

# Application for Admission to an Illinois Veterans' Home

## Anna Veterans' Home

792 N. Main Street  
Anna, IL 62906  
(618) 833-5394

## LaSalle Veterans' Home

1015 O'Connor Avenue  
LaSalle, IL 61301  
(815) 410-8375

## Chicago Veterans' Home

4250 N. Oak Park Ave.  
Chicago, IL 60634  
(773) 794-3763

## Manteno Veterans' Home

One Veterans Drive  
Manteno, IL 60950  
(815) 468-6581, x226

## Quincy Veterans' Home

1707 N. 12th Street  
Quincy, IL 62301  
(217) 222-8641, x02454

### PLEASE READ INSTRUCTIONS BEFORE COMPLETING APPLICATION

Assistance in completing this application may be obtained from any of the above offices. All questions on this form must be answered. The information provided will be used to determine eligibility; appropriate level of care; and to allow preliminary planning for care and treatment. **This application can only be signed by the applicant or their legal representative.**

### APPLICANT INFORMATION

APPLICANT'S FULL NAME: \_\_\_\_\_

CURRENT ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_ COUNTY: \_\_\_\_\_

PRIMARY PHONE NUMBER: (\_\_\_\_) \_\_\_\_\_ ALTERNATE PHONE NUMBER: (\_\_\_\_) \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ BIRTHPLACE: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_

MARITAL STATUS: ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED ☐ NEVER MARRIED

NUMBER OF DEPENDENTS: \_\_\_\_\_ FORMER OCCUPATION OF VETERAN: \_\_\_\_\_

HAVE YOU EVER BEEN CONVICTED OF A FELONY? ☐ YES ☐ NO WHEN? \_\_\_\_\_

### PERSON TO CONTACT IF DIFFERENT FROM APPLICANT

FULL NAME: \_\_\_\_\_

CURRENT ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_ COUNTY: \_\_\_\_\_

PRIMARY PHONE NUMBER: (\_\_\_\_) \_\_\_\_\_ ALTERNATE PHONE NUMBER: (\_\_\_\_) \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

### MILITARY INFORMATION

STATUS: ☐ VETERAN ☐ NON-VETERAN ☐ GOLD STAR PARENT ☐ OTHER: \_\_\_\_\_

SERVICE BRANCH: ☐ ARMY ☐ NAVY ☐ MARINES ☐ AIR FORCE ☐ COAST GUARD ☐ MERCHANT MARINE

SERVED DURING: ☐ WORLD WAR II ☐ KOREA ☐ VIETNAM ☐ PERSIAN GULF/OEF/OIF ☐ OTHER: \_\_\_\_\_

DID YOU RECEIVE AN EXPEDITIONARY MEDAL? ☐ YES ☐ NO WERE YOU A P.O.W? ☐ YES ☐ NO

DATE ENTERED ACTIVE SERVICE: \_\_\_\_\_ PLACE ENLISTED: \_\_\_\_\_

DATE OF DISCHARGE: \_\_\_\_\_ PLACE DISCHARGED: \_\_\_\_\_

TYPE OF DISCHARGE: \_\_\_\_\_ SERVICE #: \_\_\_\_\_

DO YOU HAVE A VA CLAIM #? ☐ YES ☐ NO VA CLAIM #: \_\_\_\_\_

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## DEMOGRAPHICS INFORMATION

HAVE YOU PREVIOUSLY LIVED IN OR APPLIED FOR ADMISSION AT AN ILLINOIS VETERANS' HOME? ☐ YES ☐ NO

IF YES, WHICH HOME? \_\_\_\_\_ WHEN? \_\_\_\_\_

ARE YOU PRESENTLY ON A WAITING LIST AT ONE OF THE ILLINOIS VETERANS' HOMES? ☐ YES ☐ NO

IF YES, WHICH HOME? \_\_\_\_\_ WHEN? \_\_\_\_\_

WHAT CARE LEVEL ARE YOU APPLYING FOR? ☐ SKILLED NURSING ☐ INDEPENDENT LIVING

I HAVE LIVED IN THE STATE OF ILLINOIS CONTINUOUSLY FOR THE PAST YEAR / 12 MONTHS. ☐ YES ☐ NO

RESIDENCE ADDRESS FOR LAST 12 MONTHS:

\_\_\_\_\_ FROM: \_\_\_\_\_ TO: \_\_\_\_\_

## NEXT OF KIN/FRIENDS INFORMATION

LIST ALL INFORMATION ON SPOUSE (INCLUDING MAIDEN NAME) AND ALL CHILDREN BORN OR LEGALLY ADOPTED OF THIS UNION.  
LIST CHILDREN BORN OF PREVIOUS MARRIAGE(S). USE ADDITIONAL SHEET IF NECESSARY.

| FULL NAME | RELATIONSHIP | DOB | ADDRESS | PHONE |
|-----------|--------------|-----|---------|-------|
|-----------|--------------|-----|---------|-------|

|       |       |       |       |       |
|-------|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

## LIST PERSONS TO NOTIFY IN CASE OF EMERGENCY, OR IF ADDITIONAL INFORMATION IS NEEDED.

#1 PERSON: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PRIMARY PHONE #: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ ALTERNATE PHONE #: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

#2 PERSON: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PRIMARY PHONE #: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ ALTERNATE PHONE #: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

#3 PERSON: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PRIMARY PHONE #: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ ALTERNATE PHONE #: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

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## FINANCIAL INFORMATION – BANK ACCOUNTS

THE APPLICANT IS CHARGED A MONTHLY MAINTENANCE CHARGE TO LIVE AT AN ILLINOIS VETERANS' HOME. THE FOLLOWING FINANCIAL INFORMATION IS NEEDED FOR BOTH THE VETERAN AND SPOUSE TO PROPERLY ADVISE AN APPLICANT AND SPOUSE ABOUT V.A. BENEFITS.

| NAME OF BANK / CREDIT UNION / SAVINGS & LOAN | AMOUNT | ACCOUNT TYPE | LOCATION |
|----------------------------------------------|--------|--------------|----------|
|                                              |        |              |          |
|                                              |        |              |          |
|                                              |        |              |          |
|                                              |        |              |          |
|                                              |        |              |          |

## FINANCIAL INFORMATION - MONTHLY INCOME AMOUNTS

(BRING SUPPORTING DOCUMENTATION AT ADMISSION)

VETERAN

SPOUSE

MILITARY RETIREMENT, VETERAN'S PENSION OR SERVICE

CONNECTED COMPENSATION (DISABILITY %? \_\_\_\_\_) \$ \_\_\_\_\_ \$ \_\_\_\_\_

SOCIAL SECURITY \$ \_\_\_\_\_ \$ \_\_\_\_\_

MONTHLY INTEREST / DIVIDENDS \$ \_\_\_\_\_ \$ \_\_\_\_\_

VA PENSION BENEFITS \$ \_\_\_\_\_ \$ \_\_\_\_\_

ANNUITY \$ \_\_\_\_\_ \$ \_\_\_\_\_

RENTAL PROPERTY (NET) \$ \_\_\_\_\_ \$ \_\_\_\_\_

OTHER PENSION or INCOME \$ \_\_\_\_\_ \$ \_\_\_\_\_

TOTAL MONTHLY INCOME \$ \_\_\_\_\_ \$ \_\_\_\_\_

IF ABOVE INCOME GOES TO A REPRESENTATIVE PAYEE, PLEASE PROVIDE THEIR NAME, ADDRESS, AND PHONE #:

## FINANCIALLY RESPONSIBLE PERSON

FULL NAME

RELATIONSHIP

DOB

STREET ADDRESS, CITY, STATE, AND ZIP

## INSURANCE POLICIES

HEALTH INSURANCE (NON-MEDICARE) ☐ YES ☐ NO MONTHLY PREMIUM COST: \_\_\_\_\_

COMPANY: \_\_\_\_\_ POLICY NO: \_\_\_\_\_

PLEASE BRING INSURANCE CARD ON ADMISSION. MEDICARE PARTICIPATION IS MANDATORY  
(IF NOT CURRENTLY PARTICIPATING, YOU WILL BE ENROLLED AT ADMISSION)

MEDICARE: PART A (HOSPITALIZATION) ☐ YES ☐ NO EFFECTIVE DATE \_\_\_\_\_

MEDICARE: PART B (MEDICAL COVERAGE) ☐ YES ☐ NO EFFECTIVE DATE \_\_\_\_\_

PRE-PAID FUNERAL ARRANGEMENTS ☐ YES ☐ NO (PROVIDE COPY OF AGREEMENT)

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## ADVANCE DIRECTIVES AND LEGAL AUTHORITY

DO YOU HAVE ANY OF THE FOLLOWING ADVANCE DIRECTIVES OR LEGAL APPOINTMENTS:

|                                        |                                                    |
|----------------------------------------|----------------------------------------------------|
| LIVING WILL                            | <input type="radio"/> YES <input type="radio"/> NO |
| LEGAL GUARDIANSHIP                     | <input type="radio"/> YES <input type="radio"/> NO |
| POWER OF ATTORNEY – HEALTHCARE         | <input type="radio"/> YES <input type="radio"/> NO |
| POWER OF ATTORNEY – FINANCIAL/PROPERTY | <input type="radio"/> YES <input type="radio"/> NO |

NOTE: IF YOU ANSWERED YES TO ANY OF THESE QUESTIONS REGARDING ADVANCE DIRECTIVES OR LEGAL AUTHORITY, YOU **MUST** PROVIDE A COPY OF THOSE DOCUMENTS BEFORE OR UPON ADMISSION.

I agree to abide by and obey the rules and regulations governing the Illinois Veterans' Homes and to accept transfer to a hospital, special treatment center, or Home if in the opinion of the Medical Staff, such transfer is deemed advisable. I/We understand that should I/We receive additional income or be eligible for any additional income at any future date, from any sources, that it is mandatory that it be reported to the Home, and that failure to do so shall be cause for discharge.

This authorizes the Home Administrator or designee to verify any facts relative to my/our financial status or income.

I have read or have had read to me, all questions and answers on this form and the answers are true and complete to the best of my knowledge and belief. I also understand that any falsification regarding the provided information will be reason for discharge from the Home.

SIGNED: \_\_\_\_\_

DATE: \_\_\_\_\_

**IMPORTANT NOTICE:** This application must be fully completed in all portions and accompanied by a copy of the applicant's Discharge Certificate or DD 214, and the ILLINOIS DEPARTMENT OF VETERANS' AFFAIRS - HEALTH QUESTIONNAIRE. If this form is signed by anyone other than the applicant, a copy of their legal authority must accompany the application.

This State Agency is requesting disclosure of information necessary to accomplish the statutory purpose of P.A. 79- 1384, Paragraph 5. Inasmuch as this information is VOLUNTARY, failure to provide this information may prevent admission to a Veterans' Home.

## TO BE COMPLETED BY DEPARTMENT PERSONNEL

Applicant (meets) / (does not meet) Veterans' eligibility criteria.

Signature of the Adjutant Date \_\_\_\_\_

Applicant medically (eligible) / (ineligible)

Signature of Medical Officer Date \_\_\_\_\_

This application has been investigated and it is recommended that the applicant (be admitted) / (not be admitted) to reside in the Illinois Veterans' Homes.

Signature of the Administrator Date \_\_\_\_\_



# Health Questionnaire

APPLICATION WILL NOT BE REVIEWED UNLESS THIS FORM IS COMPLETED AND A COPY OF THE LAST OR MOST RECENT HISTORY AND PHYSICAL OR DISCHARGE SUMMARY COMPLETED BY A LICENSED PROVIDER IS ATTACHED. ALSO INCLUDE THE MOST RECENT 90 DAYS OF NURSING PROGRESS NOTES.

APPLICANT NAME: \_\_\_\_\_ DATE OF EXAM: \_\_\_\_\_

CURRENT RESIDENCE? ☐ HOME ☐ HOSPITAL ☐ NURSING HOME

NURSING HOME/HOSPITAL NAME AND ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_ COUNTY: \_\_\_\_\_

## 1. DIAGNOSIS

|  |  |  |
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## 2. CURRENT MEDICATIONS/SUPPLEMENTS (Type; Strength; Dosage)

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|  |  |  |
|  |  |  |
|  |  |  |

## 3. ALLERGIES

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|  |

## 4. HX OF INFECTIOUS DISEASES

| DISEASE       | DATE | SITE OF INFECTION |
|---------------|------|-------------------|
| VRE           |      |                   |
| ESBL          |      |                   |
| C-DIFF        |      |                   |
| HERPES ZOSTER |      |                   |
| COVID-19      |      |                   |
| OTHER         |      |                   |

## 5. VACCINATIONS

| VACCINE                  | YES | NO | DATE | DATE | TB/MANTOUX RESULTS |
|--------------------------|-----|----|------|------|--------------------|
| TB TEST/MANTOUX          |     |    |      |      |                    |
| PREVNAR                  |     |    |      |      |                    |
| PNEUMOVAX                |     |    |      |      |                    |
| INFLUENZA                |     |    |      |      |                    |
| TDAP                     |     |    |      |      |                    |
| SHINGLES / HERPES ZOSTER |     |    |      |      |                    |
| COVID-19 SERIES          |     |    |      |      |                    |

# Health Questionnaire

## 6. PAST SURGERIES (When and What)

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|  |  |
|  |  |

## 7. PAST INJURIES (When and What)

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## 8. PAST MAJOR DISEASES (When and What)

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|  |

## 9. FAMILY MEDICAL HISTORY (When and What)

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|  |
|  |

## 10. LIFESTYLE HISTORY

TOBACCO USER ☐ YES ☐ NO    AGE STARTED \_\_\_\_\_ TYPE \_\_\_\_\_    AGE STOPPED USING TOBACCO \_\_\_\_\_

ALCOHOL USER ☐ YES ☐ NO    AGE STARTED \_\_\_\_\_ TYPE \_\_\_\_\_    AGE STOPPED USING TOBACCO \_\_\_\_\_

DATE COMPLETED ALCOHOL PROGRAM \_\_\_\_\_

RECREATIONAL DRUG USER ☐ YES ☐ NO    AGE STARTED \_\_\_\_\_ TYPE \_\_\_\_\_    AGE STOPPED USING TOBACCO \_\_\_\_\_

DATE COMPLETED ALCOHOL PROGRAM \_\_\_\_\_

EXPLANATION: \_\_\_\_\_

## 11. BEHAVIORAL HEALTH (Does applicant have a history of the following. Explain all "yes answers)

PSYCHIATRIC TREATMENT ☐ YES ☐ NO

VERBALLY / PHYSICALLY COMBATIVE ☐ YES ☐ NO

CHEMICAL ABUSE ☐ YES ☐ NO

RESISTIVE TO CARE ☐ YES ☐ NO

ALCOHOLISM ☐ YES ☐ NO

"SUNDOWN" SYNDROME ☐ YES ☐ NO

DEPRESSION ☐ YES ☐ NO

ELOPEMENT RISK ☐ YES ☐ NO

PTSD ☐ YES ☐ NO

INVOLUNTARY DISCHARGE FROM HEALTHCARE FACILITY ☐ YES ☐ NO

SUICIDAL ☐ YES ☐ NO

EXPLANATION: \_\_\_\_\_

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## 12. ACTIVITIES OF DAILY LIVING (Can applicant do the following by themselves)

GET DRESSED ☐ YES ☐ NO ☐ PARTIALLY  
 TOILET SELF ☐ YES ☐ NO ☐ PARTIALLY  
 CONTINENT OF BOWEL ☐ YES ☐ NO ☐ PARTIALLY  
 CONTINENT OF BLADDER ☐ YES ☐ NO ☐ PARTIALLY  
 BATHE ☐ YES ☐ NO ☐ PARTIALLY  
 ORAL HYGIENE ☐ YES ☐ NO ☐ PARTIALLY  
 TRANSFER SELF ☐ YES ☐ NO ☐ PARTIALLY  
 MAKE NEEDS KNOWN ☐ YES ☐ NO ☐ PARTIALLY  
 PREPARE & TAKE MEDICATION ☐ YES ☐ NO ☐ PARTIALLY

USE STAIRS SAFELY ☐ YES ☐ NO ☐ PARTIALLY  
 REPOSITION IN BED ☐ YES ☐ NO ☐ PARTIALLY  
 OPERATE WHEELCHAIR ☐ YES ☐ NO ☐ PARTIALLY  
 OPERATE MEDICAL EQUIPMENT ☐ YES ☐ NO ☐ PARTIALLY  
 FEED SELF ☐ YES ☐ NO ☐ PARTIALLY  
 AMBULATE SELF ☐ YES ☐ NO ☐ PARTIALLY  
 MENTALLY COMPETENT ☐ YES ☐ NO ☐ PARTIALLY  
 ABLE TO CLEARLY SPEAK ☐ YES ☐ NO ☐ PARTIALLY  
 ABLE TO UNDERSTAND SPEECH ☐ YES ☐ NO ☐ PARTIALLY

EXPLANATION: \_\_\_\_\_

## 13. SPECIAL NEEDS (Explain any "Yes" answers below)

OXYGEN ☐ YES ☐ NO  
 NEBULIZER TX ☐ YES ☐ NO  
 INHALER ☐ YES ☐ NO  
 TRACH CARE ☐ YES ☐ NO  
 DYSPNEA ☐ YES ☐ NO  
 ACCU CHECKS ☐ YES ☐ NO

NOCOMPLETE BED CARE ☐ YES ☐ NO  
 APHASIC ☐ YES ☐ NO  
 EPILEPSY ☐ YES ☐ NO  
 CARDIAC PATIENT ☐ YES ☐ NO  
 PACEMAKER / DEFIB ☐ YES ☐ NO  
 FOLEY CATHETER ☐ YES ☐ NO

NOCOLOSTOMY ☐ YES ☐ NO  
 STOMA ☐ YES ☐ NO  
 DEAF ☐ YES ☐ NO  
 BLIND ☐ YES ☐ NO  
 PRESSURE INJURY ☐ YES ☐ NO  
 SPECIAL DIET ☐ YES ☐ NO

EXPLANATION: \_\_\_\_\_

## 14. DURABLE MEDICAL EQUIPMENT

GLASSES ☐ YES ☐ NO  
 DENTURES ☐ YES ☐ NO  
 HEARING AIDS ☐ YES ☐ NO

CONTACTS ☐ YES ☐ NO  
 WALKER ☐ YES ☐ NO  
 CANE ☐ YES ☐ NO

WHEELCHAIR ☐ YES ☐ NO  
 CRUTCHES ☐ YES ☐ NO  
 BRACE ☐ YES ☐ NO

COMMENTS: \_\_\_\_\_

## 15. FALLS

RECENT FALLS? ☐ YES ☐ NO DATE: \_\_\_\_\_ INJURIES? \_\_\_\_\_

COMMENTS: \_\_\_\_\_

## ADDITIONAL COMMENTS / OTHER RELEVANT NOTES

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NOTICE TO EXAMINING CLINICIAN: History, symptoms, and physical findings must be recorded in sufficient detail to clearly support the diagnoses. Include recent history of current diagnosis of infectious disease with pertinent pathology information. PURSUANT TO 210 ILCS 45/2-213 a facility shall administer or arrange for administration of a pneumococcal vaccination to each resident, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, who has not received this immunization prior to or upon admission to the facility, unless the resident refuses the offer for vaccination or the vaccination is medically contraindicated. A facility shall document in each resident's medical record that a vaccination against pneumococcal pneumonia was offered and administered, arranged, refused, or medically contraindicated

Based on the applicant's current medical status, placement for the following care levels is appropriate:

INDEPENDENT LIVING: ☐ YES ☐ NO

SKILLED NURSING CARE: ☐ YES ☐ NO

Signed: \_\_\_\_\_ Name: \_\_\_\_\_  
Examining Clinician Printed / Typed

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date: \_\_\_\_\_ Phone: \_\_\_\_\_

This State Agency is requesting disclosure of information necessary to accomplish the statutory purpose pursuant to 20 ILCS 2805, et. seq., Department of Veterans Affairs Act. Inasmuch as this information is VOLUNTARY, failure to provide the information may prevent admission to an Illinois Veterans' Home.