

Texas State Veterans Homes

Application for Admission



George P. Bush, Chairman

For assistance, please contact the Texas Veterans Land Board
toll free at 1-800-252-VETS (8387)
Last Update: 5/17/2017

Texas Veterans Land Board • George P. Bush, Chairman
Stephen F. Austin Building ♦ 1700 North Congress Avenue ♦ Austin, Texas 78701-1496
P.O. Box 12873 ♦ Austin, Texas 78711-2873
512.463.5060 ♦ 800.252.VETS ♦ Fax: 512.463.1425
texasveterans.com

TEXAS STATE VETERANS HOMES

AMARILLO - BIG SPRING - BONHAM - EL PASO - FLORESVILLE - MCALLEN - TEMPLE - TYLER

Thank you for making an application to a Texas State Veterans Home. Please attach a copy of the veteran's discharge document (DD 214 or equivalent). If acting on behalf of the proposed resident, also attach a copy of guardianship documentation or a signed durable medical power of attorney. For your own security, applications are not accepted online due to the personal nature of the information contained in them. You will need to hand deliver, mail, or fax the application directly to the home of choice.

If you have questions as you are completing the application, please contact the home directly, or call the Texas Veterans Land Board at 1-800-252-VETS (8387).

Ussery-Roan
Texas State Veterans Home
1020 Tascosa Road Amarillo,
Texas 79124-1504
Phone: 806-322-VETS (8387)
Fax: 806-322-8388

Frank M. Tejada
Texas State Veterans Home
200 Veterans Drive
Floresville, Texas 78114-2709
Phone: 830-216-9456
Fax: 830-393-7764

Lamun-Lusk-Sanchez Texas
State Veterans Home 1809
North Highway 87
Big Spring, Texas 79720-0793
Phone: 432-268-VETS (8387)
Fax: 432-268-1987

Alfredo Gonzalez
Texas State Veterans Home
301 E. Yuma Avenue
McAllen, Texas 78503-1388
Phone: 956-682-4224
Fax: 956-682-4668

Clyde W. Cospers
Texas State Veterans Home
1300 Seven Oaks Road
Bonham, Texas 75418-3254
Phone: 903-640-VETS (8387)
Fax: 903-640-4281

William R. Courtney
Texas State Veterans Home
1424 Martin Luther King Jr. Lane
Temple, Texas 76504-5941
Phone: 254-791-8280
Fax: 254-791-0262

Ambrosio Guillen
Texas State Veterans Home
9650 Kenworthy Street
El Paso, Texas 79924-6011
Phone: 915-751-0967
Fax: 915-751-0980

Watkins-Logan
Texas State Veterans Home
11466 Honor Lane
Tyler, Texas 75708-3296
Phone: 903-617-6150
Fax: 903-617-6498

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APPLICATION FOR ADMISSION

Today's Date _____

This application is for placement in the veterans home located in _____

Applicant's Name _____

Category: Veteran _____ Spouse _____ Surviving Spouse _____ Gold Star Parent _____

PERSONAL INFORMATION

How did you hear about Texas State Veterans Homes? _____

Applicant's Name _____

Date of Birth _____ Current Age _____ Gender: M _____ F _____

VA Claim # _____ Social Security Number _____

Marital Status _____ Spouse's Name _____

Permanent Address _____
(Street) (City) (State) (Zip Code)

Email Address _____

Home Phone _____ Other Phone _____

Present Location of Applicant: Home _____ Hospital _____ Nursing Facility _____ Other _____
Current Address (If applicant resides other than at home, please provide the name, address and telephone number of the hospital, nursing facility or other location. Please insert on line below.)

Primary Responsible Party (party who handles applicant's financial and/or medical affairs)

Name _____ Relationship _____ Financial _____ Medical _____

Address _____

Home Phone _____ Other Phone _____

Legal Relationship: Self _____ Power of Attorney _____ Legal Guardian _____ Surrogate Decision Maker _____

Secondary Responsible Party (party who handles applicant's financial and/or medical affairs)

Name _____ Relationship _____ Financial _____ Medical _____

Address _____

Home Phone _____ Other Phone _____

Legal Relationship: Self _____ Power of Attorney _____ Legal Guardian _____ Surrogate Decision Maker _____

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MEDICAL INFORMATION

Primary Physician _____

Address _____

Phone _____ Fax _____

Is your physician willing to come to the Texas State Veterans Home to continue caring for you?

Yes _____ No _____

Diagnosis Requiring Long-Term Care *(attach copy of medical records or fill out completely)*

Other Pertinent Diagnosis _____

Current Medications

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Continue on additional page, if necessary.)

Known Allergies _____

Additional Information _____

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HEALTH INSURANCE INFORMATION

Primary Medical

Carrier _____

Address _____

Phone _____ Fax _____

Policy # _____ Group # _____

Name of Policyholder _____

Secondary Medical

Carrier _____

Address _____

Phone _____ Fax _____

Policy # _____ Group # _____

Name of Policyholder _____

Dental Insurance

Carrier _____

Address _____

Phone _____ Fax _____

Policy # _____ Group # _____

Name of Policyholder _____

Other Health Insurance/Long-Term Care Insurance

Carrier _____

Address _____

Phone _____ Fax _____

Policy # _____ Group # _____

Name of Policyholder _____

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MEDICARE INFORMATION

Do you have Medicare Part A? Yes_____ No_____

Do you have Medicare Part B? Yes_____ No_____

Do you have Medicare Part D? Yes_____ No_____

Do you have pharmacy coverage? Yes_____ No_____

Carrier _____

Address _____

Phone _____ Fax _____

Policy # _____ Group # _____

Name of Policyholder _____

INCOME INFORMATION

Usual Occupation _____ Date Last Employed _____

Last Employer _____

Name _____ Address _____ Phone _____

If applicant is receiving VA income benefits:

Service Connected (SC) Disability Pension \$_____per month	Service Connected Disability Rating by VA _____%	Non-Service Connected (NSC) Pension \$_____per month
--	--	--

Aid and Attendance \$_____per month	House Bound \$_____per month
--	---------------------------------

Monthly income *before* deductions

Social Security _____per month	Military Retirement \$_____per month
Private Pension _____per month	Workers Compensation \$_____per month
Other Income _____per month	Source _____
_____per month	_____

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If monthly income is not enough to pay applicant's portion of costs, what other resources are available? (*checking, savings, investments, etc.*) RATES ARE SUBJECT TO CHANGE AT ANY TIME.

TEXAS VETERANS SERVICE INFORMATION

Branch of Service _____

Type of Discharge _____

Date Entered _____

State/County of Entry _____

Date Discharged _____

Discharge Location _____

Texas Resident Since _____

Voter Registration County _____

X _____
Signature of Applicant/Responsible Party

Date



AUTHORIZATION TO RELEASE PATIENT INFORMATION

Please complete this form. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. This release is not valid without an authorized signature and date or if it has expired.

Resident Name: _____
Last First MI Previous Name, if any

DOB: _____ SS# _____ Phone: _____
Home Cell

Resident Address: _____
Street City State Zip Code

I authorize _____ to disclose to _____

Address: _____
Street City State Zip Code

Phone: _____ Fax: _____ Email: _____

Covering the periods of healthcare from (date) _____ to (date) _____

For the purpose of: _____
(If requested by the patient, state "At the request of the Individual")

Method of disclosure: Mail Verbal Pick Up Fax Email

The following information may be released: (ex. clinical summaries, lab reports, nurses' notes, or all medical records)

I give specific authorization to disclose the following information as well as documents that contain reference to:
_____ HIV test results and documentation of AIDS diagnosis
_____ Drug and alcohol abuse treatment records
_____ Psychiatric/Mental Health treatment records

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying the facility in writing.

Completion of this authorization form will not affect my treatment, payments, or eligibility for benefits. As a patient, I have the right to access my clinical records. Copies of the records may be obtained with reasonable notice and payment of copying cost. I understand the information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Texas privacy regulations.

Unless revoked earlier, this authorization expires upon this date or event: _____

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this authorization, if requested. A photocopy of this authorization is as valid as the original.

Signature of Patient (or Patient Representative) Date

Printed Name of Patient (or Patient Representative) Authority of Representative to act for Patient

For Office Use: Identity Verified by _____