Kansas Soldiers' Home
714 Sheridan – Unit 128
Fort Dodge KS 67843
(620) 227-2121
Fax: (620) 225-6331

Kansas Veterans' Home
1220 World War II Memorial Drive
Winfield KS 67156
(620) 221-9479
Fax: (620) 229-9050

APPLICATION FOR ADMISSION

Application for: ☐ Kansas Soldiers' Home ☐ Kansas Veterans' Home ☐ First Available
Level of Care: ☐ Long Term Care ☐ Assisted Living/Domiciliary ☐ Undetermined

Name of Applicant: _____
Last First Middle

Date of Birth: _____ SS#: _____ Gender: _____

Home Address: _____ Telephone No. _____
Street

_____
City State County Zip Code

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Name of Spouse: _____
Last First Middle

Present Location of Applicant (If other than home): _____

Address: _____
Street City State Zip Code

Medicare No. _____ ☐ Part A ☐ Part B Effective Date: _____
Medicaid Case No. _____ CIN No. _____ County: _____
Effective Date: _____ Pending Application/Date Submitted: _____
Medical Insurance Name and No._____ Insurance Prescription Card No. _____
Attending Physician: _____ Telephone No. _____
Address: _____
Street City State Zip Code
Please Supply Copies of ALL Insurance Cards

Check all that apply: ☐ POW ☐ Veteran ☐ Veteran's Spouse ☐ Veteran's Widow/er ☐ Gold Star Parent
Do you have a service-connected disability rated by the VA? ☐ Yes ☐ No
If yes: Disability: _____ Percent: _____
Have you been convicted of a felony? ☐ Yes ☐ No (If yes, please explain on a separate piece of paper)

Designated Representative(s):

Name	Address and Zip Code	Home Phone	Work Phone	Relationship

Responsible Party: Email Address: _____ Cell Phone No. _____

Funeral Home: _____
Name Address Phone No.

Power of Attorney/Guardian(s)/Conservators
(Attach copies of Power of Attorney, Guardianship and Conservator Court Orders)

Name: _____ Telephone No. _____

Address: _____
Street City State Zip Code

Name: _____ SS#: _____

Do you desire to have a Veteran Service Representative review your financials to determine possible qualifications of financial benefits? Please select ☐ Yes ☐ No

You may choose to submit your application without disclosing your financial information by checking the box below.

☐ I do not wish to disclose my financial information and agree to pay the full rate.

Applicant Resources:

Salary ……$ _____/Month
Social Security ……..……$ _____/Month
Retirement Pension Name (Please Specify) _____ $ _____/Month
Veteran's Pension ……..……...……$ _____/Month
Railroad Pension ……...…...……$ _____/Month
Supplementary Security Income …….....……$ _____/Month
Other Monthly Income (Please Specify) _____ $ _____/Month
Do you have a pre-paid funeral contract? Please select ☐ Yes ☐ No
(If yes, please provide a copy)

Assets:

Name of Investment/Broker Accts. _____Present Value_____
Address of Investment/Broker Accts. _____
Checking Account: Bank _____Account No._____Amount _____
Bank _____Account No._____Amount _____
Saving Account: Bank _____Account No._____Amount _____
Bank _____Account No._____Amount _____
Real Estate: ☐ Yes ☐ No
Name/Address of Trusts _____Date Trust Established _____
Beneficiaries _____Amount _____
Other Assets _____

Liabilities:

Mortgage ……...……...……$ _____/Month
Credit Card Institution(s) _____ $ _____/Month
Other: Specify _____ $ _____/Month

BY SIGNING THIS APPLICATION, I AUTHORIZE THE FACILITY TO VERIFY WITH BANKS, EMPLOYERS, VETERAN'S ADMINISTRATION, SOCIAL SECURITY, MEDICAID, INSURANCE AND/OR OTHER INSTITUTIONS ACCURACY OF INFORMATION THAT I HAVE DISCLOSED.

To the best of my knowledge all the above information is correct and valid.

_____ _____
Signature of Applicant or Responsible Party (**REQUIRED**) Date

For Official Use Only:

Comments: _____
☐SC ☐ PP ☐ MCA ☐ MCD ☐ MCP ☐ RR ☐ NP ☐ Other (Specify): _____

_____ _____

Signature	Date

Name: _____ SS#: _____

Medical Information

Dressing	Grooming	Toilet
☐ Completely Independent	☐ Completely Independent	☐ Completely Independent
☐ Needs Minor Assistance	☐ Needs Minor Assistance	☐ Needs Minor Assistance
☐ Needs Total Assistance	☐ Needs Total Assistance	☐ Needs Total Assistance

Feeding	Bathing	Incontinent
☐ Completely Independent	☐ Completely Independent	☐ Incontinent of Bowel and Bladder
☐ Needs Minor Assistance	☐ Needs Minor Assistance	☐ Incontinent of Bladder
☐ Needs Total Assistance	☐ Needs Total Assistance	☐ Indwelling Catheter or related device

☐ Special Diet: _____

Ambulation	Assistive Device with Ambulation
☐ Completely Independent	☐ None
☐ Needs Minor Assistance	☐ Walker
☐ Needs Total Assistance	☐ Wheelchair
	☐ Other (Specify) _____

Any other information you feel we need to know to care for you or our loved one: (Such as hobbies, home routine, etc.)

_____

_____

_____

_____

_____

_____

The information for this page of the application was obtained or provided by:

☐ KSH Staff ☐ KVH Staff ☐ Other (Specify): _____

The information for this page of the application was obtained through:

☐ Visit with applicant ☐ Interview ☐ Medical Professional
☐ Applicant or Responsible Party ☐ Other (Specify): _____

Additional medical information may be required to fully process your application. Please be sure and include required medical release forms. This will enable us to obtain the additional medical information.

Name: _____ SS#: _____

Please initial each paragraph then sign and date the bottom of this page.

_____ If I am accepted, I agree to abide by the rules and regulations of the Kansas Veterans' Home/Kansas Soldiers' Home. I realize that the facility is operated in full compliance with the Civil Rights Act of 1964, and the Americans with Disabilities Act of 1990, and that I am to cooperate with the Kansas Veterans' Home/Kansas Soldiers' Home in maintaining full compliance.

_____ I understand that no alcoholic beverages are allowed on the grounds. I understand that tobacco use (smoking or chewing) is not allowed within the facility buildings.

_____ I understand that payment is due on the day of admission.

_____ I further acknowledge that I am responsible for any monthly financial obligation to the Kansas Veterans' Home/Kansas Soldiers' Home. In the event I am unable to competently manage my affairs, my legal representative, guardian, or other responsible party may act on my behalf. Notice of changes in charges or services that occur after admission will be made 30 days before the effective date of the change. The changes shall not take place until notice is given.

In the event you are in need of financial assistance or may be in of financial assistance in the future please initial each paragraph below:

_____ If I am paying less than the full rate. I understand that any pending application or retroactive receipt (back payment) of any income needs to be reported immediately to the Business Office and that any retroactive receipt of income (whether anticipated or unanticipated) will be applied to my monthly fee charge as an adjustment backdated to the effective date of the award.

_____ I understand that it may be necessary for me to provide copies of bank statements periodically to verify my financial position, and that I must keep my account current.

_____ If I am paying less than the full rate. I understand that as a condition for continued residency, all veterans and non-veterans must apply for Medicaid benefits.

_____ If I am paying less than the full rate. And a wartime veteran or a surviving spouse of a wartime veteran, I must apply for monetary pension benefits from the United States Department of Veterans Affairs. I must inform the Kansas Veterans' Home when benefits are awarded.

The answers I have provided in this application are true and complete to the best of my knowledge and belief, and I understand that if I knowingly make a false statement of any material facts in completing this application, I may be subject penalties for fraud, including possible criminal prosecution, as provided for in the Kansas Statues.

Signature: _____ Date: _____
(Applicant or POA