OKLAHOMA DEPARTMENT OF VETERANS AFFAIRS

Application for Admission to State Veterans Home

Veteran's Information:

Last Name | First Name | Middle

Address | City | State | Zip Code

Male: ☐ Female: ☐ Birthdate | Race | County

Home Phone | Cell Phone | Religious Preference

SSN | VA Claim # | Birthplace (City & State)

Preferred First Name: | Previous Occupation | Veteran's Marital Status (enter history below)

If currently married, has veteran's spouse had prior marriages? ☐ Yes ☐ No If yes, number of previous marriages

Date of Marriage	Place of Marriage	Name of Spouse	Type of Marriage ex. ceremony, common, tribal	Reason for Termination ex. death, divorce	Date of Termination	Place of Termination

Education: Graduate Degree ☐ Bachelors Degree ☐ Some College ☐ HS Diploma ☐ 8th Grade/Less ☐ No School ☐

MILITARY SERVICE INFORMATION

Does Veteran have a service connected rating from the VA? YES ☐ NO ☐ Disability rating percent: %

FIRST STINT OF ACTIVE DUTY

Branch of Service: Army ☐ Air Force ☐ Navy ☐ Marines Corps ☐ Coast Guard ☐ Service Number: | Highest Rank Attained:

Date of Enlistment: | Where Enlisted (City & State):

Date of Discharge: | Where Discharged (City & State):

Type of Discharge: | Wars Served (if any):

Honors Received:

SECOND STINT OF ACTIVE DUTY

Branch of Service: Army ☐ Air Force ☐ Navy ☐ Marines Corps ☐ Coast Guard ☐ Service Number: | Highest Rank Attained:

Date of Enlistment: | Where Enlisted (City & State):

Date of Discharge: | Where Discharged (City & State):

Type of Discharge: | Wars Served (if any):

Honors Received: | Is veteran an ex-POW? YES ☐ NO ☐

(If veteran served more than two active duty stints in military service, attach an additional sheet with the same information as above for each additional stint.)

AS PROOF OF THE VETERAN'S MILITARY INFORMATION PROVIDED, THE FOLLOWING IS REQUIRED:

1. VETERAN'S DISCHARGE PAPERS (FORM DD-214) OR OTHER SEPARATION DOCUMENTS FOR EACH STINT OF SERVICE.
2. VERIFICATION OF POW STATUS (IF CHECKED "YES" FOR EX-POW).
3. VA DISABILITY RATING DOCUMENT (IF CHECKED "YES" FOR SERVICE CONNECTED DISABILITY RATING FROM VA).

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Family Information

Note: Birth date and Social Security number is required for Spouse and all dependent children of the Veteran

Primary Contact: First Name: Initial: Last Name:

Relation Soc Sec. #: Birth date:

Home Phone: Other Phone: Email:

Street Address: City: State: Zip Code:

Other Contact First Name: Initial: Last Name:

Relation Soc Sec. #: Birth date:

Home Phone: Other Phone: Email:

Street Address: City: State: Zip Code:

Other Contact First Name: Initial: Last Name:

Relation Soc Sec. #: Birth date:

Home Phone: Other Phone: Email:

Street Address: City: State: Zip Code:

Other Contact First Name: Initial: Last Name:

Relation Soc Sec. #: Birth date:

Home Phone: Other Phone: Email:

Street Address: City: State: Zip Code:

Required

Father's Name: Birthplace:

Mother's Maiden Name: Birthplace:

Legal Information

☐ YES ☐ NO **Does veteran have a** ☐ **Living Will,** ☐ **Advance Directive , or** ☐ **DNR?** (Check all applicable and attach copies of the documents.)

☐ YES ☐ NO **Has veteran granted Durable Power of Attorney for Health Care?** (If yes, attach copies of applicable documents.)

☐ YES ☐ NO **Has veteran granted Durable Power of Attorney/ Financial?** (If yes, attach copies of applicable documents.)

☐ YES ☐ NO **Does veteran have a Legal Guardian?** (If yes, attach copies of applicable documents.)

☐ YES ☐ NO **Does veteran have a legal Financial Custodian/ Fiduciary?** (If yes, attach copies of applicable documents.)

☐ YES ☐ NO **Does veteran have a will?** (If yes, please provide the specific location)

REQUIRED DOCUMENTS:

1. A COPY OF THE LEGAL DOCUMENT FOR ANY OF THE ABOVE IDENTIFIED AS THE LEGAL GUARDIAN.
2. IF VETERAN REGULARLY CONTRIBUTES TO SUPPORT OF A SPOUSE, PROVIDE COPY OF THE MARRIAGE CERTIFICATE.
3. IF VETERAN CONTRIBUTES REGULARY TO SUPPORT OF A DEPENDENT CHILD, PROVIDE COPY OF BIRTH CERTIFICATE FOR EACH.

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Medical Information

FOR ADMISSION TO AN OKLAHOMA VETERANS CENTER, A CURRENT PHYSICIAN'S STATEMENT OR HOSPITAL SUMMARY CONTAINING DIAGNOSIS, PROGNOSIS, MEDICATIONS AND HISTORY IS REQUIRED.

Veteran's Physician: Name: Phone Number:

Address: City: State: Zip Code:

IF WITHIN THE LAST YEAR, THE VETERAN HAS BEEN IN A HOSPITAL, NURSING HOME OR OTHER FULL OR PARTIAL CARE FACILITY, PLEASE PROVIDE THE FOLLOWING INFORMATION FOR THE FACILITIES.

Name of Facility: Phone Number:

Address: City: State:

Name of Facility: Phone Number:

Address: City: State:

TO BETTER SERVE THE VETERAN, PLEASE ANSWER THE FOLLOWING QUESTIONS

- ☐ YES ☐ NO **Does veteran use a dialysis machine?**
- ☐ YES ☐ NO **Is veteran alert and able to answer questions correctly?**
- ☐ YES ☐ NO **Can veteran feed, dress and bathe independently?**
- ☐ YES ☐ NO **Does veteran use a ☐ wheelchair, ☐ walker, ☐ cane?**
- ☐ YES ☐ NO **Has veteran ever been hospitalized for any type of mental problems? If YES, provide name & location of institution below:**
- ☐ YES ☐ NO **Is veteran ambulatory?**
- ☐ YES ☐ NO **Does veteran have a tendency to wander?**
- ☐ YES ☐ NO **Does veteran use a CPAP or BiPap machine?**
- ☐ YES ☐ NO **Does veteran exhibit inappropriate sexual behaviors?**

Institution Name: **City:** **State:**

Responsible Party

☐ YES ☐ NO **Is the veteran financially responsible for his own affairs?**

If above answer is no, please provide the following information about the financially responsible party: Relation to Veteran

First Name: Initial: Last Name: Soc Sec #:

Home Phone: Cell Phone: Email:

Street Address: City: State: Zip Code:

Burial Information

PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT THE CHOSEN FUNERAL HOME AND BURIAL POLICY, IF ANY

Funeral Home Phone Number: Fax Number:

Address: City: State: Zip

Insurance Co. City: State:

Name of Insured: Name of Beneficiary:

Amount of Insurance: $ Amount/Frequency of Premium: $ Group Number: Policy Number:

Is burial policy irrevocable? ☐ YES ☐ NO

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Financial Information

Provide the gross monthly amount for all income sources and documentation to verify the amounts. Please provide prior year's income tax documents, if applicable. Attach an additional sheet if needed.

SOURCE OF INCOME	VETERAN	SPOUSE	DEPENDENT CHILD	DEPENDENT CHILD	DEPENDENT CHILD
Social Security					
US Civil Service					
VA Benefit					
Military Retirement					
Supplemental Social Security					
Distributions					
Wages / Salary					
Interest					
Other Income					

Assets

List all assets owned by the veteran, the veteran's spouse and the veteran's dependent children. Include homes, vehicles, land, banking accounts, CD's, stocks, bonds, mutual funds, IRA's, etc. Attach documents to verify asset value.

ASSET DESCRIPTION	ASSET LOCATION	MARKET VALUE	DEBT	NET VALUE

Insurance Information

PLEASE PROVIDE INFORMATION AND INSURANCE CARDS AS APPLICABLE FOR ALL INSURANCE POLICIES INVOLVING THE VETERAN, THE VETERAN'S SPOUSE OR THE VETERAN'S DEPENDENT CHILDREN.

Does the veteran have Medicare? ☐ **NONE** ☐ **Part A only** ☐ **PartA&B**

LIFE INSURANCE? ☐ **YES** ☐ **NO**

Name of Company: _____ City: _____ State _____

Name of Insured: _____ Name of Beneficiary: _____

Amount of Insurance: $_____ Amount/Frequency of Premium: $_____ Group Number: _____ Policy Number: _____

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HEALTH/HOSPITALIZATION INSURANCE? ☐ YES ☐ NO

Name of Company: _____ City: _____ State: _____

Name of Insured: _____ Name of Beneficiary: _____

Amount of Insurance: $_____ Amount/Frequency of Premium: $_____ Group Number: _____ Policy Number: _____

AMBULANCE POLICY? ☐ YES ☐ NO

Name of Company: _____ City: _____ State: _____

Name of Insured: _____ Name of Beneficiary: _____

Amount of Insurance: $_____ Amount/Frequency of Premium: $_____ Group Number: _____ Policy Number: _____

SCOPE OF SERVICE STATEMENT

All Oklahoma Veterans Centers are by licensure long term nursing facilities. Specifically, the scope of care is that normally associated with a skilled nursing care operation. While the centers provide limited physician, physician's assistant and/or nurse practitioner, pharmaceutical, diagnostic laboratory and radiological services, either in house or on a contractual basis, there is no intent to represent that care beyond that associated with a skilled nursing care level will be provided. Patients with medical or psychological needs, which in the judgment of the center's administrative and professional staff are beyond those associated with the scope of services normally provided, will not be admitted or in cases where a patient's condition changes following admission to require services other than those normally provided, such patient shall be discharged or transferred to an appropriate facility.

Discrimination on the basis of race, color, sex, age, handicap, religion, national origin, source of payment or economic condition is prohibited.

I certify that I have read and understand the information provided on this form and that the above answers are true and correct to the best of my knowledge and belief.

Date: _____ Signature of Veteran: _____
(or Guardian, Custodian or Relative if veteran is unable)

☐ **In lieu of written signature, I attest that I have read and understand the information provided on this form and that the above answers are true and correct to the best of my knowledge and belief.**

SUBMIT THE COMPLETED APPLICATION AND THE REQUESTED DOCUMENTS TO THE CENTER WHERE YOU WISH TO APPLY. PLEASE CALL WITH ANY QUESTIONS.

If the center of choice is unable to admit the Veteran, please select acceptable alternate centers by placing a check mark below. Your application will be shared with all centers checked for potential admission.

	Ardmore
	Claremore
	Clinton
	Lawton/Ft. Sill
	Norman
	Sulphur
	Talihina

Ardmore Veterans Center
1015 S. Commerce
P.O. Box 489
Ardmore, Oklahoma 73402
Ph: (580) 223-2266
Fax: (580) 221-5606

Clinton Veterans Center
1701 S. 4th St.
P.O. Box 1209
Clinton, Oklahoma 73601
Ph: (580) 331-2200
Fax: (580) 323-4834

Claremore Veterans Center
3001 W. Blue Starr Drive
P.O. Box 988
Claremore, Oklahoma 74018
Ph: (918) 342-5432
Fax: (918) 342-0835

Norman Veterans Center
1776 E. Robinson
P.O. Box 1668
Norman, Oklahoma 73070
Ph: (405) 360-5600
Fax:(405) 321-3647

Sulphur Veterans Center
304 E. Fairlane
Sulphur, Oklahoma 73086
Ph: (580) 622-2144
Fax: (580) 622-5881

Talihina Veterans Center
10014 SE 1138th Ave.
P.O. Box 1168
Talihina, Oklahoma 74571
Ph: (918) 567-2251
Fax: (918) 567-3825

Lawton/Ft. Sill Veterans Center
501 SE Flower Mound Road
P.O. Box 849
Lawton, Oklahoma 73502
Ph:(580)354-4157 Ph:(580)354-4158
Fax: (580) 354-4156

For agency use:

Received: _____

Admit: _____ Forward App:_____