

Charlotte Hall Veterans Home Admission Application

Nursing Home OR Assisted Living (please circle)

Veteran OR Spouse (please circle)

1. Mr. Mrs. Ms.

Last Name: _____ First Name: _____ Middle Initial _____

2. Current Address: _____ County _____

City: _____ State: _____ Zip: _____

3. Current Telephone Number: () _____

4. Age : _____ Date of Birth: _____ Birthplace : _____

5. Marital Status: Single Married Divorced Widowed Separated (if so, legal date: _____)

6. Religious Preference: _____

7. Social Security Number : _____

8. Military Service : Army Navy Marine Corps Air Force Coast Guard Other _____

9. Date Entered Service : _____ Date Separated : _____

Service Number : _____ Type of Discharge : _____

10. War Era: WWI WWII (Europe) WWII (South Pacific) Korean Vietnam Gulf War Peacetime

11. Do you have a service connected disability? Yes No If yes, what percent: _____

12. Were you a POW? Yes No

13. Does anyone have power of attorney /guardianship for your affairs? Yes No

If so, please provide a copy

Healthcare POA: _____ Financial POA : _____

14. Is there an Advance Directive or Living Will in place? _____ **If so, please provide a copy**

Any prearranged funeral arrangements? Yes No What funeral home: _____

15. Name of Spouse/Responsible Party: _____ Relationship _____

Address : _____

City : _____ State : _____ Zip : _____

Home Phone () _____ Work Phone () _____ Cell Phone () _____

16. Alternate person to contact : _____ Relationship : _____

Address : _____

City : _____ State : _____ Zip : _____

Home Phone () _____ Work Phone () _____ Cell Phone () _____

16. Have you ever been treated for mental illness / problems? Yes No If yes, please complete:

Diagnosis: _____ Dates of Treatment : _____

Name of Facility or Physician : _____

Address: _____

City : _____ State : _____ Zip : _____

17. Have you ever been treated for Drug/Alcohol problems: Yes No If yes, please complete:

Diagnosis : _____ Dates of Treatment : _____

Name of Facility or Physician : _____

Address : _____

City : _____ State : _____ Zip : _____

18. Name of Primary Care Physician : _____

Address : _____

City : _____ State : _____ Zip : _____

Are you enrolled in the VA medical center? Yes No

19. Do you have medical/health insurance: Yes No

Medicare number: _____

Private Insurance (Blue Cross/Blue Shield, AARP, etc) :

Company Name: _____ Policy Number: _____

20. Have you enrolled in a Medicare part D program: Yes No

If yes, which one: _____ PDP ID#: _____

21. Do you have Long Term Care Insurance: Yes No If yes:

Company Name: _____

****Please include copies of your Military discharge/DD214, health insurance cards (front and back) , Drivers License/State ID and any other requested information with this form.**

How did you hear about Charlotte Hall Veterans Home? _____

Your Signature or Responsible Party : _____

Date : _____