

# 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)

Updated: February 2018

**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](http://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: 956-992-0602

## **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 (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

\_\_\_\_\_

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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 \_\_\_\_\_