

State of Rhode Island
Office of Veterans Services
Rhode Island Veterans Home
480 Metacom Avenue
Bristol, Rhode Island 02809-2488
(401) 253-8000

APPLICATION FOR ADMISSION TO THE RHODE ISLAND VETERANS HOME, BRISTOL, R.I. 02809

1. Last Name First Name Middle Name Maiden Name				2. VA Claim No.		3. Social Security No.		POW Yes <input type="checkbox"/> No <input type="checkbox"/>	
4. Active Military Service <input type="checkbox"/> Army <input type="checkbox"/> U.S. Air Force <input type="checkbox"/> Navy <input type="checkbox"/> Merchant Marine <input type="checkbox"/> Marine Corp <input type="checkbox"/> Coast Guard				Rank & Organization		War		Purple Heart Yes <input type="checkbox"/> No <input type="checkbox"/>	
Service Serial Number	Date of Entry Active Service	City & State from which Inducted or Enlisted		Date of Discharge	City & State from which Discharged		Type of Discharge		
5. Home Address						5a. Telephone Number (Landline/Mobile)			
6. Present Address (if different from above)						5b. Telephone Number			
7. Sex		8. Date of Birth		9. Place of Birth		10. Email Address			
11. Past Occupation			Education		12. Marital Status		<input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married <input type="checkbox"/> Separated		
13. Religion/Church/Synagogue			14. Have you a Driver's License? Yes <input type="checkbox"/> No <input type="checkbox"/>			15. Have you a Will? Yes <input type="checkbox"/> No <input type="checkbox"/> 15a. Location of Will? (if applicable)			
16. Driver's License Number (if applicable)			16a. Make/Model of Vehicle (if applicable)			16b. Vehicle Registration Number (if applicable)			
17. Spouse's Name (First & Maiden)			17a. Spouse's Birth Date			17b. Spouse's Date of Death			
18. Resident of Rhode Island From: To:			19. Citizen of U.S.A. Yes <input type="checkbox"/> No <input type="checkbox"/>			20. Is this a Readmission? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. Medical Insurance Claim Numbers Medicare Part A# _____ Medicare Part B# _____			Blue Cross # _____ Blue Shield # _____			Medicaid # _____ Other # _____			
22. Have You Ever Been Treated for A Psychiatric Illness (Specify Physician, Facility & Date)					22a. Has Legal Guardian been Appointed Yes <input type="checkbox"/> No <input type="checkbox"/>				
					22b. Date appointed (If applicable) _____ (Include Certified Copy)				
23. Have You Ever Been Treated for Substance Abuse (Specify Physicians, Facility & Date)									
24. In Event of my Death, I Designate as my Funeral Director (Name & Address)						24a. Telephone Number			
25. Name and Address of Next of Kin, Relative or Friend (Primary Contact for Health Care/Financial Decisions)						24b. Telephone Number (Work/Home/Mobile)			
26. Name and Address of Next of Kin, Relative or Friend (Specify Relationship)						26a. Telephone Number (Work/Home/Mobile)			

IF ADMITTED TO THE RIVH, I AGREE TO ABIDE BY & OBEY ALL THE RULES & REGULATIONS OF THE HOME; & I WILL PERFORM ALL THE DUTIES REQUIRED OF ME & OBEY ALL THE LAWFUL ORDERS OF THE OFFICERS OF THE HOME. FURTHERMORE, I UNDERSTAND THAT I MUST PAY THE MONTHLY FEE ASSESSED BY THE HOME FOR THE COST OF MY CARE, WHICH FEE IS MANDATED BY RHODE ISLAND GENERAL LAW § 30-24-10, AND ANY FAILURE TO MAKE PAYMENT WHEN DUE SHALL BE CAUSE FOR DISMISSAL FROM THE HOME AFTER ADMINISTRATIVE DUE PROCESS. IN ADDITION, I UNDERSTAND THAT TO REMAIN AT THE HOME, I REALIZE THAT FAILURE TO COMPLY WITH THE HOME'S RULES AND REGULATIONS WILL RESULT IN MY BEING SUMMARILY DISCHARGED. IN MAKING THIS APPLICATION, I DO SO OF MY OWN FREE WILL AND ACCORD WITH A SINCERE DESIRE ON MY PART TO ENTER THE VETERANS HOME. I CERTIFY THAT ALL THE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I CONSENT THAT ANY PHYSICIAN, SURGEON, DENTIST, HOSPITAL OR OTHER HEALTH FACILITY THAT HAS TREATED OR EXAMINED ME FOR ANY PURPOSE OF THAT I HAVE CONSULTED PROFESSIONALLY, MAY FURNISH THE RIVH ANY INFORMATION ABOUT MYSELF AND I WAIVE ANY PRIVILEGE WHICH RENDERS SUCH INFORMATION CONFIDENTIAL.

Date

Signature of Veteran/Guardian/P.O.A.

FINANCIAL STATEMENT

Name: _____ Social Security No.: _____

INCOME

LIST ALL YOUR INCOME AND THAT OF YOUR SPOUSE AND/OR DEPENDENT(S)							
(If additional space is needed, please attach a separate sheet.)							
ANSWER EVERY ITEM	NO	YES	PENDING	VETERAN		SPOUSE AND/OR DEPENDENT(S)	
				Amount Received	How Often Received	Amount Received	How Often Received
Earnings from Employment							
Social Security Pension							
Veteran's Pension							
Veteran's Compensation							
Other Government Pensions							
Private Pensions							
Dividends							
Interest							
Workmen's Compensation							
Temporary Disability Insurance (TDI)							
Annuities or Insurance							
Other: Specify Source							

PROVIDE THE FOLLOWING INFORMATION FOR EACH SUPPORTED PERSON

Name of Supported Person	Address	Soc. Sec. #	Relationship	Date of Birth (DOB)

MAJOR BATTLES, CAMPAIGNS, DECORATIONS, CITATIONS, ETC.

Rhode Island General Law, Section § 30-24-10 provides in part: The director (of the Department of Human Services) shall determine the net per diem expenses of maintenance of residents in the facility and shall assess against each resident who has "net income", as defined herein, a fee equal to eighty percent (80%) of the resident's net income, provided that fee shall not exceed the actual cost of care and maintenance for the resident; and provided that an amount equal to twenty percent (20%) of the maintenance fee assessed shall be allocated to and deposited in the veterans' restricted account.

For the purposes of this section, "net income" is defined as gross income minus applicable federal and state taxes and minus: an amount equal to one hundred fifty dollars (\$150.00) per month of residency and fifty percent (50%) of any sum received due to wounds incurred under battle conditions for which the resident received the purple heart; and the amount paid by a resident for the support and maintenance of his or her spouse, parent(s), minor child(ren) who is/are blind or permanently and totally disabled as defined in title XVI of the Federal Social Security Act, 42 U.S.C. 1381 - 1383d. subject to a maximum amount to be determined by rules and regulations as shall be adopted by the director.

The fees shall be paid monthly to the home and any failure to make payment when due shall be cause for dismissal from the facility. Prior to dismissal, the resident shall be afforded administrative due process.

I certify that I am the spouse or other person to be supported by the veteran. I certify that the foregoing statements regarding my income and relationship to the veteran are true and complete to the best of my knowledge and belief. I agree to inform the RI Veterans Home of any changes in this information. I consent to have any agency or person having custody of this information to furnish the RI Veterans Home any information about myself and I waive any privilege which renders such information confidential

Date Signed

Signature of Veteran's spouse or other supported person

