

 Department of Veterans Affairs		APPLICATION FOR EXTENDED CARE SERVICES	
SECTION I - GENERAL INFORMATION			
1. VETERAN'S NAME (Last, First, MI)		2. SOCIAL SECURITY NUMBER	
SECTION II - INSURANCE INFORMATION			
ANSWER YES OR NO WHERE APPLICABLE (OTHERWISE PROVIDE THE REQUESTED INFORMATION)			
3. ARE YOU ELIGIBLE FOR MEDICAID? <input type="checkbox"/> YES <input type="checkbox"/> NO		3A. ARE YOU ENROLLED IN MEDICARE PART A (Hospital Insurance) <input type="checkbox"/> YES <input type="checkbox"/> NO	
4. ARE YOU ENROLLED IN MEDICARE PART B (Medical Insurance) <input type="checkbox"/> YES <input type="checkbox"/> NO		4B. MEDICARE CLAIM NUMBER (If applicable)	
5. ARE YOU COVERED BY HEALTH INSURANCE (including coverage through a spouse)? (If "YES", provide the following information for all insurance company(s) providing coverage to you.) <input type="checkbox"/> YES <input type="checkbox"/> NO			
6. NAME OF INSURANCE COMPANY		6A. ADDRESS OF INSURANCE COMPANY	
6C. NAME OF POLICY HOLDER		6D. RELATIONSHIP OF POLICY HOLDER	
7. NAME OF INSURANCE COMPANY		7A. ADDRESS OF INSURANCE COMPANY	
7C. NAME OF POLICY HOLDER		7D. RELATIONSHIP OF POLICY HOLDER	
8. NAME OF INSURANCE COMPANY		8A. ADDRESS OF INSURANCE COMPANY	
8C. NAME OF POLICY HOLDER		8D. RELATIONSHIP OF POLICY HOLDER	
6E. POLICY NUMBER		6F. GROUP NAME AND/OR NUMBER	
7E. POLICY NUMBER		7F. GROUP NAME AND/OR NUMBER	
8E. POLICY NUMBER		8F. GROUP NAME AND/OR NUMBER	
6B. PHONE NUMBER OF INSURANCE COMPANY		7B. PHONE NUMBER OF INSURANCE COMPANY	
8B. PHONE NUMBER OF INSURANCE COMPANY		8B. PHONE NUMBER OF INSURANCE COMPANY	
SECTION III - SPOUSE/DEPENDENT INFORMATION			
9. CURRENT MARITAL STATUS (Check one) <input type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> LEGALLY SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9A. SPOUSE'S NAME (Last, First, MI)	
9B. SPOUSE RESIDING IN THE COMMUNITY? (Provide address and phone number if different from veteran) <input type="checkbox"/> YES <input type="checkbox"/> NO (If "No", explain)		9C. SPOUSE'S SOCIAL SECURITY NUMBER	
10. DEPENDENT'S NAME (Last, First, MI)		10A. DEPENDENT'S DATE OF BIRTH	
10C. DEPENDENT RESIDING IN THE COMMUNITY? (Provide address and phone number if different from veteran) <input type="checkbox"/> YES <input type="checkbox"/> NO (If "No", explain)		10B. DEPENDENT'S SOCIAL SECURITY	
11. DEPENDENT'S NAME (Last, First, MI)		11A. DEPENDENT'S DATE OF BIRTH	
11C. DEPENDENT RESIDING IN THE COMMUNITY? (Provide address and phone number if different from veteran) <input type="checkbox"/> YES <input type="checkbox"/> NO (If "No", explain)		11B. DEPENDENT'S SOCIAL SECURITY	
We need to collect information regarding income, assets and expenses for you and your spouse. If you do not wish to provide this information you must sign agreeing to make copayments and will be charged the maximum copayment amount for all services. See the top of page 2, read, sign and date.			