The Commonwealth of Massachusetts

Executive Office of Health and Human Services
Soldiers' Home in Holyoke
110 Cherry Street
Holyoke, MA 01040-2829
(413) 532-9475

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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
10. Provide photocopy of Social Security benefits you receive.
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

SOLDIERS' HOME IN HOLYOKE
Application for Long Term Care

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:
Hospital: Date of admission into present facility:
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: _____

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

****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.

Yes ☐ **No** ☐ **Discuss with family** ☐

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.

Yes ☐ **No** ☐ **Discuss with family** ☐

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?

Yes ☐ **No** ☐ **Discuss with family** ☐

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?

Yes ☐ **No** ☐ **Discuss with family** ☐

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.

DATE _____ **VETERAN NAME:**_____

PRESENT MEDICATIONS; (INCLUDE ANY OVER THE COUNTER MEDICINES.)

_____

_____

_____

ALLERGIES:

MEDICATIONS _____

OTHER _____

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

	YES	NO		YES	NO
ABDOMINAL PAIN	☐	☐	HERNIA	☐	☐
ARTHRITIS / JOINT PAIN	☐	☐	HEADACHES	☐	☐
			1. TENSION	☐	☐
ASTHMA / EMPHYSEMA	☐	☐	2. MIGRAINE	☐	☐
BACK PAIN	☐	☐	HEARING DEFICIT	☐	☐
			1. RINGING OF EARS	☐	☐
COLDS, CHRONIC	☐	☐			
1. COUGH	☐	☐	HEART DISEASE	☐	☐
2. SORE THROATS	☐	☐	1. MURMUR	☐	☐
			2. PACEMAKER	☐	☐
CONSTIPATION, CHRONIC	☐	☐	3. PALPITATIONS	☐	☐
1. BLOOD IN STOOL	☐	☐			
			HEMORRHOIDS	☐	☐
CHEST PAIN / PRESSURE	☐	☐			
			JAUNDICE	☐	☐
DIARRHEA, CHRONIC	☐	☐			
1. BLACK STOOL	☐	☐	LEG CRAMPS	☐	☐
DIFFICULTY SWALLOWING	☐	☐	MENSTRUAL PROBLEMS	☐	☐
			1. MENOPAUSE	☐	☐
DIZZINESS	☐	☐	2. HYSTERECTOMY	☐	☐
FAINTING/UNCONSCIOUS	☐	☐	NERVOUSNESS	☐	☐
FATIGUE	☐	☐	NIGHT SWEATS	☐	☐
FEVER	☐	☐	NAUSEA	☐	☐
FEELING COLD	☐	☐	NUMBNESS / TINGLING	☐	☐

	YES	NO
NOSE BLEEDS (FREQUENT)	☐	☐
PARALYSIS	☐	☐
PERSISTENT HOARSENESS	☐	☐
SEIZURE DISORDER	☐	☐
1. CONVULSIONS	☐	☐
SEVERE INDIGESTION	☐	☐
SHORTNESS OF BREATH	☐	☐
SINUS PROBLEMS	☐	☐
SKIN RASH	☐	☐
STOMACH PROBLEMS	☐	☐
1. ULCERS	☐	☐
2. INTESTINAL BLEEDING	☐	☐

	YES	NO
THIRST	☐	☐
TUBERCULOSIS EXPOSURE	☐	☐
URINARY PROBLEMS	☐	☐
1. BLOOD IN URINE	☐	☐
2. PROTEIN IN URINE	☐	☐
3. KIDNEY STONES	☐	☐
4. NUMBER OF TIMES YOU GET UP AT NIGHT TO URINATE. _____		
VISUAL PROBLEMS	☐	☐
1. BLURRED VISION	☐	☐
2. CATARACTS	☐	☐
3. DECREASED VISION	☐	☐
VOMITING	☐	☐
WEIGHT GAIN	☐	☐
WEIGHT LOSS	☐	☐

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 ?_____

FAMILY HISTORY OF:	YES	NO		YES	NO
COLON CANCER	____	____	HYPERTENSION	____	____
PROSTATE CANCER	____	____	DIABETES	____	____
BREAST CANCER	____	____	HEART DISEASE	____	____
KIDNEY DISEASE	____	____	THYROID DISEASE	____	____

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 _____

SOLDIERS' HOME in HOLYOKE
MEDICARE SECONDARY PAYER QUESTIONNAIRE

Veteran Name: _____
Veteran # (if applicable) _____
Date: _____

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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