



# STATE OF INDIANA

Michael R. Pence, Governor

## INDIANA VETERANS' HOME

3851 N. River Road  
West Lafayette, IN 47906  
Telephone: (765) 463-1502

Enclosed is the application for admission to the Indiana Veterans' Home. The professional and compassionate team at the Indiana Veterans' Home appreciates your interest in the only state veterans' home in Indiana.

Here are some important items to keep in mind as you complete your application:

- **Please use the checklist for required documentation for applying to the Indiana Veterans' Home.** The Admissions Department is available to complete the application for you either over the phone or in person – (will need signature upon admission.)
- **We accept Medicare A, Medicaid, private insurance and private payment. Special benefits are available for veterans with a service-connected disability rating of 70% or higher.** When applicable, veteran benefits may also help pay for a part of your stay. If your insurance and benefits do not cover the full cost of your care and you are unable to pay from your own funds, we will help you apply for Medicaid after your admission to the Indiana Veterans' Home.
  - *Enclosed is the financial checklist. The Indiana Veterans' Home will gladly provide you with an estimated rate cost upon receiving requested documentation.*
- **Veterans with a VA Service Connected Disability of 70% or greater or determined by the VA to meet the criteria for the Veterans' Administration VA Higher Per Diem Program participation, under 38 U.S.C. § 1745, qualify for free nursing care at the Indiana Veterans' Home.**
- **The current rate to reside at the Indiana Veterans' Home is \$285.24\* per day.** This is a comprehensive rate and includes nursing care, room, meals, housekeeping, laundry service, and recreation activities. We will work with you to determine your best options to pay for your stay with us.
- Effective April 1, 2016, the Indiana Veterans' Home Independent Living (Domiciliary) rate is \$138.00\* per day. The Indiana Veterans' Home did research and decided to reduce the domiciliary rate to the State Veterans' Home domiciliary United States average daily rate.
- **If you currently live at home and plan to move into nursing care, please contact your local Area Agency on Aging to set up a Pre-Admission Screening (PAS).** The PAS must be completed before entering any nursing home in the state of Indiana. You can reach your Area Agency on Aging by calling (800) 986-3505. Please note: PAS is not required for applicants entering our independent living building.

The Indiana Veterans' Home encourages anyone that has financial questions regarding the daily cost of living payments, to call our Trust Department at (765) 497-8552 to discuss the payment process. A Medicaid Specialist is also available by emailing [Medicaid@ivh.in.gov](mailto:Medicaid@ivh.in.gov).

If you have any questions about our application or the required documentation, please contact the Admissions Department at your convenience.

Best Regards,

Tamara M.D. Smith, Admissions and Marketing Director

Indiana Veterans' Home :: 3851 N. River Road :: West Lafayette, IN 47906

Phone: (765) 463-1502 :: Fax (765) 497-8004 :: [admissions&marketing@ivh.in.gov](mailto:admissions&marketing@ivh.in.gov)

\*The daily rate is subject to change on an annual basis.



# Indiana Veterans' Home

## Admissions Checklist

Documentation and information required to apply for admission to the Indiana Veterans' Home

Applicant Name: \_\_\_\_\_

### INDIANA VETERANS' HOME APPLICATION

- Completed application –**
  - Admissions Department will coordinate and IVH will assist with completion of the application (either questions over phone and/or in person or will type out information for applicant.)

### PERSONAL IDENTIFICATION

- Military discharge papers (DD214) / VA Military Data Screen / VA SC Disability % Proof**
- Face sheet from current hospital / facility / or VA (if applicable)**
- Marriage certificate/death certificate/divorce decree/separation papers (if within 5 years)**
  - Required if Spouse or Surviving Spouse before admission.
- Copy of Power of Attorney(s) Medical and/or Financial, or Guardianship documents (if applicable)**
  - Required to have in place and provide copy if applicant cannot sign for self.
- Social Security card / Medicare & other Health Insurance Cards**
  - Admissions Dept will scan on Day of Admission

### Medical

- Current History and Physical including all diagnoses**
- Chest x-ray Results (Per Policy – Must not be older than 6 months upon admission)**
- Complete list of current medications**
- Nursing notes**
- Social services notes**
- Pysch / behavior notes (if applicable)**

**Please Note: Need the most current and all applicable clinical information to determine if the IVH team can meet the needs of the applicant. IVH can provide a listing of the requested documentation to the appropriate discharge planners, doctor, nursing home, etc. prior to other provider sending clinical to discuss further and to prevent IVH requesting more paperwork that could result in a delay of the Admissions Committee Decision.**

### FOR INDIVIDUALS ENTERING SKILLED NURSING CARE

- Copy of Pre-Admission Screening (PAS/PASRR) Approval**
  - PAS Process is a requirement for all nursing homes in the state of Indiana.

Please call 800.986.6505 to contact your local Area Agency on Aging if any questions regarding the new PASRR regulations effective July 1, 2016.

**PLEASE NOTE: The Financial checklist is enclosed in this packet. Copies requested are needed for IVH to assist the new admission with applying for applicable benefits to offset any debt.**

Indiana Veterans' Home

3851 N. River Road :: West Lafayette, IN 47906

(765) 463-1502 – Main Switchboard :: [admissions&marketing@ivh.in.gov](mailto:admissions&marketing@ivh.in.gov)

*Proudly serving those who served.*

Edited: July 2015

(Please note: subject to change if need is determined.)



**APPLICATION FOR ADMISSION  
TO INDIANA VETERANS' HOME**

State Form 37561 (R7/6-14) Form A No. 1

FEDERAL REGULATION Public Law 22

This State Agency is requesting your Social Security number only to expedite the processing of this form. You are not required to provide this information and cannot be penalized for declining to provide it.

**Instructions:**

1. Every blank must be filled in. If the question does not apply, write "N/A".
2. Please provide all documentation specified on the Admissions Checklist.
3. When completed, please submit fully completed application Indiana Veterans' Home by one of the following ways:

Email: [admissions&marketing@ivh.in.gov](mailto:admissions&marketing@ivh.in.gov)

or Fax: (765) 497-8004

or certified mail/FEDEX/UPS: Indiana Veterans' Home, ATTN: Admissions, 3851 N. River Road, West Lafayette, IN 47906

Name (first, middle, last)	Age
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Date of birth (MM/DD/YYYY)	Place of birth
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Present address in full (number and street or Rural Route, city, state and ZIP Code)	Telephone number (with area code) (       )
	Religion                      Race

Previous Occupation	Mother's Maiden Name	DNR // Full Code
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Are you ? (select one of the below)

Married                      Single                      Widowed                      Divorced                      Separated

**Give record of all marriages below (if additional space is needed please attach separate list):**

NAME OF SPOUSE	Date & Place of Marriage	Date and Place of Death

**Veteran's military service:**

Branch	Dates of Service	Place of Enlistment & Discharge	Which VA are you associated with?

**Where have you resided for the past five (5) years? (if additional space is needed please attach separate list):**

Street Adress	City	State	From	To

**Additional Military Information**

American Legion?	Yes	No
Veterans of Foreign Wars?	Yes	No
Disabled American Veteran?	Yes	No
Is Veteran a former prisoner of war?	Yes	No
Was Veteran awarded the Purple Heart?	Yes	No

**Give name, address and telephone number in order of Emergency Contacts:**

Name	Address	Relationship	Phone Number

Financial Evaluation			
<b>Social Security Number:</b>		<b>Medicare Number:</b>	
<b>Other Insurance Provider Name:</b>		<b>Advantage / Supplemental / Part D / Other</b>	
<b>Do you have any of the following income sources?:</b>			
Pension or Retirement Income	Pension(s) or Retirement(s) Provider Name:	Monthly Amount(s): \$                    //                    \$	
Social Security Income	Do you have a Rep Payee? YES / NO	Monthly Amount(s): \$                    //                    \$	
Additional Income	Provider Name:	Monthly Amount(s): \$                    //                    \$	
VA Service Connected Disability Rating	VA Service Connected Disability Rating: _____ %	Supporting documentation attached? Yes / No VA facility seen for disability? _____	
Checking Account	Bank Name:	Current Balance: \$	
Savings Account	Bank Name:	Current Balance: \$	
Stocks, Bonds, Annuities or Certificates of Deposit	Bank Name / Type (Stock, Bond, etc.):	Current Balance: \$	
Have you owned any real property within the last three years?	YES / NO	If Yes, Total Real Property Estimated Value: \$	
Do you have a will? Yes                    No		Do you have one of the following: POA                    HCR                    Guardian	
Do you have a prepaid funeral? Yes                    No		If Yes, with whom?	
Do you have life insurance? Yes                    No		If Yes, with whom?	Face value
Do you have life insurance? Yes                    No		If Yes, with whom?	Policy(s) number(s)
Are you currently a resident of a residential or care facility? Yes                    No		Do you agree to abide by all the laws and regulations governing the Home? Yes                    No	
Residency Verification			
<b>This verification can be made by an elected township, city or county official, or by an individual not related to the applicant.</b>			
Printed or typed name		Please check one: Neighbor Elected or Appointed Official	
Signature			
Address (number and street, city, state, and ZIP code)			
Dated this _____ day of _____, 20 _____			
<b>Do you, in consideration of being admitted and maintained in the Indiana Veterans' Home, understand that you or your estate are obligated to pay full cost of care and maintenance? (Depending on the amount of your current assets and income from any source this rate may be reduced.)</b> Yes                    No			
<b>I acknowledge by signing this form the information provided on this application is accurate to the best of my knowledge and understanding.</b>			
Signature of applicant		Date signed (MM/DD/YYYY)	

# Indiana Veterans' *Home* Financial Checklist (Medicaid)

Applicant's Name: \_\_\_\_\_

<b>SECTION 1 (URGENT MATERIALS NEEDED PRIOR OR UPON ADMISSION)</b>	
	Proof of all income (3 months), including, but not limited to, paycheck stubs, Social Security, pension and other retirement income, unemployment benefits or veterans benefits (or tax returns for the past 3 years)
	Copies of statements for all bank accounts, including savings (3 months), checking (3 months), certificates of deposit (CDs), and retirement accounts [including IRAs and 401(k) accounts].
<b>SECTION 1 – PART A (REQUIRED FOR SPOUSAL ALLOWANCE)</b>	
	Utility bills (e.g., electricity, gas, water, sewage)
	Phone bills
	Homeowner's insurance
	Mortgage payments or lot rental receipts
	Property taxes
	Condo fees
	Copy of deed to home (if paid off)
	Automobile insurance
	Copy of title to car (if paid off)
	Health insurance premiums
	Other recurring spousal expenses
<b>SECTION 2 – (NEEDED AS SOON AS POSSIBLE)</b>	
	Statements for all life insurance policies or annuities showing ownership, face value and current cash surrender value, and effective date of policy
	Copies of all stocks or United States savings bonds
	Copy of all vehicle titles or registration
	Copy of deeds for all homes and/or property
	Copy of cemetery lot deed or burial accounts
	Letter from the Auditor's office stating that applicant has not owned property in the last 5 years.
	Copy of Prepaid Irrevocable Funeral Arrangements (contract and listing of services)
	Documentation of any prior gifts from applicant in the past 5 years (e.g., gifts to another for expenses, transfer of property or assets to another, etc.)
	Health insurance premiums
	Prescription drug plans (premium and verification of coverage)
	Medical bills for the last 3 months (if any)
<b>INDEPENDENT LIVING RESIDENTS</b>	
If you plan to bring your car with you when you are admitted to the Indiana Veterans' Home, please provide:	
	Copy of current driver's license
	Copy of current vehicle registration and car insurance

# AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of my protected health information as described below. I understand signing this authorization is voluntary and I do not need to sign this form to assure treatment, payment or eligibility of benefits. I understand that the information disclosed may be subject to re-disclosure by the recipient and the privacy of the information may no longer be protected by the law.

The specific organization that is authorized to disclose my protected health information is:

\_\_\_\_\_  
(Name and Address of Facility/individual to Release the Protected Health Information)

The specific organization or individual to which the information is to be released:

\_\_\_\_\_  
(Name and Address of Facility/individual to Receive the Protected Health Information)

The specific protected health information that is authorized to be disclosed is:

- |  |   |
|--|---|
| <input checked="" type="checkbox"/> Physician order                                    | <input checked="" type="checkbox"/> Medication record         |
| <input checked="" type="checkbox"/> Physician progress notes                           | <input checked="" type="checkbox"/> Treatment record          |
| <input checked="" type="checkbox"/> History and physical                               | <input checked="" type="checkbox"/> Laboratory results        |
| <input checked="" type="checkbox"/> Immunization record & TB Screening                 | <input checked="" type="checkbox"/> X-ray and imaging reports |
| <input checked="" type="checkbox"/> Nurses' notes                                      | <input checked="" type="checkbox"/> Consultation reports      |
| <input checked="" type="checkbox"/> Discipline specific progress notes. Specify: _____ |   |

Other: \_\_\_\_\_  
\_\_\_\_\_

The purpose of the disclosure of my protected health information is:

I understand this authorization is automatically void on the following date, event or condition \_\_\_\_\_, but in any case, is only in effect sixty (60) days from the date of signature below under Indiana Law.

I understand that I may revoke this authorization at any time by notifying the organization in writing, but if I do it won't have any effect on any actions taken before the revocation was received.

By signing this authorization, I acknowledge that I have read and understand this authorization. I understand that my protected health information will be disclosed in accordance with this authorization.

\_\_\_\_\_  
Signature of resident or authorized representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of resident or authorized representative

\_\_\_\_\_

\_\_\_\_\_  
Description of authority, if signed by representative

\_\_\_\_\_  
Address of resident or authorized representative