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)

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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: 512.475.2294
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

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

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

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

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

Alfredo Gonzalez
Texas State Veterans Home
301 E. Yuma Avenue
McAllen, Texas 78503-1388
Phone: 956-682-4224
Fax: 956-992-0602

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

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 (APPLICANT)

How did you hear about Texas State Veterans Homes? ___________________________________

Date of Birth ________________________ Current Age ________ Gender: M_____ F_____

VA Claim # ______________________ Social Security Number ________________________

Marital Status ______________________ Spouse's Name _____________________________

Permanent Address ____
(Street) *(City)* *(County)* *(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.)*

____

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

Name ____________________________ Relationship ______ Financial ______ Medical______

Address ____

Email Address ____

Home Phone ______________________ Cell 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 ____

Email Address ____

Home Phone ______________________ _ Cell 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

____

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 Ambrosio Guillen Texas State Veterans Home

Address: 9650 Kenworthy Street El Paso TX 79924
Street City State Zip Code

Phone: (915) 751-0967 Fax: (915) 751-0980 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 ______________________________