

# Idaho State Veterans Home

## Application for Admission



### **Boise**

320 Collins Road  
Boise, ID 83702  
PH: (208) 780-1616  
Fax: (208) 780-1617

### **Lewiston**

821 21st Avenue  
Lewiston, ID 83501  
PH: (208) 750-3638  
Fax: (208) 750-3616

### **Pocatello**

1957 Alvin Ricken Drive  
Pocatello, ID 83201  
PH: (208) 235-7838  
Fax: (208) 235-7801

### **Post Falls**

590 S Pleasant View Rd 101  
Post Falls, ID 83854  
PH: (208) 415-3434  
Fax: (208) 415-3435

## IDAHO STATE VETERANS HOME APPLICATION FOR ADMISSION

Thank you for considering our Idaho State Veterans Homes (ISVH) as the 24-hour skilled nursing facility to care for your loved one. Idaho has four facilities; located in Boise, Lewiston, Pocatello, and Post Falls.

Applicants for nursing care must be a veteran (wartime or peacetime) or the spouse, widow, or widower of a veteran eligible for admission to a Home. Specific requirements are:

- Proof of honorable service in the United States Military, (DD214 or Military Discharge) showing a minimum of 90 days active-duty service, separated, or discharged from military service earlier than ninety (90) days under honorable conditions because of service-connected disability.
- Spouses, widows, or widowers eligible for nursing care, must provide a copy of the veteran's honorable military service (DD214 or Military Discharge) on whose service they are qualified, and a proof of marriage (license or certificate) and/or a death certificate, when applicable.
- Applicants must be a resident of the State of Idaho at the time of admission to a Home.
- All veteran residents must also either be in receipt of or apply for a VA pension. Application can be made through the Office of Veterans Advocacy; a State Service Officer is located at each Veterans Home and can assist veteran residents with this process.

The admissions committee will review each application carefully to ensure the Veterans Home is able to provide the appropriate level of care and services needed for the applicant. A Home shall not accept applicants or continue to extend care to residents for whom the facility does not have the capability or services to provide an appropriate level of care.

**All residents are responsible for the cost of their care; charges are due the first of each month and must be paid in full by the resident or guardian on or before the 10th day of the month.**

Payment sources for nursing care can be from income and liquid assets (including social security and pensions), private insurance, Medicaid insurance, or Medicare insurance. If eligible for Medicare, the applicant must elect to participate, unless participation is waived by the Home Administrator. Participation in a Medicare Part D prescription drug coverage plan is also encouraged as this coverage helps to reduce costs for those who are paying privately for their care. The Home can provide a list of participating plans. Care charges are as follows:

### **SEMI-PRIVATE ROOM RATE BOISE, LEWISTON, POCATELLO**

- **VETERAN NURSING CARE** – Effective January 1, 2023, the daily rate for nursing care is **\$263.00 per day** (includes medical supplies) plus other ancillary, special items, and service charges.
- **ELIGIBLE NON-VETERAN NURSING CARE** – Effective July 1, 2022, the current daily rate for all non-Veteran spouses is **\$263.00 per day** (includes medical supplies) plus other ancillary, special items, service charges, and current VA per diem rate.

### **PRIVATE ROOM RATE POST FALLS**

- **VETERAN NURSING CARE** – Effective November 1, 2022, the daily rate for nursing care is **\$370.00 per day** (includes medical supplies) plus other ancillary, special items, and service charges.
- **ELIGIBLE NON-VETERAN NURSING CARE** – Effective November 1, 2022, the current daily rate for all non-Veteran spouses is **\$370.00 per day** (includes medical supplies) plus other ancillary, special items, and service charges.

**NOTE:** *All rate information listed on this form is subject to change without notice.*

Assistance with completing admissions documents and Medicaid applications is available from the Homes. Some veterans are also eligible for assistance from the Veterans Benefits Administration – service-connected disability claims/ aid and attendance benefits/ non-service-connected pensions. A State Service Officer is assigned to each Veterans Home and will review eligibility for VA benefits and assist with required applications.

Our Admissions Coordinator looks forward to hearing from you. Thank you for your interest in Idaho State Veterans Homes.

# IDAHO STATE VETERANS HOME APPLICATION FOR ADMISSION

Today's Date: \_\_\_\_\_

Requested Admission Date: \_\_\_\_\_

This application is for placement in the Idaho State Veterans Home located in:

Boise

Pocatello

Post Falls

Lewiston

**NOTE: The Idaho State Veterans Home – Post Falls is a non-smoking facility. This restriction applies to staff, residents, and visitors.**

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

Applicant Status:  Veteran

Spouse of a Veteran

## **Personal Information**

Date of Birth: \_\_\_\_\_

(Month) (Day) (Year)

Place of Birth: \_\_\_\_\_

(City) (State)

Gender:  Male  Female

Social Security Number: \_\_\_\_\_

Branch of Service: \_\_\_\_\_

Religious Preference: \_\_\_\_\_

Date of Entry: \_\_\_\_\_

Date of Discharge: \_\_\_\_\_

Former Occupation: \_\_\_\_\_

POW:  Yes  No

Purple Heart Recipient:  Yes  No

Pearl Harbor Survivor:  Yes  No

Service Connected:  Yes  No

Service-Connected Rating \_\_\_\_\_%

Do you currently receive care at the VA Medical Center?  Yes  No If yes, which Team? \_\_\_\_\_

Permanent Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Present Location:  Home  Assisted Living  Nursing Home  Hospital

Name of Present Location: \_\_\_\_\_

*(If applicant resides other than at home, please provide the name of the facility, the address and phone number).*

Marital Status:  Married  Widowed  Separated  Divorced  Single

Spouse's Name: \_\_\_\_\_ Spouse's SSN: \_\_\_\_\_

Spouse's DOB: \_\_\_\_\_ Date of Marriage: \_\_\_\_\_

Does Applicant have an electric wheelchair or scooter?  Yes  No

*If yes, the applicant will need to pass a safe driving evaluation upon admission to operate the device in the facility.*

Has applicant ever resided at any Idaho State Veterans Home?  Yes  No

If yes, which Home?  Boise  Pocatello  Post Falls  Lewiston

Has applicant ever been convicted of, or entered a plea of guilty, no contest, or had a withheld judgment to a felony or sexual offense?  Yes  No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

# IDAHO STATE VETERANS HOME APPLICATION FOR ADMISSION

## Contact Information

Primary Contact/Responsible Party (*person who handles financial or medical affairs*)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

(Street) (City) (State) (Zip)

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Secondary Contact

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

(Street) (City) (State) (Zip)

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

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## Health Insurance Information

Please include, with this application, a copy (**front and back**) of the applicant's Medicare, Private Insurance, and Medicaid Cards.

Do you have **Medicare**?  Yes  No

Medicare Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Do you have **Medicare D Prescription Coverage**?  Yes  No

Plan Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Do you have **Other Health Insurance**?  Yes  No

Policy Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Policy Type: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Do you have **Long Term Care Coverage**?  Yes  No

Policy Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Policy Type: \_\_\_\_\_ Effective Date: \_\_\_\_\_

# IDAHO STATE VETERANS HOME APPLICATION FOR ADMISSION

## Financial Information

A copy of the applicant's current bank statements and proof of income is required prior to admission.

### **Applicant Monthly Income *before* Deductions:**

Social Security: \$ \_\_\_\_\_  
Private Pension: \$ \_\_\_\_\_  
Military Retirement: \$ \_\_\_\_\_  
VA Pension: \$ \_\_\_\_\_  
Other Income: \$ \_\_\_\_\_  
**Total:** \$ \_\_\_\_\_

### **Spouse Monthly Income *before* Deductions:**

Social Security: \$ \_\_\_\_\_  
Private Pension: \$ \_\_\_\_\_  
Military Retirement: \$ \_\_\_\_\_  
VA Pension: \$ \_\_\_\_\_  
Other Income: \$ \_\_\_\_\_  
**Total:** \$ \_\_\_\_\_

### **Other Resources:**

Checking Account: \$ \_\_\_\_\_ Savings Account: \$ \_\_\_\_\_  
Investments: \$ \_\_\_\_\_ Other Liquid Assets: \$ \_\_\_\_\_  
Life Insurance Cash Value: \$ \_\_\_\_\_  
Property: \$ \_\_\_\_\_ Address: \_\_\_\_\_  
Vehicles: \$ \_\_\_\_\_ Year/model \_\_\_\_\_  
Revocable or Irrevocable Personal Trust:  Yes  No If yes, date it was done? \_\_\_\_\_  
Pre-Paid Burial Arrangements:  Yes  No  
Funeral Home: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Has the applicant sold, transferred ownership, or gifted any property or financial asset in the last 5 years?

Yes  No If yes, please explain: \_\_\_\_\_

Financial Responsible Party (name and address where bills should be sent): \_\_\_\_\_

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**I do hereby affirm, to the best of my knowledge that the above statements are true and I understand that any falsification regarding my monthly income or assets will be reason for discharge from the Home. If applying for nursing care, I further affirm that my income may be such that I am unable to defray the necessary expenses of the medical care for which I am applying. I further understand that I can be discharged from the Home for refusal or failure to pay the established maintenance charge or related expenses.**

\_\_\_\_\_  
*Signature of Applicant/Responsible Party*

\_\_\_\_\_  
*Date*