State of New Jersey
APPLICATION FOR ADMISSION
NEW JERSEY VETERANS MEMORIAL HOME

Thank you for your interest in the New Jersey Veterans Memorial Homes. The applicant, or their responsible agent, will fill out the application following the directions below. Please note: a physician must complete and sign where indicated. Once the application is filled out in its entirety, mail it to the Veterans Memorial Home of your choice (listed on page 2.) The application consists of:

- ❖ Part 1 - Personal Information
- ❖ Part 2 - Military Service Information
- ❖ Part 3 - Eligibility Requirements
- ❖ Part 4 - Insurance Information
- ❖ Part 5 - Advance Directive Information
- ❖ Part 6 - Emergency Contact Information
- ❖ Part 7 - Burial Arrangements
- ❖ Part 8 - Applicant's Information
- ❖ Part 9 - Medical Information & Questionnaire **(to be completed by your physician**)
- ❖ New Jersey Administrative Code (N.J.A.C.) 5A: 5 - Chapter 5, which establishes the requirements for eligibility for admission, pre-admission screening, admission review and implementation, computation of the care maintenance fee for NJ veterans' facilities, and the basis for discharge or transfer from such; may be viewed on-line at the link below: **https://www.nj.gov/military/veterans/memorial-homes/assets/documents/NJAC-5A-5-VeteransHomeAdmissionEligibility.pdf**

INSTRUCTIONS:

► The information requested is necessary to determine your eligibility for admission to a New Jersey Veterans Memorial Home in accordance with New Jersey Administrative Code 5A: 5 – Chapter 5.

► Please PRINT OUT this application. Either fill in all the required information in ink or fill out the application on-line and print out the completed forms; (they will not be saved). Next, mail the completed application to the Veterans Memorial Home to which you want to apply.

► Ensure required information on the application is complete prior to mailing. The application will only be processed when the entire application is completed and all required documents are submitted. If the required information is missing or incomplete, this will delay admission. Failure to inform the facility of any change of address or telephone number could cancel the admission process entirely.

► Please review the "Pre-Submission Work-Sheet" at the back of this application for a check-off list of documents that must be submitted with this application.

To establish the basic eligibility of all applicants, the following documentation is required as indicated:

- Proof of an other than dishonorable discharge
- Birth certificate
- Verification of marital status (e.g. marriage certificate, divorce papers, death certificate) (**Only veteran spouse applicants need to provide this information as applicable.)**
- Verification of New Jersey residency **(Out-of-state applicants may apply. Preference is given to NJ residents.)**
- Medical information (Parts 8 & 9 and as requested)

Please note that if the applicant is currently receiving Hospice services, these Hospice services can be continued in the Veterans Memorial Home.

APPLICATION FOR ADMISSION

NEW JERSEY VETERANS MEMORIAL HOME

INSTRUCTIONS (Continued)

PLEASE NOTE: Only the original application, with original signatures, will be accepted and must be mailed directly to the **FACILITY OF CHOICE** as listed below. Please keep a copy of the original application and accompanying documents for your records. **Important:** for quality control purposes, PLEASE - only apply to one facility. If you have an interest in other facilities, please check the box(es) below and your information will be shared with the applicable Admissions Officer(s) after consideration of your application.

☐ **New Jersey Veterans Memorial Home at MENLO PARK**
Attention: Social Service Department
P.O. Box 3013; 132 Evergreen Road
Edison, New Jersey 08818-3013
Main Telephone: (732) 452-4100
Admissions Officer: (732) 452-4272
nj.gov/military/veterans/memorial-homes/menlo-park

☐ **New Jersey Veterans Memorial Home at PARAMUS**
Attention: Social Service Department
1 Veterans Drive
Paramus, New Jersey 07652
Main Telephone: (201) 634-8200
Admissions Officer: (201) 634-8435
nj.gov/military/veterans/memorial-homes/paramus

☐ **New Jersey Veterans Memorial Home at VINELAND**
Attention: Social Service Department
524 North West Boulevard
Vineland, New Jersey 08360-2895
Main Telephone: (856) 405-4200
Admissions Officer: (856) 405-4261
nj.gov/military/veterans/memorial-homes/vineland

Please feel free to call us at one of the above telephone numbers if you have additional questions, require help filling out the application, or if we can be of any other assistance to you and your family.

"SERVING THOSE WHO SERVED"

****All components of this document have been reviewed and are current as of August 2023.***

State of New Jersey
DEPARTMENT OF MILITARY AND VETERANS AFFAIRS
APPLICATION FOR ADMISSION

NO INDIVIDUAL WILL, ON THE GROUNDS OF RACE, COLOR, CREED, AGE, SEX, DIFFERENTLY ABLED, SEXUAL ORIENTATION, NATIONAL ORIGIN, OR ABILITY TO PAY, BE DENIED ADMISSION, CARE OR ANY OTHER BENEFIT PROVIDED BY THE NEW JERSEY DEPARTMENT OF MILITARY AND VETERANS AFFAIRS.

PART 1 – PERSONAL INFORMATION

NAME (Last) (First) (Middle)		SOCIAL SECURITY NUMBER _____ - _____ - _____
ADDRESS (Permanent)		TELEPHONE NUMBER ( ) -
CITY	COUNTY	ZIP CODE
PRESENT LOCATION (Facility Name or Home)	DATE OF BIRTH _____/_____/_____	GENDER: ◯ (M) ◯ (F) ◯ (O) RACE _____
ADDRESS	PLACE OF BIRTH	RELIGION

MARITAL STATUS (Verification Required)

Married ◯ Single ◯ Widowed ◯ Divorced ◯ Legal Separation ◯ (How Long? _____ years)

NAME OF SPOUSE **Spouse info only required when spouse is the applicant.**	SPOUSE'S SOCIAL SECURITY #: _____ - _____ - _____
SPOUSE'S ADDRESS	SPOUSE'S DATE OF BIRTH _____/_____/_____
PLACE OF MARRIAGE	DATE OF MARRIAGE _____/_____/_____

PART 2 - MILITARY SERVICE INFORMATION
(IMPORTANT: Attach Copy of Release or Military Discharge Papers)

BRANCH AND SERVICE NUMBER	DATE AND STATE OF ENLISTMENT	DATE AND PLACE OF DISCHARGE	TYPE OF DISCHARGE

Do you have any service-connected disability that is confirmed by an award letter? ◯ YES ◯ NO

Percentage of Disability _____ Reason for disability _____

PART 3 - ELIGIBILITY REQUIREMENTS

In compliance with the eligibility requirements, I do hereby apply for admission to the _____ veterans' long-term care facility and declare the following statements and information to be true. I am applying as a:

Veteran ☐ Gold Star Parent ☐ Widow-Widower ☐ Spouse ☐

RESIDENCE CERTIFICATE FOR THE STATE OF NEW JERSEY

I, the undersigned, am a resident of the State of New Jersey, or meet the eligibility requirements in accordance with N.J.A.C. 5A: 5-1.2. (**Out-of-state applicants may apply. Proof of NJ residency is only required for preference.)**

_____ Applicant's Signature

_____ Date

PART 4 – INSURANCE INFORMATION

APPLICANT'S MEDICARE # _____
EFFECTIVE DATE: _____/_____/_____
PART A ☐ PART B ☐ PART D ☐
_____
OTHER MEDICAL/LTC/PDP INSURANCE: _____
I.D. #: _____ INSURANCE CO. NAME: _____
_____
LIST INSURANCE POLICIES YOU HAVE: (Burial, Life, Long-Term Care)
Give the name of the company and the face and/or current cash value.
_____

PART 5 - ADVANCE DIRECTIVE INFORMATION

Type of Advance Directive: _____
POLST Form: ☐ YES ☐ NO

Legal Guardian: _____
Power of Attorney: _____
Conservator: _____

THIS SPACE INTENTIONALLY LEFT BLANK.

PART 6 - EMERGENCY CONTACT

PERSON TO BE NOTIFIED IN AN EMERGENCY. (List two. If applicant has a Guardian, Conservator, or Power of Attorney, copies of the legal documents establishing such authority must be attached.)

POA NAME:
_____
ADDRESS:
_____
CITY, STATE, ZIP CODE:

RELATIONSHIP: _____
WORK PHONE NUMBER: ( ) -
HOME PHONE NUMBER: ( ) -
CELL PHONE NUMBER: ( ) -

NAME:
_____
ADDRESS:
_____
CITY, STATE, ZIP CODE:

RELATIONSHIP: _____
WORK PHONE NUMBER: ( ) -
HOME PHONE NUMBER: ( ) -
CELL PHONE NUMBER: ( ) -

PART 7 - BURIAL ARRANGEMENTS

Name of Undertaker**:** _____
Address and Phone Number: _____
Person responsible for funeral expenses:
_____ _____
(Print Name) (Signature)
Address:_____
Relationship to Resident _____Telephone: Home ( )_____ Work ( ) _____
Do you have a Will? ☐ Yes ☐ No Executor's Name: _____
Executor's Address: _____

State of New Jersey
Department of Military and Veterans Affairs

Part 8 – Applicant's Information

Our ability to determine if we can adequately care for an individual is dependent on the information provided in this application.

Part 8: To be completed by the applicant, the family or the caregiver.

Applicant's Name: ______________________________ Date of Birth: ________________

(Please Print)

Applicant's Current Address: ______________________________

Gender: ☐ Male ☐ Female ☐ Other (Non-binary) Height: ______ Weight: ______

At the time of application, this person resides at: ☐-Own Home; ☐-Assisted Living; ☐-NursingHome;
☐-Hospital; ☐-Other (please explain): ______________________________

Facility Name and Address: ______________________________

Applicant **understands** and is **aware** that they are being admitted to a nursing home? ☐ YES ☐ NO

Please provide the name and contact information for the caregiver who could give the most accurate information regarding the applicant's hygiene practices and preferences, eating abilities, dressing abilities, ambulation abilities, etc.

Caregiver's Name: ______________________________

(Please Print)

Relationship - Check most appropriate: ☐ - Relative; ☐ - Home health staff; ☐ - Assisted living staff;
☐- Hospital staff; ☐- Nursing home staff; ☐- Other (specify): ______________________

Home Phone #: ______________ Mobile Phone #: ______________ Work Phone#: ______________

Please complete legibly. Please **send** any available medical records, reports and diagnostic studies **with the application**.

Please give a list of **physicians**, **hospitals**, and/or other **healthcare facilities** where medical records may be obtained.

Doctor's or Facility's Name	Doctor's or Facility's Address

★★

Part 9: Medical Information (To be completed by the Applicant's Physician)

1. **ADAPTIVE EQUIPMENT:** ☐-Cane; ☐-Crutches; ☐-Walker; ☐-Wheelchair; ☐-Oxygen; ☐-Prosthesis; ☐-Other______

2. **MOUTH**: ☐-Natural Teeth; ☐-Edentulous; ☐-Dentures

3. **SLEEPING HABITS:** ☐- Normal ☐-Awake freq. at night; ☐ - Daily naps; ☐ -Difficulty falling asleep ☐ -Other

4. **FALLS:** ☐ -Within last week; ☐ -Within last month; ☐ -Within last 3 months; ☐ -Within last 6 months or longer

5. Does the applicant need a locked or secured unit: ☐ YES ☐ NO

6. Is the applicant equipped with an implantable device? ☐ YES ☐ NO **If yes**, please provide details:

____

Applicant's Name_____ **Part 9: Medical Information (continued)**

If "Yes" is checked for A, B, or C below, **please submit a summary** of both past and present treatments the applicant has received. If "Yes" is checked for C, please list the **specific diagnosis**: _____

A. History of Alcoholism	☐ Yes	☐ No	☐ Active	☐ Remission
B. History of Drug Addiction	☐ Yes	☐ No	☐ Active	☐ Remission
C. History of Psychiatric Illness	☐ Yes	☐ No	☐ Active	☐ Remission

Has the applicant ever been evaluated by or are they currently under the care of a psychiatric professional? ☐ Yes ☐ No
Has the applicant ever been a patient in a psychiatric care facility? ☐ Yes ☐ No
If yes, explain: _____
Facility(ies):_____ Admission date(s): _____
Name of Physician: _____ Physician's Phone Number: _____

Has the applicant ever expressed thoughts of self-harm or attempted suicide? ☐ Yes ☐ No

COMMUNICABLE DISEASES:

1. Does the applicant have a current diagnosis of, or past history of, any of the following:

a. Clostridium difficile:	☐ Current	☐ History	☐ None	☐ Unknown
b. Extended Spectrum Beta Lactamases:	☐ Current	☐ History	☐ None	☐ Unknown
c. Hepatitis A:	☐ Current	☐ History	☐ None	☐ Unknown
d. Hepatitis B:	☐ Current	☐ History	☐ None	☐ Unknown
e. Hepatitis C:	☐ Current	☐ History	☐ None	☐ Unknown
f. HIV Infection:	☐ Current	☐ History	☐ None	☐ Unknown
g. MRSA:	☐ Current	☐ History	☐ None	☐ Unknown
h. Pnuemonia:	☐ Current	☐ History	☐ None	☐ Unknown
i. Septicemia:	☐ Current	☐ History	☐ None	☐ Unknown
j. UTI during last 30 days:	☐ Current	☐ History	☐ None	☐ Unknown
k. VRE:	☐ Current	☐ History	☐ None	☐ Unknown
l. Wound infection:	☐ Current	☐ History	☐ None	☐ Unknown
m. Other infection(s) - please list:				

Please explain and provide lab results _____

2. PPD/TB Skin Test is required or the application will be considered incomplete and returned.
Date of PPD/ TB skin test: _____ Results:_____
If PPD/TB Skin Test is Positive, chest x-ray is required.
Date of chest x-ray: _____ Radiologist's findings: _____

VACCINATION STATUS:

Influenza Vaccine - Date received: _____ Shingles Vaccine – Date received: _____
Pneumovax - Date received: _____ Hepatitis A & B Vaccine:_____
Tetanus Booster – Date received: _____
COVID Initial Series Date(s) and Manufacturer:_____
Booster #1 and Booster #2 Dates received (as applicable): _____
Additional COVID Boosters (if applicable): _____
COVID History (if applicable): _____

DIALYSIS STATUS: Is this applicant on **Hemodialysis**? ☐ Yes ☐ No
Is this applicant on **Peritoneal Dialysis?** ☐ Yes ☐ No
Frequency of treatments: _____ X per week - Fluid Restrictions: _____
Name of Dialysis Center: _____

Applicant's Name_____ **Part 9: Medical Information (continued)**

Pain - Describe the applicant's reports of pain: *frequency*; *intensity* (on a scale of 1-10; ten being the worst); and the *site of the pain*.

Pain Site	Pain Frequency	Intensity (1-10)	Pain Treatment

Allergies - (Please list):

Does applicant have a history of surgical procedures? ☐ **Y or** ☐ **N**	**If yes, please provide details below:**

Please indicate Behavioral/Psychiatric Diagnoses below ↓

Diagnosis	Current	History	Diagnosis	Current	History
Alzheimer's Disease			Depression		
Antisocial Personality Disorder			Post Traumatic Stress (PTSD)		
Anxiety Disorder			Psychosis		
Bipolar/Manic Depression			Schizophrenia		
Dementia (with Behavior Disturbances)			Substance Abuse		
Dementia (without Behavior Disturbances)			**Other Diagnoses** (list below):		

Please indicate the Primary (#1); Secondary (#2); Tertiary (#3); (and other) Diagnoses below ↓

Diagnosis	Current	History	Diagnosis	Current	History
Acute Myocardial Infarction			Hyperthyroidism		
Anemia			Hypotension		
Aphasia			Hypothyroidism		
Arteriosclerotic Heart Disease (ASHD)			Macular Degeneration		
Arthritis			Missing limb (Which limb?): _____		
Asthma			Movement Disorder/Chorea		
Cancer (type:_____)			Multiple Sclerosis		
Cardiac Dysrhythmias			Osteoporosis		
Cardiovascular Disease			Paraplegia		
Cataracts			Parkinson's Disease		
Cerebral Palsy			Peripheral Vascular Disease		
Cerebrovascular Accident			Pressure Ulcers		
Congestive Heart Failure			Quadriplegia		
Deep Vein Thrombosis			Renal Failure		
Diabetes Mellitus			Kidney Disease / Kidney Stones (please circle)		
Diabetic Retinopathy			Seizure Disorder		
Emphysema / COPD			Stasis Ulcer(s)		
Glaucoma			Transient Ischemic Attacks (TIA)		
Hemiplegia / Hemiparesis			Traumatic Brain Injury (TBI)		
Hip Fracture – Left / Right			**Other Diagnoses** (list below):		
History of Falls					
Hypertension					

Applicant's Name_____ **Part 9: Medical Information (continued)**

Medications: Medication list is to include all **scheduled**, as well as **PRN** [*as needed*], medications

Applicant's Medications	Dose	Time	Route	Reason

Treatments: Please list any treatments, or attach a copy of a treatment list which includes this information

Applicant's Treatments	Dose	Time	Route	Reason

At this Physical Examination the Applicant's Vital Signs were as follows:

Blood Pressure:_____ Pulse (Apical):_____ Pulse (Radial):_____ Temperature:_____

Cardiac Rhythm:_____ Needs Rehabilitation: ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

Prognosis: ☐ Stable ☐ Improving ☐ Deteriorating ---- **Rehabilitation Potential:** ☐ Good ☐ Limited ☐ Poor

PLEASE LIST THE MAIN REASON(S) THAT THIS APPLICANT REQUIRES 24/7 SKILLED NURSING CARE:_____

Must be Signed by a Licensed Physician; Advance Practice Nurse; or N.J. Physician's Assistant

Professional's Signature: _____

Name and Title (please print): _____

Address: _____

Telephone #_____ Fax #_____

Date Signed:_____

State of New Jersey
Department of Military and Veterans Affairs (DMAVA)
New Jersey Veterans Memorial Homes (VMH)

EVALUATION OF ACTIVITIES OF DAILY LIVING

TO BE COMPLETED BY PRIMARY CAREGIVER! (Family Member, Home Health Aide, or Facility Caregiver)

(Check that which applies in each category)

COMMUNICATION	☐ Transmits messages/receives information ☐ Limited ability ☐ Nearly or totally unable	SPEECH	☐ Transmits messages/receives information ☐ Limited ability ☐ Nearly or totally unable
HEARING	☐ Good ☐ Hearing slightly impaired ☐ Nearly or totally unable ☐ Virtually/completely deaf	SIGHT	☐ Good ☐ Vision adequate/unable to read/see details ☐ Vision limited – Gross object differentiation ☐ Blind
TRANSFER	☐ No assistance ☐ Equipment only ☐ Supervision only ☐ Requires human transfer w/wo equipment ☐ Bedfast	AMBULATION	☐ Independent w/wo assistive device ☐ Walks with supervision ☐ Walks with continuous human support ☐ Bed to chair (total help) ☐ Bedfast
ENDURANCE	☐ Tolerates distances (250 feet sustained activity) ☐ Needs intermittent rest ☐ Rarely tolerates short activities ☐ No tolerance	MENTAL AND BEHAVIOR STATUS	☐ Alert ☐ Agreeable ☐ Confused ☐ Disruptive ☐ Disoriented ☐ Apathetic ☐ Comatose ☐ Well motivated
TOILETING	☐ No assistance ☐ Bathroom ☐ Assistance to and from and transfer ☐ Bedside commode ☐ Total assistance including personal hygiene, help w/clothes ☐ Bedpan	BATHING	☐ No assistance ☐ Tub ☐ Supervision only ☐ Shower ☐ Assistance ☐ Sponge bath ☐ Is bathed
DRESSING	☐ Dresses self ☐ Minor assistance ☐ Needs help to complete dressing ☐ Has to be dressed	FEEDING	☐ No assistance ☐ Minor assistance, needs tray set up only ☐ Help feeding/encouraging ☐ Is fed
BLADDER CONTROL	☐ Continent ☐ Rarely incontinent ☐ Occasional-once/week or less ☐ Frequent – up to once a day ☐ Total incontinence ☐ Catheter, Indwelling	BOWEL CONTROL	☐ Continent ☐ Rarely incontinent ☐ Occasional-once/week or less ☐ Frequent – up to once a day ☐ Total incontinence ☐ Ostomy
SKIN CONDITION	☐ Intact ☐ Dry/Fragile ☐ Irritations (Rash) Number_____ ☐ Open wound Stage_____ ☐ Decubitus	WHEELCHAIR USE	☐ Independence ☐ Assistance in difficult maneuvering ☐ Wheels a few feet ☐ Unable to use ☐ N/A

SIGNATURE OF PERSON COMPLETING THIS FORM: **Date___/___/_____**

FAMILY MEMBER	HOME HEALTH AIDE	FACILITY CAREGIVER

State of New Jersey
Department of Military and Veterans Affairs (DMAVA) New Jersey Veterans Memorial Homes (VMH)

QUESTIONNAIRE ON BEHAVIORAL NEEDS

Applicant's Name:							**Date:**
		FREQUENCY					
	BEHAVIORS	DAILY	UP TO 5 DAYS/ WEEK	NOT IN LAST 30 DAYS	NOT IN LAST 6 MONTHS	NEVER	COMMENTS
1	Wandering or getting lost						
2	Exit seeking or elopement risk						
3	Refuses to take medications as ordered						
4	Resists necessary care						
5	Difficulty getting along with others						
6	Sleeps during day and awake all night						
7	Verbally abusive to others						
8	Attempting to break furniture or glass						
9	Attempts to hit, punch, kick, choke or spit at others unprovoked						
10	Screaming or yelling						
11	Physically aggressive behavior towards you, other family members or staff/others at a facility						
12	Attempting to throw furniture at others						
13	Attempts to throw self on floor						
14	Taking others belongings						
15	Being suspicious, accusative and/or paranoid						
16	Seeing or talking to people or things that are not there						
17	Suicidal or homicidal ideations						
18	Exposing self to others						
19	Rummaging through others belongings						
20	Hiding things (money, jewelry, keys, etc.)						
21	Hoarding things						
22	Attempting to eat non-food items						
23	Sexually inappropriate touching						
24	Voiding or defecating in inappropriate locations						
25	Makes overtly sexual remarks, jokes, comments etc.						
26	Attempting to have non-consensual sexual intercourse or sexual contact with others						
27	Attempts to bruise, cut or hurt self						

If the applicant lives in the community, please have the applicant's **Physician** complete this form:

_____ _____ __/__/__

PHYSICIAN'S SIGNATURE PHYSICIAN'S NAME (Please Print) DATE

If the applicant lives in a nursing home, assisted living, or other type of facility, please have the **Charge Nurse** or **Social Worker** complete this form:

_____ _____ __/__/__

NURSE'S or SOCIAL WORKER'S SIGNATURE NURSE'S or SOCIAL WORKER'S NAME (Please Print) DATE

State of New Jersey
DEPARTMENT OF MILITARY AND VETERANS AFFAIRS

"PRE-SUBMISSION WORKSHEET" FOR APPLICANTS / FAMILIES REQUIRED COPIES OF DOCUMENTS

- ☐ BIRTH CERTIFICATE / SOCIAL SECURITY CARD (See PART 1)
- ☐ VERIFICATION of MARRIAGE STATUS (See PART 1) **For Veteran spouse applicants only.**
- ☐ DIVORCE DECREE / SEPARATION PAPERS (See PART 1) **For Veteran spouse applicants only.**
- ☐ DEATH CERTIFICATE (See PARTS 1 and 3) **For Veteran spouse applicants only (if applicable.)**
- ☐ MILITARY RECORDS (Military Discharge Papers) (See PART 2)
- ☐ AWARD LETTER (Proof of service-connected disability) **(If applicable.)**
- ☐ VERIFICATION OF NEW JERSEY RESIDENCY **If applicant is a NJ resident (for preferred placement.)**
- ☐ INSURANCE CARDS (See PART 4)

****(Please be sure to copy the FRONT and BACK of ALL INSURANCE CARDS)****

- ☐ MEDICARE CARD – PART A and B (See PART 4)
- ☐ MEDICARE PART D – PRESCRIPTION DRUG PLAN (PDP) AND I.D. #
- ☐ GUARDIANSHIP / POWER OF ATTORNEY/CONSERVATOR PAPERS **(If applicable.)**
- ☐ ADVANCE DIRECTIVES for HEALTH CARE **(If applicable.)**
- ☐ MEDICAL INFORMATION (See PARTS 8 and 9)