OMB Number: 2900-0629
Estimated Burden: 90 min.
Expiration date: 5/31/2005

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?	3A. ARE YOU ENROLLED IN MEDICARE PART A *(Hospital Insurance)*	3B. EFFECTIVE DATE *(If "Yes")*
☐ YES ☐ NO	☐ YES ☐ NO	

4. ARE YOU ENROLLED IN MEDICARE PART B *(Medical Insurance)*	4A. EFFECTIVE DATE *(If "Yes")*	4B. MEDICARE CLAIM NUMBER *(If applicable)*
☐ YES ☐ NO		

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.)*

☐ YES ☐ NO

6. NAME OF INSURANCE COMPANY	6A. ADDRESS OF INSURANCE COMPANY	6B. PHONE NUMBER OF INSURANCE COMPANY

6C. NAME OF POLICY HOLDER	6D. RELATIONSHIP OF POLICY HOLDER	6E. POLICY NUMBER	6F. GROUP NAME AND OR NUMBER

7. NAME OF INSURANCE COMPANY	7A. ADDRESS OF INSURANCE COMPANY	7B. PHONE NUMBER OF INSURANCE COMPANY

7C. NAME OF POLICY HOLDER	7D. RELATIONSHIP OF POLICY HOLDER	7E. POLICY NUMBER	7F. GROUP NAME AND/OR NUMBER

8. NAME OF INSURANCE COMPANY	8A. ADDRESS OF INSURANCE COMPANY	8B. PHONE NUMBER OF INSURANCE COMPANY

8C. NAME OF POLICY HOLDER	8D. RELATIONSHIP OF POLICY HOLDER	8E. POLICY NUMBER	8F. GROUP NAME AND/OR NUMBER

SECTION III - SPOUSE/DEPENDENT INFORMATION

9. CURRENT MARITAL STATUS *(Check one)* ☐ MARRIED ☐ NEVER MARRIED ☐ LEGALLY SEPARATED ☐ WIDOWED ☐ DIVORCED	9A. SPOUSE'S NAME *(Last, First, MI)*

9B. SPOUSE RESIDING IN THE COMMUNITY? *(Provide address and phone number if different from veteran)* ☐ YES ☐ NO *(If "No", explain)*	9C. SPOUSE'S SOCIAL SECURITY NUMBER

10. DEPENDENT'S NAME *(Last, First, MI)*	10A. DEPENDENT'S DATE OF BIRTH	10B. DEPENDENT'S SOCIAL SECURITY

10C. DEPENDENT RESIDING IN THE COMMUNITY? *(Provide address and phone number if different from veteran)* ☐ YES ☐ NO *(If "No", explain)*		

11. DEPENDENT'S NAME *(Last, First, MI)*	11A. DEPENDENT'S DATE OF BIRTH	11B. DEPENDENT'S SOCIAL SECURITY

11C. DEPENDENT RESIDING IN THE COMMUNITY? *(Provide address and phone number if different from veteran)* ☐ YES ☐ NO *(If "No", explain)*		

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.