THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF VETERANS SERVICES
Massachusetts Veterans Home at Chelsea
100 Summit Ave., Chelsea, MA 02150
TEL: (617) 884-5660 FAX: (617) 884-1162
www.mass.gov/che • www.mass.gov/veterans

MAURA T. HEALEY
GOVERNOR

JON SANTIAGO, MD, MPH
SECRETARY, EOVS

KIMBERLEY DRISCOLL
LIEUTENANT GOVERNOR

CHRISTINE BALDINI
SUPERINTENDENT

Thank you for your interest regarding admission to the Skilled Nursing Facility for Long Term Care (nursing home) at the Massachusetts Veterans Home at Chelsea. This application and forms must be completed to start the admissions process. Eligibility for admission is based on state law. Applicant 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.

To process your application, it is imperative that the entire application and all forms be completed, and the following copies provided:

- **Veterans DD214 (Honorable discharge or equivalent documentation of military service)**
- **A written order from the veterans Primary Care Physician who designates that placement for Long-term care is medically and socially appropriate.**
- **All insurance cards.**
- **All financial award letters and proof of income (Employment, Social Security, Aid & Attendance, Veterans Administration, Retirement, one month bank statement etc.)**
- **Proof of Massachusetts residency**
- **Government issued Photographic Identification (i.e., Mass Drivers License, etc.)**
- **Healthcare Proxy and Guardianship, Power of Attorney documents, if applicable**

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

Please complete, sign, and mail to the address at the top of this letter, Attention Admissions or you can email it to Admissions Coordinator Janieka Jones at Janieka.Jones2@mass.gov. If you have any questions, please call the Admissions Office at 617-887-7146.

Upon receipt of your application, if it meets the admission criteria, you will be placed on a bed availability waiting list. The demand for beds far exceeds the availability often resulting in a substantial delay between the time of application and actual admission of the patient. A screening will take place sometime between application and admission. At that time, a nurse from the Home will conduct an assessment for appropriateness.

Remember, the application and forms must be completed, and copies of all required documentation (listed above) must be provided, or your application will not be processed and will be returned to you.

WE ARE A SMOKE-FREE FACILITY

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

COPIES	√
DD 214 (honorable discharge or equivalent documentation of military service)	
A written order from the veterans Primary Care Physician who designates that placement for Long-term care is medically and socially appropriate.	
All Insurance Cards	
Financial Award Letters and Proof of Income (Employment, Social Security, Aid & Attendance, Veterans Administration, Retirement, one month bank statement etc.)	
If applicable, copy of VA award letter proving service connection	
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)	
Department of Veterans Affairs Application for Health Benefits-**10-10EZ form**	

WE ARE A SMOKE-FREE FACILITY

MASSACHUSETTS VETERANS HOME AT CHELSEA
100 SUMMIT AVE.
CHELSEA, MA 02150
617-887-7146

FILL OUT COMPLETELY, NO BLANK SPACES, IF NOT APPLICABLE, PUT "N/A"

PLEASE CHECK LEVEL OF CARE NEEDED: LTC _____ MEMORY LOSS CARE _____

1. **NAME**: _____ _____ _____
FIRST MIDDLE LAST

SOCIAL SECURITY NUMBER: _____

Where is the veteran now? (circle one) Home Long Term Care Hospital

2. **DATE OF APPLICATION**

3. **CURRENT HOME ADDRESS**

NAME OF FACILITY (IF APPLICABLE) _____

NUMBER AND STREET _____ APT# _____

CITY, STATE & ZIP CODE _____ _____

HOME TELEPHONE NO. _____

CELL TELEPHONE NO. _____

EMAIL: _____

4A. **SEX M ( ) F ( )**

4B. **DATE OF BIRTH (MM/DD/YYYY)**

_____

4C. **RELIGION**

_____

4D. **RACE (OPTIONAL)**

_____

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

7. **ARE YOU SERVICE CONNECTED (CIRCLE WHAT APPLIES)** Y N **IF Y, WHAT PERCENTAGE?** _____%

8. **MARITAL STATUS (CIRCLE WHAT APPLIES)** SINGLE MARRIED SEPARATED DIVORCED WIDOWED

9. **FIRST CONTACT**

NAME _____

RELATIONSHIP _____

ADDRESS _____

CITY & STATE_____ ZIP CODE_____

HOME NUMBER _____ CELL NUMBER_____

WORK NUMBER _____ EMAIL_____

10. **SECOND CONTACT**

NAME _____

RELATIONSHIP _____

ADDRESS _____

CITY & STATE_____ ZIP CODE_____

HOME NUMBER _____ CELL NUMBER_____

WORK NUMBER _____ EMAIL_____

WE ARE A SMOKE-FREE FACILITY

11. **PRE-ARRANGED FUNERAL INFORMATION**

NAME OF FUNERAL PARLOR _____

ADDRESS _____

CONTACT PERSON AND PHONE NO. _____

12. **FINANCIAL INFORMATION**

GROSS MONTHLY INCOME		VETERAN	SPOUSE
1. SOCIAL SECURITY	1.		
2. VA SERVICE-CONNECTED COMPENSATION	2.		
3. VA NON SERVICE CONNECTED COMPENSATION	3.		
4. VA AID AND ATTENDANCE/HOUSEBOUND BENEFITS	4.		
5. MILITARY RETIREMENT	5.		
6. OTHER RETIREMENT (Company, State, Local, etc.)	6.		
7. Regular distributions from CD's, IRA's, Money Market Funds, Rental Income	8.		
8. INTEREST INCOME:	9.		
TOTAL:			

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

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

WE ARE A SMOKE-FREE FACILITY

Funeral/Burial Arrangements

I DO have Funeral arrangements completed: ☐

I DO NOT have Funeral arrangements made at this time: ☐

I have Funeral arrangements in process currently: ☐

Paperwork of arrangements provided: ☐

Name of Funeral Home:

Address:

Contact Person:

WE ARE A SMOKE-FREE FACILITY

MASSCHUSETTS VETERANS HOME AT CHELSEA
DAILY CARE CHARGES

LONG TERM CARE (NURSING HOME)/MEMORY LOSS CARE

*Veteran without spouse is charged a daily care charge of $30.00 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.

*Veteran with spouse is charged a daily care charge of $30.00 per day with a spousal exemption of $1,500.00 from income combined of Veteran and spouse. Income shall not include VA Aid and Attendance and/or VA Housebound, which shall be retained by the Home.

Please note any Veteran who provides an award letter from the VA indicating he/she is 70% service connected or higher is exempt from any daily care charge no matter of marital status.

Charges are billed monthly and timely payment to the Massachusetts Veterans Home at Chelsea is required. The Superintendent has the authority to terminate the stay of a patient/resident for failure to pay the Daily care charge.

THE AMOUNT OF THE DAILY CARE CHARGE MAY CHANGE ON A PERIODIC BASIS WITHOUT NOTICE IN ACCORDANCE WITH THE COMMONWEALTH OF MASSACHUSETTS REGULATIONS.

***Income verification will be requested periodically.**

WE ARE A SMOKE-FREE FACILITY

TO WHOM SHOULD WE SEND MAIL/BILLS

Name of veteran: _____

Please give/send mail, including all bills, to: (check one below):

***Please note we are only able to send mail to one person and cannot split certain mailing items between different parties.*

____ Veteran

____ Other

If other checked, please list address where mail will be sent to:

_____
Name

_____ Apt#_____
Address

_____ _____
City State, Zip code

Home phone: _____

Cell phone: _____

Email: _____

WE ARE A SMOKE-FREE FACILITY

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF VETERANS SERVICES
Massachusetts Veterans Home at Chelsea
100 Summit Ave., Chelsea, MA 02150
TEL: (617) 884-5660 FAX: (617) 884-1162
www.mass.gov/che • www.mass.gov/veterans

MAURA T. HEALEY
GOVERNOR

JON SANTIAGO, MD, MPH
SECRETARY, EOVS

KIMBERLEY DRISCOLL
LIEUTENANT GOVERNOR

CHRISTINE BALDINI
SUPERINTENDENT

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 long-term care 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)

LONG TERM CARE 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.**

WE ARE A SMOKE-FREE FACILITY

HAVE YOU EVER BEEN CONVICTED OF A FELONY? Y N
IF YES, EXPLAIN:

HAVE YOU EVER BEEN CONVICTED OF ANY OTHER OFFENSE AGAINST THE LAW? (*See below before answering). Y N
IF YES, EXPLAIN:

DATE OF COURT OFFENSE: DISPOSITION:

---

*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;

4. 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 THE 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 the Applicant

WE ARE A SMOKE-FREE FACILITY