

# VETERAN HOMES OF CALIFORNIA

# PILOT-APPLICATION INQUIRY

Applicant Information (Complete to the best of your ability)									
Last Name			First		MI		Social Security Number		
Address (Street, City, State, Zip)					Phone Number(s)		Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Applicant now at:	<input type="checkbox"/> Home <input type="checkbox"/> Alone		<input type="checkbox"/> Home w/caregiver <input type="checkbox"/> Home w/ family		<input type="checkbox"/> Nursing Home		<input type="checkbox"/> Hospital		<input type="checkbox"/> Other _____
Status: <input type="checkbox"/> veteran <input type="checkbox"/> spouse of veteran <input type="checkbox"/> widow of veteran <input type="checkbox"/> Parent of Veteran <input type="checkbox"/> Other _____									
Military Service Number		Date/ Place of Discharge			Have DD214 (Military Discharge Papers)		Branch of Service		
Marital Status: <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		Birthplace (City, State)			Citizenship		Birth date		
Applicant has (check all that apply) <input type="checkbox"/> Advance Directives <input type="checkbox"/> General Power of Attorney (POA) Name & Relationship _____ <input type="checkbox"/> POLST <input type="checkbox"/> Health Care POA Name & Relationship _____					Attending Physician _____ Physician Phone _____ Emergency Name and Contact Address: _____				
Inquirer/ Agency Information									
Last Name		First		Agency		Relationship		Date	
Street Address						Apartment/Unit #			
City			State			ZIP			
Phone			E-mail Address						
Desired Home:	<input type="checkbox"/> Barstow		<input type="checkbox"/> Chula Vista		<input type="checkbox"/> Lancaster		<input type="checkbox"/> Ventura		<input type="checkbox"/> West LA
Desired Level of Care	<input type="checkbox"/> DOM		<input type="checkbox"/> RCFE		<input type="checkbox"/> ICF		<input type="checkbox"/> SNF		
Insurance Information									
How will the resident pay for care? (check all that apply) <input type="checkbox"/> Private pay <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Long Term Care Insurance <input type="checkbox"/> Other specify _____									
Medicare Part A Number _____					Medicaid Number _____				
Medicare Part B <input type="checkbox"/> yes <input type="checkbox"/> no					Effective date _____				
VA Card <input type="checkbox"/> Yes <input type="checkbox"/> No Number _____					Other Insurance _____				
VA Medical Center of Service _____					Policy number _____				
Long Term Care Insurance: _____					Policy number _____				
FUNCTIONAL STATUS									
Ambulation		Bladder		Bowel		Dining			
<input type="checkbox"/> Independent		<input type="checkbox"/> Continent		<input type="checkbox"/> Continent		<input type="checkbox"/> Independent			
<input type="checkbox"/> Walker		<input type="checkbox"/> Incontinent		<input type="checkbox"/> Incontinent		<input type="checkbox"/> Needs assistance			
<input type="checkbox"/> Wheelchair									
<input type="checkbox"/> Bedbound									
OFFICE USE ONLY	Initial Phone Contact/IDB Date _____ Medical Records Requested _____ Application Complete _____								

For further assistance with this form, please call Lancaster Home at 661-974-8141, Ventura Home at 805-659-7502  
 Fax completed form for Lancaster to 661-974-8189 Fax Completed for Ventura to 805-659-7559

ADT  
2/24/11