NEW MEXICO STATE VETERANS HOME

Admission Checklist

To be provided by applicant and/or responsible person(s):

Current History and Physical (less than 90 days) __________

Face sheet, History and Physical, Current Physician's orders, Medication sheet, Social Service Notes, Special services notes, and other pertinent information.

Copy of DD-214 (discharge from service) __________

Copy of Marriage License __________

Bank Statement, copies of third party insurance coverage cards (Medicare, Medicaid, Pharmacy Cards (Medicare D, etc.) and/or Personal insurance) __________

Copy of Durable Power of Attorney, Living Will for Health Care, Guardianship __________

Complete Application:

- Application for Admission __________
- Daily Living Skills __________
- Financial Disclosure Summary __________
- Medicaid Application __________

Revised 3/17/11

NEW MEXICO STATE VETERANS HOME
992 SOUTH BROADWAY
TRUTH OR CONSEQUENCES, NM 87901

APPLICATION FOR ADMISSION

Services are provided without regard to race, color, national orlgin, religion, sexual preference, age, handicap, or sex

APPLICANT INFORMATION: **Date:_____/____/____**

Name:____________________________________ Social Security #:_____-_____-______

Address:______________________ City/State:________________________ Zip:___________

County of Residence: __________________ Home Phone #: (____)__________________

Sex: _____Male _____Female Ethnic Group: ________________________

Date of Birth: ____/_____/______ Age: _______ Place of Birth: _________________________

Marital Status: _____Single _____Married _____Widow(er) _____Divorced

Father's Name: _______________________ Mother's Maiden Name: _______________________

Religious Preference:_____________________ Church/Synagogue: ______________________

Address: __________________________ City/State/Zip: _________________________________

What was/is Occupation: ______________________________ Company:_____________________

Branch of Service: ____________ Highest Rank:________ Dates of Service: __/__/__ to __/__/__

Honorable Discharge: __ Yes __ No Service Connected Disability: __Yes If Yes, ___% __ No

Personal/Family Physician:_____________________________ Telephone: (___)______________

Address: _________________________ City/State/Zip: ___________________________________

Last Hospital Admission: ____________________ Date:___/___/___Telephone: (___)_________

Address: ____________________________ City/State/Zip:_______________________________

Current Placement (Name of Hospital, Nursing Home, etc.)_______________________________

PERSON(S) TO NOTIFY IN CASE OF EMERGENCY: (for additional info please use another sheet)

Name:____ Relation:____________________

Address: __________________________ City/State/Zip:_________________________________

Home Phone: (___)______________________ Emergency /CellPhone #(___)________________

NM STATE VETERANS' HOME
DAILY LIVING SKILLS INVENTORY

Name:________________ Sex:____ DOB:________S.S#:__________________

PRESENT MEDICAL DIAGNOSIS/CONDITIONS: ________________________
____
____

PAST MEDICAL HISTORY:(operations, injuries, illnesses, hospitalizations, psychiatric treatment: include dates): ___________________________________
____
____

PRE-ADMISSION SCREENING:

Do you have a diagnosed or suspected mental disorder other than dementia?
(Please check one) [ ] Yes [ ] NO

Is there any indication of mental retardation? (Please check one) [ ] Yes [ ] No

ADL's: Using the following criteria, please choose the number (0-4) that best describes you or your family member's performance in Activities of Daily Living.

0 **Independent -** No Assist; help or supervision supplied 1 or 2 times per week.

1 **Supervision** -Supervision 3 times per week or supervision and physical assist 1or 2 time per week.

2 **Limited Assistance** - Residents highly involved in activity - receives physical help in maneuvering of limbs or other non-weight bearing activity 3 + times weekly.

3 **Extensive Assistance** - Residents performs part of activity but requires physical help 3 + times weekly with weight bearing support or full assist with other ADL's less than full time.

4 **Total Dependence** - Caregiver must perform all daily living skills 7 days per week.

Score (0-4) Please score yourself/your family member.

_____ **Bed Mobility**: How resident moves to and from lying position, turns side to side, and positions body while in bed.

_____ **Transfer**: How resident moves between surfaces - to/from bed, chair, wheelchair, standing position. (Exclude to/from bath/ toilet)

_____ **Locomotion**: How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair

_____ **Dressing**: How resident puts on, fasten, and takes off all items of street clothing, including donning/removing prosthesis.

_____ **Eating**: How resident eats and drinks (regardless of skill).

_____ **Toilet use**: How resident uses the toilet room (or commode, bedpan, urinal; transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.

_____ **Personal Hygiene**: How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and genitals (EXCLUDE baths and showers).

Please use a new criteria (0-4 as follows) for Bathing:

Bathing: How a resident takes a fully body bath, sponge bath, and transfer in/out of tub/shower (excluding washing of back of hair)

Bathing
Score
____

0 - Independent: no help provided
1- Supervision: Oversight help only
2- Physical help limited to transfer only
3- Physical help in part of bathing activity
4- Total dependence.

Continence: Control of bladder/bowels in last 14 days

Continence
Score
____

0-Continent: Complete Control
1-Usually continent
2-Occasionally incontinent
3-Frequently incontinent
4-Incontinent

Circle One

Are you or your family member on a scheduled toileting plan ? Yes No
Any recent change in continence? Yes No
Any skin problems or treatments? Yes No

Please check any that apply:
External Catheter _____ Enemas _____ Irrigation _____ Pads _____
Ostomy _____ Indwelling Catheter _____ Briefs ______

Vision: Adequate _____ Impaired ______ Highly Impaired ____ Severely Impaired:______

Speech: Speaks _____ Writes Messages _____ Signs/Gestures _____ Sounds _____
Communication board ____

Hearing: Adequate _____ Minimal Difficulty _____ Absent Hearing _____ Hear only on special situations _____

Oral Problems: Chewing Problem _____ swallowing Problem _____ Mouth Pain ____

Nutritional Problems:

Dehydrated_____ Complains of Hunger_____ Feeding Tube _____ Supplement ______
Drinks or eats well ______Does not eat or drink well _____ Therapeutic diet ______
Mechanically altered diet _____

Body Control Problems:

Bedfast _____ Balance problems _____ Contracture ______ Hemiplegia _____
Quadriplegia _____ Amputation _____ Hemiparesis _____ Loss of voluntary movement to hands, leg trunks or arms _____

Do you or your family member use any of the following ? Hearing Aide ______
Dentures ____ Glasses ____ Brace or Prosthesis ___ Cane/Walker____
Mechanical Lift _____ Wheelchair _____ Special feeding tube ___

Restraints:

Bed rails_____ Trunk Restraint_____ Limb Restraint_____ Chemical Restraint _______

Circle One:

If your use a wheel chair, can you propel it yourself? Yes No
Any problems with falls? Yes No Frequent _____ Infrequent ______

Please check any that apply:

Psychosocial Well-Being: At ease with others _____ At ease doing planned activities _____ Establishes own goal _____ Absence of personal contact with family or friends _______ Openly expresses conflict or anger with family or friends _____

Mood Patterns: Sad or anxious mood ____ Tearfulness _____ Failure to eat _____ Motor agitation (pacing, hand-wringing, picking) _____Withdrawal from self care or leisure activities ____Recurrent thoughts of death ____ Suicidal thoughts/actions _____

Behavior Patterns: Wandering ___ Verbally abusive___ Physically abuse___ Socially Inappropriate/Disruptive Behavior___ Resists Care(medication, treatments, ADL care)____

Memory Problems: Short term memory okay ______ Long term memory okay _____

Any prior treatment for alcohol/drug problems? **Yes** **No**

Any history of communicable disease ? **Yes** **No**

List date of last chest x-ray or TB test results:_________________________________

Has applicant had flu immunization and date of last administration. _____ Yes _____No
Date_______________

Has applicant had pneumovax immunization and date of administration. ___Yes ___No
Date_______________

Any other immunizations and dates.____

Any history of MRSA, VRE, Hepatitis, or other infectious disease and dates. _______________

____

Please list medications taken: ____

____

____

____

ALLERGIES**:** ____

____

Please add any concerns or additional information you think might be helpful for you or your family member's needs: ____

____

____

____

____

_______________________________________ _______________________

Signature Date Relationship

NEW MEXICO STATE VETERANS' HOME
992 S. Broadway
Truth or Consequences, New Mexico 87901

FINANCIAL DISCLOSURE STATEMENT

Name: ______________________________ **Social Security #:** ________________________

Spouse's Name (If applicable):___________________ Social Security #:_________________

Do you own or have interest in property other than the property which is the primary residence of spouse or dependent children? _____Yes _____No

MONTHLY INCOME (Pensions, Rental Income, Annuities, Social Security, Interest Income, etc.):

Source	Applicant	Spouse
_________________________________	$_____________	$_____________
_________________________________	$_____________	$_____________
_________________________________	$_____________	$_____________

BANK ACCOUNTS: <u>PLEASE PROVIDE BANK STATEMENT</u>

Bank Name, Address & Zip Code	Type of Account (Checking/Savings)	Account Balance
___________________________________	________________	$______________
__________________________________	________________	$______________

Health Insurance

Medicare #: ____________________Medicaid #:________________________
Pharmcy Rx Card # ___________________
(Medicare D Card, etc.)
Insurance Policy #: _____________________________________
Company: _____________________________________
Address: _____________________________________
City/State/Zip: _____________________________________

<u>C E R T I F I C A T I O N</u>

The Department of Health and The New Mexico State Veterans' Home are authorized to investigate the financial information provided by applicants or their representative(s) to determine their ability to pay for services. Any applicant or representative(s) who knowingly withholds or falsifies financial information shall be liable for all expenses incurred for legal action related to the recovery of valid indebtedness to the State of New Mexico.

I hereby certify that the foregoing information is true and correct to the best of my knowledge and belief. I agree to report any change in income to the Financial Specialist of the New Mexico State Veterans' Home.

____
Name of Person Completing Information (Please print)

____ Date:_____/_____/_____
Signature of Person Completing Information

____
Relation to Applicant, if other than Applicant