

Texas State Veterans Homes

Application for Admission



Jerry Patterson, Chairman

For assistance, please contact the Texas Veterans Land Board
toll free at 1-800-252-VETS (8387).

Last Update 5-12-2006

Texas Veterans Land Board • 1700 N. Congress Ave. • Austin, Texas 78701-1496
Mailing Address • P.O. Box 12873 • Austin, Texas 78711-2873 • www.texasveterans.com

TEXAS STATE VETERANS HOMES

BIG SPRING - BONHAM - EL PASO - FLORESVILLE - MCALLEN - TEMPLE

APPLICATION FOR ADMISSION

Thank you for making an application to a Texas State Veterans Home. Please attach a copy of the veteran's discharge document (DD 214 or equivalent). If acting on behalf of the proposed resident, also attach a copy of guardianship documentation or a signed durable medical power of attorney. Mail the application directly to the home of choice.

William R. Courtney Texas State Veterans Home

1424 Martin Luther King Jr. Lane
Temple, Texas 76504-5941
Phone: 254-791-8280
Fax: 254-791-0262

Frank M. Tejada Texas State Veterans Home

200 Veterans Drive
Floresville, Texas 78114-2709
Phone: 830-216-9456
Fax: 830-393-7764

Lamun-Lusk-Sanchez Texas State Veterans Home

1809 North Highway 87
Big Spring, Texas 79720-0793
Phone: 432-268-VETS (8387)
Fax: 432-268-1987

Clyde W. Cospers Texas State Veterans Home

1300 Seven Oaks Road
Bonham, Texas 75418-3254
Phone: 903-640-VETS (8387)
Fax: 903-640-4281

Ambrosio Guillen Texas State Veterans Home

9650 Kenworthy Street
El Paso, Texas 79924
Phone: 915-751-0967
Fax: 915-751-0980

Alfredo Gonzalez Texas State Veterans Home

301 E. Yuma Avenue
McAllen, Texas 78503-1388
Phone: 956-682-4224

This application is for placement in the veterans home located in _____

Today's Date: _____

Category: Veteran _____ Spouse _____ Surviving Spouse _____ Gold Star Parent _____

PERSONAL INFORMATION

How did you hear about Texas State Veterans Homes? _____

Applicant's Name _____

Date of Birth _____ Current Age _____ Gender: M _____ F _____

VA Claim # _____ Social Security # _____

Place of Birth _____

Marital Status _____ Spouse's Name _____

Permanent Address _____

Email Address _____

Home Phone _____ Other Phone _____

Present Location of Applicant Home _____ Hospital _____ Nursing Facility _____ Other _____

Current Address (If applicant resides other than at home, please provide the name, address, and telephone number of the hospital, nursing facility or other location.) _____

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Applicant's Name _____

Name of **Primary** Responsible Party (*party who handles applicant's financial and/or medical affairs*)

Name _____ Relationship _____ Financial _____ Medical _____

Address _____

Home Phone _____ Work Phone _____

Legal

Relationship Self _____ Power of Attorney _____ Legal Guardian _____ Surrogate Decision Maker _____

Name of **Secondary** Responsible Party (*party who handles applicant's financial and/or medical affairs*)

Name _____ Relationship _____ Financial _____ Medical _____

Address _____

Home Phone _____ Work Phone _____

Legal

Relationship Self _____ Power of Attorney _____ Legal Guardian _____ Surrogate Decision Maker _____

MEDICAL INFORMATION

Primary Physician _____

Address _____

Phone _____ Fax _____

Is your physician willing to come to the Texas State Veterans Home to continue caring for you?

Yes _____ No _____

Diagnosis Requiring Long-Term Care (*attach copy of medical records or fill out completely*)

Other Pertinent Diagnoses _____

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Applicant's Name _____

Current Medications	Name	Dosage	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Continue on additional page, if necessary.

Known Allergies _____

Additional Information _____

HEALTH INSURANCE INFORMATION

Primary Medical

Carrier _____

Address _____

Phone _____ Fax _____

Policy # _____ Group # _____

Name of Policyholder _____

Secondary Medical

Carrier _____

Address _____

Phone _____ Fax _____

Policy # _____ Group # _____

Name of Policyholder _____

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Applicant's Name _____

Dental Insurance

Carrier _____

Address _____

Phone _____ Fax _____

Policy # _____ Group # _____

Name of Policyholder _____

Other Health Insurance/Long-Term Care Insurance

Type _____ Coverage _____

Carrier _____

Address _____

Phone _____ Fax _____

Policy # _____ Group # _____

Name of Policyholder _____

Do you have Medicare Part A? Yes _____ No _____

Do you have Medicare Part B? Yes _____ No _____

INCOME INFORMATION

Usual Occupation _____ Date Last Employed _____

Last Employer _____

(name/address/phone) _____

If applicant is receiving VA income benefits:

Service Connected (SC) Disability Compensation \$ _____ per month	Service Connected Disability Rating by VA _____ %	Non-Service Connected (NSC) Pension \$ _____ per month
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Aid and Attendance \$ _____ per month	House Bound \$ _____ per month
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Monthly income *before* deductions

Social Security _____ per month Military Retirement \$ _____ per month

Private Pension _____ per month Workers Compensation \$ _____ per month

Other Income _____ per month Source _____
_____ per month _____

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Applicant's Name _____

If monthly income is not enough to pay applicant's portion of costs, what other resources are available?
(checking, savings, investments, etc.): RATES ARE SUBJECT TO CHANGE AT ANY TIME.

TEXAS VETERAN SERVICE INFORMATION

Branch of Service	_____	Type of Discharge	_____
Date Entered	_____	State/County of Entry	_____
Date Discharged	_____	Discharge Location	_____
Texas Resident Since	_____	Voter Registration County	_____

X

Signature of Applicant/Responsible Party

Date

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AUTHORIZATION FOR RELEASE OF INFORMATION

Applicant's Name _____

Social Security Number _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize and direct any hospital, clinic, medical service facility, medical practice, doctor, insurance company, or other person or institution in possession of any records pertaining to my health, medical condition(s), or medical treatments(s) to release originals or copies of the same to the Texas State Veterans Home, its authorized professional medical service providers, long-term care facilities operators, and/or the medical director for each Texas State Veterans Home. A photocopy or facsimile copy of this authorization/release is as valid as the original.

I hereby release, indemnify and hold harmless forever any party who complies in good faith with this authorization from any claim by me, my guardian, my attorney in fact or any other representative, or my estate, based on an assertion of breach of privilege, privacy or other right or duty owed to me.

Signature of Applicant/Responsible Party

Date

Signature of Witness

Date

Printed Name of Witness

Date

If you have any questions, please contact the home or call the Texas Veterans Hotline at 1-800-252-VETS (8387).

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