COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF VETERANS SERVICES
Massachusetts Veterans Home at Holyoke
110 Cherry Street
Holyoke, MA 01040-2829
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mass.gov/HLY

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EXECUTIVE DIRECTOR

Massachusetts Veterans Home at Holyoke
Long-Term Care Admission Application

Thank you for your interest in the Veterans Home at Holyoke. At the Veterans Home at Holyoke, our mission is to provide ‘Care with Honor, Dignity, and Respect’ in the best possible health care environment for eligible veterans who reside in the Commonwealth of Massachusetts. To be eligible to apply for admission, a veteran must be a resident of the Commonwealth and be able to provide proof of an honorable discharge from the armed forces, as well as demonstrate a need for long term care placement as defined by CMS ref: 42 CFR § 483.24 Quality of Life. See appendix for LTC SNF Admissions Screening Checklist: Level 4 Long Term Care Custodial. Long Term Care (LTC) / Skilled Nursing Facility (SNF).

The first step in the process is to complete this application for admission. The application must be filled out in its entirety, with the most accurate information possible. It must be signed at the end of the application by the veteran applicant or by one of the following individuals: Legal Guardian or Invoked Health Care Proxy. If this application is filled out by either of these, we require a copy of the invoked health care proxy or guardianship papers.

Once completed and signed, please return the application along with the following required documents:

- ☐ Copy of the veteran’s military separation papers – known as DD Form 214
- ☐ Copy of Health Care Proxy
- ☐ Proof of veteran’s residency. Examples include valid Massachusetts driver’s license; official Mass ID card; registered voter status letter; utility bill or other bill from veteran’s current residence; Massachusetts income tax return.
- ☐ Completed veteran medical information (enclosed form) and all requested medical documents
- ☐ Enclosed receipt of HIPAA policy
- ☐ A copy (front and back) of all health insurance and prescription cards (this includes Medicare).
- ☐ Signed Primary Care Provider’s Order for Long-Term Care
- ☐ Medicare Secondary Payer Questionnaire: Enclosed - Please complete the entire form to the best of your ability
- ☐ Completed Financial Worksheet

You may return completed application and required documents by:

Fax: 413-552-4757 Attn: Admitting
U.S. Mail: Veterans Home at Holyoke, 110 Cherry Street, Holyoke, MA 01040
In person: Admitting Office

We are happy to assist you in the process.

If, at any time, you have any questions about this process, please do not hesitate to contact us directly at 413-552-4764.

Thank you again for your interest in admission to the Veterans Home. We look forward to receiving your complete materials and are happy to answer any questions you may have throughout the process.

Sincerely,

The Admissions Team
413-552-4764

Veterans Home at Holyoke Long-Term Care Admission Application

Veteran Name: ____ Date of Birth: __________________

Address: ____

City: ________________________ State: ________________ Zip: ____________________

SS#: ________________________ Gender: ________________ Religion: ______________________

Height: ______ Weight: ______ Preferred language, if other than English: _______________________

Marital Status: ☐Married ☐Divorced ☐Widowed ☐Never Married ☐Separated

No individual will be denied admission, care, or any other benefit provided by the Commonwealth of Massachusetts on the grounds of race, color, creed, age, sex, differently abled, national origin or ability to pay.

Best contact person regarding this application

Name: ____

Relationship: ____

Address: ____

City: ________________________ State: ________________ Zip: ____________________

Phone Number: ____

Email Address: ____

How do you prefer to communicate? ☐Telephone ☐U.S. Mail ☐Email

Does the veteran have any industrial or automobile accident litigation pending or activity involving insurance and liability of another, i.e. Workers' Comp? ☐ Yes ☐No

Does the veteran have a service-connected disability rating from the VA? ☐Yes ☐No

***If YES**, please provide a document from the VA indicating the percentage.* ______________________

Where is the veteran currently residing?

☐In own residence with adult companion
☐Home alone
☐In a long-term care facility/hospital

Name of Facility: ____
How long has the veteran resided there? ______________________________________
On which type of unit does the veteran reside? (Secure, etc.) ______________________

☐Other ____

Communication and Contact Information

I ____________________________________ give my permission for the Veterans Home at Holyoke to discuss my application with the following people:

Contact Person:

Name: ____

Relationship: ____

Address: ____

City, State, Zip: ____

Phone Number: ____

Email Address Required: ____

Preferred communication? ☐ Telephone ☐ U.S. Mail ☐ Email ☐ Text

Contact Person:

Name: ____

Relationship: ____

Address: ____

City, State, Zip: ____

Phone Number: ____

Email Address Required: ____

Preferred communication? ☐ Telephone ☐ U.S. Mail ☐ Email ☐ Text

Financially Responsible Person:

Name: ____

Relationship: ____

Address: ____

City, State, Zip: ____

Phone Number: ____

Email Address Required: ____

Preferred communication? ☐ Telephone ☐ U.S. Mail ☐ Email ☐ Text

Demographic Information

State regulations (801 CMR 8.00) require that we ask applicants for their demographic information (race and ethnicity). You are not required to provide this information but are encouraged to do so. You may select one or more designations for race and/or ethnicity. The law provides that we may not discriminate based on this information, or on whether you choose to provide it. This information will not be used in determining your eligibility for admission. **If you do not wish to provide some or all of this information, please check below.**

The Home does not discriminate based on race, color, religious creed, national origin, sex, sexual orientation, gender identity, genetic information, ancestry, age, or disability.

Asian

☐ Chinese
☐ Japanese
☐ Filipino
☐ Korean
☐ Vietnamese
☐ Asian Indian
☐ Laotian
☐ Cambodian
☐ Bangladeshi
☐ Hmong
☐ Indonesian
☐ Malaysian
☐ Pakistani
☐ Sri Lankan
☐ Taiwanese
☐ Nepalese
☐ Burmese
☐ Tibetan
☐ Thai
☐ Other Asian (Please Specify)

____

Pacific Islander

☐ Native Hawaiian
☐ Guamanian
☐ Samoan
☐ Fijian
☐ Tongan
☐ Chamorro
☐ Marshallese
☐ Other Pacific Islander (Please Specify)

____

African American

☐ African American
☐ Jamaican
☐ Haitian
☐ Nigerian
☐ Ethiopian
☐ Cape Verdean
☐ Somali
☐ Other African American (Please Specify)

____

Latino

☐ Mexican
☐ Puerto Rican
☐ Cuban
☐ Salvadoran
☐ Dominican
☐ Colombian
☐ Guatemalan
☐ Other Latino (Please Specify)

____

Caucasian

☐ German
☐ Irish
☐ English
☐ Italian
☐ Polish
☐ Portuguese
☐ French
☐ Scottish
☐ Russian
☐ Other Caucasian (Please Specify)

____

American Indian or Alaska Native

☐ Navajo Nation
☐ Blackfeet Tribe of the Blackfeet Indian Reservation of Montana
☐ Native Village of Barrow Inupiat Traditional Government
☐ Nome Eskimo Community
☐ Aztec
☐ Maya
☐ Other American Indian or Alaska Native (Please Specify)
____

☐ Other Race or Ethnicity (Please Specify) ____________________________________
☐ Do not wish to answer

____
Please Print Resident Veteran / Legal Representative

____ _____________________
Signature

Funeral Arrangements

Name of Funeral Home: ____

Address: ____

Phone Number: ____

Admissions Application Signature

In compliance with the eligibility requirement, I do hereby apply for admission to the Veterans Home at Holyoke, a long-term care facility for veterans, and I declare the following statement to be true: I, the undersigned, am a resident of the State of Massachusetts in accordance with M.G.L. c. 4, sec.7, cl. 43rd as amended by the Acts of 2005, ch.130.
Pursuant to the Federal Privacy Act of 1974, you are hereby notified that disclosure of your social security number is mandatory. Disclosure of the social security number is required pursuant to 38 CFR §1.575(b), 108 CMR 4.03, and M.G.L. Chapter 115, § 4. The social security number is used to verify your identity.

All information gathered in this form is considered protected health information and will only be used as outlined in the Health Insurance Portability and Accountability Act (HIPAA) Privacy Notice, which you will receive and sign acknowledgment thirty (30) days prior to admission.

This application is true and complete to the best of my knowledge.

Signature: ____

Printed Name: _________________________________ Date: ________________

Signed by:
☐Veteran
☐Invoked Health Care Proxy
☐Legal Guardian

A reminder: All documents must be signed by the veteran, unless the veteran's Health Care Proxy has been invoked, or if the veteran has a court appointed legal guardian.

If a health care provider has determined the veteran lacks the capacity to make medical decisions, a signed order from the provider must be submitted with this application. The Health Care Proxy will be responsible for signing appropriate documents.

Veterans Home at Holyoke - Medicare Secondary Payer Questionnaire

Veteran's Name: ____

Veterans' Home Number (if known):____________________________

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 NO, never employed: ☐Yes ☐No

3. Do you have employer group health plan coverage? ☐Yes ☐No

If YES, insurer name and address: ______________________________

Policy Number: ___________________________

Group Number: ___________________________

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 name and address: ______________________________

If NO, date of retirement, if applicable: _________________________

If NO, Never Employed? ☐Yes ☐No

5. Are you covered under your spouse's Employee Group Health Insurance Plan (EGHP)? ☐Yes ☐No

If YES, insurer name and address: ______________________________

Policy Number: ___________________________

Group Number: ___________________________

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 paid by Government Research program? ☐Yes ☐No

8. Has the Dept. of Veterans Affairs (VA) 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 Number: _________________________ 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 number: _____________________________ Is liability insurance available? ☐Yes ☐No

Name and address of Liability Insurer: ____

____

Name and address of Responsible party: ____

____

Insurance claim number: _______________________________

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

Is the applicant entitled to Medicare solely based on ESRD? ☐Yes ☐No

Please contact our Billing Department with questions about this document. 413-552-4709

Veterans Home at Holyoke – Financial Information Worksheet

Gross Income From All Resources: Proof of ALL income must be provided – (Copy of most recent Federal Income Tax Return, copies of all bank, retirement, Social Security, VA – within last 60 days).

Income Source	Monthly Income Amount from Veteran	Monthly Income Amount from Spouse/Other
VA Award - Provide Pension Award Letter and copy of VA check/amount deposited in account		
VA Service Connected or Non-Service Pension or Housebound Aid & Attendance		
Social Security Benefits - Provide Copy of Benefit Statement(s)		
Social security (not SSI)		
Social Security Disability		
Retirement Income- Provide 1099-R		
Annuity Income - Provide 1099 and/or End of Year Statement		
IRA Distributions - Provide 1099-R and/or End of Year Statement		
Interest Income Provide 1099-INT		
Dividend Income - Provide 1099R/1099INT		
Wages or Salary - Provide W-2		
Unemployment Benefits		
Savings Account Balance		
Checking Account Balance		
Other (please list & describe)		

Marital Status: ☐Married ☐Divorced ☐Widowed ☐Never Married ☐Separated

To the best of my knowledge, the information provided herein is complete and accurate. I understand that providing erroneous, inaccurate or incomplete information could result in room and board charges being retroactively applied to my account.

____ ____________________________

Signature of veteran, or person authorized to sign for veteran Date

Part 10 – Eligibility Requirement

In compliance with the eligibility requirement, I do hereby apply for admission to the Veterans Home at Holyoke, veterans' long-term care facility and declare the following statements and information to be true.

Residence Certificate for State of Massachusetts

I, the undersigned, am a resident of the State of Massachusetts in accordance with M.G.L. c. 4, sec.7, cl. 43rd as amended by the Acts of 2005, ch.130.

____ ____________________________

Signature of Applicant

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Primary Care Provider's Order for Long-Term Care

Name and Address of Primary Care Provider:

____
____
____
____ Date: __________________

The patient whose name is listed below is medically and socially appropriate for residing in the Veterans Home at Holyoke, a Long-Term Care facility.

As of the date noted above, I am the Primary Care Provider for:

____
Full name of Veteran

Respectfully,

____
Signature of Provider

ADM-040

Veterans Home at Holyoke - Veteran Medical Information Update Request

Name: ____________________________________ DOB:_______________ Date:_______________

Has the veteran had COVID-19? ☐ Yes, when? _____ ☐ No

Please provide current vaccination dates: ____

Does the veteran have a history of falls? ☐ Yes ☐ No ______________________________________

Has the veteran had a recent fall? ☐ Yes ☐ No When was the last fall? ______________________

Does veteran currently have history of wandering outside of residence, gets lost or exit seeks?

☐Yes ☐ No If yes, of what nature? ____

Does the veteran have a history of cognitive deficits? (Impaired judgment, impulsivity, forgetfulness)

☐ Yes ☐ No If yes, please describe: ____

Is the veteran combative with care? ☐ Yes ☐ No If yes, please describe: ______________________

Does the veteran have a mental health diagnosis? (Suicidality, depression, PTSD, anxiety, hallucinations)

☐ Yes ☐ No If yes, of what nature? ____

Have these issues been treated? ☐ Yes ☐ No

Does the veteran have a history of substance abuse issues? ☐ Yes ☐ No

If yes, of what nature? ____

Are these issues active? ☐ Yes ☐ No
Have these issues been treated? ☐ Yes ☐ No

How often does the veteran drink alcohol? ____

Does the veteran smoke or consume marijuana? ☐ Yes ☐ No

Does the veteran smoke cigarettes? ☐ Yes ☐ No

- **The Veterans Home at Holyoke is a smoke-free facility. No veteran resident, visitor or staff of the VHH may engage in tobacco use on the VHH grounds.**

Does the veteran have a history of aggression or assault? ☐ Yes ☐ No
If yes, of what nature? ____

Are there any other unique or special circumstances or needs you feel we should be aware of such as equipment for mobility or personal care, medical supplies, adaptive equipment, daily rituals, etc.

____

Require Medical Treatments: ☐ oxygen ☐ CPAP ☐ nebulizer ☐ dialysis ☐ wound care ☐ catheter

☐ ostomy ☐ feeding tube ☐ Other: ____

Use Equipment: ☐ cane ☐ walker ☐wheelchair ☐ prosthesis ☐ hearing aids ☐ eyeglasses ☐ dentures

Others: ____

Required Therapies: ☐ occupational ☐ physical ☐ speech ☐ nutritional Other: ___________________

Dietary Needs: (swallowing issues/restrictions/intolerance/special needs/ground/puree):

☐ Yes ☐ No ☐ Unknown

If yes, list: ____

____

Does veteran have problems with memory? ☐ Yes ☐ No ☐ Unknown

Does veteran have a Rogers Order? ☐ Yes ☐ No ☐ Unknown

Any Safety Concerns: ____

____

Please describe the veteran's level of function and/or assistance required in the following areas: Category 3-6 (**BOLD**) are considered criteria for LTC qualification by CMS regulation.

1. Ambulation: ☐ Independent ☐ Supervision ☐ Hands on assistance
2. Assistive devices needed for ambulation: ☐ Cane ☐ Walker ☐ Wheelchair
3. **Bathing:** ☐ Independent ☐ Supervision ☐ Hands on assistance
4. **Dressing/Undressing:** ☐ Independent ☐ Supervision ☐ Hands on assistance
5. **Toileting:** ☐ Independent ☐ Supervision ☐ Hands on assistance
6. **Eating:** ☐ Independent ☐ Supervision ☐ Hands on assistance
7. Mobility outside of residence: ☐ Independent ☐ Supervision ☐ Hands on assistance

You must provide us with the following updated medical information from your medical provider & care facility for this application:

- ☐ Current medication list
- ☐ Current Diagnosis list
- ☐ Most recent physical exam
- ☐ Most recent progress note
- ☐ Immunization Record to include COVID-19 & boosters
- ☐ Clinical Specialists Consults
- ☐ Psychiatric/Behavioral Consult
- ☐ Most Recent Nurses Notes
- ☐ Fall Risk & Number of Falls
- ☐ Elopement Risk

The above documents can be:

Faxed to:
413-552-4757

Emailed to:
Magaly.King@mass.gov (Admissions Coordinator) or,
David.DesLauriers@mass.gov (RN Clinical Coordinator)

Mailed to:
Veterans Home at Holyoke
110 Cherry Street
Holyoke, MA, 01040
Attn: Admissions

If assistance is needed, please feel free to call 413-532-9475 and ask to speak with the Admissions Department.

Appendix

Long-Term Care Skilled Nursing Facility Admissions Screening Checklist

Level	Check all that Apply
Level 2 Skilled Nursing Immediate	☐ IV Medications or fluids ☐ Complex wound care ☐ New feeding tube ☐ Recent major surgery ☐ Oxygen dependent with frequent treatments ☐ Dialysis ☐ Total assist with transfers ☐ Two person assist with bed mobility CMS Ref: 42 CFR § 409.31 to § 409.33 Skilled Services
Level 3 Skilled Nursing Routine	☐ PT OT ST needed ☐ Stable wound care ☐ Medication management ☐ Post acute weakness or deconditioning ☐ Stand by or one person assist transfers ☐ Limited ambulation with device ☐ Set up assist for meals CMS Ref: 42 CFR § 483.65 and § 409.31
Level 4 Long-Term Care Custodial	☐ Bathing assist ☐ Dressing assist ☐ Toileting assist ☐ Incontinence care ☐ Eating cueing ☐ Dementia supervision ☐ Long-term placement request CMS Ref: 42 CFR § 483.24 Quality of Life
Non-Qualifying	☐ Independent with bathing, dressing, toileting ☐ Ambulates independently or with device ☐ Manages medications independently ☐ No daily skilled needs CMS Ref: Does not meet 42 CFR C 409 skilled criteria

CMS Regulatory References Used

42 CFR § 409.31 to § 409.33 Skilled nursing and therapy service requirements.
42 CFR § 483.24 Quality of life and person-centered care.
42 CFR § 483.30 Nursing services staffing and competency.
42 CFR § 483.70 Facility administration and admission practices.