

# The Commonwealth of Massachusetts

Executive Office of Health and Human Services

Soldiers' Home in Holyoke

110 Cherry Street

Holyoke, MA 01040-2829

**CHARLES D. BAKER**  
GOVERNOR

**MARYLOU SUDDERS**  
SECRETARY, EOHHS

**BENNETT W. WALSH**  
SUPERINTENDENT

Tel.: 413-532-9475

Fax: 413-538-7968

[www.mass.gov/hly/](http://www.mass.gov/hly/)

Thank you for your recent inquiry regarding admission to the Domiciliary Program at the Soldiers' Home in Holyoke. Enclosed is an application and forms that must be completed in order to start the admissions process. Eligibility for admission is based in part on state law. There are also physical requirements and a willingness to adhere to the rules and regulations of the facility.

Applicants must be a Commonwealth of Massachusetts resident. To be a "veteran" under Massachusetts law a person is required to have either 180 days of regular active duty service and a last discharge or release under honorable conditions or 90 days of active duty service, one (1) day of which is during "wartime" and a last discharge or release under honorable conditions.

**In order to process your application, it is imperative that the entire application and all forms be completed and the following copies provided:**

- **Veteran's DD214 (Honorable discharge or equivalent documentation of military service)**
- **All insurance cards**
- **All financial award letters and proof of income (Employment, Social Security, Aid & Attendance, Veterans Administration, Retirement, etc.)**
- **Proof of Massachusetts residency**
- **Government Issued Photographic Identification (i.e., Mass. Driver's License, etc.)**
- **All healthcare proxy, guardianship, Power of Attorney documents, if applicable**

**You must include, if eligible, Medicare A, B and D or qualifying pharmacy plan. Also, under Massachusetts General Laws Chapter 115, veterans are encouraged to apply for all financial and medical benefits that they are entitled to.**

Please complete, sign, and return all forms and copies of the above to:

Soldiers' Home in Holyoke  
**Attention:** Dorm Social Worker  
110 Cherry Street  
Holyoke, MA 01040

Only upon receipt of the signed, completed forms and all required copies will your application will be processed. Once this process is completed you will be called for an interview.

If you have any questions, please call the Domiciliary Social Worker Carrie Farrant, at 413-552-4736.

SOLDIERS' HOME IN HOLYOKE  
110 CHERRY STREET  
HOLYOKE, MA 01040  
413-532-9475

PLEASE PRINT LEGIBLY

APPLICATION FOR DOMICILIARY PROGRAM

1. <b>NAME</b> _____ FIRST MIDDLE LAST <b>SOCIAL SECURITY NUMBER</b> _____	2. <b>DATE OF APPLICATION</b> _____
--	--

3. <b>CURRENT HOME ADDRESS</b> STREET & NUMBER _____ CITY & STATE _____ ZIP CODE _____ HOME TELEPHONE NO. _____ CELL TELEPHONE NO. _____	4A. <b>SEX</b> M <input type="checkbox"/> F <input type="checkbox"/> 4B. <b>DATE OF BIRTH</b> _____ 4C. <b>RELIGION (OPTIONAL)</b> _____ 4D. <b>RACE (OPTIONAL)</b> _____
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5. <b>BRANCH OF SERVICE</b>	<b>DATE ENTERED ACTIVE DUTY (DD/MM/YYYY)</b>	<b>DATE OF SEPARATION (DD/MM/YYYY)</b>	<b>RANK</b>	<b>TYPE OF DISCHARGE</b>	6. <b>OCCUPATION</b>
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7. **MARITAL STATUS**  
SINGLE  MARRIED  SEPARATED  DIVORCED  WIDOWED   
**NUMBER OF CHILDREN UNDER 18 YEARS OF AGE** \_\_\_\_\_  
**DO YOU CONTRIBUTE TO SUPPORT OF OTHERS?** Yes  No  **IF YES, PLEASE SPECIFY:** \_\_\_\_\_  
**DO YOU USE A SERVICE ANIMAL?** Yes  No  **IF SO, FOR WHAT PURPOSE?** \_\_\_\_\_

8. **NAME AND ADDRESS OF NEXT OF KIN/EMERGENCY CONTACT**

#1 NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY & STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
HOME NUMBER \_\_\_\_\_ CELL PHONE \_\_\_\_\_  
WORK NUMBER \_\_\_\_\_ E-MAIL \_\_\_\_\_

#2 NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY & STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
HOME NUMBER \_\_\_\_\_ CELL PHONE \_\_\_\_\_  
WORK NUMBER \_\_\_\_\_ E-MAIL \_\_\_\_\_

**9. LEGAL ISSUES**

**DO YOU HAVE ANY ACTIVE RESTRAINING ORDERS ANYWHERE, EITHER AGAINST YOU OR AS AN ORDER OF PROTECTION FOR YOU?** YES  NO

**IF SO, PLEASE EXPLAIN** \_\_\_\_\_  
\_\_\_\_\_

**ARE YOU CURRENTLY ON PROBATION OR PAROLE?** YES  NO

**IF YES, NAME OF COURT, PAROLE OFFICER AND CONTACT NUMBER**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HAVE YOU EVER BEEN CONVICTED OF A FELONY?** YES  NO

**IF YES, EXPLAIN**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HAVE YOU EVER BEEN CONVICTED OF ANY OTHER OFFENSE AGAINST THE LAW?** YES  NO

**(\*SEE BELOW BEFORE ANSWERING) IF YES, EXPLAIN**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\* You are not required to furnish information on:

1. Any offense committed prior to your seventeenth (17) birthday, unless such offense was bound over for trial in superior court;
2. A first misdemeanor conviction for drunkenness, simple assault, speeding, minor traffic violations, affray, or disturbance of the peace;
3. A misdemeanor conviction which occurred more than five (5) years ago, unless you have been convicted of any offense within the last five (5) years.
3. A misdemeanor conviction which resulted in a period of incarceration which ended more than five (5) years ago, unless you have been convicted of any offense within the last five (5) years.

**THE ANSWERS TO ALL QUESTIONS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

**Failure to comply will result in discharge from the Program.**

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Signature, title, and telephone number of person  
completing application on behalf of applicant

**10. REFERRED FROM**

FACILITY \_\_\_\_\_

ADDRESS \_\_\_\_\_  
\_\_\_\_\_

**REFERRED BY**

CASE WORKER/SOCIAL WORKER

NAME \_\_\_\_\_

TELEPHONE \_\_\_\_\_

**11. PRE-ARRANGED FUNERAL INFORMATION**

NAME OF FUNERAL HOME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CONTACT PERSON AND TELEPHONE NO. \_\_\_\_\_

12. **FINANCIAL INFORMATION**

SOURCE OF INCOME

(PLEASE MATCH UP SOURCE TO APPROPRIATE NUMBERED LINE)

GROSS **MONTHLY** AMOUNT

- 1. VETERANS ADMINISTRATION:
  - 1A. COMPENSATION (SERVICE CONNECTED) 1A. \_\_\_\_\_
  - 1B. PENSION (NON-SERVICE CONNECTED) 1B. \_\_\_\_\_
- 2. RETIREMENT PENSION 2. \_\_\_\_\_
- 3. SOCIAL SECURITY 3. \_\_\_\_\_
- 4. AID & ATTENDANCE/HOUSE BOUND 4. \_\_\_\_\_
- 5. CHAPTER 115 (MA VETERANS SERVICES) 5. \_\_\_\_\_
- 6. INCOME FROM OTHER SOURCES (DESCRIBE) \_\_\_\_\_ 6. \_\_\_\_\_  
(DIVIDENDS, ANNUITIES, INTEREST ON BANK ACCOUNTS, BONDS, SECURITIES, RENTS)
- 7. TOTAL **MONTHLY** INCOME FROM **ALL** SOURCES 7. \_\_\_\_\_

13. **HEALTH INSURANCE INFORMATION**

TYPE OF HEALTH INSURANCE: (CHECK ALL THAT APPLY)

MEDICARE PART A  MEDICARE PART B  MEDICARE PART D  MEDEX   
BLUE CROSS  OTHER  NONE  MASSHEALTH

MEDICARE CERTIFICATE NUMBER \_\_\_\_\_ EFFECTIVE DATE PART A \_\_\_\_\_ PART B \_\_\_\_\_

MEDEX CERTIFICATE NUMBER \_\_\_\_\_ BLUE CROSS CERTIFICATE NUMBER \_\_\_\_\_

OTHER HEALTH INSURANCE:

SUBSCRIBER'S NAME \_\_\_\_\_

NAME OF PLAN \_\_\_\_\_

ADDRESS OF PLAN \_\_\_\_\_

POLICY NUMBER \_\_\_\_\_

CONTACT PERSON, PHONE NUMBER AND ADDRESS IF PRE-ADMISSION APPROVAL REQUIRED:

\_\_\_\_\_  
\_\_\_\_\_

**PLEASE ATTACH HEALTH CARE PROXY, POWER OF ATTORNEY, GUARDIANSHIP, AND/OR CONSERVATORSHIP, IF APPLICABLE**

I HEREBY AUTHORIZE THE PHYSICIANS AND STAFF OF THE SOLDIERS' HOME IN MASSACHUSETTS TO RENDER SUCH TREATMENT AS IS FOUND NECESSARY AND TO PERFORM ANY EXAMINATION THAT IS DEEMED ADVISABLE.

THE ANSWERS TO ALL QUESTIONS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
SIGNATURE, TITLE AND TELEPHONE NUMBER OF  
PERSON COMPLETING APPLICATION ON BEHALF OF  
APPLICANT

PURPOSE: Please provide in a brief statement on how long you anticipate staying in the Domiciliary and your future goals:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SOLDIERS' HOME IN HOLYOKE MASSACHUSETTS  
DAILY CARE CHARGES**

**RESIDENTIAL/INDEPENDENT LIVING**

Veterans pay \$10.00 per day with a \$300.00 personal exemption from monthly income. Income shall not include VA Aid and Attendance and/or VA Housebound, which shall be retained by the Home. Upon admission, if you are able, we will request that you deposit \$300 in a Soldiers' Home bank account in your name. We will ask that this be replenished back to \$300 at the start of each month.

Please note that charges are billed on a monthly basis and timely payment to the Soldiers' Home is required. The Superintendent has the authority to terminate the stay of a resident for failure to pay the Daily Care Charge.

***WITHOUT NOTICE IN ACCORDANCE WITH COMMONWEALTH OF MASSACHUSETTS REGULATIONS THE AMOUNT OF THE DAILY CARE CHARGE MAY CHANGE ON A PERIODIC BASIS. IT WILL BE EXPECTED THAT YOU PROVIDE UPDATED FINANCIAL INFORMATION ONCE A YEAR VERIFYING YOUR INCOME.***

I UNDERSTAND THE ABOVE CHARGES AND EXPECTATIONS \_\_\_\_\_  
Veteran Signature

**SOLDIERS' HOME IN HOLYOKE  
HEALTHCARE PROVIDER FORM**

Please list all of the healthcare providers who have provided care or treatment to you for the **past three years**. All private, public, state, military and VA hospitals, physicians, clinics and nursing associations should also be included. Try to approximate the date(s) of care as closely as possible.

NAME OF HEALTH CARE PROVIDER/FACILITY	ADDRESS	TELEPHONE	DATE(S) OF CARE

I agree to assist the Soldiers' Home in Holyoke in obtaining my full medical records.

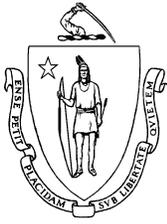
\_\_\_\_\_ Signature \_\_\_\_\_ Date

**Enclosed are medical record request forms to be completed and returned with this application. There should be a form for each facility/healthcare provider listed above. Please use these forms as follows:**

- Department of Veteran Affairs Form 10-5345 to be used **only** for VA facilities (2 copies)
- Authorization for Release of Medical Information (Soldiers' Home form) for all other facilities (3 copies)

If you need additional copies of either the Department of Veteran Affairs Form 10-5345 or the Soldiers' Home Authorization for Release of Medical Information form, please contact the Domiciliary Social Worker at 413-552-4736.





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www.mass.gov/hly/

**PLEASE PRINT CLEARLY**

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

YOUR NAME: \_\_\_\_\_

YOUR ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

I hereby authorize (name of facility) \_\_\_\_\_

to release information from my medical record from the **past 3 years** to: **Soldiers' Home in Holyoke**  
**Attention: Domiciliary Social Worker**  
**110 Cherry Street**  
**Holyoke, MA 01040**

This authorization covers the following records:

1. Records only for my treatment of \_\_\_\_\_

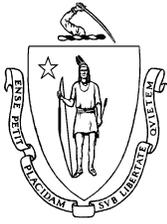
2. Complete copy of medical record.

***This authorization is for continuing care here at the Soldiers' Home in Massachusetts (Holyoke)***

- This authorization covers treatment for Alcohol Abuse, Drug Abuse, Psychiatric Treatment, HIV/AIDS
- The information released to the Soldiers' Home will not be re-disclosed unless:  
A. The patient signs another Authorization for Release; or B. in event of emergency.
- The patient may revoke the authorization in writing, which will be valid, unless action has already been taken on the authorization, and the written revocation will be sent to the Director of Health Information Management
- This authorization expires three (3) months from date signed.
- I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Signature of Patient or Legal Representative \_\_\_\_\_

Printed Name of Patient or Patient Representative \_\_\_\_\_ Date \_\_\_\_\_



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## **AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

YOUR NAME: \_\_\_\_\_

YOUR ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

I hereby authorize (name of facility) \_\_\_\_\_

to release information from my medical record from the **past 3 years** to: **Soldiers' Home in Holyoke**  
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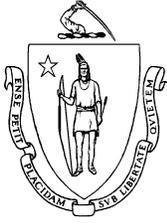
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**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

YOUR NAME: \_\_\_\_\_

YOUR ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

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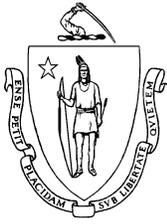
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**STATEMENT OF UNDERSTANDING  
UPON ADMISSION TO  
THE DOMICILARY AT  
THE SOLDIERS' HOME IN HOLYOKE**

This is to acknowledge that I have read and I fully understand and accept the fact that my admission to the Domiciliary at the Soldiers Home in no way carries the implication that I am guaranteed elevation to any other level of care at any time during my stay at the Soldiers' Home in Holyoke.

I accept admission to the Dormitory with the clear understanding and realization that my status as a resident does not entitle me to automatic admittance to the Long Term Care section of the Soldiers' Home. Should my health condition change in the future, I understand that I will have to apply for Long Term Care at the Soldiers Home and may have to seek other living arrangements while awaiting a decision on my application.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



**FOR YOUR CONVENIENCE, WE HAVE PROVIDED THIS CHECK LIST TO INSURE THAT YOU RETURN ALL  
REQUIRED DOCUMENTATION**

<b>COPIES</b>	
DD 214 (honorable discharge or equivalent documentation of military service)	<input type="checkbox"/>
Insurance Cards	<input type="checkbox"/>
Financial Award Letters and Proof of Income (Employment, Social Security, Aid & Attendance, Veterans Administration, Retirement, etc.)	<input type="checkbox"/>
Proof of Massachusetts Residency (License, Utility bill, etc.)	<input type="checkbox"/>
Government Issued Photographic Identification (i.e., Mass. Driver's License, etc.)	<input type="checkbox"/>
Health Care Proxy, Power of Attorney, Guardianship (if applicable)	<input type="checkbox"/>
<b>MEDICATION</b>	
All applicants who are accepted for admission are required to have a minimum of a 2 week supply of all medication.	<input type="checkbox"/>
<b>RELEASES OF INFORMATION</b>	
All applicants must provide signed releases of information allowing Soldiers Home Staff to obtain current and past medical, psychiatric, and substance abuse records.  You may have previously provided such releases prior to receiving this application. If so, please disregard.	<input type="checkbox"/>

**Soldiers' Home in Holyoke  
DOMICILIARY**

**ALL APPLICANTS HAVING A HISTORY OF SUBSTANCE ABUSE AND BEING REFERRED BY A SUBSTANCE ABUSE PROGRAM MUST HAVE A MINIMUM OF 3-MONTHS OF DOCUMENTED SOBRIETY**

**GENERAL INFORMATION**

Referral Program/Agency: \_\_\_\_\_

How long has the participant been involved in the program? \_\_\_\_\_

Contact Person: \_\_\_\_\_

Telephone #: (\_\_\_\_) \_\_\_\_\_ Ext.: \_\_\_\_\_

Address: \_\_\_\_\_

**SUBSTANCE ABUSE HISTORY**

How long has the applicant been alcohol/drug free? \_\_\_\_\_

Drugs of Choice: \_\_\_\_\_

# Detox: \_\_\_\_\_ Most Recent: \_\_\_\_\_ Date: \_\_\_\_\_

# Treatment Programs: \_\_\_\_\_ Most Recent: \_\_\_\_\_ Date: \_\_\_\_\_

# Discharges: \_\_\_\_\_ Reason: \_\_\_\_\_

Longest period of sobriety: \_\_\_\_\_

Any self Help (AA/NA) community group involvement? \_\_\_\_\_

Substance Abuse service needs: \_\_\_\_\_

**MEDICAL/MENTAL HEALTH**

Does the applicant have a current or past history of outstanding medical or mental illness for which they receive health services?

YES  NO

Outstanding Medical Conditions \_\_\_\_\_

Medications \_\_\_\_\_

Outstanding Mental Health Conditions \_\_\_\_\_

Medications \_\_\_\_\_

Allergies \_\_\_\_\_

Most Recent PPD Test Date \_\_\_\_\_ Results \_\_\_\_\_

Mass Health: YES  NO

Primary Care Provider: \_\_\_\_\_

**EMPLOYMENT/JOB TRAINING/VOLUNTEER**

Last Job: \_\_\_\_\_ Date: \_\_\_\_\_

Other Skills/Training:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**WAIT LIST PROCEDURE**

In the event the program is full, the Domiciliary Social Worker will use the following procedures to determine the status of applicants. Applicants who are interviewed and accepted by the admission team will be placed on the Domiciliary wait-list for the Soldiers Home according to the date of their application.

IF THE APPLICANT HAS LEFT THEIR PROGRAM OR FOUND ALTERNATIVE HOUSING, THE DOMICILIARY SOCIAL WORKER SHOULD BE NOTIFIED IMMEDIATELY.

Applicants will be grouped according to the week they received an interview with the Domiciliary Social Worker. As beds become available, they will be filled from the Acceptance Waiting List. A random urinalysis will be requested at the date of a scheduled move in.

We look forward to hearing from you and please contact the Domiciliary Social Worker at (413) 552-4736 if you should have any questions.