

Michigan Department of Military & Veterans Affairs
Michigan Veterans Homes
APPLICATION FOR ADMISSION
FOR THE GRAND RAPIDS HOME FOR VETERANS
3000 Monroe Ave. NW, Grand Rapids, MI 49505-3397

Thank you for your interest in the Grand Rapids Home for Veterans. Your application will be given *immediate* attention.
You can help the application process by submitting the following documents or information with your application.

Medical

- Medical history and physical exam of the applicant within the past 90 days. (Required) Must use attachment #2
- Chest x-ray report of applicant within the past 30 days. (Required)

Documents

- DD-214 (Report of Separation, Military Record of Service or Enlistment Record.) For help obtaining this record please contact MI Veterans Trust Fund in Lansing for help (517) 284-5299 or the contact the county where the veteran resided at the time of discharge from service. www.archives.gov/research_room/vetrecs
- Copy of Social Security Card.
- Marriage certificate copy if currently married.
- Divorce papers or death certificate for all prior marriages of either the veteran or spouse if currently married.
- Widow(er) needs to submit marriage certificate and veteran's death certificate.
- For applicants with dependents, please fill out attachment #1.
- Birth certificates for all minor children being claimed as dependents.
- If applicable: Guardianship paper, Conservatorship paper, Power of Attorney, Durable Power of Attorney, Patient Advocate form.

Insurance Information

- Copies of insurance cards (front and back), including Medicare, Medicaid and secondary insurance if applicable.
- Copy of nursing care insurance policy if applicable.

Financial

- Verification of income and assets. This includes copies of any current bank account statements, land contracts, Social Security or other pension award letters or checks.
- Call the Member Income and Assessment Office (616) 364-5382 to get an estimate of your projected monthly room and board assessment.** See Computation of Fees sheet for more information.

Taxes

- Must supply a copy of the past three year's Federal Income Tax forms if filed.

Funeral Arrangement

- Copies of any prepaid funeral arrangement papers.

Wheelchair Rental

If renting a wheelchair, check with your rental company to see if the insurance company will continue to cover the wheelchair after admission to a veterans' facility. (GRHV can provide a wheelchair after admission)

After the application is received, it is reviewed for completeness, eligibility and level of care. The applicant (or interested other party) will be notified by the Admissions Office to schedule an admission date and time, indicate placement on the waiting list or advise you if we are unable to meet the needs required.

At the time of admission, you will be asked to sign a Member Contract. The purpose of this contract is to outline your financial responsibility required to the Grand Rapids Home for Veterans for your cost of care, Supplementary Services and Member Rights & Responsibilities. **If you would like a copy of this contract prior to admission, please call us at 616-364-5382 or 616-365-4305.**

**If you have any questions or wish to know the status of your application, please call: Admissions: 844-711-7986 or e-mail: DMVA-Admissions@michigan.gov
Business Office: 616-364-5382 or 616-365-4305
VA Benefits: 616-364-5357
Fax: 616-364-5373**

APPLICANT INFORMATION, Continued

Religious Preference

Father's Full Name <input type="checkbox"/> Living <input type="checkbox"/> Deceased	Mother's Full Maiden Name <input type="checkbox"/> Living <input type="checkbox"/> Deceased
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Number of Living Children (Please list below)

Name	Age	Street & Number	City	State	Zip	Phone

Do you have a advanced directive or some other document directing medical care/decisions? No Yes (please provide document)

EMERGENCY CONTACT INFORMATION/RESPONSIBLE PARTY

Responsible Party Name	Relationship to Applicant	E-Mail Address
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Street Address	City	State	Zip Code
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Home Phone Number	Work Phone Number	Cell Phone Number
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Emergency Contact Name	Relationship to Applicant	E-Mail Address
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Street Address	City	State	Zip Code
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Home Phone Number	Work Phone Number	Cell Phone Number
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Secondary Contact Name	Relationship to Applicant	E-Mail Address
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Street Address	City	State	Zip Code
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Home Phone Number	Work Phone Number	Cell Phone Number
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Third Contact Name	Relationship to Applicant	E-Mail Address
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Street Address	City	State	Zip Code
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Home Phone Number	Work Phone Number	Cell Phone Number
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FUNERAL ARRANGEMENTS

Funeral Home Preference (Name and Address)

Are Prepaid Arrangements Made? Yes No (Please provide a copy.)

Cemetery Preference (Name and Address)

Are Prepaid Arrangements Made? Yes No (Please provide a copy.)

MILITARY SERVICE INFORMATION			
A copy of the veteran's discharge or DD214 must accompany this application.			
Wars Served In	Discharge Type from Service	Branch of Service	If Dependent of a Veteran
<input type="checkbox"/> WWII <input type="checkbox"/> Cold War <input type="checkbox"/> Korean <input type="checkbox"/> Persian Gulf <input type="checkbox"/> Vietnam <input type="checkbox"/> Iraqi Freedom <input type="checkbox"/> Other <input type="checkbox"/> Enduring Freedom	<input type="checkbox"/> Honorable <input type="checkbox"/> Medical <input type="checkbox"/> Retirement	<input type="checkbox"/> Air Force <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Marines <input type="checkbox"/> Navy	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Widowed <input type="checkbox"/> Spouse <input type="checkbox"/> Former Spouse
Service Serial No.		VA Claim No.	
Date of Entry into Active Duty		Separation Date	
Residence at Time of Entry			
Place of Enlistment		Place of Discharge	
Did a veterans' service organization assist you with your claim? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please provide name of organization: _____			
INSURANCE INFORMATION			
Medicare No. (if covered)	Part A Hospital Effective Date	<input type="checkbox"/> Yes <input type="checkbox"/> No	Part B Medical Effective Date
Other Medical Coverage Claim No.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Company Name of Insurance Carrier Address	
Prescription Coverage Claim No.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Company Name of Insurance Carrier Address	
Dental Coverage Claim No.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Company Name of Insurance Carrier Address	
Vision Coverage Claim No.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Company Name of Insurance Carrier Address	
APPLICANT'S FINANCIAL DATA			
This financial statement <u>must</u> be completed and signed by applicant, spouse, guardian or responsible person. <i>All questions must be answered.</i> If the answer is none, put none.			
PERSON HAVING FINANCIAL RESPONSIBILITY IF OTHER THAN APPLICANT			
Name (Last, First, Middle)		Phone ()	
Address (Street and Number)	City	State	Zip Code
Please check appropriate box: NOTE: Please provide documentation for each box checked.			
<input type="checkbox"/> Financially Responsible	<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Conservator	<input type="checkbox"/> DPOA <input type="checkbox"/> POA <input type="checkbox"/> Patient Advocate
Occupation of Applicant		Last Date Worked	
Former Employer		Years of Service	
Former Employer		Years of Service	
Automobile(s) – Year and Make			

APPLICANT'S FINANCIAL DATA, Continued				
MONTHLY INCOME		GROSS		NET
V.A. Disability Pension or Compensation		\$		\$
Social Security		\$		\$
Other Retirement Income (Source: _____)		\$		\$
Please list other income below:		\$		\$
1.		\$		\$
2.		\$		\$
3.		\$		\$
Rental Property Income		\$		\$
Land Contract Income (please provide a copy)		\$		\$
Dividends		\$		\$
Interest		\$		\$
Name and Address of Banks, Savings & Loan, Credit Unions		Type of Account: (please list) Savings, Certificate of Deposit (CD), Checking, IRA, Other		Amount
1.				\$
2.				\$
3.				\$
4.				\$
5.				\$
Name of Life Insurance Companies		Beneficiaries		Amount
1.				\$
2.				\$
<p>Are you or your dependents receiving, or will be receiving, long- or short-term nursing care insurance payments? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please provide a copy)</p>				
LOCATION OF REAL ESTATE				
Street Address	City	State	Zip Code	Value
1.				\$
2.				\$
OTHER INVESTMENTS – IDENTIFY				\$
1.				\$
2.				\$
3.				\$
4.				\$
5.				\$
<p>NOTE: Please provide past 3 years of federal income taxes if taxes were filed.</p>				

APPLICANT’S FINANCIAL DATA, Continued

Have you sold, transferred or created a joint tenancy (ownership) in any property within the last 36 months? (This includes cash and bank accounts.)

Applicant Yes No

Applicant’s Spouse Yes No

If yes, to (or with) whom:

Date of transaction:

In what amount:

APPLICANT’S HISTORY

Have you ever been arrested or convicted of a felony? Yes No **Of a misdemeanor?** Yes No

If yes, please list all arrests and/or convictions:

Are you currently on parole/probation? Yes No

Although a disqualification is possible, a previous conviction does not automatically disqualify an applicant of consideration for residency at the Home. However, if an applicant fails to reveal any previous arrest and/or convictions, s/he shall be **disqualified** for admission.

If at any time after being admitted, it was found that there was misleading, false, concealed and/or omitted information pertaining to having been arrested or convicted of a misdemeanor and/or felony, then the resident shall be **immediately discharged** from the Home.

Please review your application and make certain that the information provided is accurate before placing your signature on this document acknowledging that all information provided is truthful and to the best of your knowledge.

I, _____, further depose and say that I will, if admitted to the Facilities, agree to notify the Grand Rapids Home for Veterans or the D.J. Jacobetti Home of all changes in benefits or estate. I further depose and say that the foregoing questions have been carefully read by me or to me, and that the answers I have given to the same are true to the best of my knowledge and belief. I fully understand and agree that, if I am admitted to the Home, I must abide by the laws of the State of Michigan pertaining to the Home and the rules and regulations of the Home and hereby agree to pay the balance of any funds accumulated while a member.

Check this box to confirm agreement with the above statements.

Applicant’s Signature

Attachment No. 1 – Admission Application to Grand Rapids Home for Veterans

FINANCIAL STATEMENT FOR DEPENDENTS

FOR VETERANS OR APPLICANTS WITH DEPENDENTS ONLY

Applicants **WITHOUT** dependents, go on to Attachment No. 2
 This financial statement must be completed and signed by applicant, spouse, or conservator.
All questions must be answered. If the answer is none, put none.

Spouse's Name:		Social Security Number:		
Date Last Worked:				
INCOME SPOUSE AND/OR MINOR CHILDREN		MONTHLY INCOME		
		GROSS	NET	
Wages (Source: _____)		\$	\$	
Social Security		\$	\$	
Other Retirement Income (indicate source below)		\$	\$	
1.		\$	\$	
2.		\$	\$	
3.		\$	\$	
Rental Property Income		\$	\$	
Land Contract Income		\$	\$	
Dividends		\$	\$	
Interest		\$	\$	
Other Income (indicate source below)		\$	\$	
1.		\$	\$	
2.		\$	\$	
3.		\$	\$	
Name and Address of Banks, Savings & Loan, Credit Unions	Type of Account: (please list) Savings, Certificate of Deposit (CD), Checking, IRA, Other	Amount		
1.		\$		
2.		\$		
3.		\$		
4.		\$		
5.		\$		
Automobile(s) – Year and Make				
Name of Life Insurance Companies		Beneficiaries		Amount
1.				\$
2.				\$
LOCATION OF REAL ESTATE				
Street Address	City	State	Zip Code	Value
1.				\$
2.				\$
OTHER INVESTMENTS - IDENTIFY				Value
1.				\$
2.				\$
MONTHLY EXPENSES				
LIVING EXPENSES AND INDEBTEDNESS				AMOUNT
Food and Clothing				\$
Telephone				\$
Electricity				\$
Water & Sewage				\$
Heat				\$
Taxes				\$
Home Insurance				\$
Health Insurance (other than Medicare)				\$

Life Insurance		\$
Car Payments	Balance owed \$ _____	\$
Car Expense		\$
Rent or Mortgage Payment		\$
Other Expenses and Debts (indicate source below)		\$
1.		\$
2.		\$
3.		\$
4.		\$
5.		\$

DEPENDENT CHILDREN

DEPENDENT CHILDREN INCLUDE THOSE UNDER 18 YEARS OF AGE AND THOSE WHO, BECAUSE OF A DISABILITY, ARE STILL CONSIDERED DEPENDENTS

Name	Social Security Number	Birth Date	Source of Income (if any)	Amount
1.				\$
2.				\$
3.				\$

MONTHLY MEDICAL EXPENSES

List All Medical Expenses (indicate source below)	Amount	Reimbursement Expected	Medical Costs Not Reimbursed	Balance Owed
1.				
2.				
3.				
4.				
5.				
6.				

Michigan Felony Statute False Pretenses

Michigan Compiled Laws Annotated Section 750.218 provides:

“Any person who shall by any false token or writing obtain from this State Institution care and services, the value of which exceeds \$100 by intentional fraudulent misrepresentations or false signature before a notary shall be guilty of a felony punishable by imprisonment in state prison for a period not to exceed ten (10) years...”

It is unfortunate that a minority of veterans make false representations concerning their income and assets upon admission to this facility. This detracts from the services we are able to provide and increases the monthly costs to the honest veterans.

NOTICE AGREEMENT

For and in consideration of my admission to the Grand Rapids Home for Veterans, I hereby agree payment to the Board of Managers of the Facilities of any balance of money accumulated while a member of the Facilities, or due to me, or on deposit with any bank, trust company, corporation or with any individual, at the time of my death; provided all such sums shall be first expended to pay for residual maintenance costs attributable to the deceased individual, and shall then be paid to the spouse, minor children, or dependent mother or father in the order named.

If no such relative shall be found within a period of two years, or if no claim for the sums has been made within a period of two years, the balance of the money shall be paid into a fund in the hands of the Board of Managers of the Facilities to be expended by the Board of Managers to improve the service of the Facilities, pursuant to MCLA 36.61 as amended, P.A. 1905, No. 313.

I agree to notify the Grand Rapids Home for Veterans of any increases and decreases of income, assets, and expenses prior to the admission of this individual, and after his/her admission to the Grand Rapids Home for Veterans.

Signed by: (Please check one) Spouse Guardian Other responsible person

Name (printed) _____

Signature _____ Date _____

