pennsylvania
DEPARTMENT OF MILITARY
AND VETERANS AFFAIRS

APPLICATION FOR ADMISSION TO A PENNSYLVANIA STATE VETERANS' HOME

The application for admission to a Pennsylvania State Veterans' Home consists of six parts and requests information needed to determine eligibility for admission. **The application must be completed and submitted in its entirety.**

The applicant must complete Parts I, II, III, IV and VI. Part V must be completed and signed by a physician. **Additionally, a copy of the applicant's honorable military discharge/separation document must be submitted with the application (example: DD214).** *If required information is not furnished, the application will be returned for completion* resulting in a delay to the admission process. Failure to keep us informed of any address change or telephone contact number could also delay or cancel your admission.

It is the policy of the Department of Military and Veterans Affairs to process all applications without regard to race, color, national origin, religious creed, age, sex, ancestry or handicap. There is no distinction in eligibility for, or in the manner of, providing any applicant services provided by, or through, the Pennsylvania State Veterans' Homes. All Pennsylvania State Veterans' Homes are available without distinction to all residents and visitors; regardless of race, color, national origin, religious creed, age, sex, ancestry or handicap. All persons and organizations that have occasion to refer residents for admission are to do so without regard to the resident's race, color, national origin, religious creed, age, sex, ancestry or handicap.

PLEASE NOTE: WE DO NOT ACCEPT FAXED APPLICATIONS. Only the **original application** with **original signatures** will be accepted and must be mailed directly to the following address:

Department of Military and Veterans Affairs
Bureau of Veterans' Homes
Attn: Admission's Office
Bldg. S-0-47, Fort Indiantown Gap
Annville, Pennsylvania 17003-5002

www.paveterans.state.pa.us

"Pennsylvania cares for its veterans, and their spouses and children."

BVH Form-101 (Revised Jan. 2013)

Instruction Sheet for Completing the Application for Admission to a State Veterans' Home

The instruction sheet is designed to provide the applicant with step-by-step instructions for filling out the Application for Admission to a State Veterans' Home (BVH Form-101). The following list will assist the applicant and ensure that the application is submitted with all required documentation. Once the application is received at the Department of Military and Veterans Affairs, it is date stamped, reviewed and sent to the Home(s) that the applicant has/have chosen.

Please note: Do not send an application directly to the Home of choice as this will only delay the processing time.

Part I - General Information

Question 1-12: Contains general information that pertains to the applicant. **Please note: If the applicant is a spouse of a veteran, a copy of the marriage certificate is required in order to process the application.**

Question 13: If a Power of Attorney or Legal Guardian is in effect, please provide a copy of the order declaring Power of Attorney or the Legal Guardian documentation.

Question 14: Indicate individual we should contact regarding this application process.

Question 15: Indicate Veterans' Home preference.

Please note: If interested, you may choose up to two (2) Homes. Indicate this by marking 1 beside your first choice, and 2 beside your second choice.

Question 16: Felony charges.

Part II - Military Services Record

Complete all areas of Part II. **Please remember to include a copy of the applicant's honorable military discharge/separation documents (example: DD214).** Applications that do not contain a discharge/separation document will be returned. **Additionally, take note of the home of record at time of entry into the military.** If the applicant was born in a state other than Pennsylvania, and had a home of record at time of entry into the military service other than Pennsylvania, the applicant ***must*** submit proof of Pennsylvania residency.

If you cannot locate your military discharge/separation document, please contact your County Director of Veterans' Affairs, a Regional Veterans' Affairs Office or the National Personnel Record's Center in St. Louis, Missouri at **1-866-272-6272 Option 4 or www.archives.gov/veterans/evetrecs/index.html**

Part III - Financial Information

Please provide all applicable financial information. It is **not** necessary to send copies of bank statements when making application.

Part IV - Residency Requirements

Please pay particular attention to the **"NOTE"** regarding a **bonafide** resident of the Commonwealth of Pennsylvania.

Part V - Medical Information

Our medical forms consist of three pages. **The MA 51 form question #10 on page 9 requires the signature of the applicant/responsible party.**

Medical information ***must*** be **completed and signed by a physician.** The first page is the **instruction page for Form MA51;** the second page is the **Medical Evaluation Form MA51;** and the third page is the **Activities of Daily Living Assessment Sheet.**

Part VI – Outreach Survey

This form is optional.

Frequently Asked Questions

Question: How much does it cost to stay in a State Veterans' Home?
Answer: Cost of care and income-related questions will be answered by the **Revenue Office** of the Home you have chosen.

Question: When can I expect to be admitted?
Answer: Each completed application is date stamped and forwarded to the Home of choice for further review and processing. Once the Home has made the determination of level of care, the applicant's name is placed on the appropriate waiting list by date of application. Each applicant is admitted in order of application date.

Question: Who can I contact if I have any questions?
Answer: If you need assistance completing the application, you may contact the **Admission Coordinator at the Home, or you may contact the Bureau of Homes,** Fort Indiantown Gap.

Admission's Office - Fort Indiantown Gap	717-861-8906
Delaware Valley Veterans' Home	215-856-2718
Gino J. Merli Veterans' Center	570-961-4348
Hollidaysburg Veterans' Home	814-696-5352
Soldiers' and Sailors' Home	814-878-4939
Southeastern Veterans' Center	610-948-2406
Southwestern Veterans' Center	412-665-6782

PART I. GENERAL INFORMATION

1. Name of Applicant:_____ ☐ Veteran ☐ Male
(Last) (First) (Middle) ☐ Spouse ☐ Female

(If you are a spouse of a veteran, please be sure to include a copy of your marriage certificate along with the original application.)

2. Mailing Address:_____
(No. & Street) (City) (State) (Zip Code)

3. County:_____ **4.** Telephone Number: (_____) _____

5. Date of Birth:_____ **6.** Place of Birth:_____
(Month / Day / Year) *(City / State)*

7. Social Security Number:_____

8. Marital Status: ☐ Married ☐ Never Married ☐ Widowed ☐ Divorced ☐ Separated

9. Medicare Insurance Information: Part A ☐ Yes ☐ No Part B ☐ Yes ☐ No Part D ☐ Yes ☐ No

Copay Insurance Company_____ Number_____

10. Medicaid Access Number_____

11. Is your current address different than mailing address? ☐ Yes ☐ No If yes, indicate name and address of residency:_____

Contact Person:_____
(Name) *(Phone Number)*

12. Have you ever been a resident of a Pennsylvania State Veterans' Home? ☐ Yes ☐ No

Name of Home:_____

Date of Residence:_____

13. Do you have a Power of Attorney (POA) in affect? ☐ Yes ☐ No Legal Guardian? ☐ Yes ☐ No

If yes, is it: ☐ Medical ☐ Financial

If yes, list your POA/Guardian's Contact Information:

_____ _____
(Name) *(Relationship to Applicant)*

_____
(POA/Guardian's Address) *(City)* *(State)* *(Zip Code)*

(_____) (_____)
(POA/Guardian's Home Phone Number) *(POA/Guardian's Work Phone Number)*

_____ (_____)
(POA/Guardian's E-mail Address) *(POA/Guardian's Cell Phone)*

(IMPORTANT: Please be sure to include a copy of your Power of Attorney.)

14. Whom should we contact regarding this application?

_____ _____
(Name) *(Relationship to Applicant)*

_____
(Address) *(City)* *(State)* *(Zip Code)*

(_____) (_____)
(Home Phone Number) *(Work Phone Number)*

_____ (_____)
(E-mail address) *(Cell Phone)*

15. Indicate Veterans' Home Preference:

You may choose 2 Homes, if interested. If you choose 2 Homes, indicate a number 1 beside your first choice and a number 2 beside your second choice.

____	☐ Hollidaysburg Veterans' Home, Hollidaysburg, PA 16648 (Blair County)	814-696-5352
____	☐ Pennsylvania Soldiers' and Sailors' Home, Erie, PA 16512 (Erie County)	814-878-4939
____	☐ Southeastern Veterans' Center, Spring City, PA 19475 (Chester County)	610-948-2406
____	☐ Gino J. Merli Veterans' Center, Scranton, PA 18503 (Lackawanna County)	570-961-4348
____	☐ Southwestern Veterans' Center, Pittsburgh, PA 15206 (Allegheny County)	412-665-6782
____	☐ Delaware Valley Veterans' Home, Philadelphia, PA 19154 (Philadelphia County)	215-856-2718

16. Have you ever been convicted of a felony? ☐ Yes ☐ No If yes, date convicted: _____

PART II. MILITARY SERVICES RECORD

(IMPORTANT: Attach Copy of Release or Military Discharge for Latest Period of Service.)

☐ Army ☐ Navy ☐ Air Force ☐ Marine Corps

☐ Coast Guard ☐ PA National Guard ☐ Merchant Marine ☐ Reserve

Service Number:	**Date Entered Service:**	**Date of Separation:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Character of Discharge: _____ Rank at Time of Discharge: _____

Are you registered in the U.S. Veteran's Administration System? ☐ Yes ☐ No

If so, please provide your Veteran's Administration number: _____

Do you have a service-connected disability? ☐ Yes _____ % ☐ No

PART III. FINANCIAL INFORMATION

A showing of financial need is required for admission to a State Veterans' Home. The following information is needed to assess your eligibility for admission:

A. Provide monthly income from the Federal Government:

1. VA Compensation $ _____
2. VA Pension $ _____
3. Military Retirement Pay $ _____

B. Other Income: Provide veteran and spouse's monthly income in dollar amounts.

	Veteran	Spouse
1. Social Security	$	$
2. Retirement/Pension	$	$
3. Employment	$	$
4. Supplemental Security Income (SSI)	$	$
5. Interest/Dividends	$	$
6. Rent/Royalties	$	$

C. Investments

1. Bank Accounts (Savings/Checking)	$	$
2. Stocks/Bonds	$	$
3. Annuities	$	$
4. Trust Funds	$	$
5. Certificates of Deposit	$	$
6. Burial Fund	☐ Yes ☐ No	
7. Real Estate	☐ Yes ☐ No	

Name on Deed: _____ Location: _____

Have you transferred or assigned title to assets or income to anyone in the past three (3) years?

☐ Yes ☐ No If Yes, explain: _____

_____

D. Verification Information

For verification purposes, please list contact information of all financial institutions.

Name of Institution(s): _____

Address: _____

Phone Number: _____

PART IV. RESIDENCY REQUIREMENTS

1. Were you a resident of Pennsylvania when you entered the military? ☐ Yes ☐ No

2. Are you currently a resident of Pennsylvania? ☐ Yes ☐ No

NOTE: Acceptance to a Pennsylvania State Veterans' Home is open only to bonafide residents of the Commonwealth of Pennsylvania. You must be a bonafide resident for a minimum of six months. If the applicant is not a bonafide resident of Pennsylvania, or did not enter the armed forces of the United States, or the Pennsylvania Military Forces from Pennsylvania, the applicant will not qualify for admission to a Pennsylvania State Veterans' Home.

SIGNATURE AND CERTIFICATION

READ CAREFULLY BEFORE SIGNING

I have read, or have heard, the questions contained in Parts I, II, III, and IV of this application for admission to a Pennsylvania State Veterans' Home. I hereby certify under penalty of law that the foregoing information is true and correct to the best of my knowledge and belief. I understand that if I do not provide accurate information, I will be subject to discharge from the Home and prosecuted for violation of 18 Pa. C.S. paragraph 4904 (relating to unsworn falsification to authorities).

By signing this application, I hereby give my expressed written consent to the Commonwealth of Pennsylvania, Department of Military and Veterans' Affairs, through its Bureau of Veterans' Homes, to obtain information to verify this application from any source. I specifically direct the U.S. Veterans' Administration, the Department of Defense, the Armed Forces, and any banks, financial institutions or others with information about my military service, financial status, or medical condition including drug/alcohol or mental health related conditions to release any and all information from my records to any authorized agent of the Bureau of Veterans' Homes for purpose of processing this application. I hereby specifically authorize the Bureau of Veterans' Homes to use the information provided in this form for purpose of processing this application. I hereby authorize the Bureau of Veterans' Homes to review and discuss my medical records.

I understand that, if I am admitted to a State Veterans' Home, my estate and I will be legally obligated to pay for the full cost of my care and maintenance while a resident of the Home. I further understand that the Commonwealth is authorized to recover the costs of maintaining persons in State Veterans' Homes in accordance with Pennsylvania law. **No person will be denied admission to a Veterans' Home on grounds of inability to pay maintenance fees**. I agree to pay the maintenance charges and to inform the Home, at once, of any changes in my financial circumstances that may affect my ability to pay. I understand that, although my estate and I remain obligated to pay the full charge, the amount of periodic payments may be reduced depending on the amount of my income. If I am admitted to the Home, I agree to abide by all rules and regulations governing the Home.

_____ _____

(Applicant/Responsible Party Signature) (Date) ***(Witness Signature)***

If applicant is unable to sign this application, the person signing for the applicant must indicate and provide
proof of legal authority for signing; such as, Power of Attorney, Court Order, Guardianship, etc.

INSTRUCTIONS FOR COMPLETING MA-51 MEDICAL EVALUATION

NOTE: THE MA-51 IS VALID AS LONG AS IT REFLECTS THE CURRENT CONDITIONS FOR THE APPLICANT

At the top of the page, mark if this is a new or updated MA-51.

Questions 1-7 are self-explanatory.

8. **Physician License Number.** Enter the physician license number, not the Medical Assistance number.
9. **Evaluation At.** Enter 1-5 to describe where evaluation took place. If 5 is used, specify where evaluation was completed.
10. **Signature.** Applicant should sign if able. If unable, legal guardian or responsible party may sign.
11. **Essential Vital Signs.** Self-explanatory.
12. **Medical Summary.** Include any medical information you feel is important for determination of level of care. **Please list patient's known allergies in this section.**
13. **Vacating of building.** How much assistance does the patient require to vacate the building?
14. **Medication Administration.** Is the patient capable of being trained to self-administer medications?
15. **Diagnostic Codes and Diagnoses.** ICD-9-CM diagnostic codes should be put in the blocks, then written by name in the space next to the block. List diagnoses starting with primary, then secondary, and finally tertiary. There is room for any other pertinent diagnoses.
16. **Professional and Technical Care Needs.** Indicate care needed. Examples of "other" include mental health and case management.
17. **Physician Orders.** Orders should meet needs indicated in box 16. Medications should have diagnoses to support their use.
18. **Prognosis.** Indicate patient's prognosis based on current medical condition.
19. **Rehabilitation Potential.** Indicate based on current condition. Should be consistent with box 18.

20A. Physician's Recommendation. Physician must recommend patient's level of care. If the box for "other" is checked, write in level of care. In order to provide assistance to a physician in the level of care recommendation, the following definitional guidelines should be considered:

Nursing Facility Clinically Eligible (NFCE)	Personal Care Home	ICF/MR Care	ICF/ORC Care	Inpatient Psychiatric Care
Requires health-related care and services because the physical condition necessitates care and services that can be provided in the community with Home and Community Based Services or in a Nursing Facility.	Provides Personal Care services such as meals, housekeeping, & ADL assistance as needed to residents who live on their own in a residential facility.	Provides health-related care to MR individuals. More care than custodial care but less than in a NF.	Provides health-related care to ORC individuals. More care than custodial care but less than in a NF.	Provides inpatient psychiatric services for the diagnoses and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

20B. Complete only if Consumer is NFCE and will be served in a Nursing Facility. Check whether the patient will be eventually be discharged from facility based on current prognosis. If yes, check expected length of stay.

20C. The physician must sign and date the MA-51. A licensed physician must sign the MA-51. It may not be signed by a "physician in training" (a Medical Doctor in Training [MT] or an Osteopathic Doctor in Training [OT].

Questions 21 and 22 completed by the OPTIONS Unit in the Area Agency on Aging.

MA 51 - 1/04

MEDICAL EVALUATION ☐ NEW ☐ UPDATED

1. MA RECIPIENT NUMBER	2. NAME OF APPLICANT (Last, first, middle initial)	3. SOCIAL SECURITY NO.	4. BIRTHDATE	5. AGE	6. SEX

7. ATTENDING PHYSICIAN	8. PHYSICIAN LICENSE NUMBER

9. EVALUATION AT (Description and code) ☐

01 Hospital
02 NF
03 Personal Care/Dom Care
04 Own House/Apartment
05 Other (Specify) _____

10. For the purpose of determining my need for TITLE XIX INPATIENT CARE, Home and Community Based Services, and if applicable, my need for a shelter deduction, I authorize the release of any medical information by the physician to the County Assistance Office, State Department of Public Welfare or its agents.

SIGNATURE - APPLICANT OR PERSON ACTING FOR APPLICANT _____ DATE _____

11. HEIGHT	WEIGHT	BLOOD PRESSURE	TEMPERATURE	PULSE RATE	CARDIAC RHYTHM

12. MEDICAL SUMMARY

13. IN EVENT OF AN EMERGENCY THE PATIENT CAN VACATE THE BUILDING
☐ 1. Independently ☐ 2. With Minimal Assistance ☐ 3. With Total Assistance

14. PATIENT IS CAPABLE OF ADMINISTERING HIS/HER OWN MEDICATIONS
☐ 1. Self ☐ 2. Under Supervision ☐ 3. No

15. ICD-9-CM DIAGNOSTIC CODES

PRIMARY (Principal)
SECONDARY
TERTIARY

16. PROFESSIONAL AND TECHNICAL CARE NEEDED - CHECK ✓ EACH CATEGORY THAT IS APPLICABLE
☐ Physical Therapy ☐ Speech Therapy ☐ Occupational Therapy ☐ Inhalation Therapy ☐ Special Dressings ☐ Irrigations
☐ Special Skin Care ☐ Parenteral Fluids ☐ Suctioning ☐ Other (Specify) _____

17. PHYSICIAN ORDERS
Medications _____
Treatment _____
Rehabilitative and Restorative Services _____
Therapies _____
Diet _____
Activities _____
Social Services _____
Special Procedures for Health and Safety or to Meet Objectives _____

18. PROGNOSIS - CHECK ✓ ONLY ONE
☐ 1. Stable ☐ 2. Improving ☐ 3. Deteriorating

19. REHABILITATION POTENTIAL - CHECK ✓ ONLY ONE
☐ 1. Good ☐ 2. Limited ☐ 3. Poor

20A **PHYSICIAN'S RECOMMENDATION** To the best of my knowledge, the patient's medical condition and related needs are essentially as indicated above. I recommend that the services and care to meet these needs can be provided at the level of care indicated - check ✓ only one

☐ Nursing Facility Clinically Eligible Services to be provided at home or in a nursing facility
☐ Personal Care Home Services provided in a Personal Care Home
☐ ICF/MR Care Services to be provided at home or in an Intermediate care facility for the mentally retarded
☐ ICF/ORC Care Services to be provided at home or in an Intermediate care facility for consumers with ORCs
☐ Inpatient Psychiatric Care
☐ Other (Please Specify) _____

20B. **COMPLETE ONLY IF CONSUMER IS NURSING FACILITY CLINICALLY ELIGIBLE AND WILL BE SERVED IN A NURSING FACILITY.**
ON THE BASIS OF PRESENT MEDICAL FINDINGS THE PATIENT MAY EVENTUALLY RETURN HOME OR BE DISCHARGED ☐ YES ☐ NO If Yes, Check ✓ Only One ☐ 1. Within 180 days ☐ 2. Over 180 days

20C. **PHYSICIAN'S SIGNATURE**

PHYSICIAN (PRINTED NAME) _____ TELEPHONE _____ PHYSICIAN SIGNATURE _____ DATE _____

FOR DEPARTMENT USE Medical and other professional personnel of the Medicaid agency or its designee MUST evaluate each applicant's or recipient's need for admission by reviewing and assessing the evaluations required by regulations

21A. **MEDICALLY ELIGIBLE** ☐ Yes ☐ No ☐ Medically Appropriate for Waiver Services

21B. **Length of Stay** ☐ Within 180 days ☐ Over 180 days

22 **Comments. Attach a separate sheet if additional comments are necessary.**

REVIEWER'S SIGNATURE AND TITLE _____ DATE _____

ORIGINAL TO CAO - RETAIN PHOTOCOPY FOR YOUR FILE

MA 51 - 1/04

PART V. ACTIVITIES OF DAILY LIVING ASSESSMENT SHEET

EVALUATION (CIRCLE ALL THAT APPLY IN EACH CATEGORY)			
COMMUNICATION	1. TRANSMITS MESSAGES/RECEIVES INFORMATION 2. LIMITED ABILITY 3. NEARLY OR TOTALLY UNABLE	**SPEECH**	1. SPEAKS CLEARLY W/OTHERS 2. LIMITED ABILITY 3. UNABLE TO SPEAK CLEARLY OR NOT AT ALL
HEARING	1. GOOD 2. HEARING SLIGHTLY IMPAIRED 3. LIMITED HEARING (E.G. MUST SPEAK LOUDLY) 4. VIRTUALLY/COMPLETELY DEAF	**SIGHT**	1. GOOD 2. VISION ADEQUATE-UNABLE TO READ DETAILS 3. VISION LIMITED-GROSS OBJECT DIFFERENTIATION 4. BLIND
AMBULATION	1. NO ASSISTANCE 2. WITH THE AID OF: _____ 3. SUPERVISION ONLY 4. REQUIRES HUMAN TRANSFER W/WO EQUIP. 5. BEDFAST	**BATHING**	1. NO ASSISTANCE 2. SUPERVISION ONLY 3. ASSISTANCE 4. SHOWER 5. TUB 6. SPONGE BATH
ENDURANCE	1. TOLERATES DISTANCES (250' SUSTAINED ACTIVITY) 2. NEEDS INTERMITTENT REST 3. RARELY TOLERATES SHORT 4. NO TOLERANCE	**FEEDING**	1. NO ASSISTANCE 2. MINOR ASSISTANCE, NEEDS TRAY SET-UP ONLY 3. HELP W/FEEDING/ENCOURAGING 4. IS FED 5. TUBE FED
TOILETING	1. NO ASSISTANCE 2. ASSISTANCE TO & FROM & TRANSFER 3. TOTAL ASSISTANCE & INCLUDING PERSONAL HYGIENE, HELP WITH: A. BATHROOM B. CLOTHING C. BEDSIDE COMMODE D. BEDPAN	**MENTAL STATUS**	1. ALERT 2. CONFUSED 3. DISORIENTED 4. COMATOSE
		BEHAVIOR STATUS	1. AGREEABLE 2. DISRUPTIVE 3. APATHETIC 4. COMBATIVE, AGGRESSIVE 5. WANDERS ___DAY ___NIGHT
DRESSING	1. DRESSES SELF 2. MINOR ASSISTANCE 3. NEEDS HELP TO COMPLETE DRESSING 4. HAS TO BE DRESSED	**WHEELCHAIR USE**	1. INDEPENDENT 2. ASSISTANCE IN DIFFICULT MANEUVERING 3. WHEELS A FEW FEET 4. UNABLE TO USE FEET 5. NA
SKIN CONDITION	1. INTACT 2. DRY/FRAGILE 3. IRRITATION (RASH) 4. OPEN WOUND 5. DECUBITUS #_____ STAGE _____	**BOWEL & BLADDER CONTROL**	1. CONTINENT 2. RARELY CONTINENT 3. OCCASIONAL- ONCE/WEEK OR LESS 4. FREQUENT-UP TO ONCE A DAY 5. TOTAL INCONTINENCE 6. OSTOMY/ILEOSTOMY
DECISION MAKING	1. ABLE TO HANDLE OWN FINANCES 2. UNABLE TO HANDLE OWN DECISIONS	**HOSPICE**	1. NEEDS HOSPICE CARE 2. DOES NOT NEED HOSPICE CARE
FALLS	1. NOT AT RISK FOR FALLS 2. AT RISK FOR FALLS	**DIET**	1. REGULAR 2. SPECIAL_____
MOUTH	1. NATURAL TEETH 2. EDENTULOUS 3. DENTURES ☐ UPPER ☐ LOWER	**SLEEP HABITS**	1. NORMAL 2. AWAKE FREQUENTLY AT NIGHT 3. DIFFICULTY FALLING ASLEEP 4. NAPS DURING THE DAY

RECENT SURGERIES/FRACTURES		
PHYSICIAN NAME (PLEASE PRINT)	**PHYSICIAN SIGNATURE**	
ADDRESS	**PHONE**	**DATE SIGNED**
	FAX	

PART VI. OUTREACH SURVEY (OPTIONAL)

We are constantly looking for better ways to reach our veterans and their spouses. In order to do so, we ask that you please fill out this survey. Supplying us with answers will help us improve service to all Pennsylvania's veterans.

Name:_____

1st Veterans' Home Preference:_____

How did you hear about our services?

☐ Internet ☐ Pamphlet/Publication ☐ Radio/Television Ad

☐ Friends/Family ☐ Veterans' Home Resident ☐ Veteran Service Office

☐ Exhibit/Display ☐ Veterans' Service Organization ☐ County Director

☐ Facility/Agency

☐ Other (please specify)_____

_____