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. _____

NEW MEXICO STATE VETERANS HOME
992 SOUTH BROADWAY
TRUTH OR CONSEQUENCES, NM 87901

APPLICATION FOR ADMISSION

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

APPLICANT INFORMATION: **Date:_____/____/____**

Name:_____ Social Security #:_____-_____-_____

Address:_____ City/State:_____ Zip:_____

County of Residence: _____ Home Phone #: (____)_____

Sex: ___Male ___Female Ethnic Group: _____ Tribal Member__Y__N Tribe_____

Date of Birth: ____/_____/_____ Age: _____ Place of Birth: _____

Marital Status: _____Single _____Married _____Widow(er) _____Divorced

Father's Name: _____ Mother's Maiden Name: _____

Religious Preference:_____ Church/Synagogue: _____

Address: _____ City/State/Zip: _____

What was/is Occupation: _____ Highest Education:_____

Branch of Service: _____ Highest Rank:_____ Dates of Service: __/__/__ to __/__/__

Honorable Discharge: __ Yes __ No Service Connected Disability: __Yes If Yes, ___% __ No

Personal/Family Physician:_____ Telephone: (___)_____

Address: _____ City/State/Zip: _____

Last Hospital Admission: _____ Date:___/___/___Telephone: (___)_____

Address: _____ City/State/Zip:_____

Current Placement (Name of Hospital, Nursing Home, at Home, etc.)_____

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 1or 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 his/her room and adjacent corridor on 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)

Bathing
Score

_____

0 - Independent: no help provided
1- Supervision: Oversight help only
2- Physical help limited to transfer only
3- Physical help in part of bathing activity
4- Total dependence.

Continence: Control of bladder/bowels in last 14 days

Continence
Score

_____

0-Continent: Complete Control
1-Usually continent
2-Occasionally incontinent
3-Frequently incontinent
4-Incontinent

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 your use a wheel chair, 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 _____

Mood Patterns: Sad or anxious mood ____ Tearfulness _____ Failure to eat _____ Motor agitation (pacing, hand-wringing, 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.):

Source	**Applicant**	**Spouse**
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____

BANK ACCOUNTS: PLEASE PROVIDE THREE MONTHS OF BANK STATEMENT

Bank Name, Address & Zip Code	**Type of Account** (Checking/Savings)	**Account Balance**
_____	_____	$_____
_____	_____	$_____

Health Insurance

Medicare #: _____Medicaid #:_____
Pharmcy Rx Card # _____
(Medicare D Card, etc.)
Insurance Policy #: _____
Company: _____
Address: _____
City/State/Zip: _____

C E R T I F I C A T I O N

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

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