IMPORTANT---MUST READ!!

Thank you for your interest in the Soldiers’ Home in Holyoke. **To be considered for admission to the facility, there are four important steps you must complete.** Admission to the Home will be delayed if these steps are not completed or requested documentation is missing.

**STEP 1. Application**

1. Complete the application form in its entirety.
2. Provide a copy of the veteran’s discharge papers (also known as a DD-214).
3. Provide recent medical records or a letter from the veteran’s doctor detailing present condition.
4. Complete and sign the enclosed Veteran’s Administration 1010-EZ form.
5. Provide photocopies all current health insurance cards (front and back).
6. Provide photocopy of marriage certificate (if applicable).
7. Provide photocopy of Health Care Proxy (forms available through this office).
8. If applicable, provide photocopy of any other advance directives, such as Power of Attorney, living will, and guardianship order.
9. Please provide current copies of the following as proof of income:
   a.) pension stubs
   b.) annuity statements
   c.) 1099 R’s (end of year statements)
   d.) copies of all bank statements showing these deposits
11. If you filed taxes last year, please provide a photocopy.

Once all items are completed and gathered, please call the Admissions Coordinator, John C. Beaton, at (413) 532-9475, ext. 5321139 to set up an appointment for Step 2 and Step 3.

**STEP 2. Schedule a tour of the facility.**

Tours are conducted Monday through Friday, 9:00 a.m. to 4:00 p.m. **NOTE:** The veteran is **not** required to take a tour if he/she is unable to do so. Family members, caregivers, health care agent and/or any other responsible party may take part on behalf of the veteran.
STEP 3.
Schedule an appointment to sign admission documents.
Often, this paperwork can be signed on the day the tour is conducted. However, a separate date and time can be arranged if it is more convenient. During this meeting, policies and procedures are explained and any questions are answered.
NOTE: The veteran or health-care proxy or other legally responsible party must be the person signing the admission documents.

STEP 4.
Medical Assessment.
Upon completion of steps 1, 2, and 3, the Admissions Department will schedule a medical assessment. A nurse from the Home conducts the assessment. Most of the time, we will send the nurse to wherever the veteran resides, either at home or at a facility. If the veteran seeks the “assisted living” unit, (2nd floor), and is fairly independent in normal day to day activities, the veteran must come to the Admissions Department for the medical assessment. If any veteran seeking admission to the Soldiers’ Home is able to report here for the medical assessment, he/she is encouraged to do so, as it expedites this final step in the admissions process.

Upon completion of these four steps, the veteran is placed on an active call list and will be contacted as bed-space becomes available.

It is our pleasure to be of assistance to any eligible veteran seeking admission to the Soldiers’ Home in Holyoke. If, at any time, you have any questions about this admission process, please do not hesitate to contact me directly at 413-532-9475, extension 5321139.

Sincerely,

John C. Beaton
Admissions Coordinator
The Soldiers’ Home in Holyoke
DATE:

NAME:

ADDRESS:

CITY, STATE, ZIP:

PHONE:

SOCIAL SECURITY #:

D.O.B: ________________ PLACE OF BIRTH:_________________________________________

DO YOU HAVE ANY SERVICE CONNECTED DISABILITIES? ______
IF YES, WHAT PERCENT? ______ WHAT FOR? _________________________________________

DO YOU HAVE ANY INDUSTRIAL OR AUTOMOBILE ACCIDENT LITIGATION PENDING? ______

WHERE IS THE VETERAN NOW?
Home: __________________________ Date of admission into present facility: _______________________
Hospital: __________________________
Long Term Care Facility: __________________________

DOCTOR:

SOCIAL WORKER (IF PRESENTLY IN HOSPITAL OR NURSING HOME):

DIAGNOSIS:

PRIMARY CONTACT PERSON:

Name: __________________________
Address: __________________________
City, State, Zip: __________________________
Phone: Home: __________________________ Work: __________________________ Other: __________________________

Relationship to veteran:

Are you also the veterans’ health care agent, guardian or power of attorney? Please circle all that apply.

The names of the veteran’s parents and their birthplaces – if known (even if they are deceased).

If the veteran has GI insurance, the amount it is for (written proof is NOT necessary for this).

Has the veteran ever had any previous care at any VA facility? If so, where and when? Inpatient? Outpatient?

What is the veteran’s religious denomination (if any)?

What was the veteran’s primary occupation?
What is the veteran’s marital status?

If the veteran is *married, divorced or widowed*, the following spousal information is needed:

Social Security number:      Maiden name:
Date of birth:              Place of marriage:

Approximately how many years has the veteran lived in Massachusetts?

Once the veteran is admitted, who would you like to be the first contact person? *(This is the person listed as the Health Care Agent on the Health Care Proxy)*

Name:
Address:
City, State, Zip:
Phone: Home:                  Work:                  Other:
Relationship to the veteran:

The second contact person:
Name:
Address:
City, State, Zip:
Phone: Home:                  Work:                  Other:
Relationship to the veteran:

The third contact person (if any):
Name:
Address:
City, State, Zip:
Phone: Home:                  Work:                  Other:
Relationship to the veteran:

To whom shall we send the room and board bill every month? *(Guarantor)*
Name:
Address:
City, State, Zip:
Phone: Home:                  Work:                  Other:
Relationship to the veteran:
In order to ascertain the charge for room and board that you or your veteran will be paying, it is necessary to verify income for both the veteran and the veteran’s spouse. Spousal income aids in the exemption determination.

Documentation required consists of:

1) A copy of the last two months of bank statements for both the veteran and the veteran’s spouse.

2) A copy of the veteran’s most recent signed income tax return, if filed.

3) A copy of check stubs from Social Security, private pensions, VA pensions and all other sources of income for both the veteran and the veteran’s spouse.

4) Assessed or appraised values of income-producing real estate such as rental units.

Please fill out this Financial Worksheet which MUST BE UPDATED ANNUALLY**

NAME:_________________________________________________
MARITAL STATUS: _____________________________________

<table>
<thead>
<tr>
<th>GROSS INCOME</th>
<th>VETERAN</th>
<th>SPOUSE</th>
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<tbody>
<tr>
<td>SOCIAL SECURITY</td>
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<td>US CIVIL SERVICE</td>
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<td>US RAILROAD RETIREMENT</td>
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<td>MILITARY RETIREMENT</td>
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<td>UNEMPLOYMENT BENEFITS</td>
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<tr>
<td>OTHER RETIREMENT (Company, State, local, etc.)</td>
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<tr>
<td>TOTAL WAGES FROM EMPLOYMENT</td>
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<tr>
<td>MISCELLANEOUS INCOME: (Circle One) MONTHLY YEARLY</td>
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<tr>
<td>Regular Distributions from CD’s, IRA’s, Money Market Funds, Rental Income</td>
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<tr>
<td>INTEREST INCOME: (Circle One) MONTHLY YEARLY</td>
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<tr>
<td>From CD's, IRA's, Money Market Funds, Bank Accounts</td>
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<tr>
<td>WORKERS’ COMP. OR BLACK LUNG BENEFIT</td>
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<tr>
<td>PENSION FROM VA SERVICE/NON SERVICE CONNECTED</td>
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<tr>
<td>ALL OTHER INCOME (Not covered above)</td>
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</table>

**PLEASE NOTE THAT THIS FORM MUST BE UPDATED IN JANUARY OF EVERY YEAR. FAILURE TO DO SO MAY RESULT IN THE VETERAN’S DISCHARGE FROM THIS FACILITY.
DAILY ROOM/BOARD RATES

This price includes medications

-70% or MORE SERVICE CONNECTED DISABILITY (S.C.D.) = NO CHARGE.

-60% or LESS S.C.D. = $0.00 to $30.00 PER DAY SLIDING SCALE. (DETERMINED BY VETERAN/SPOUSAL MONTHLY GROSS INCOME).

BED HOLD RATES

If hospitalized within the first 30 days of admission:

70% or more S.C.D. = $253.20 per day for days 1 through 4.
No charge for days 5 through 10.
$253.20 per day for days 11 and up.

60% or less S.C.D. = $95.82 per day for days 1 through 4.
No charge for days 5 through 10.
$95.82 PLUS DAILY ROOM/BOARD RATE per day for days 11 and up.

If hospitalized after the first 30 days of admission:

70% or more S.C.D. = No charge for days 1-10.
$253.20 per day AFTER day 10.

60% or less S.C.D. = No charge for days 1-10.
$95.82 PLUS daily room/board rate per day AFTER day 10.

VETERANS ARE ALLOWED 12 OVERNIGHT PASSES EACH CALENDAR YEAR.

IF A VETERAN EXCEEDS 12 OVERNIGHT PASSES IN A CALENDAR YEAR,
THEY WILL BE BILLED AS FOLLOWS:

- 70% or more S.C.D. = $253.20 per day after day 12.

- 60% or less S.C.D. = $95.82 per day PLUS DAILY ROOM/BOARD RATE after day 12.
SOLDIERS’ HOME IN HOLYOKE
TREATMENT OPTIONS

Veteran name:_____________________________

Because you are a veteran living at the Soldiers’ Home, we want to be respectful of your preferences concerning how aggressive you wish to have your medical care managed. Only you or your Health Care Proxy has an understanding of how you view such issues as “quality of life” or how you would define “life sustaining treatments”.

Please review the options listed below and check the appropriate box. We have provided brief descriptions for each area. Choosing one of the options does not preclude you from changing your mind at a later date. If you have questions about any of these areas, please contact the Director of Social Services at the Home and he will attempt to help clarify any issues you may have. Thank you for your cooperation.

Do Not Hospitalize

This would direct the Soldiers’ Home to manage your care out of the Soldiers’ Home. Such a decision would be made if you and/or your family decide that they do not wish further aggressive treatments for ANY condition.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Discuss with family</th>
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Nutritional Support via tube feeding

Should you be unable to swallow would you want to have a feeding-tube surgically inserted which would allow the staff to provide you with nutritional supplements? This would require that you be sent to a hospital to have the tube inserted.

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<tr>
<th>Yes</th>
<th>No</th>
<th>Discuss with family</th>
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I.V. Therapy for antibiotics and/or fluids

There may be an instance when regular oral antibiotics are not effective or you are not able to swallow fluids. Would you want to have an I.V. inserted allowing for the administration of medicines or fluid?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Discuss with family</th>
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</table>

Diagnostic Tests

In the event that you become ill, would you want to undergo diagnostic testing such as blood tests, x-rays, electrocardiograms, CT scans, endoscopy, etc?

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<tr>
<th>Yes</th>
<th>No</th>
<th>Discuss with family</th>
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Please specify any exceptions:
Amputation

If it becomes necessary to restore your health or prevent your death from occurring, would you agree to undergo an amputation of an arm, leg, or foot?

Yes       No       Discuss with family

Kidney Dialysis

In the event that my kidneys fail, I would wish to undergo periodic (three times per week) kidney dialysis at an outside facility. This would require being sent to an outside hospital for a surgical procedure to make dialysis possible.

Yes       No       Discuss with family

Palliative Care

Palliative Care is appropriate if you wish to have your symptoms managed, not cured, and choose to focus on the quality of your life rather than extending your life, and you only want to be kept comfortable and pain free. You may not have an end-stage diagnosis or limited time to live and therefore would not be appropriate for hospice care but you do opt for limiting the care you receive.

Yes       No       Discuss with family

Hospice Care

Hospice care is only appropriate for you if you who have a medical condition that if left untreated will take your life within 6-months. Under Hospice care the focus is on symptom management, pain control, and quality of life with an understanding your death will occur in the near future. The Soldiers’ Home is capable of providing Hospice Care on the Comfort Care Unit, and other long-term care floors within the facility.

Yes       No       Not approp.

Organ Donation

Selected tissues and organs are eligible for donation by older adults. The Soldiers’ Home in Holyoke encourages its veterans to consider organ donation. i.e. skin and eyes if appropriate.

Yes       No       Not approp.
I CHOOSE NOT TO COMPLETE THIS ADVANCE DIRECTIVE FORM AT THIS TIME AND I UNDERSTAND THAT I MAY DO SO AT A LATER DATE.

INITIAL REVIEW

________________________________________  _______________________
Veteran or Health Care Proxy                                              Date

________________________________________  _______________________
Witness                                                                 Date

________________________________________  _______________________
Attending Physician                                                               Date

Your signature does not prevent you from changing your mind in the future and re-signing a new TREATMENT OPTIONS FORM. All decision/options will be discussed when required.
PRESENT MEDICATIONS: (INCLUDE ANY OVER THE COUNTER MEDICINES.)

____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

ALLERGIES:

MEDICATIONS ______________________________________________________________

OTHER _________________________________________________________________________

REVIEW OF SYSTEMS: DO YOU OR HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>ABDOMINAL PAIN</td>
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<tr>
<td>ARTHRITIS / JOINT PAIN</td>
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<td>ASTHMA / EMPHYSEMA</td>
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<td>BACK PAIN</td>
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<tr>
<td>COLD, CHRONIC</td>
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<tr>
<td>1. COUGH</td>
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<td>2. SORE THROATS</td>
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<tr>
<td>CONSTIPATION, CHRONIC</td>
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<tr>
<td>1. BLOOD IN STOOL</td>
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<tr>
<td>CHEST PAIN / PRESSURE</td>
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<td>1. BLACK STOOL</td>
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<td>DIFFICULTY SWALLOWING</td>
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<td>DIZZINESS</td>
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<td>FAINTING/UNCONSCIOUS</td>
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<tr>
<td>FATIGUE</td>
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<tr>
<td>FEVER</td>
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<tr>
<td>FEELING COLD</td>
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<tr>
<td>HERNIA</td>
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<tr>
<td>HEADACHES</td>
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<tr>
<td>HEART DISEASE</td>
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<tr>
<td>HEARING DEFICIT</td>
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<tr>
<td>1. RINGING OF EARS</td>
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<td>HEART DISEASE</td>
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<tr>
<td>1. MURMUR</td>
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<td>2. PACEMAKER</td>
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<td>3. PALPITATIONS</td>
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<td>HEMORRHOIDS</td>
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<td>JAUNDICE</td>
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<td>LEG CRAMPS</td>
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<td>MENSTRUAL PROBLEMS</td>
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<td>1. MENOPAUSE</td>
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<td>NIGHT SWEATS</td>
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<td>NAUSEA</td>
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<td>NUMBNESS / TINGLING</td>
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<tr>
<td>Condition</td>
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<td>NOSE BLEEDS (FREQUENT)</td>
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<td>1. BLOOD IN URINE</td>
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<td>2. PROTEIN IN URINE</td>
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<td>3. KIDNEY STONES</td>
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<tr>
<td>SEIZURE DISORDER</td>
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<tr>
<td>1. CONVULSIONS</td>
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<tr>
<td>SEVERE INDIGESTION</td>
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<td>1. BLOOD IN URINE</td>
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<tr>
<td>3. KIDNEY STONES</td>
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<tr>
<td>4. NUMBER OF TIMES YOU GET UP AT NIGHT TO URINATE</td>
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<td>SHORTNESS OF BREATH</td>
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<td>VISUAL PROBLEMS</td>
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<td>1. BLURRED VISION</td>
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<td>2. CATARACTS</td>
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<td>3. DECREASED VISION</td>
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<td>SINUS PROBLEMS</td>
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<td>SKIN RASH</td>
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<td>STOMACH PROBLEMS</td>
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<td>1. ULCERS</td>
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<td>2. INTESTINAL BLEEDING</td>
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<tr>
<td>WEIGHT GAIN</td>
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<tr>
<td>WEIGHT LOSS</td>
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**DO YOU SMOKE?** ______ IF YES HOW MANY PACKAGES PER DAY? ______ NUMBER OF YEARS ______

**ALCOHOL:** HOW MUCH PER WEEK? _____________________________

**COFFEE, TEA OR COLA:** HOW MANY CUPS PER DAY? _______________

<table>
<thead>
<tr>
<th>Disease</th>
<th>YES</th>
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<th>YES</th>
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<tr>
<td>COLON CANCER</td>
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<tr>
<td>PROSTATE CANCER</td>
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<td>BREAST CANCER</td>
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<tr>
<td>THYROID DISEASE</td>
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**OCCUPATION:** (PRESENT) ______________________________ NO. OF YEARS ______

( PREVIOUS ) ______________________________ NO. OF YEARS ______
CHIEF COMPLAINT

__________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

DATE

OF LAST PHYSICAL _________________________

M.D. _________________________________________

PAST HISTORY:

1. LIST ANY CHRONIC CONDITIONS I.E. (HIGH BP, DIABETES, HEART / LUNG DISEASE)

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

2. LIST ANY HOSPITALIZATIONS INCLUDE SURGERIES, INJURIES AND SERIOUS ILLNESSES.

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

FAMILY: PLEASE PROVIDE INFORMATION ON FAMILY MEMBERS LISTED BELOW.

LIVING OR DECEASED / AGE / GENERAL HEALTH / CAUSE OF DEATH

FATHER _______________________________________

MOTHER _______________________________________ 

BROTHERS ___________________________________

SISTERS _____________________________________

CHILDREN ___________________________________
Veteran Name: ____________________________________________
Veteran # (if applicable) _________________________________
Date: ___________________________________________________

1. Are you entitled to Medicare based on:
   ____ Age
   ____ Disability
   ____ End-Stage Renal Disease (ESRD)

2. Are you currently employed?     YES     NO
   If YES, employer name and address:
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________
   If NO, date of retirement: __________________
   If Never Employed: ______________________

3. Do you have employer group health plan coverage (EGHP)?  YES     NO
   If YES, insurer name and address:
   ___________________________________________________________________
   ___________________________________________________________________
   Policy #: __________________________
   Group #: __________________________
   Does employer have 20 or more employees?    YES     NO
   Does employer have 100 or more employees?    YES     NO

4. Is your spouse employed?    YES     NO
   If YES, spouse’s name:
   ___________________________________________
   Spouse’s employer and address:
   ___________________________________________________________________
   ___________________________________________________________________
   If NO, date of retirement: ________________
   If Never Employed ________________________

5. Are you covered under your spouse’s EGHP?  YES     NO
If YES, insurer name and address:
____________________________________
____________________________________
____________________________________

Policy #:
______________

Group #:
______________

Does employer have 20 or more employees? YES NO

Does employer have 100 or more employees? YES NO

6. Are you receiving Black Lung (BL) Benefits? YES NO

7. Are services to be paid by a Government Research program? YES NO

8. Has the Veterans Administration authorized and agreed to pay for care? YES NO

9. Is injury / illness a work related accident / condition? YES NO

   If YES, name and address of workers’ compensation:

   ______________________________________
   ______________________________________
   ______________________________________

   Policy or ID#:
   ______________________
   Accident date:
   ______________________
   Employer’s name and address:
   ______________________________________
   ______________________________________
   ______________________________________

10. Is injury / illness due to a non-work related accident? YES NO

    Accident date:
    ______________________

    If YES, name and address of no fault insurer:

    ______________________________________
    ______________________________________
    ______________________________________

    Name and address of policy holder:
    ______________________________________
    ______________________________________
    ______________________________________

    Insurance claim #: ______________________
Is liability insurance available?  

YES  NO

Name and address of Liability Insurer:

____________________________________  
____________________________________  
____________________________________

Name and address of Responsible party:

____________________________________  
____________________________________  
____________________________________

Insurance claim #:

____________________________________

11. Do you have End Stage Renal Disease or kidney transplant?  

YES  NO  

If YES, date of transplant:  

_________________

12. Have you received maintenance dialysis treatments?  

YES  NO  

If YES, date dialysis began:  

_________________

13. Have you participated in a self-dialysis training program?  

YES  NO  

If YES, date training began:  

_________________

14. Are you within the 30-month coordination period?  

YES  NO

15. Is patient entitled to Medicare solely on the basis of ESRD?  

YES  NO
Bed Bug Prevention Policy

Due to growing concerns about the presence of bed bugs in our community, the Soldiers’ Home in Holyoke is implementing a new policy that will make several requests of our veterans and their visitors. **NO** bed bugs have been found in our facility to date, but facilities and clinical leaders believe it is prudent at this point to enhance our existing preventive measures.

We ask that veterans and visitors help us minimize the chances of a problem developing, with the following preventive measures.

**Bed Bug Prevention Policy**

- Please only bring necessary items into the facility. Blankets, luggage, bags, stuffed animals and other possessions that are not essential should be left at home.
- Items brought into the facility should be placed in plastic or paper bags.
- Veterans will be asked by medical staff members if they are currently in contact with bed bugs or have been exposed to them in recent past. If the answer to either question is yes, belongings and clothing will be either returned to the family or decontaminated with a short duration heat treatment and returned back to the veteran.
- **A veteran’s application will not be turned down if they answer yes to being exposed.**
- If you are a visitor of a veteran and are currently in contact with bed bugs or have been exposed to them in the recent past, we ask that you not come to the facility if possible.
- It is important that people are forthcoming with staff in discussing their exposure to bed bugs. Without this cooperation, our efforts to control these insects will be weakened.

**Key Facts about Bed Bugs**

- Bed bugs do not pose a public health threat, but they can cause skin irritations and other minor problems.
- The presence of bed bugs is not related to the cleanliness of a person’s surroundings.
- Anyone can pick-up bed bugs and unknowingly carry them on clothing or other items.
- Their small size (adults are about the size of a tomato seed) makes them difficult to detect.

We thank you in advance for your consideration of our bed bug prevention policy.

r/r 12/10, 3/11, 4/12