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/

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 Forrant, 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. **NAME** _____
FIRST MIDDLE LAST

SOCIAL SECURITY NUMBER _____

2. **DATE OF APPLICATION**

3. **CURRENT HOME ADDRESS**

STREET & NUMBER _____

CITY & STATE _____

ZIP CODE _____

HOME TELEPHONE NO. _____

CELL TELEPHONE NO. _____

4A. **SEX** M ☐ F ☐

4B. **DATE OF BIRTH**

_____

4C. **RELIGION (OPTIONAL)**

_____

4D. **RACE (OPTIONAL)**

_____

5. **BRANCH OF SERVICE**	**DATE ENTERED ACTIVE DUTY** (DD/MM/YYYY)	**DATE OF SEPARATION** (DD/MM/YYYY)	**RANK**	**TYPE OF DISCHARGE**	6. **OCCUPATION**

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.

Privacy Act and Paperwork Reduction Act Information. The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA19 "Patient Medical Record – VA" and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED

TO: DEPARTMENT OF VETERAN AFFAIRS (*Print or type name and address of health care facility)*	PATIENT NAME (*Last, First, Middle Initial)*
	SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Soldiers' Home **Attn: Domiciliary Social Worker**
110 Cherry Street
Holyoke, MA 01040

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☐ OTHER (*Specify)*

For the past 3 years.

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

For admission to the Soldiers' Home.

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____(date supplied by patient); or (3) under the following condition(s):

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

DATE	SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (***Attach authority to sign, e.g., POA***)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter *Name, Address, Social Security Number)*	**TYPE AND EXTENT OF MATERIAL RELEASED**	
	DATE RELEASED	RELEASED BY

VA FORM
MAY 2005 **10-5345** USE EXISTING STOCK OF VA FORM 10-5345, DATED NOV 2004.

OMB Number: 2900-0260
Estimated burden: 2 minutes

VA Department of Veterans Affairs	**REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION**

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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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PLEASE PRINT CLEARLY

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

YOUR NAME: _____

YOUR ADDRESS: _____

_____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

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YOUR ADDRESS: _____

_____

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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

The Commonwealth of Massachusetts

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Soldiers' Home in Holyoke
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Holyoke, MA 01040-2829

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CORI REQUEST FORM

The Executive Office of Health and Human Services has been certified by the Criminal History Systems Board for access to conviction and pending criminal case data. As a residential applicant, I understand that a criminal offender record information (CORI) check will be conducted for conviction and pending criminal case information only and that such information will not necessarily disqualify me. The information below is correct to the best of my knowledge.

_____
APPLICANT SIGNATURE (unless otherwise preempted by law)

RESIDENTIAL APPLICANT INFORMATION (PLEASE PRINT)

_____ _____ _____
LAST NAME FIRST NAME MIDDLE NAME

_____ _____
MAIDEN NAME OR ALIAS (IF APPLICABLE) PLACE OF BIRTH

_____ _____ - _____ - _____ _____
DATE OF BIRTH SOCIAL SECURITY NUMBER ID Theft Index PIN (if applicable)*

_____
MOTHER'S MAIDEN NAME

CURRENT AND FORMER ADDRESSES:

_____

_____

_____

SEX: _____ HEIGHT: _____ft. _____in. WEIGHT: _____ EYE COLOR: _____

STATE DRIVER'S LICENSE NUMBER: _____
(include state of issue)

THE ABOVE INFORMATION WAS VERIFIED BY REVIEWING THE FOLLOWING FORM OF GOVERNMENT ISSUED PHOTOGRAPHIC IDENTIFICATION: _____

REQUESTED BY: _____
SIGNATURE OF CORI AUTHORIZED EMPLOYEE

*The CHSB Identity Theft Index PIN Number is to be completed by those applicants that have been issued an identity Theft PIN Number by the CHSB. Certified agencies are required to provide all applicants the opportunity to include this information to ensure the accuracy of the CORI request process. **All CORI request forms that include this field are required to be submitted to the CHSB via mail or by fax to 617-660-4614.**

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

COPIES	
DD 214 (honorable discharge or equivalent documentation of military service)	☐
Insurance Cards	☐
Financial Award Letters and Proof of Income (Employment, Social Security, Aid & Attendance, Veterans Administration, Retirement, etc.)	☐
Proof of Massachusetts Residency (License, Utility bill, etc.)	☐
Government Issued Photographic Identification (i.e., Mass. Driver's License, etc.)	☐
Health Care Proxy, Power of Attorney, Guardianship (if applicable)	☐
MEDICATION	
All applicants who are accepted for admission are required to have a minimum of a 2 week supply of all medication.	☐
RELEASES OF INFORMATION	
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.	☐

Soldiers' Home in Holyoke
DOMICILIARY

ALL APPLICANTS HAVING A HISTORY OF SUBSTANCE ABUSE AND BEING REFERRED BY A SUBSTANCE ABUSE PROGRAM MUST HAVE A MININIMUM 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.