



Kansas Soldiers Home

Application for Admission



Please include the following with your application:

Applicant(s) Name: _____

Documentation:	Enclosed	Do not have
Admission Application (This package)	_____	_____
State Home Program Application for Veteran Care Medical Certification Form 10-10SH (completed by physician)	_____	_____
Department of Defense Form 214 / Proof of Active Military Service	_____	_____
Verification of all income / liquid assets (stocks, bonds, mutual funds, etc.)	_____	_____
Current statements on all bank accounts including: checking, savings, & Certificates of Deposit	_____	_____
Previous year Income Tax Form(s)	_____	_____
Copies of Medicare & all other insurance cards	_____	_____
Birth Certificates	_____	_____
Marriage Certificate	_____	_____
Death Certificate (of Veteran if a widow is applying)	_____	_____
Divorce Decree(s) as necessary	_____	_____
General Power of Attorney	_____	_____
Durable Power of Attorney	_____	_____
Guardianship/Conservator	_____	_____
Living Will	_____	_____
Funeral and Burial Arrangement Policy	_____	_____
DNR Directives	_____	_____
Authorization for Release of Medical Records (Attached) Requires Signature	_____	_____
Kansas Soldiers' Home Applicant's Agreement (Attached) Requires Signature	_____	_____
TB Skin Test Results (within past three months)	_____	_____

**KANSAS SOLDIERS' HOME
714 SHERIDAN, UNIT 128
FORT DODGE, KANSAS 67843-9068
620-227-2121**

APPLICATION FOR ADMISSION

PART I – BIOGRAPHICAL INFORMATION				
1. TYPE OF HOUSING APPLIED FOR: _____ NURSING HOME CARE _____ DOMICILIARY CARE _____ COTTAGE				
2. APPLICANT'S NAME(LAST, FIRST, MI)		3. OTHER NAME USED (ALIAS)		4. SOCIAL SECURITY NUMBER
5. MEDICARE NUMBER		6. DATE OF BIRTH		7. PLACE OF BIRTH
8. PERMANENT ADDRESS			9. TEMPORARY ADDRESS (FROM _____ TO _____)	
8A. STREET ADDRESS			9A. STREET ADDRESS	
8B. CITY	8C. STATE		9B. CITY	9C. STATE
8D. ZIP CODE	8E. COUNTY		9D. ZIP CODE	9E. COUNTY
8F. HOME TELEPHONE NUMBER ()			9F. HOME TELEPHONE NUMBER ()	
10. APPLICANT'S GENDER ____ MALE ____ FEMALE	11. MOTHER'S MAIDEN NAME		12. MOTHER'S NAME	13. FATHERS NAME
14. IF APPLICANT IS NOT A VETERAN, INDICATE RELATIONSHIP TO THE VETERAN: ____ SPOUSE ____ WIDOW ____ WIDOWER ____ FATHER ____ MOTHER ____ DEPENDENT CHILD				
15. HAS THE APPLICANT EVER BEEN CONVICTED OF A FELONY: ____ YES ____ NO, IF THE ANSWER IS YES, PROVIDE THE COUNTY AND STATE WHERE THE CONVICTION OCCURRED, DATE OF CONVICTION, AND FOR WHAT CRIME:				
16. POWER OF ATTORNEY OR CONSERVATOR OR GUARDIAN: NAME AND ADDRESS:				
17. VA CLAIM NUMBER	18. RELIGIOUS PREFERENCE	19. RAILROAD RET #	20. CIVIL SERVICE #	
21. NUMBER OF YEARS RESIDED IN KANSAS: _____		22. OTHER HEALTH INSURANCE COMPANY, GROUP, ID# AND MONTHLY PREMIUM:		
23. EDUCATION HIGHEST YEAR ATTAINED: _____				
PART II – EMERGENCY CONTACT DATA				
1A. FIRST NEXT OF KIN	2B. RELATIONSHIP	1C. HOME TELEPHONE # ()	1D. WORK TELEPHONE # ()	
1E ADDRESS(NUMBER, STREET, CITY, STATE, ZIP CODE)				
2A. SECOND NEXT OF KIN	2B. RELATIONSHIP	2C.HOME TELEPHONE # ()	2D. WORK TELEPHONE # ()	
PERSON TO HANDLE FINANCIAL AFFAIRS OTHER THAN APPLICANT				
NAME	RELATIONSHIP	ADDRESS	HOME TELEPHONE	WORK TELEPHONE

PART III- APPLICANT/SPOUSE DATA

1. APPLICANT'S EMPLOYMENT STATUS(Check one) <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Not Employed <input type="checkbox"/> Unknown				
2. SPOUSE'S EMPLOYMENT STATUS(Check one) <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Not Employed <input type="checkbox"/> Unknown				
APPLICANT'S OCCUPATION: _____				
3. MARITAL STATUS: <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widow <input type="checkbox"/> Divorced <input type="checkbox"/> Separated				
4. SPOUSE'S NAME IN FULL:			5. DATE OF BIRTH:	
6. BIRTHPLACE(City):	6A. STATE:	7. DATE OF MARRIAGE:	8. SOCIAL SECURITY #:	
9. SPOUSE'S MEDICARE #:	10. HOW MARRIAGE ENDED:	11. WHEN:		

**FURNISH A COPY OF ALL DIVORCE DECREES, MARRIAGE CERTIFICATES, AND DEATH CERTIFICATES
VETERAN AND CURRENT SPOUSE**

PART IV – MILITARY SERVICE DATA

1A. LAST BRANCH OF SERVICE:	1B. LAST SERVICE #:	1C. LAST DATE OF ENTRY:	1D. LAST DISCHARGE DATE:	1E. DISCHARGE TYPE:
2A. PRIOR BRANCH OF SERVICE:	2B. PRIOR SERVICE #:	2C. PRIOR DATE OF ENTRY:	2D. PRIOR DISCHARGE DATE:	3E. DISCHARGE TYPE:
MILITARY SERVICE INFORMATION: <input type="checkbox"/> WW I <input type="checkbox"/> WW II <input type="checkbox"/> KOREAN <input type="checkbox"/> VIETNAM <input type="checkbox"/> OTHER				
ARE YOU: SC VETERAN <input type="checkbox"/> YES <input type="checkbox"/> NO NSC VETERAN <input type="checkbox"/> YES <input type="checkbox"/> NO MILITARY RETIREE <input type="checkbox"/> YES <input type="checkbox"/> NO				
PRISONER OF WAR STATUS <input type="checkbox"/> YES <input type="checkbox"/> NO WHERE _____ EXPOSURE TO AGENT ORANGE <input type="checkbox"/> YES <input type="checkbox"/> NO				
EXPOSURE TO RADIATION <input type="checkbox"/> YES <input type="checkbox"/> NO COMBAT SERVICE <input type="checkbox"/> YES <input type="checkbox"/> NO RECEIVING A & A <input type="checkbox"/> YES <input type="checkbox"/> NO				
RECEIVING HOUSEBOUND <input type="checkbox"/> YES <input type="checkbox"/> NO RECEIVING VA PENSION <input type="checkbox"/> YES <input type="checkbox"/> NO				
RECEIVING VA DISABILITY <input type="checkbox"/> YES <input type="checkbox"/> NO				

PART V – FINANCIAL INCOME

Income Source	Veteran	Spouse	Freq.	Address Where Income is Mailed
GROSS WAGES				
SOCIAL SECURITY				
VETERANS AFFAIRS PENSION				
VETERANS AFFAIRS COMPENSATION				
MILITARY RETIREMENT				
RAILROAD RETIREMENT				
CIVIL SERVICE ANNUITIES				
STATE RETIREMENT BENEFITS				
COMPANY RET. _____				
SALE/RENT OR REAL ESTATE				
DIVIDENDS/INTEREST, ANNUITIES				
FARM & OTHER BUSINESS INCOME				
OTHER: _____				
TOTAL				

PART V – FINANCIAL (CONT)

(ALL INCOME SHOULD BE BROKEN DOWN TO A MONTHLY AMOUNT. HOWEVER, IF THE INCOME IS RECEIVED QUARTERLY OR ANNUALLY, PLEASE PLACE A (Q) OR (A) RESPECTIVELY IN THE FREQ. COLUMN).

ASSETS				
ASSET	VETERAN	SPOUSE	DEBT	LOCATION & ADDRESS OF ASSET
Checking # _____				
Savings # _____				
Certificate of Deposit				
Other Cash Deposits				
Stocks & Bonds (Market Value)				
US Saving Bonds				
Treasury Notes or Bills				
Mutual Funds				
Trust Funds				
IRA Accounts				
Prepaid Burial Account				
Personal Residence (Mkt. Value)				
Business Property (Mkt. Value)				
Farm Property (Mkt. Value)				
Rental Property (Mkt. Value)				
Oil and Gas Leases				
Other Real Estate				
TOTAL ASSETS				
MOTOR VEHICLES				
MAKE AND MODEL	YEAR	VALUE	DEBT	

PART VI – MEDICAL INFORMATION

FIELD ASSESSMENT

(Please check the appropriate box)

DRESSING

- Completely Independent
- Needs Minor Assistance
- Needs Total Assistance

GROOMING

- Completely Independent
- Needs Minor Assistance
- Needs Total Assistance

TOILET

- Completely Independent
- Needs Minor Assistance
- Occasionally Wets & Soils Self
- Incontinent

FEEDING

- Completely Independent
- Needs Assistance
- Must be Fed
- Special Diet _____

AMBULATION

- Able to evacuate a Building without Mechanical or Personal Assistance: No Limiting Factors
- Requires Wheelchair but Operates Independently _____
- Requires Wheelchair Assistance
- Other Self Help Devices (Please Indicate Type): _____

ANTICIPATED LEVEL OF CARE

- Has Indwelling Catheter, Colostomy or Related Device- (Please Indicate Below)

BATHING

- Completely Independent
- Needs Assistance
- Needs Total Assistance

SUPERVISION NEEDED

- None
- Minimum
- Strict

ANTICIPATED LEVEL OF CARE

- Light
- Moderate
- Heavy
- Total

The information contained in the Field Assessment was obtained by: Field Observation Interviewing Family Member Interviewing Physician Interviewing Nursing Home Personnel Other: _____ If information was obtained other than self observation; please provide the name and relationship of the person you obtained the information from:

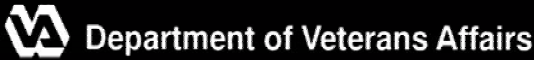
IT IS ABSOLUTELY ESSENTIAL THAT ADEQUATE MEDICAL DATA, INCLUDING THE LIST OF MEDICATIONS AND TREATMENTS, BE INCLUDED WITH THE APPLICATION.

Does the applicant have a pre-paid burial arrangement? Yes No With Whom? _____

(Provide name and address) _____

Does the applicant have a preference in terms of a Funeral Home? Yes No With Whom? _____

(Provide name and address) _____



**STATE HOME PROGRAM APPLICATION FOR VETERAN CARE
 MEDICAL CERTIFICATION**

PART I - ADMINISTRATIVE

STATE HOME FACILITY		DATE ADMITTED	GENDER <input type="checkbox"/> M <input type="checkbox"/> F
RESIDENT'S NAME (Last, First, Middle)		SOCIAL SECURITY NUMBER	
RESIDENT'S STREET ADDRESS		AGE	DATE OF BIRTH
CITY, STATE AND ZIP CODE		ADVANCED MEDICAL DIRECTIVE <input type="checkbox"/> NO <input type="checkbox"/> YES	

PART II - HISTORY AND PHYSICAL (Use separate sheet if necessary)

HISTORY

HEIGHT	WEIGHT	TEMP	PULSE	BP	HEAD/EYES/EAR/NOSE AND THROAT		
NECK				CARDIOPULMONARY			
ABDOMEN				GENITOURINARY			
RECTAL				EXTREMITIES			
NEUROLOGICAL				ALLERGY/DRUG SENSITIVITY			
X-RAY/ LAB	CHEST X-RAY	DATE	RESULTS	CBC	DATE	RESULTS	
	SEROLOGY						
	URINALYSIS	DATE	ALBUMEN	SUGAR	ACETONE		

CHECK ALL BOXES THAT APPLY OR CIRCLE NA

IS DEMENTIA THE PRIMARY DIAGNOSIS <input type="checkbox"/> YES <input type="checkbox"/> NO	IS THERE A DIAGNOSIS OF MENTAL ILLNESS <input type="checkbox"/> YES <input type="checkbox"/> NO	HAS RESIDENT RECEIVED MENTAL SERVICES WITHIN THE PAST 2 YEARS <input type="checkbox"/> YES <input type="checkbox"/> NO	IS CLIENT A DANGER TO SELF OR OTHERS <input type="checkbox"/> YES <input type="checkbox"/> NO
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IS THERE ANY PRESSING EVIDENCE OF MENTAL ILLNESS SUCH AS:

<input type="checkbox"/> SCHIZOPHRENIA	<input type="checkbox"/> PARANOIA	<input type="checkbox"/> OTHER PSYCHOTIC OR MENTAL DISORDERS LEADING TO CHRONIC DISABILITY
<input type="checkbox"/> MOOD SWINGS	<input type="checkbox"/> SOMATOFORM DISORDER	<input type="checkbox"/> PANIC OR SEVERE ANXIETY DISORDER
		<input type="checkbox"/> PERSONALITY DISORDER

OXYGEN <input type="checkbox"/> MASK <input type="checkbox"/> PRN <input type="checkbox"/> NASAL CANULAR <input type="checkbox"/> CONTINUOUS		<input type="checkbox"/> TUBE FEEDING <input type="checkbox"/> OSTOMY <input type="checkbox"/> TRACHOSTOMY	<input type="checkbox"/> DECUBITUS ULCERS <input type="checkbox"/> DRAINING WOUND <input type="checkbox"/> WOUND CULTURED	FOLEY CATHETER <input type="checkbox"/> TEMPORARY <input type="checkbox"/> PERMANENT
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REFERRING PHYSICIAN	PRIMARY DIAGNOSIS
SECONDARY DIAGNOSIS	TERTIARY DIAGNOSIS

TYPE OF CARE RECOMMENDED: SKILLED NURSING HOME CARE DOMICILIARY CARE ADULT DAY HEALTH CARE HOSPITAL

MEDICATION AND TREATMENT ORDERS ON ADMISSION, CONTINUE ON SEPARATE SHEET IF NECESSARY

PRINTED OR TYPED NAME OF PRIMARY PHYSICIAN ASSIGNED	SIGNATURE OF PRIMARY PHYSICIAN ASSIGNED
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STATE HOME PROGRAM APPLICATION FOR VETERAN CARE - MEDICAL CERTIFICATION, CONTINUED

RESIDENT'S NAME (Last, First, Middle)	SOCIAL SECURITY NUMBER
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EVALUATION (Select an appropriate number in each category)

COMMUNICATION	<input type="checkbox"/> 1. Transmits messages/receives information <input type="checkbox"/> 2. Limited ability <input type="checkbox"/> 3. Nearly or totally unable	SPEECH	<input type="checkbox"/> 1. Speaks clearly with others of same language <input type="checkbox"/> 2. Limited ability <input type="checkbox"/> 3. Unable to speak clearly or not at all
HEARING	<input type="checkbox"/> 1. Good <input type="checkbox"/> 2. Hearing slightly impaired <input type="checkbox"/> 3. Limited hearing (e.g.- must speak loudly) <input type="checkbox"/> 4. Virtually/completely deaf	SIGHT	<input type="checkbox"/> 1. Good <input type="checkbox"/> 2. Vision adequate - Unable to read/see details <input type="checkbox"/> 3. Vision limited - Gross object differentiation <input type="checkbox"/> 4. Blind
TRANSFER	<input type="checkbox"/> 1. No assistance <input type="checkbox"/> 2. Equipment only <input type="checkbox"/> 3. Supervision only <input type="checkbox"/> 4. Requires human transfer w/wo equipment <input type="checkbox"/> 5. Bedfast	AMBULATION	<input type="checkbox"/> 1. Independence w/wo assistive device <input type="checkbox"/> 2. Walks with supervision <input type="checkbox"/> 3. Walks with continuous human support <input type="checkbox"/> 4. Bed to chair (total help) <input type="checkbox"/> 5. Bedfast
ENDURANCE	<input type="checkbox"/> 1. Tolerates distances (250 feet sustained activity) <input type="checkbox"/> 2. Needs intermittent rest <input type="checkbox"/> 3. Rarely tolerates short activities <input type="checkbox"/> 4. No tolerance	MENTAL AND BEHAVIOR STATUS	<input type="checkbox"/> 1. Alert <input type="checkbox"/> 2. Confused <input type="checkbox"/> 3. Disoriented <input type="checkbox"/> 4. Comatose <input type="checkbox"/> 5. Agreeable <input type="checkbox"/> 6. Disruptive <input type="checkbox"/> 7. Apathetic <input type="checkbox"/> 8. Well motivated
TOILETING	<input type="checkbox"/> 1. No assistance <input type="checkbox"/> 2. Assistance to and from and transfer <input type="checkbox"/> 3. Total assistance including personal hygiene, help with clothes <input type="checkbox"/> A. Bathroom <input type="checkbox"/> B. Bedside commode <input type="checkbox"/> C. Bedpan	BATHING	<input type="checkbox"/> 1. No assistance <input type="checkbox"/> 2. Supervision only <input type="checkbox"/> 3. Assistance <input type="checkbox"/> 4. Is bathed <input type="checkbox"/> A. Tub <input type="checkbox"/> B. Shower <input type="checkbox"/> C. Sponge bath
DRESSING	<input type="checkbox"/> 1. Dresses self <input type="checkbox"/> 2. Minor assistance <input type="checkbox"/> 3. Needs help to complete dressing <input type="checkbox"/> 4. Has to be dressed	FEEDING	<input type="checkbox"/> 1. No assistance <input type="checkbox"/> 2. Minor assistance, needs tray set up only <input type="checkbox"/> 3. Help feeding/encouraging <input type="checkbox"/> 4. Is fed
BLADDER CONTROL	<input type="checkbox"/> 1. Continent <input type="checkbox"/> 2. Rarely incontinent <input type="checkbox"/> 3. Occasional - once/week or less <input type="checkbox"/> 4. Frequent - up to once a day <input type="checkbox"/> 5. Total incontinence <input type="checkbox"/> 6. Catheter, indwelling	BOWEL CONTROL	<input type="checkbox"/> 1. Continent <input type="checkbox"/> 2. Rarely incontinent <input type="checkbox"/> 3. Occasional - once/week or less <input type="checkbox"/> 4. Frequent - up to once a day <input type="checkbox"/> 5. Total incontinence <input type="checkbox"/> 6. Ostomy
SKIN CONDITION	<input type="checkbox"/> 1. Intact <input type="checkbox"/> 2. Dry/Fragile <input type="checkbox"/> 3. Irritations (Rash) Number _____ <input type="checkbox"/> 4. Open wound Stage _____ <input type="checkbox"/> 5. Decubitus	WHEEL CHAIR USE	<input type="checkbox"/> 1. Independence <input type="checkbox"/> 2. Assistance in difficult maneuvering <input type="checkbox"/> 3. Wheels a few feet <input type="checkbox"/> 4. Unable to use <input type="checkbox"/> NA

SIGNATURE OF REGISTERED NURSE OR REFERRING PHYSICIAN	DATE
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PHYSICAL THERAPY (To be completed by Physical Therapist or Referring Physician) NEW REFERRAL CONTINUATION OF THERAPY

SENSATION IMPAIRED <input type="checkbox"/> YES <input type="checkbox"/> NO	RESTRICT ACTIVITY <input type="checkbox"/> YES <input type="checkbox"/> NO	PRECAUTIONS <input type="checkbox"/> CARDIAC <input type="checkbox"/> OTHER (Specify)	FREQUENCY OF TREATMENT
TREATMENT GOALS: <input type="checkbox"/> ACTIVE <input type="checkbox"/> COORDINATING ACTIVITIES <input type="checkbox"/> FULL WEIGHT BEARING <input type="checkbox"/> WHEELCHAIR INDEPENDENT <input type="checkbox"/> STRETCHING <input type="checkbox"/> ACTIVE ASSISTIVE <input type="checkbox"/> NON-WEIGHT BEARING <input type="checkbox"/> PROGRESS BED TO WHEELCHAIR <input type="checkbox"/> COMPLETE AMBULATION <input type="checkbox"/> PASSIVE ROM <input type="checkbox"/> PROGRESSIVE RESISTIVE <input type="checkbox"/> PARTIAL WEIGHT BEARING <input type="checkbox"/> RECOVERY TO FULL FUNCTION			

ADDITIONAL THERAPIES <input type="checkbox"/> O. T. <input type="checkbox"/> SPEECH <input type="checkbox"/> DIETARY	SIGNATURE OF AND TITLE OF THERAPIST	DATE
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SOCIAL WORK ASSESSMENT (To be completed by Social Worker)

PRIOR LIVING ARRANGEMENTS	LONG RANGE PLAN
ADJUSTMENT TO ILLNESS OR DISABILITY	SIGNATURE OF SOCIAL WORKER
	DATE

VA AUTHORIZATION FOR PAYMENT

DATE RECEIVED BY VA	ELIGIBILITY FOR PER DIEM PAYMENT <input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED	LEVEL OF CARE RECOMMENDED <input type="checkbox"/> NHC <input type="checkbox"/> DOMICILIARY <input type="checkbox"/> HOSPITAL <input type="checkbox"/> ADHC
REASON FOR DISAPPROVAL	<input type="checkbox"/> APPROVED	REASON FOR DISAPPROVAL
	<input type="checkbox"/> DISAPPROVED	
SIGNATURE OF VA OFFICIAL	DATE	SIGNATURE OF VA PHYSICIAN
		DATE

Chairman
Edward Wieggers
Vice Chairman
Jim Buterbaugh
Member
Michael Neer
Member
Joy D. Moser
Member
Jonathan P. Smalls

Executive Director
Jack Fowler
Soldiers' Home
Steve Dunkin, Superintendent
Veterans' Home
Jim Hays, Superintendent
Cemetery Program
Kafer Peele, Director



KANSAS

Kansas Soldiers' Home
714 Sheridan Unit 98
Fort Dodge, KS 67843
Telephone: (620)-227-2121
Fax: (620) 227-0107

WWW.KCVA.ORG

MARK PARKINSON, GOVERNOR

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____ hereby authorize the use and disclosure of my health information as indicated below. I understand that action has been taken in reliance on the authorization. I also understand that if the individual or organization authorized to receive this information is not required to comply with current privacy regulations, my health information may be disclosed to others and no longer protected by current state and federal privacy regulations.

Date of birth: _____

Social security number: _____

Hereby authorize: _____

The release of the information checked and/or listed below for the time period beginning on 1 year previous and ending on present

- | | |
|--|---|
| <input checked="" type="checkbox"/> Complete Health Care Record(s) | <input checked="" type="checkbox"/> Discharge Summary |
| <input checked="" type="checkbox"/> History & Physical Examination | <input checked="" type="checkbox"/> Progress Notes |
| <input checked="" type="checkbox"/> Minimum Data Set | <input checked="" type="checkbox"/> Care Plans |
| <input checked="" type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Dental Records |
| <input checked="" type="checkbox"/> Medical/Treatment Records | <input type="checkbox"/> Photographs, Video Tapes, Digital, or other images |
| <input checked="" type="checkbox"/> Pathology Reports | <input type="checkbox"/> Billings Statements |
| <input checked="" type="checkbox"/> X-Ray Reports | <input type="checkbox"/> Emergency Care Records |
| <input checked="" type="checkbox"/> Transcribed Reports | <input type="checkbox"/> Consultant Reports |
| <input checked="" type="checkbox"/> Nurses' Notes | <input type="checkbox"/> Other: _____ |

The information checked and/or listed above is to be released to:

Kansas Soldiers Home
Attn: Social Services
714 Sheridan, Unit 128
Fort Dodge, Kansas 67843-9068
(620) 227-2121 ext. 143 or 119
(Fax) (620) 227-0107

For the purpose(s) of: Admission to Kansas Soldiers' Home

I understand that the individual, organization, or entity receiving my health information may receive financial or in-kind compensation in exchange for using or disclosing the information described above.

Unless otherwise revoked by me, I understand that this authorization will expire on _____ or upon the completion of the use of the information for the purpose it was intended, whichever is earlier.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

Signature of resident or legal representative: _____

Witness: _____

Date: _____

A copy of this record must be provided to the person making the request and a copy must be filed in the medical record.

APPLICANT'S AGREEMENT
KANSAS SOLDIERS' HOME

1. I agree to fully comply with the laws of the State of Kansas and the rules and regulations of the Kansas Soldiers' Home, if permitted to become a member, to obey and abide by all the orders of the Superintendent and/or his designee, and promptly perform all the duties required of me as a member of the Kansas Soldiers' Home.
2. I authorize the Kansas Commission on Veterans' Affairs to conduct an investigation to determine the total value of my property and assets before my admission as a member of the Home and to investigate my financial status at any time while I am a Home member in order to determine my ability to pay maintenance charges as established by the rules and regulations of the Home. I understand that I will be charged according to my ability to pay, and I agree to pay for my residence at the Kansas Soldiers' Home at the rate prescribed and in accordance with my resources. I understand that the charge may change with an increase or decrease in my income or for authorized exclusions of my income. I understand that should I receive additional income or be eligible for additional income at any future date from any source that I must report it to the Home and that failure to do shall be cause for my discharge.
3. I agree that if my personal property is unclaimed for a period of 30 days after the date of my voluntary departure or any other discharge from the Home, the Superintendent is authorized to claim such property for public auction or use by the Home.
4. I declare that I have been a bonafide resident of the State of Kansas for at least two years prior to making application for admission.
5. I agree that any personal funds, securities, other valuables not deposited for safe keeping with the Kansas Soldiers' Home and retained by me in my personal possession shall be kept at my own risk. This includes all sensory aids, i.e. hearing aids, dentures, glasses, etc.
6. In the event that any portion of this agreement for any reason whatsoever is invalid, the remaining portion of this agreement shall nevertheless be valid, enforceable, and effectual, as though the invalid portion or portions have never been a part of it.

I have read, or have had read to me, all questions and answers on this form, and the answers to all questions are true and complete to the best of my knowledge and belief.

How did you hear about the Kansas Soldiers' Home? _____

(Applicant's Signature)

(Date)

(Spouse's Signature)

(Date)