Don't staple the pages of this application together!

1. Some providers *scan* the application, and if you staple, that means removing staples from 1000 applications every week or month.
2. If you include a letter, don't staple that either: providers need to quickly get to your waitlist data and your cover page just gets in the way.

**You must answer EVERY question on EVERY page.**

**IF YOU FAIL TO DO SO, YOUR APPLICATION WILL PROBABLY BE REJECTED, OR EVEN THROWN INTO THE GARBAGE.**

Use #10 double-window envelopes. Fold on the line, and addresses will fit in the windows.

Dear

I am applying to the following waitlist, which I believe is open: *App Generated:*

**Housing Authority or Management Office Only**

**Is this waitlist closed? Any other questions or concerns?** *Fill in the appropriate circle(s) below and fax this page to HousingWorks at the number below – and we will correct the problem. Hundreds of thousands of applicants check our free website to see what lists are open! Keeping us updated will save you many phone calls, reduces frivolous applications - and takes only 10 minutes a year.*

○ **This particular waitlist is closed: The only open waitlists we have at present are:**

_____

○ **This is not the correct application. The correct application is available by/from:**

_____

○ **Any other info you wish to tell HousingWorks?**

_____

**Your position or title at this housing program:** _____

**Your signature**: _____

**HousingWorks Fax**: **617-536-8561**

HOUSINGWORKS
For Everyone

Online Page

**Head of Household's FIRST NAME**

**Head of Household's MIDDLE NAME**

**Head of Household's LAST NAME**

**YOUR MOTHER'S MAIDEN NAME**

| **HoH's SOCIAL SECURITY NUMBER** | **HoH's DATE OF BIRTH** | **GENDER** |
|---|---|---|
| | | |

**ETHNICITY**
Also provide your race at right!

**RACE:** Asian , Black, White, Native American, Pacific Islander, Multi-racial
Do **NOT** write Spanish, Hispanic, Latino here – and do **NOT** write your country!

**REQUESTED ACCOMMODATIONS ○ = ● Do you need a:**

- ○ **Fully Accessible Wheelchair** Unit
- ○ **No-Steps unit** (elevator to any floor)
- ○ **First-Floor unit only**
- ○ **Blind Accessible** Unit
- ○ **Deaf Accessible** Unit
- ○ unit designed for **Environmental Allergies**
- ○ Need an **Interpreter**
- ○ **Domestic Violence Victim**

**HoH's CAREER STAGE**

○ Employed ○ Unemployed ○ Retired ○ FT Student ○ PT Student

**MOBILE RENTAL ASSISTANCE**

○ I do not have mobile rental assistance ○ Mobile Section 8 voucher ○ MRVP ○ AHVP ○ VASH or similar

**Head of Household** - Any **Felony/Conviction?** ○ Yes ○ No Any **Misdemeanor Conviction?** ○ Yes ○ No

**Other Members:** Any **Felony Convictions?** ○ Yes ○ No Any **Misdemeanor Conviction?** ○ Yes ○ No

Is anyone in HH subject to a **lifetime sex offender registration** in any state? ○ Yes ○ No

| **TOTAL HOUSEHOLD SIZE** | | | | **How much money does your family receive in a year?** | |
|---|---|---|---|---|---|
| ○ | ←# Adults | ←# Children | ←**Total #** | ○ | **.00** |

| **YOUR HOME TELEPHONE** | **SECOND TELEPHONE** |
|---|---|
| | |

**YOUR EMAIL ADDRESS**

**BEST MAILING ADDRESS**
**This is:**

**SECOND MAILING ADDRESS**
This is:

| # **BEDROOMS NEEDED?** | **SPECIAL CIRCUMSTANCES? -** *some programs may assign you a priority status* |
|---|---|
| | ○ Disability ○ Elder ○ Veteran ○ Fleeing Domestic Violence<br>○ Displaced by:_____ ○ Rent-burdened ○ Other |

SOLDIERS' HOME IN MASSACHUSETTS
91 CREST AVENUE
CHELSEA, MA 02150
617-884-5660

1. APPLICATION FOR

_____ ALZHEIMER'S UNIT _____ SKILLED NURSING FACILITY _____ REHABILITATION UNIT

_____ DORMITORY _____ SUPERVISED DORMITORY _____ ACUTE CARE

2. NAME

_____ _____ _____
FIRST MIDDLE LAST

3. DATE OF APPLICATION

4. HOME ADDRESS

STREET & NUMBER _____

CITY & STATE _____

ZIP CODE _____ TELEPHONE NO. _____

5. OCCUPATION

6. PLACE OF BIRTH

6a. SEX M ( ) F ( )

| 7. SERVICE NUMBER | BRANCH OF SERVICE | DATE ENTERED ACTIVE DUTY | DATE OF SEPARATION | RANK | TYPE OF DISCHARGE |
|---|---|---|---|---|---|
| | | | | | |

| 8. SOCIAL SECURITY NUMBER | 9. VA CLAIM NUMBER | 10. DATE OF BIRTH |
|---|---|---|
| | | |

11. MARITAL STATUS _____ SINGLE _____ MARRIED _____ SEPARATED _____ DIVORCED _____ WIDOWED

NUMBER OF CHILDREN UNDER IS YEARS OF AGE _____

DO YOU CONTRIBUTE TO SUPPORT OF OTHERS? _____ SPECIFY _____

MAIDEN NAME OF WIFE _____

12. NAME AND ADDRESS OF NEXT OF KIN RELATIONSHIP

HOME TELEPHONE NUMBER WORK TELEPHONE NUMBER

13. NAME AND ADDRESS OF PERSON TO BE NOTIFIED IN EMERGENCY RELATIONSHIP

HOME TELEPHONE NUMBER WORK TELEPHONE NUMBER

14. LENGTH OF CONTINUOUS RESIDENCY IN MASSACHUSETTS IMMEDIATELY PRIOR TO DATE OF THIS APPLICATION _____YEARS

HOW VERIFIED _____

15. HAVE YOU EVER BEEN TREATED AT THE SOLDIERS' HOME, CHELSEA? _____ YES _____ NO IF YES, WHEN? _____

SOLDIERS' HOME NUMBER (IF KNOWN) _____

16. IF DISABLED VETERAN - PERCENT OF DISABILITY 0% FOR WHAT CONDITION _____

17. IF RECENTLY HOSPITALIZED - NAME OF HOSPITAL _____ DATE OF DISCHARGE _____

| 18. REFERRED FROM | 19. REFERRED BY |
|---|---|
| 20. RELIGION (OPTIONAL) | 21. RACE (OPTIONAL) |

**FINANCIAL** INFORMATION

| **SOURCE** | **GROSS MONTHLY AMOUNT** |
|---|---|
| 1. COMPENSATION (SERVICE CONNECTED) | $123 |
| 2. PENSION NON-SERVICE CONNECTED) | $123 |
| 3. RETIREMENT | $123 |
| 4. AID & ATTENDANCE/HOUSE BOUND | $123 |
| 6. INCOME FROM OTHER SOURCES (DESCRIBE) _____ *(DIVIDENDS, ANNUITIES, INTEREST ON BANK ACCOUNTS, BONDS, SECURITIES, INCOME FROM RENTS)* | $1,234 |
| 7. TOTAL MONTHLY INCOME FROM ALL SOURCES | $1,726 |

HEALTH INSURANCE INFORMATION

TYPE OF HEALTH INSURANCE: CHECK ALL THAT APPLY )

MEDICARE PART A ☐ MEDICARE PART B ☐ MEDEX ☐

NONE ☐ BLUE CROSS ☐ OTHER ☐

MEDICARE CERTIFICATE NUMBER _____ EFFECTIVE DATE PART A _____ PART B _____

MEDEX CERTIFICATE NUMBER _____ BLUE CROSS CERTIFICATE NUMBER _____

OTHER HEALTH INSURANCE:

SUBSCRIBER'S NAME _____

NAME OF PLAN _____

ADDRESS OF PLAN _____

POLICY NUMBER _____

CONTACT PERSON, PHONE NUMBER AND ADDRESS IF PRE-ADMISSION APPROVAL REQUIRED:

Type Name Here Enter Phone Number Here

Enter Address on This Line

IF YOU ARE ENTITLED TO HOSPITAL CARE FROM ANY SOURCE NOT IDENTIFIED ABOVE OR BY REASON OF A COURSE OF ACTION AGAINST ANY PARTY, PLEASE GIVE:

NAME _____

ADDRESS _____

TELEPHONE _____

I HEREBY AUTHORIZE THE PHYSICIANS AND STAFF OF THE SOLDIERS' HOME IN MASSACHUSETTS TO RENDER SUCH TREATMENT AS IS FOUND NECESSARY AND TO PERFORM ANY EXAMINATION WHICH IS DEEMED ADVISABLE.

THE ANSWERS TO ALL QUESTIONS ARE TRUE AND COMPLETE- TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ *SIGNATURE OF APPLICANT*

_____ *SIGNATURE, TITLE AND TELEPHONE NUMBER OF PERSON COMPLETING APPLICATION ON BEHALF OF APPLICANT*

/md

TO: Soldiers' Home
Admission Office

Please list all private, public, military and VA hospitals or clinics where you have been an inpatient or outpatient during the last five years. Try to approximate dates as best as you can.

| HOSPITAL/CLINIC | DATE(S) |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

This is a complete list of my medical history and I agree to assist the Soldiers' Home in obtaining the full medical records of these services.

Signed: _____ Date: _____

Referring Agents' Signature: _____

Agency: _____

Address: _____

Telephone No. _____

/md
2/95

**THE COMMONWEALTH OF** MASSACHUSETTS
**EXECUTIVE OFFICE OF HEA LTH AND HUMAN SERVICES**

**SOLDIERS' HOME**
91 CREST AVENUE
CHELSEA, MA 02150

**MICHAEL RESCA**
**COMMANDANT**

TEL. (617) 884-5660 Voice/TTY

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name _____ Date of Birth _____

Address _____

Social Security # _____ Soldiers' Home # _____

I hereby authorize: _____

_____

_____

to release information from my medical record to: Dormitory Admission Clerk
Soldier's Home
91 Crest Avenue
Chelsea, MA 02150

This authorization covers the following records:

( ) 1. Records only for my treatment of _____

( ) 2. Complete copy of medical record.

The purpose of this disclosure is _____

This authorization covers treatment for alcohol abuse, drug and psychiatric treatment.

This authorization expires six (6) months from date signed

_____ _____
Signature of Patient Date

/md
2/95

Form Approved: OMB No. 2900-0025
Respondent Burden: 7.5 minutes

Department of Veterans Affairs

# REQUEST FOR AND CONSENT TO RELEASE OF INFORMATION FROM CLAIMANT'S RECORDS

**NOTE:** The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, United States Code, and will authorize release of the information you specify. The information may also be disclosed outside VA as permitted by law to include disclosures as stated in the "Notices of Systems of VA Records" published in the Federal Register in accordance with the Privacy Act of 1974.

**RESPONDENT BURDEN:** VA may not conduct or sponsor, and the respondent is not required to respond, to this collection of information unless it displays a valid OMB Control Number. The Privacy Act of 1974 (5 U.S.C. 552a) and VA's confidentiality statute (38 U.S.C. 5701) as implemented by 38 CFR 1.526(a) and 38 CFR under any other provision of law. The information requested is approved under OMB Control Number 2900-0025 and is necessary to ensure that the statutory requirements of the Privacy Act and VA's confidentiality statute are met.

Responding to this collection of information is voluntary. However, if the information is not furnished, we may not be able to comply with your request. Public reporting burden for this collection of information is estimated to average 7.5 minutes per respondent, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspects of this collection of information, including suggestions for reducing this burden, to the VA Clearance Officer (045A4, 810 Vermont Avenue, NW, Washington, DC 20420. **SEND COMMENTS ONLY. DO NOT SEND THIS FORM OR REQUESTS FOR BENEFITS TO THIS ADDRESS.**

| TO | Department of Veterans Affairs | NAME OF VETERAN *(Type or print)* | |
|---|---|---|---|
| | | VA FILE NO. *(Include prefix)* | SOCIAL SECURITY NO. |

NAME AND ADDRESS OF ORGANIZATION AGENCY, OR INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

ATTN: DORMITORY ADMISSIONS

## VETERAN'S REQUEST

I hereby request and authorize the Department of Veterans Affairs to release the following information from the records identified above to the organization, agency, or individual named hereon: ▶

NAME

INFORMATION REQUESTED *(Number each item requested and give the dates or approximate dates - period from and to - covered by each.)*

Any information regarding the following:

Alcohol/Drug Abuse
Psychiatric Treatment
Sickle Cell Anemia
Infection with Human Immunodeficienty Virus (HIV)
Copy of Hospital Summaries/Outpatient Treatment for last five (5) years.

PURPOSE(S) FOR WHICH THE INFORMATION IS TO BE USED.

For admission to Soldiers' Home

*NOTE: Additional information may be listed on the reverse side of this form.*

| SIGNATURE AND ADDRESS OF CLAIMANT, OR FIDUCIARY, IF CLAIMANT IS INCOMPETENT | DATE |
|---|---|
| | |

OMB Number: 2900-0260
Estimated burden: 2 minutes
Expiration Date: 10/31/2004

Department of Veterans Affairs

# REQUEST FOR AND CONSENT TO RELEASE OF MEDICAL RECORDS PROTECTED BY 38 U.S.C. 7332

**The Paperwork Reduction Act of 1995** requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We expect that the time expended by all individuals completing this form will average 2 minutes. This includes the time to read instructions, gather the necessary facts and fill out the form. The purpose of this form is to specifically outline the circumstances under which we may disclose data.

◀ The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. and will authorize release of information you specify. Your disclosure of the information requested on this form is voluntary. However, if the information is not furnished, Department of Veterans Affairs will be unable to comply with the request.

**ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.**

**TO: DEPARTMENT OF VETERANS AFFAIRS** *(Print or type name and address of health care facility)*

PATIENT NAME *(Last, First, Middle Initial)*

SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

ATTN: DORMITORY ADMISSIONS

**VETERAN'S REQUEST:** I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☐ OTHER *(Specify)*

For Last Five (5) Years

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED

For Admission to Soldiers' Home Program

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

**AUTHORIZATION:** I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time except to the extent that action has already been taken to comply with it. redisclosure of my medical records by those receiving the above authorized information may not be accomplished without my further written consent. Without my express revocation, the consent will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); or (3) under the following conditions(s):

**I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.**

DATE

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT

**FOR VA USE ONLY**

IMPRINT PATIENT DATA CARD *(Name, Address, Social Security Number)*

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED

RELEASED BY

GUIDELINES FOR ASSESSING DAILY CHARGES
AT THE
SOLDIERS' HOME IN MASSACHUSETTS

**HOSPITAL PATIENTS**

For MARRIED patients, the first $1,000 of the veteran's gross monthly income (from all sources) is exempt. Spousal income will not be used in the calculation of a veteran's income. Following this deduction, the patient will be charged $15 per day up to a maximum monthly charge of $465.

For UNMARRIED patients, the first $200 of gross monthly income is exempt. Following this deduction, the resident will be charged $15 per day up to a maximum monthly charge of $465.

**DORMITORY RESIDENTS**

For ALL dormitory residents, the first $200 of gross monthly income is exempt. Following this deduction, the resident will be charged $5 per day up to a maximum monthly charge of $155.

Charges are billed on a monthly basis and timely payment to the Soldiers' Home is required. The Commandant has the authority to terminate the stay of a patient/resident for failure to pay the Daily Care Charge.

THE AMOUNT OF THE DAILY CARE CHARGE MAY CHANGE ON A PERIODIC BASIS WITHOUT NOTICE IN ACCORDANCE WITH COMMONWEALTH OF MASSACHUSETTS REGIULATIONS.

These guidelines for Assessing Daily Charges at the Soldiers' Home in Massachusetts Ref. C 150, Act 1990 Sec. 46 and Sec. 383) have been explained and presented to me and/or my representative and I have had the opportunity to ask any questions that I may have.

| _____ | _____ | _____ |
|---|---|---|
| Signature of Patient/Representative | Soldiers' Home # | Date |
| _____ | _____ | _____ |
| Signature of Witness | Date | |

/md
2/95

ADDRESOGRAPH

**SOLDIERS' HOME IN MASSACHUSETTS**

**HEALTH INSURANCE QUESTIONNAIRE**

NAME _____ SH# _____

*(CIRCLE YES OR NO AND COMPLETE)*

1. ARE YOU DISABLED? YES NO IF YES, DATE OF DISABILITY _____

2. ARE YOU RETIRED? YES NO IF YES, DATE OF RETIREMENT _____

3. ARE YOU MARRIED? YES NO IF YES, NAME OF SPOUSE _____

4. ARE YOU CURRENTLY WORKING FULL OR PART-TIME? YES NO

5. IS YOUR SPOUSE CURRENTLY WORKING FULL OR PART-TIME? YES NO

6. ARE YOU COVERED UNDER AN EMPLOYER GROUP HEALTH PLAN THROUGH YOUR CURRENT OR FORMER EMPLOYMENT? YES NO

7. ARE YOU COVERED THROUGH THE CURRENT OR FORMER EMPLOYMENT OF YOUR SPOUSE OR ANOTHER FAMILY MEMBER? YES NO

   IF YES, PROVIDE THE FOLLOWING: NAME OF INSURED _____
   RELATIONSHIP TO PATIENT (SELF, SPOUSE OR OTHER) _____
   NAME AND ADDRESS OF EMPLOYER _____
   NAME AND ADDRESS OF INSURER, HMO, ETC. _____
   GROUP IDENTIFICATION NUMBER _____
   POLICY IDENTIFICATION NUMBER _____

   IF YES, HOW MANY EMPLOYEES DOES YOUR EMPLOYER OR YOUR SPOUSE'S EMPLOYER HAVE? UNDER 100 _____ OVER 100 _____

8. HAVE YOU RECEIVED A KIDNEY TRANSPLANT? YES NO
   IF YES, DATE _____

9. HAVE YOU RECEIVED MAINTENANCE DIALYSIS TREATMENTS? YES NO
   IF YES, DATE DIALYSIS BEGAN _____

10. DO YOU HAVE A FEE SERVICE CARD FROM THE DEPARTMENT OF VETERANS AFFAIRS? YES NO

**SOLDIERS' HOME IN MASSACHUSETTS**
**ADMISSION QUESTIONNAIRE**

NAME _____ SH# _____

1. OCCUPATION _____
   ADDRESS OF EMPLOYER _____
   EMPLOYER TELEPHONE NUMBER _____
   IS THIS HOSPITALIZATION DUE TO EMPLOYMENT? YES NO

2. SPOUSE'S NAME _____
   MOTHER'S NAME _____
   FATHER'S NAME _____

3. ARE THERE ADVANCE BURIAL ARRANGEMENTS? YES NO
   NAME OF MORTICIAN _____
   ADDRESS _____
   TELEPHONE NUMBER _____
   BURIAL LOCATION _____

4. DO YOU HAVE A WILL? YES NO
   LOCATION OF WILL _____
   NAME OF EXECUTOR _____
   TELEPHONE NUMBER _____

5. DO YOU HAVE LIFE INSURANCE? YES NO
   LOCATION OF POLICY _____

6. ARE THERE ADVANCE MEDICAL DIRECTIVES? YES NO
   NAME OF DESIGNEE _____
   LOCATION OF DIRECTIVE _____

7. HAVE YOU MADE A DECISION CONCERNING RESUSCITATION ORDERS?
   DO NOT RESUSCITATE _____
   RESUSCITATE _____
   NO DECISION MADE _____

_____ _____
NAME OF PERSON COMPLETING FORM DATE

COMMONWEALTH OF MASSACHUSETTS
EXECUTIV OFFICE OF HEALTH AND HUMAN SERVICES
**SOLDIERS' HOME**
91 CREST AVENUE CHELSEA, MA 02150
TEL (617) 884-5660 VOICE/TTY

WILLIAM D. O'LEARY
*SECRETARY*

MICHAEL RESCA
*COMMANDANT*

*EOHHS*
*XEOSH*

# DORMITORY RESIDENT APPLICATION

Soldiers' Home has been certified by the Criminal History Systems Board for access to conviction and pending criminal case data. As an applicant/employee for the position of _____.
I understand that a criminal record check will be conducted for conviction and pending criminal case information only and that it will not necessarily disqualify me. The information below is correct to the best of my knowledge.

_____
*Applicant/Employee Signature*

---

*APPLICANT/EMPLOYEE INFORMATION* (PLEASE PRINT)

_____ _____ _____
*LAST NAME* FIRST NAME MIDDLE NAME

_____
*MAIDEN* NAME OR ALIAS (IF APPLICABLE)

_____ _____
*DATE OF BIRTH:* SOCIAL SECURITY NUMBER:

ADDRESS:

---

**FOR OFFICIAL USE ONLY**

REQUESTED BY _____
SIGNATURE OF CORI AUTHORIZED EMPLOYEE

---

**CHSB USE ONLY**

RECORD ATTACHED: _____ NO RECORD: _____

HAVE YOU EVER BEEN *CONVICTED OF A FELONY?* *YES* *NO*
IF *YES, EXPLAIN*

*HAVE YOU EVER BEEN CONVICTED OF ANY OTHER OFFENSE AGAINST THE LAW?* *YES* *NO*
*(See below before answering*)*

*EXPLAIN:*

*DATE OF COURT OFFENSE* _____ *DISPOSITION:*

---

***You are not required to furnish information for:***

(1) Any offense committed prior to your seventeenth (17) birthday, unless such offense was bound over for trial in superior court;

(2) A first misdemeanor conviction for drunkenness, simple assault, speeding, minor traffic violations, affray, or disturbance of the peace;

(3) A misdemeanor conviction which occurred more than five (5) years ago *unless you have been convicted of any offense within the last five (5) years*; or

(4) a misdemeanor conviction that resulted in a period of incarceration that ended more than five (5) years ago *unless you have been convicted of any offense within the last five (5) years*.

THE ANSWERS TO *ALL QUESTIONS ARE* TRUE AND CONOLE17E TO THE BEST OF MY KNOWLEDGE AND *BELIEF*

_____ SIGNATURE OF APPLICANT

_____ SIGNATURE, TITLE AND TELEPHONE NUMBER OF PERSON COMPLETING APPLICATION ON BEHALF OF APPLICANT

/md
1/97

**THE COMMONWEALTH OF** MASSACHUSETTS
**EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES**

**SOLDIERS' HOME**
91 CREST AVENUE
CHELSEA, MA 02150

**MICHAEL RESCA**
**COMMANDANT**

TEL. (617) 884-5660 Voice/TTY

Enclosed you will find an application for domiciliary care at the Soldiers' Home in Massachusetts. This application must be completely filled out and each page signed and dated by the applicant. The application must also be accompanied by a copy of the veteran's Form DD214 honorable discharge or equivalent documentation of military service.

Eligibility for domiciliary care is based in part on state law. Applicant must be a Commonwealth of Massachusetts resident State legislation further requires no less than 90 days active service (and in some instances not less than 180 days of active service) at least I day of which was wartime service and an honorable or general discharge. Veterans from WWI, WWII, Korea, Vietnam, Lebanon, Panama and the Persian Gulf are eligible for admission

If the applicant is being, referred by another hospital or agency, we ask the referring agency to submit all pertinent information such as; medical, psychiatric and developmental history, a social/family history, diagnosis, prognosis, current list of medications, and other relevant reports such as occupational therapy, physical therapy, and a summary of current level of functioning.

Please be advised that the admissions process may be lengthy due to delays in receiving the required medical information. If you have any questions concerning this application, please call the Dormitory Admissions Office at (617) 884-5660, Ext. 152

Thank you for your interest in the Soldiers' Home.

Please send all items to:

Dormitory Admissions
Soldiers' Home
91 Crest Avenue
Chelsea, MA 02150

/lms
2/1/01