NEW MEXICO STATE VETERANS HOME
Admission Checklist

To be provided by applicant and/or responsible person(s):

Current History and Physical (less than 90 days)
Face sheet, History and Physical, Current Physician’s orders, Physician Progress notes, Nursing Progress notes, Medication sheet, Social Service Notes, Special services notes, Labs and other pertinent information. PLEASE INCLUDE CHEST X-RAY REPORT FROM WITHIN THE LAST 12 MONTHS, OR PLEASE HAVE ONE TAKEN AND INCLUDE REPORT WITH THIS APPLICATION

Copy of DD-214 (discharge from service)

Copy of Marriage License (if married)

Three (3) months of current Bank Statements, copies of third party insurance coverage cards (Medicare, Medicaid, Pharmacy Cards (Medicare D, etc.) and/or Personal insurance)

Copy of Durable Power of Attorney, Living Will for Health Care, Guardianship

Complete Application:
Application for Admission
Daily Living Skills
Financial Disclosure Summary
What to Bring on Admission

Complete Medicaid Application:
Information Sheet for Application for Assistance
Program Application Information
Designation of Agent to Act as Authorized Representative for Medical Assistance
Signature requirement
If Medicaid is not applied for, application will not be approved for admission.
NEW MEXICO STATE VETERANS HOME
992 SOUTH BROADWAY
TRUTH OR CONSEQUENCES, NM  87901

APPLICATION FOR ADMISSION

Services are provided without regard to race, color, national origin, religion, sexual preference, age, handicap, or sex

APPLICANT INFORMATION:      Date:_____/____/____
Name:___________________________________  Social Security #:_____-_____-______
Address:_____________________ City/State:_______________________ Zip:___________
County of Residence:_______________ Home Phone #: (____)_________________
Sex:  ___Male    ___Female   Ethnic Group: _________ Tribal Member__Y__N Tribe_________
Date of Birth: ____/_____/_____    Age: _______    Place of Birth: ________________________
Marital Status: _____Single       _____Married    _____Widow(er)    _____Divorced
Father’s Name: ______________________ Mother’s Maiden Name: ______________________
Religious Preference:____________________   Church/Synagogue: _____________________
Address: _________________________   City/State/Zip: _______________________________
What was/is Occupation: ________________________  Highest Education:_________________
Branch of Service: ___________  Highest Rank:________ Dates of Service: __/__/__ to __/__/__
Honorable Discharge: __ Yes  __ No    Service Connected Disability: __Yes   If Yes, ___% __ No
Personal/Family Physician:____________________________  Telephone: (___)_____________
Address: ________________________  City/State/Zip: _________________________________
Last Hospital Admission: ___________________  Date:___/___/__  Telephone: (___)_________
Address: ___________________________  City/State/Zip:______________________________
Current Placement (Name of Hospital, Nursing Home, at Home, etc.)_______________________

PERSON(S) TO NOTIFY IN CASE OF EMERGENCY: (for additional info please use another sheet)
Name:____________________________________________  Relation:___________________
Address: _________________________  City/State/Zip:________________________________
Home Phone: (___)_____________________  Emergency /Cell Phone #(___)_______________

Revised 2/14/17
NM STATE VETERANS’ HOME
DAILY LIVING SKILLS INVENTORY

Name:_______________  Sex:____ DOB:_______ S.S#:_________________

PRESENT MEDICAL DIAGNOSIS/CONDITIONS: _______________________
____________________________________________________________________

PAST MEDICAL HISTORY: (operations, injuries, illnesses, hospitalizations, psychiatric treatment: include dates): ________________________________
____________________________________________________________________
____________________________________________________________________

PRE-ADMISSION SCREENING:

Do you have a diagnosed or suspected mental disorder other than dementia? (Please check one) [ ] Yes [ ] NO

Is there any indication of mental retardation? (Please check one) [ ] Yes [ ] No

ADL’s: Using the following criteria, please choose the number (0-4) that best describes you or your family member's performance in Activities of Daily Living.

0  Independent - No Assist; help or supervision supplied 1 or 2 times per week.

1  Supervision - Supervision 3 times per week or supervision and physical assist 1 or 2 time per week.

2  Limited Assistance - Residents highly involved in activity - receives physical help in maneuvering of limbs or other non-weight bearing activity 3 + times weekly.

3  Extensive Assistance - Residents performs part of activity but requires physical help 3 + times weekly with weight bearing support or full assist with other ADL’s less than full time.

4  Total Dependence - Caregiver must perform all daily living skills 7 days per week.

Score (0-4) Please score yourself/your family member.

_____ Bed Mobility: How resident moves to and from lying position, turns side to side, and positions body while in bed.
Transfer: How resident moves between surfaces - to/from bed, chair, wheelchair, standing position. (Exclude to/from bath/toilet)

Locomotion: How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair.

Dressing: How resident puts on, fasten, and takes off all items of street clothing, including donning/removing prosthesis.

Eating: How resident eats and drinks (regardless of skill).

Toilet use: How resident uses the toilet room (or commode, bedpan, urinal; transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.

Personal Hygiene: How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and genitals (EXCLUDE baths and showers).

Please use a new criteria (0-4 as follows) for Bathing:

Bathing: How a resident takes a fully body bath, sponge bath, and transfer in/out of tub/shower (excluding washing of back of hair)

<table>
<thead>
<tr>
<th>Bathing Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Independent: no help provided</td>
</tr>
<tr>
<td>1</td>
<td>Supervision: Oversight help only</td>
</tr>
<tr>
<td>2</td>
<td>Physical help limited to transfer only</td>
</tr>
<tr>
<td>3</td>
<td>Physical help in part of bathing activity</td>
</tr>
<tr>
<td>4</td>
<td>Total dependence</td>
</tr>
</tbody>
</table>

Continence: Control of bladder/bowels in last 14 days

<table>
<thead>
<tr>
<th>Continence Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Continent: Complete Control</td>
</tr>
<tr>
<td>1</td>
<td>Usually continent</td>
</tr>
<tr>
<td>2</td>
<td>Occasionally incontinent</td>
</tr>
<tr>
<td>3</td>
<td>Frequently incontinent</td>
</tr>
<tr>
<td>4</td>
<td>Incontinent</td>
</tr>
</tbody>
</table>
Circle One

Are you or your family member on a scheduled toileting plan?  
Yes  No

Any recent change in continence?  
Yes  No

Any skin problems or treatments?  
Yes  No

Please check any that apply:
External Catheter _____  Enemas _____  Irrigation _____  Pads _____
Ostomy _____  Indwelling Catheter _____  Briefs _____

Vision:  Adequate _____  Impaired _____  Highly Impaired _____  Severely Impaired:_____

Speech:  Speaks _____  Writes Messages _____  Signs/Gestures _____  Sounds _____
Communication board _____

Hearing:  Adequate _____  Minimal Difficulty _____  Absent Hearing _____  Hear only on special situations _____

Oral Problems:  Chewing Problem _____  Swallowing Problem _____  Mouth Pain _____

Nutritional Problems:
Dehydrated _____  Complains of Hunger _____  Feeding Tube _____  Supplement _____
Drinks or eats well _____  Does not eat or drink well _____  Therapeutic diet _____
Mechanically altered diet _____

Body Control Problems:
Bedfast _____  Balance problems _____  Contracture _____  Hemiplegia _____
Quadriplegia _____  Amputation _____  Hemiparesis _____  Loss of voluntary movement to hands, leg trunks or arms _____

Do you or your family member use any of the following?  
Hearing Aide _____
Dentures _____  Glasses _____  Brace or Prosthesis _____  Cane/Walker _____
Mechanical Lift _____  Wheelchair _____  Special feeding tube _____

Restraints:
Bed rails _____  Trunk Restraint _____  Limb Restraint _____  Chemical Restraint _____

Circle One:
If your use a wheel chair, can you propel it yourself?  Yes  No
Any problems with falls?  Yes  No  Frequent _____  Infrequent _____

Please check any that apply:
Psychosocial Well-Being:  At ease with others _____  At ease doing planned activities _____  Establishes own goal _____  Absence of personal contact with family or friends _____  Openly expresses conflict or anger with family or friends _____
**Mood Patterns:** Sad or anxious mood _____ Tearfulness _____ Failure to eat _____
Motor agitation (pacing, hand-wringing, picking) _____ Withdrawal from self care or leisure activities _____ Recurrent thoughts of death _____ Suicidal thoughts/actions _____

**Behavior Patterns:** Wandering ____ Verbally abusive___ Physically abuse___ Socially Inappropriate/Disruptive Behavior___ Resists Care(medication, treatments, ADL care)____

**Memory Problems:** Short term memory okay ______ Long term memory okay ____

Any prior treatment for alcohol/drug problems? Yes ______ No ______
Any history of communicable disease? Yes ______ No ______
List date of last chest x-ray or TB test results: __________________________
Has applicant had flu immunization and date of last administration. _____ Yes _____ No ______
Date ______
Has applicant had pneumovax immunization and date of administration. ___ Yes ___ No ______
Date ______
Any other immunizations and dates. ________________________________________
Any history of MRSA, VRE, Hepatitis,C-DIFF or other infectious disease and dates. __________
____________________________________________________________________________

Please list medications taken: ______________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

**ALLERGIES:** ____________________________________________________________
____________________________________________________________________________

Please add any concerns or additional information you think might be helpful for you or your family member's needs: ________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

____________________________________  _______________________
Signature                        Date    Relationship
FINANCIAL DISCLOSURE STATEMENT

Name: _____________________________   Social Security #: ________________________

Spouse’s Name (If applicable):___________________  Social Security #:__________________

Do you own or have interest in property other than the property which is the primary residence of spouse or dependent children?  _____Yes  _____No

MONTHLY INCOME (Pensions, Rental Income, Annuities, Social Security, Interest Income, etc.):

<table>
<thead>
<tr>
<th>Source</th>
<th>Applicant</th>
<th>Spouse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
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BANK ACCOUNTS: PLEASE PROVIDE THREE MONTHS OF BANK STATEMENT

<table>
<thead>
<tr>
<th>Bank Name, Address &amp; Zip Code</th>
<th>Type of Account (Checking/Savings)</th>
<th>Account Balance</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>

Health Insurance

Medicare #:  ____________________  Medicaid #:  ____________________
Pharmacy Rx Card #  ____________________
(Medicare D Card, etc.)
Insurance Policy #:  ____________________
Company:  ____________________________________
Address:  ____________________________________
City/State/Zip:  ____________________________________

CERTIFICATION

The Department of Health and The New Mexico State Veterans’ Home are authorized to investigate the financial information provided by applicants or their representative(s) to determine their ability to pay for services. Any applicant or representative(s) who knowingly withholds or falsifies financial information shall be liable for all expenses incurred for legal action related to the recovery of valid indebtedness to the State of New Mexico.

I hereby certify that the foregoing information is true and correct to the best of my knowledge and belief. I agree to report any change in income to the Financial Specialist of the New Mexico State Veterans’ Home.

___________________________________________
Name of Person Completing Information (Please print)

___________________________________________  Date:_____/_____/_____
Signature of Person Completing Information

Relation to Applicant, if other than Applicant
New Mexico State Veterans’ Home
What to Bring on Admission

The following items may be brought with you when reporting for admission to the New Mexico State Veterans Home.

The quantities listed below for the various items should be considered the maximum recommendation to bring with you to the Home. We provide a bedside table, Armoire, over the bed table and sitting chair and a small closet 78"x16"x22"deep including 8" drawer on bottom, each vanity has four drawers for each resident.

All electrical items including electronics must be safety inspected by our maintenance department. If approved, the items will be delivered to the resident room. If deemed unsafe, electronic item will be sent back with family or disposed of.

Upon admission all clothing and blankets received at the facility will be delivered to Admission Office and will be placed in a dryer before delivered to resident room.

New items brought to the facility should be delivered to Lead Aide or House RN. Because of limited space, when new items are brought in to the facility the same quantity of old items will be exchanged back to the family or donated. If the preference of the resident/family is to keep the old items, new items can be sent back to family or donated. Excess items will be disposed of after 30 days.

Personal Care Items
No personal furniture allowed, furniture is provided
Small TV- NO Larger than 21 inches
Razor and accessories
Hair Care Items
Alarm clock or small clock radio
Laptop/tablet
We are unable to accommodate a desktop computer

Health Care Items
Eyeglasses with case
Hearing Aid and Dentures
Personal wheelchair, walker, cane, crutches and approved self-help devices

Clothing Items
Ten changes of underwear or undergarments
Ten pairs of socks or hose
Two pair of pajamas or two night gowns
One bathrobe
One pair of bedroom slippers – non-slip
Maximum ten changes of clothing (Shirts and pants, blouses, slacks, dresses)
Sweater, Coat or Light Jacket
Two pair of shoes (See appropriate Foot Wear Letter)
All Clothes must be machine washable, permanent press materials.

______________________________   _____________
Signature Resident/POA     Date