cataracts
_____ Glaucoma

OTHER
_____ Anemia
_____ Arthritis
_____ Cancer
_____ Diabetes mellitus
_____ Explicit terminal prognosis
_____ Hypothyroidism
_____ Osteoporosis
_____ Seizure disorder
_____ Septicemia
_____ Urinary tract infection (in last 30 days)

ALLERGIES
_____ List: _____
_____
_____

2. PROBLEMS/CONDITIONS AND SIGNS/SYSTEMS
_____ Constipation
_____ Diarrhea
_____ Dizziness/Vertigo
_____ Fecal Impaction
_____ Fever
_____ Hallucinations/ Delusions
_____ Internal Bleeding
_____ Joint pain
_____ Pain (daily/almost daily)
_____ Recurrent lung aspirations in last 90 days
_____ Shortness of breath (Dyspnea)
_____ Syncope (fainting)
_____ Vomiting
_____ Respiratory infection
_____ Chest pain
_____ Other
Location: _____
_____
_____

3. EDEMA (Check all that apply in the prior 7 days)

_____ Edema - none
_____ Edema - generalized
_____ Edema - localized not pitting
_____ Edema - pitting
_____ Edema - other

4. CONDITIONS RELATED TO MR/DD STATUS (Check all conditions that are related to MR/DD Status, that were manifested before age 22, and are likely to continue indefinitely).

_____ Not applicable – No MR/DD
_____ MR/DD with Organic Condition
_____ Cerebral Palsy
_____ Down's Syndrome
_____ Autism
_____ Epilepsy
_____ Other organic condition related to MR/DD
_____ MR/DD with no organic condition
_____ Unknown

5. RESIDENTIAL HISTORY (PAST 5 YEARS) (Check all settings lived in during the past 5 years prior to admission)

_____ Prior stay at this nursing facility
_____ Other nursing facility/residential facility
_____ MH/psychiatric setting
_____ MR/DD setting
_____ NONE OF ABOVE

6. MENTAL HEALTH HISTORY
Does applicant's RECORD indicate any history of mental retardation, mental illness, or any other mental health problems?

_____ No
_____ Yes

Specify:

_____
_____
_____
_____
_____

7. IMMUNIZATION HISTORY

PCV 13 Pneumococcal	Date:	_____	Hepatitis	Date:	_____
PPSV 23 Pneumococcal	Date:	_____	Tetanus	Date:	_____
Influenza	Date:	_____	D-Tap	Date:	_____

Laboratory Test Results Including Blood/Urine/Cultures (Describe or include copy)

PPD/Mantoux (Date/Results)

EKG (Summarize and include copy)

MEDICATION(S) (Dosage, frequency, and length of time prescribed)

X-Rays

Chest (date)

Other (dates)

Surgical History and Dates

PHYSICAL EXAMINATION

(To Be Completed By Physician or Designee)

BP _____ P _____ R _____ T _____ Wt _____ Ht _____

	NORMAL	ABNORMAL (EXPLAIN)
EARS: LEFT		
RIGHT		
EYES		
NOSE		
THROAT		
TEETH		
NECK		
BREASTS		
HEART		
LUNGS		
TRUNK/BACK		
ABDOMEN		
GENITAL/PELVIC		
RECTAL		
LOWER EXT.		
VEINS/ARTERIES		
LYMPH NODES		
SKIN		
NEUROLOGICAL		

Print Physician's Name

Signature