NEW MEXICO STATE VETERANS HOME
Admission Checklist

To be provided by applicant and/or responsible person(s):

Current History and Physical (less than 90 days)
Face sheet, History and Physical, Current Physician’s orders, Physician Progress notes,
Nursing Progress notes, Medication sheet, Social Service Notes, Special services notes,
Labs and other pertinent information. PLEASE INCLUDE CHEST X-RAY REPORT FROM
WITHIN THE LAST 12 MONTHS, OR PLEASE HAVE ONE TAKEN AND INCLUDE REPORT
WITH THIS APPLICATION

Copy of DD-214 (discharge from service)

Copy of Marriage License (if married)

Three (3) months of current Bank Statements,
copies of third party insurance coverage
cards (Medicare, Medicaid, Pharmacy Cards
(Medicare D, etc.) and/or Personal insurance)

Copy of Durable Power of Attorney, Living Will
for Health Care, Guardianship

Complete Application:
Application for Admission
Daily Living Skills
Financial Disclosure Summary
What to Bring on Admission

Complete Medicaid Application:
Information Sheet for Application for Assistance
Program Application Information
Designation of Agent to Act as Authorized
Representative for Medical Assistance
Signature requirement
If Medicaid is not applied for, application
will not be approved for admission.

Revised 2/14/17
# APPLICATION FOR ADMISSION

*Services are provided without regard to race, color, national origin, religion, sexual preference, age, handicap, or sex*

<table>
<thead>
<tr>
<th>APPLICANT INFORMATION:</th>
<th>Date: <em><strong>/</strong></em>/___</th>
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</thead>
<tbody>
<tr>
<td>Name: ___________________ Social Security #: <em><strong>-</strong>__-</em>___</td>
<td></td>
</tr>
<tr>
<td>Address: ______________ City/State: ___________________ Zip: __________</td>
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<tr>
<td>County of Residence: _____ Home Phone #: (___) __________</td>
<td></td>
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<tr>
<td>Sex: <em><strong>Male <em><strong>Female Ethnic Group: _______ Tribal Member__Y__N Tribe</strong></em></strong></em>__</td>
<td></td>
</tr>
<tr>
<td>Date of Birth: <em><strong>/</strong></em>/___ Age: _______ Place of Birth: ______________________</td>
<td></td>
</tr>
<tr>
<td>Marital Status: _____Single _____Married _____Widow(er) _____Divorced</td>
<td></td>
</tr>
<tr>
<td>Father’s Name: ______________ Mother’s Maiden Name: ___________________</td>
<td></td>
</tr>
<tr>
<td>Religious Preference: __________ Church/Synagogue: ___________________</td>
<td></td>
</tr>
<tr>
<td>Address: ___________________ City/State/Zip: ___________________</td>
<td></td>
</tr>
<tr>
<td>What was/is Occupation: __________ Highest Education: ___________________</td>
<td></td>
</tr>
<tr>
<td>Branch of Service: __________ Highest Rank: ______ Dates of Service: <em><strong>/</strong></em>/___ to <em><strong>/</strong></em>/___</td>
<td></td>
</tr>
<tr>
<td>Honorable Discharge: __Yes __No Service Connected Disability: __Yes If Yes, ___% __No</td>
<td></td>
</tr>
<tr>
<td>Personal/Family Physician: ___________________ Telephone: (___) __________</td>
<td></td>
</tr>
<tr>
<td>Address: ___________________ City/State/Zip: ___________________</td>
<td></td>
</tr>
<tr>
<td>Last Hospital Admission: ______________ Date: <em><strong>/</strong></em>/___ Telephone: (___) __________</td>
<td></td>
</tr>
<tr>
<td>Address: ___________________ City/State/Zip: ___________________</td>
<td></td>
</tr>
<tr>
<td>Current Placement (Name of Hospital, Nursing Home, at Home, etc.) ___________________</td>
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</tr>
</tbody>
</table>

**PERSON(S) TO NOTIFY IN CASE OF EMERGENCY:** *(for additional info please use another sheet)*

| Name: ___________________ Relation: ___________________ |
| Address: ___________________ City/State/Zip: ___________________ |
| Home Phone: (___) __________ Emergency /Cell Phone #: (___) __________ |
NM STATE VETERANS’ HOME
DAILY LIVING SKILLS INVENTORY

Name:_______________  Sex:____ DOB:_______ S.S#:_________________

PRESENT MEDICAL DIAGNOSIS/CONDITIONS: _______________________
________________________________________________________________
________________________________________________________________

PAST MEDICAL HISTORY: (operations, injuries, illnesses, hospitalizations,
psychiatric treatment: include dates): _________________________________
________________________________________________________________
________________________________________________________________

PRE-ADMISSION SCREENING:

Do you have a diagnosed or suspected mental disorder other than dementia?
(Please check one)  [  ] Yes  [  ] NO

Is there any indication of mental retardation? (Please check one) [  ] Yes  [  ] No

ADL’s: Using the following criteria, please choose the number (0-4) that
best describes you or your family member's performance in Activities of Daily
Living.

0 Independent - No Assist; help or supervision supplied 1 or 2 times per
week.

1 Supervision - Supervision 3 times per week or supervision and physical
assist 1 or 2 time per week.

2 Limited Assistance - Residents highly involved in activity - receives
physical help in maneuvering of limbs or other non-weight bearing activity
3 + times weekly.

3 Extensive Assistance - Residents performs part of activity but requires
physical help 3 + times weekly with weight bearing support or full assist
with other ADL’s less than full time.

4 Total Dependence - Caregiver must perform all daily living skills 7 days per week.

Score (0-4) Please score yourself/your family member.

_____ Bed Mobility: How resident moves to and from lying position,
turns side to side, and positions body while in bed.
Transfer: How resident moves between surfaces - to/from bed, chair, wheelchair, standing position. (Exclude to/from bath/toilet)

Locomotion: How resident moves between locations in their room and adjacent corridor on the same floor. If in wheelchair, self-sufficiency once in chair.

Dressing: How resident puts on, fasten, and takes off all items of street clothing, including donning/removing prosthesis.

Eating: How resident eats and drinks (regardless of skill).

Toilet use: How resident uses the toilet room (or commode, bedpan, urinal; transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.

Personal Hygiene: How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and genitals (EXCLUDE baths and showers).

Please use a new criteria (0-4 as follows) for Bathing:

Bathing: How a resident takes a fully body bath, sponge bath, and transfer in/out of tub/shower (excluding washing of back of hair)

<table>
<thead>
<tr>
<th>Bathing Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Independent: no help provided</td>
</tr>
<tr>
<td>1</td>
<td>Supervision: Oversight help only</td>
</tr>
<tr>
<td>2</td>
<td>Physical help limited to transfer only</td>
</tr>
<tr>
<td>3</td>
<td>Physical help in part of bathing activity</td>
</tr>
<tr>
<td>4</td>
<td>Total dependence.</td>
</tr>
</tbody>
</table>

Continence: Control of bladder/bowels in last 14 days

<table>
<thead>
<tr>
<th>Continence Score</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>0</td>
<td>Continent: Complete Control</td>
</tr>
<tr>
<td>1</td>
<td>Usually continent</td>
</tr>
<tr>
<td>2</td>
<td>Occasionally incontinent</td>
</tr>
<tr>
<td>3</td>
<td>Frequently incontinent</td>
</tr>
<tr>
<td>4</td>
<td>Incontinent</td>
</tr>
</tbody>
</table>
Circle One

Are you or your family member on a scheduled toileting plan? Yes No
Any recent change in continence? Yes No
Any skin problems or treatments? Yes No

Please check any that apply:
External Catheter _____ Enemas _____ Irrigation _____ Pads _____
Ostomy _____ Indwelling Catheter _____ Briefs ______

Vision: Adequate _____ Impaired _____ Highly Impaired _____ Severely Impaired:_______

Speech: Speaks _____ Writes Messages _____ Signs/Gestures _____ Sounds _____
Communication board ____

Hearing: Adequate _____ Minimal Difficulty _____ Absent Hearing _____ Hear only on special situations ______

Oral Problems: Chewing Problem _____ swallowing Problem _____ Mouth Pain ____

Nutritional Problems:
Dehydrated_____ Complains of Hunger_____ Feeding Tube _____ Supplement _____
Drinks or eats well _____Does not eat or drink well _____ Therapeutic diet ______
Mechanically altered diet ______

Body Control Problems:
Bedfast _____ Balance problems _____ Contracture _____ Hemiplegia _____
Quadriplegia _____ Amputation _____ Hemiparesis _____ Loss of voluntary movement to hands, leg trunks or arms ______

Do you or your family member use any of the following? _____ Hearing Aide ______
Dentures _____ Glasses _____ Brace or Prosthesis ___ Cane/Walker____
Mechanical Lift _____ Wheelchair _____ Special feeding tube ___

Restraints:
Bed rails_____ Trunk Restraint____ Limb Restraint_____ Chemical Restraint _______

Circle One:
If you use a wheelchair, can you propel it yourself? Yes No
Any problems with falls? Yes No Frequent _____ Infrequent ______

Please check any that apply:
Psychosocial Well-Being: At ease with others _____ At ease doing planned activities _____
Establishes own goal _____ Absence of personal contact with family or friends ______
Openly expresses conflict or anger with family or friends ______

Revised 2/14/17
Mood Patterns: Sad or anxious mood  _____ Tearfulness _____ Failure to eat _____
Motor agitation (pacing, hand-wringer, picking) _____ Withdrawal from self care or leisure activities _____ Recurrent thoughts of death _____ Suicidal thoughts/actions _____

Behavior Patterns: Wandering ____ Verbally abusive___ Physically abuse____ Socially Inappropriate/Disruptive Behavior____ Resists Care(medication, treatments, ADL care)____

Memory Problems: Short term memory okay ______ Long term memory okay ______

Any prior treatment for alcohol/drug problems? Yes No

Any history of communicable disease? Yes No

List date of last chest x-ray or TB test results: ______________________________________

Has applicant had flu immunization and date of last administration. _____ Yes _____ No

Date________________________

Has applicant had pneumovax immunization and date of administration. ____ Yes ____ No

Date _________________________

Any other immunizations and dates.________________________________________

Any history of MRSA, VRE, Hepatitis, C-DIFF or other infectious disease and dates. __________

____________________________________________________________________________

Please list medications taken: ______________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Allergies: ___________________________________________________________________

____________________________________________________________________________

Please add any concerns or additional information you think might be helpful for you or your family member's needs: __________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

____________________________________________________________________________

Signature                      Date                      Relationship
NEW MEXICO STATE VETERANS' HOME
992 S. Broadway
Truth or Consequences, New Mexico 87901

FINANCIAL DISCLOSURE STATEMENT

Name: _____________________________   Social Security #: ____________________________
Spouse’s Name (If applicable):___________________  Social Security #:____________________

Do you own or have interest in property other than the property which is the primary residence of spouse or dependent children?  _____Yes      _____No

MONTHLY INCOME (Pensions, Rental Income, Annuities, Social Security, Interest Income, etc.):

<table>
<thead>
<tr>
<th>Source</th>
<th>Applicant</th>
<th>Spouse</th>
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BANK ACCOUNTS: PLEASE PROVIDE THREE MONTHS OF BANK STATEMENT

<table>
<thead>
<tr>
<th>Bank Name, Address &amp; Zip Code</th>
<th>Type of Account (Checking/Savings)</th>
<th>Account Balance</th>
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<tbody>
<tr>
<td></td>
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<td>$______________</td>
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Health Insurance

Medicare #:  ____________________  Medicaid #:________________________
Pharmacy Rx Card #  ____________________
(Medicare D Card, etc.)
Insurance Policy #:  ____________________
Company:  ____________________________________
Address:  ____________________________________
City/State/Zip:  ____________________________________

CERTIFICATION

The Department of Health and The New Mexico State Veterans’ Home are authorized to investigate the financial information provided by applicants or their representative(s) to determine their ability to pay for services. Any applicant or representative(s) who knowingly withholds or falsifies financial information shall be liable for all expenses incurred for legal action related to the recovery of valid indebtedness to the State of New Mexico.

I hereby certify that the foregoing information is true and correct to the best of my knowledge and belief. I agree to report any change in income to the Financial Specialist of the New Mexico State Veterans’ Home.

___________________________________________
Name of Person Completing Information (Please print)  

___________________________________________  Date:_____/_____/_____
Signature of Person Completing Information

Relation to Applicant, if other than Applicant

Revised 2/14/17
New Mexico State Veterans’ Home
What to Bring on Admission

The following items may be brought with you when reporting for admission to the New Mexico State Veterans Home.

The quantities listed below for the various items should be considered the maximum recommendation to bring with you to the Home. We provide a bedside table, Armoire, over the bed table and sitting chair and a small closet 78"x16"x22"deep including 8" drawer on bottom, each vanity has four drawers for each resident.

All electrical items including electronics must be safety inspected by our maintenance department. If approved, the items will be delivered to the resident room. If deemed unsafe, electronic item will be sent back with family or disposed of.

Upon admission all clothing and blankets received at the facility will be delivered to Admission Office and will be placed in a dryer before delivered to resident room.

New items brought to the facility should be delivered to Lead Aide or House RN. Because of limited space, when new items are brought in to the facility the same quantity of old items will be exchanged back to the family or donated. If the preference of the resident/family is to keep the old items, new items can be sent back to family or donated. Excess items will be disposed of after 30 days.

**Personal Care Items**
- No personal furniture allowed, furniture is provided
- Small TV- NO Larger than 21 inches
- Razor and accessories
- Hair Care Items
- Alarm clock or small clock radio
- Laptop/tablet
- We are unable to accommodate a desktop computer

**Health Care Items**
- Eyeglasses with case
- Hearing Aid and Dentures
- Personal wheelchair, walker, cane, crutches and approved self-help devices

**Clothing Items**
- Ten changes of underwear or undergarments
- Ten pairs of socks or hose
- Two pair of pajamas or two night gowns
- One bathrobe
- One pair of bedroom slippers – non-slip
- Maximum ten changes of clothing (Shirts and pants, blouses, slacks, dresses)
- Sweater, Coat or Light Jacket
- Two pair of shoes (See appropriate Foot Wear Letter)
- All Clothes must be machine washable, permanent press materials.

______________________________   _____________
Signature Resident/POA     Date