

**MINNESOTA DEPARTMENT OF VETERANS AFFAIRS  
ADMISSION APPLICATION**

Minneapolis	5101 Minnehaha Ave So.	Minneapolis, MN 55417	(612) 548-5731
Silver Bay	45 Outer Drive	Silver Bay, MN 55614	(218) 353-8700
Hastings	1200 East 18 <sup>th</sup> St.	Hastings, MN 55033	(651) 539-2400
Luverne	P.O. Box 539	Luverne, MN 56156	(507) 283-6200
Fergus Falls	1821 N. Park St.	Fergus Falls, MN 56537	(218) 321-2500
		Minnesota Relay Service	1-800-627-3529

Please return your completed application form directly to the Minnesota Veterans Home where you want to apply. A copy of your (or your spouse's) Armed Forces Discharge Form (DD214), along with marriage certificate (if for a spouse) must accompany this application. At any time following receipt of your application, you may contact the Home's Admission Coordinator to ascertain your placement on the waiting list, and the estimated length of time until a bed may become available. If a more rapid placement is desired, you may request that the application be shared with other Minnesota Veterans Homes that may have a shorter waiting list.

Name (last, first, middle initial)		Social Security Number		Today's Date	
Address – (Please note if currently in Skilled Nursing Home)			City, State, Zip		County
Age	Date of Birth	Place of Birth		Phone Number	
Medicare Number	Medicaid Number	Private Medical Insurance (Company name & policy number)			
Have you ever been a resident of any Minnesota Veterans Home or a client of the Minn. Veterans Adult Day Center?					
<input type="checkbox"/> Yes <input type="checkbox"/> No		If so what home or program?			
Please indicate your admission preference:					
<input type="checkbox"/> Requesting immediate placement. (Active Waiting List) <input type="checkbox"/> Do not wish placement at this time. (Inactive Waiting List)					
Military Service Record	War:			Date of Enlistment	Place of Enlistment
<input type="checkbox"/> Self <input type="checkbox"/> Spouse	<input type="checkbox"/> WWII <input type="checkbox"/> Vietnam <input type="checkbox"/> Peacetime <input type="checkbox"/> Korean <input type="checkbox"/> Persian Gulf <input type="checkbox"/> Other _____				
Date of Discharge	Type of Discharge	Branch of Service	Service Number	VA Claim Number (If any)	
				C#	
Marital Status:					
<input type="checkbox"/> Single <input type="checkbox"/> Married (Date of Marriage) _____ <input type="checkbox"/> Widowed (Date of Death of Spouse) _____ <input type="checkbox"/> Divorced, Date of Divorce (If not remarried) _____					
Spouse's (Maiden) Name			Spouse's SS Number		Spouse's Date of Birth

**\*(If you are denied admission, you may appeal in writing within 30 days  
directly to the Administrator of the Home to which you applied)**

Program Applying for:  Nursing Care  Boarding Care (Domiciliary)  Adult Day Center (Minneapolis)

Has applicant been diagnosed with Dementia/Alzheimer's?  Yes  No

Is applicant exhibiting wandering, exit seeking, intrusive or rummaging behaviors?  Yes  No

Funeral Home Preference (Name, address, phone number)	Cemetery (Name, address)

PLEASE FILL IN NAME OF ANYONE LEGALLY ASSIGNED TO THESE ROLES. IF ONE PERSON IS RESPONSIBLE FOR MORE THAN ONE AREA ENTER NAME ON EACH LINE. ALSO ATTACH A COPY OF ANY SUPPORTING DOCUMENTS.

Description	Name	Address	Phone Number
Guardianship			
Power of Attorney – Financial			
Power of Attorney – Health care			
Conservator			
Representative Payee			

**TO WHOM MAY WE SEND FINANCIAL INFORMATION/FINANCIAL STATEMENTS, ETC.**

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone # \_\_\_\_\_ Home/ Work \_\_\_\_\_

**FIRST EMERGENCY CONTACT**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_ Home/ Work/Email Address \_\_\_\_\_

**SECOND EMERGENCY CONTACT**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_ Home/ Work/Email Address \_\_\_\_\_

The information requested in this section is not required for eligibility determination, but providing it may assist in the processing of the application.

**Please check the correct response(s) to the following questions:**

- Do you have the following Medicare options?  Part A     Part B     Part D  
 Do you currently have Medical Assistance?     Yes     No  
 Do you have long term care insurance?     Yes     No  
 Do you have a service connected disability with the VA?     Yes     No    If yes, what percentage? \_\_\_\_\_

If you are receiving VA benefits, which County Veterans Service Office has been assisting you with your entitlements?

If you are receiving VA benefits, which veteran's organization/claim's office has been assisting you?

Name of Person Assisting Applicant with the Application Process:

Address:	Relationship to applicant:
	(CVSO, Family Member, Social Worker, Other-Describe)
Email Address:	Home Phone:
	Work Phone:

**PERSON COMPLETING APPLICATION**

I am applying for admission to the Minnesota Veterans Homes under provisions of Minnesota Statutes, Chapter 198. It is my understanding that access to the information in this application is limited to Minnesota Department of Veterans Affairs, as appropriate. No other use, not specifically authorized by law, will be made of this information without prior consent. I also understand that failure to supply this information may mean my eligibility cannot be determined.

Applicant's Signature: (required)	Date:
	Referred by: