

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, required only if for spouse
or surviving spouse of veteran _____

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 _____

**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 origin, 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 TO NOTIFY IN CASE OF EMERGENCY:

Name: _____ Relation: _____

Address: _____ City/State/Zip: _____

Home Phone: (____) _____ Emergency Phone #(____) _____

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 1 or 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.

Continance: Control of bladder/bowels in last 14 days

Continance
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 on 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: _____

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: PLEASE PROVIDE BANK STATEMENT

Bank Name, Address & Zip Code	Type of Account (Checking/Savings)	Account Balance
_____	_____	\$ _____
_____	_____	\$ _____

Health Insurance

Medicare #: _____ Medicaid #: _____
 Pharmacy Rx Card # _____
 (Medicare D Card, etc.)
 Insurance Policy #: _____
 Company: _____
 Address: _____
 City/State/Zip: _____

CERTIFICATION

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)

 Signature of Person Completing Information

Date: ____ / ____ / ____

 Relation to Applicant, if other than Applicant