



**Kentucky Department of Veterans Affairs
Office of Kentucky Veterans Centers**

1111 B Louisville Road
Frankfort, Kentucky 40601
Phone: (502) 564-9281 FAX: (502) 564-4036



Dear Potential Resident/Family Member:

Thank you for your interest in the Kentucky Veterans Centers. We realize that the decision to place a loved one into a long-term care facility is not an easy one, and our goal is to make the transition as effortless and pleasant as possible.

At the top of the enclosed application you will find the names of the three state veteran's nursing homes we operate. Please check the box beside the home or homes in which you are interested in applying for admission.

There are admission coordinators at each home who are trained to assist, guide, and direct you through the application process. The address and telephone numbers of the admission coordinators are listed below, and we encourage you to contact them for any assistance needed.

In order to expedite the process, we have attached a list of items that are needed to help determine your eligibility, level of care, and financial responsibility. Please forward these items to us along with your completed application. Again, if any assistance is needed, please do not hesitate to contact one of the below facilities.

Thomson-Hood Veterans Center	Eastern Kentucky Veterans Center	Western Kentucky Veterans Center
ATTN: Admissions Coordinator - Debbie Slemp Financial - Ruth Lynch	ATTN: Admissions Coordinator - Steve Noe Financial - Marsha Jett	ATTN: Admissions Coordinator - Lisa Ware Financial - Lisa Foster
100 Veterans Drive Wilmore, KY 40390 859-858-2814 800-928-4838 FAX 859-858-4039 TTYS 859-858-4226	200 Veterans Drive Hazard, KY 41701 606-435-6196 877-856-0004 FAX 606-435-6201 TTYS 606-435-6203	926 Veterans Drive Hanson, KY 42413 270-322-9087 877-662-0008 FAX 270-322-9497 TTYS 270-322-9752

We appreciate your service to the nation and extend our gratitude for the opportunity to serve you, the veterans of America's Armed Forces!

Sincerely,

Gilda C Hill

Gilda Hill, Acting Executive Director
Office of Kentucky Veterans Centers

- Thomson-Hood Veterans Center Eastern Kentucky Veterans Center Western Kentucky Veterans Center
 100 Veterans Drive 200 Veterans Drive 926 Veterans Drive
 Wilmore, Kentucky 40390 Hazard, Kentucky 41701 Hanson, Kentucky 42413

Please place a check in the box next to the home you are interested in.

No individual will, on the grounds of race, color, handicap, HIV status or national origin, be denied admission, care or any other benefit provided by the Kentucky Veterans Centers.			
INSTRUCTIONS:			
1. Applications must be TYPEWRITTEN or PRINTED IN INK.			
2. Veterans must have anything other than a dishonorable discharge and meet those criteria required by the United States Department of Veterans Affairs for veteran's status.			
3. Applicant must be a resident of Kentucky.			
COUNTY OF RESIDENCE: Where is the veteran currently living/receiving care		DATE:	
In compliance with the eligibility requirements, I do hereby apply for admission to the Kentucky Veterans long term care facility checked above, and declare the following statements and information to be true:			
NAME		SOCIAL SECURITY NUMBER	
ADDRESS (STREET OR RFD)		TELEPHONE NUMBER	
CITY, COUNTY, ZIP CODE			
DATE OF BIRTH	SEX	AGE	
PLACE OF BIRTH		RELIGION	
MARTIAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED (PLEASE PROVIDE DATES AND COPIES OF EACH) <input type="checkbox"/> WIDOWED (PLEASE PROVIDE COPY OF DEATH CERTIFICATE OF SPOUSE) <input type="checkbox"/> LEGAL SEPARATION (PLEASE PROVIDE COPY OF DECREE)			
NAME OF SPOUSE (maiden name)		SPOUSE'S SOCIAL SECURITY NUMBER	
SPOUSE'S ADDRESS		SPOUSE'S DATE OF BIRTH	
DATE AND PLACE OF MARRIAGE (PLEASE PROVIDE COPY OF MARRIAGE LICENSE)			
MILITARY SERVICE INFORMATION (Please provide copy of DD 214/Discharge)			
BRANCH AND SERVICE NUMBER	DATE AND PLACE OF ENLISTMENT	DATE AND PLACE OF DISCHARGE	TYPE OF DISCHARGE
IF YOU HAVE EVER BEEN A RESIDENT OF THE KENTUCKY VETERANS CENTER OR OTHER STATE OR FEDERAL LONG TERM CARE FACILITY, PLEASE COMPLETE THE FOLLOWING:			
DATE OF DISCHARGE	FACILITY	REASON	
HAVE YOU BEEN A PATIENT IN A HOSPITAL WITHIN THE LAST SIX MONTHS? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, please complete the following:			
Name of Hospital/Private Physician		Address of Hospital/Physician	
Name of Hospital/Private Physician		Address of Hospital/Physician	

DO YOU HAVE MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO PART A _____ PART B _____ EFFECTIVE DATES: _____ MEDICARE NUMBER _____ (Provide copy)	DOES YOUR SPOUSE HAVE MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO MEDICARE NUMBER _____ (Provide copy)	
DO YOU HAVE ANY OTHER HEALTH/MEDICAL INSURANCE: <input type="checkbox"/> Yes <input type="checkbox"/> No COMPANY AND NUMBER _____ (Provide copy & verification of premium due)	DOES YOUR SPOUSE HAVE ANY OTHER HEALTH/MEDICAL INSURANCE <input type="checkbox"/> YES <input type="checkbox"/> NO COMPANY AND NUMBER _____ (Provide copy & verification of premium due)	
INCOME AND ASSETS		
YOU HAVE TWO OPTIONS FOR PAYMENT; IF YOU CHOOSE NOT TO DISCLOSE YOUR ASSETS, PLEASE READ THE FOLLOWING STATEMENT AND SIGN:		
I DO NOT WISH TO PROVIDE MY DETAILED FINANCIAL INFORMATION. I UNDERSTAND THAT I WILL BE ASSESSED THE MAXIMUM AMOUNT FOR EXTENDED CARE SERVICES AND AGREE TO PAY THE MAXIMUM CHARGE.		
SIGNATURE _____	DATE _____	
YOUR SECOND OPTION IS TO DISCLOSE YOUR ASSETS AND YOU WILL BE CHARGED BASED ON YOUR ABILITY TO PAY. IF YOU ELECT THIS OPTION, PLEASE PROVIDE THE INFORMATION REQUESTED BELOW:		
LIST ALL REAL ESTATE YOU AND/OR YOUR SPOUSE OWN OR IN WHICH YOU AND/OR YOUR SPOUSE HAVE ANY INTEREST. (Give location, size, description and approximate value. State whether held solely or jointly with husband/wife).		
LIST ALL SECURITIES WHICH YOU AND/OR YOUR SPOUSE OWN. (Include cash on hand or in safety deposit box, savings, checking accounts, time deposits, stocks, bonds, postal savings, notes, mortgages, or any other money or securities. Give amount and where located). (Provide verification of all securities listed).		
LIST THE PERSONAL PROPERTY WHICH YOU AND/OR YOUR SPOUSE OWN. (Include auto, truck, livestock, furniture, farm equipment, business inventory, etc. Give approximate value and where located).		
LIST ANY INDEBTEDNESS OTHER THAN THAT SECURED BY YOUR PRIMARY RESIDENCE. (Include amounts, payee, due dates and reason for indebtedness).		
LIST ANY INSURANCE POLICES WHICH YOU AND/OR YOUR SPOUSE HAVE. (Include burial, life, hospital, health and accident. Give name of company and face and/or current cash value). (Provide copies).		
LIST GROSS AMOUNTS OF MONTHLY INCOME:		
	VETERAN	SPOUSE
Wages	\$	\$
VA Pension	\$	\$
Service Connected Disability _____ Percentage	\$	\$
Social Security	\$	\$
Medicare	\$	\$
Retirement Income	\$	\$
Pension Income	\$	\$
Other Retirement Income	\$	\$
Interest	\$	\$
Dividends	\$	\$
Income from rental properties	\$	\$
Court Mandated(Alimony, Child Support)	\$	\$
Other Income	\$	\$
Other Income	\$	\$

PERSONS TO BE NOTIFIED IN AN EMERGENCY. (List two. If applicant has a guardian, conservator, or power of attorney, copies of the legal documents establishing such authority must be attached).	
NAME	RELATIONSHIP
ADDRESS	WORK PHONE
CITY, STATE, ZIP CODE	HOME PHONE
NAME	RELATIONSHIP
ADDRESS	WORK PHONE
CITY, STATE, ZIP CODE	HOME PHONE
BURIAL ARRANGEMENTS	
Name of Undertaker to be called	
Address of Undertaker	
Desired Location of Burial	
Name of person taking care of arrangements, if any	
CERTIFICATION	
<p>I _____, do solemnly affirm that I fully understand requirements that must be met, and all qualifications that must be possessed by an applicant for admission to the facility. I fully understand all questions asked on this application and that all statements made by me on this application are true. I am a resident of the Commonwealth of Kentucky and affirm that because of physical disability, I am unable to continue living in my home. I further agree to accept transfer to any other health care facility, or to my home, if in the opinion of the staff such transfer is necessary. This application is my free and voluntary act.</p> <p>I also certify that I have provided all requested information regarding my assets, indebtedness and income (including that related to my spouse) and that such information is complete and correct. I also agree to provide required proof of all income, assets, and indebtedness upon request. I understand that my admission and continued stay in the Kentucky Veterans Center is subject to a true and accurate reporting of my financial status. Misrepresentation of my financial status may result in my immediate discharge from the Kentucky Veterans Center.</p> <p>I also understand that the professional staff at the facility shall have the right to deny admission if, in their opinion, my needs cannot be adequately met at the facility.</p> <p>I understand that non-medical leaves of absence from the facility in excess of twelve (12) calendar days per year will result in a charge of the regular monthly charge plus the current VA per diem rate in effect at the time of absence. Absences from the facility will be considered to have ended when the resident returns to the facility for at least a continuous 24 hour period. I understand that the resident is allowed ten (10) consecutive days during medical leaves of absence (hospital stays). Medical leaves of absence may occur more than once in a calendar year. A hospital stay will be considered to have ended when the resident returns to the facility for at least a continuous 24 hour period. Resident/Responsible Party will be given the opportunity to continue to hold the bed at a charge of the monthly fee plus the VA per diem rate. In order to be eligible for a bed hold, the veteran must have established residency by being in the facility for thirty (30) consecutive days before leave is taken.</p> <p>I hereby authorize the Kentucky Veterans Center to apply for any financial benefits to which I may be entitled.</p> <p>I understand the monthly charges by the facility and agree to pay in full any charges within ten days of receipt.</p>	
Signature of Applicant (or Legal Representative)	Date:

OKVC FORM # 01

Joseph "Eddie" Ballard Western Kentucky Veterans Center does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information about this policy, contact: Gina Marks, Administrative Branch Manager, Telephone number: (270) 322-9087, TDD or State Relay Number: (270) 322-9752

Documentary support which must be provided prior to admission includes but is not limited to the following:

- Medical records from all healthcare providers seen in the six months prior to application and extending to date of admission including recent hospital admissions
- Verification of Kentucky residency, (mail items showing current address, utility bills, driver's license, etc.)
- Copy of power of attorney/guardianship papers
- Copy of living will/advance directives
- Copy of discharge from military service, (DD214), or other military document showing dates of service
- Copy of military ID, if military retiree
- Copy of social security card
- Current history & physical, (within past 30 days)
- Current medication/treatment list, including herbal and over the counter meds
- Current PPD skin test status or proof of negative chest X-ray
- Current height and weight

If the applicant is currently in a nursing facility, please provide the additional information:

- Nursing monthly summaries
- Nursing notes for previous 3 months
- MDS Assessment and Care Plan
- Social Services notes
- Diet information
- Current medication list
- Immunization records
- Skin assessment
- Recent lab reports
- Proof of all income amounts listed herein.

FINANCIAL INFORMATION REQUIRED FOR ADMISSION:

- Verification of **ALL GROSS** income amounts applicant or spouse receive per month
- Income from previous year (pensions, social security, interest, dividends, retirement)
- Total out of pocket medical expenses for prior year (Medicare premium, health insurance premium, co-pay for office visits, medications, eye glasses, hearing aids)
- Copies of check and check stubs applicant receives for income that is not directly deposited – gross amount before withholding.
- Copy of tax return for the previous year, if applicable
- Copy of monthly premium paid on supplemental health insurance for applicant and spouse
- Copies of last three bank statements for checking and savings accounts
- Documentation of Market value of any property other than applicant's primary residence
- Documentation of Market value of additional vehicles other than applicant's primary vehicle
- Copies of Certificates of Deposit, IRA's, Stocks, Bonds, Money Market Accounts, Life Insurance Policies (cash value) and Burial Funds
- Copies of outstanding debts i.e. medical bills, credit cards
- Copy of current marriage license
- Letter from current nursing or most recent nursing home to verify financial obligation is being met or has been met
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