

## APPLICATION FOR ADMISSION

Thank you for your interest in the Grand Rapids Home for Veterans. *Your application will be given immediate attention.*  
You can help the application process by submitting the following documents or information with your application.

### ■ MEDICAL

Medical history and physical exam of the applicant within the past 90 days. *(Required for admission.)*

Chest x-ray report of applicant within the past 30 days. *(Required for admission.)*

### ■ DOCUMENTS

DD-214 (Report of Separation, Military Record of Service, or Enlistment Record.)

Birth certificates for all minor children being claimed as dependents.

Marriage certificate if currently married.

Divorce papers or death certificate for all prior marriages of either the veteran or spouse if currently married.

Widow(er) needs to submit marriage certificate and veteran's death certificate.

If applicable: Guardianship paper, Conservatorship paper, Power of Attorney, Durable Power of Attorney, Patient Advocate form.

### ■ INSURANCE INFORMATION

Copies of insurance cards, including Medicare and secondary insurance if applicable.

Copy of nursing care insurance policy if applicable.

### ■ FINANCIAL

Verification of income and assets. This includes copies of any current bank account statements, land contracts, Social Security or other pension award letters or checks.

### ■ TAXES

If married, a copy of the past year's federal income tax forms.

### ■ FUNERAL ARRANGEMENT

Copies of any prepaid funeral arrangement papers.

### ■ CONTACT PERSON

Name of contact person for medical information if applicant is currently in another health care facility.

### ■ WHEELCHAIR RENTAL

If renting a wheelchair, check with rental company to see if the insurance company will continue to cover the wheelchair after admission to a veterans' facility. (GRHV can provide a wheelchair after admission.)

After the application is received, it is reviewed for completeness, eligibility, and level of care. The applicant (or interested other party) will receive a call from the Admissions Office to schedule an admission date and time, indicate placement on the waiting list, or advise you if we are unable to meet the needs required.

**Thank you for your cooperation. If you have any questions or wish to know the status of your application, please call (616)364-5389 locally or 1-800-642-4838.**

At the time of admission, you will be asked to sign a Member Contract. The purpose of this contract is to outline your financial responsibility required to the Grand Rapids Home for Veterans for your cost of care, Supplementary Services, and Member Rights and Responsibilities. (The Member Income and Assessment Office will be able to estimate the projected monthly room and board assessment.)  
**If you would like a copy of this contract prior to admission, please call us.**

GRAND RAPIDS HOME FOR VETERANS  
 3000 Monroe Avenue, NW  
 Grand Rapids, Michigan 49505  
 Phone (616) 364-5300  
 Toll Free: 1-800-MICH-VET

MICHIGAN DEPT OF MILITARY AND VETERANS AFFAIRS

GRAND RAPIDS HOME FOR VETERANS

Veteran    Dependent    New    Readmission   Date \_\_\_\_\_ Time \_\_\_\_\_

REQUIREMENTS FOR ADMISSION TO THE GRAND RAPIDS HOME FOR VETERANS

**APPLICATION FOR ADMISSION**

All members of the Armed Forces of the United States who have been honorably discharged and served not less than 90 days during a designated wartime period: 1st World War - April 6, 1917, to November 11, 1918 (to April 1920 if served in Russia); 2nd World War - December 7, 1941, to December 31, 1946; Cold War, Korean Conflict, Vietnam War or Persian Gulf War - beginning December 31, 1946, to present may apply for admission to said facilities. Veterans must be considered unemployable. Former members of the Armed Forces, otherwise qualified, who served less than 90 days and who were honorably discharged from service and who, as the result of service, acquired a service-connected disability or disease, may be admitted. All veterans must be residents of Michigan at the time of admission, unless an accredited Michigan veteran. Subject to available space and certain other requirements, a spouse, surviving spouse, former spouse or parent of eligible veterans may also be eligible for admission.

**ALL QUESTIONS MUST BE ANSWERED.** All questions on this form, including the medical certificate, must be completed OR THE APPLICATION WILL BE RETURNED. If the question does not apply, write "none" in the blank. Qualified war service must be verified by an acceptable discharge document. Where the discharge document has been lost, a transcript of service may be obtained by writing to the Adjutant General of the state in which such applicant enlisted.

THIS LINE IS FOR OFFICE USE ONLY	MEMBER NUMBER				LEVEL OF CARE	1 DOM 2 NURSING 3 SPECIAL-ALZHEIMER'S 4 SPECIAL NEEDS M-1	PRESENT LOCATION					ADMISSION DATE		
							BLDG	FLOOR	AREA	ROOM NO.	BED	MONTH	DAY	YEAR

PERSONAL INFORMATION

Application should be made out in ink or typewritten and notarized. Please print.

V.A. CLAIM NO.	SERVICE SERIAL NO.	SOCIAL SECURITY NO.			MEDICARE NO.						
NAME OF APPLICANT - (Last, First, Middle)				SEX	BIRTH DATE MONTH DAY YEAR			CITY	BIRTHPLACE	STATE	
PERMANENT ADDRESS (Street & Number)				CITY	COUNTY	STATE	ZIP	PHONE ( )			
TEMPORARY ADDRESS (Street & Number)				CITY	COUNTY	STATE	ZIP	PHONE ( )			
HAVE YOU EVER BEEN A MEMBER AT THIS FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO   IF YES, ENTER DATE _____											
REFERRAL SOURCE				<input type="checkbox"/> Self		<input type="checkbox"/> Family		<input type="checkbox"/> Hospital*		<input type="checkbox"/> Nursing Home*	
*NAME OF FACILITY _____						PHONE NO. _____					
*PERSON REFERRING _____						TITLE _____					



COUNTY:

### SERVICE INFORMATION

WARS SERVED IN (CHECK)	DISCHARGE TYPE FROM WAR SERVICE (CHECK)	BRANCH OF SERVICE	OUTFIT	IF DEPENDENT OF A VETERAN, CHECK ONE
<input type="checkbox"/> WW1 <input type="checkbox"/> COLD WAR <input type="checkbox"/> WW2 <input type="checkbox"/> VIETNAM <input type="checkbox"/> KOREAN <input type="checkbox"/> OTHER <input type="checkbox"/> PERSIAN GULF WAR	<input type="checkbox"/> 1 HONORABLE <input type="checkbox"/> 2 MEDICAL <input type="checkbox"/> 3 RETIREMENT	<input type="checkbox"/> AIR FORCE <input type="checkbox"/> ARMY <input type="checkbox"/> COAST GUARD <input type="checkbox"/> MARINES <input type="checkbox"/> NAVY		<input type="checkbox"/> MOTHER <input type="checkbox"/> FATHER <input type="checkbox"/> WIDOWED <input type="checkbox"/> SPOUSE <input type="checkbox"/> FORMER SPOUSE

**NOTE:** A military discharge document of the eligible veteran is required. Dependents must also provide proof of relationship to the eligible veteran. A marriage certificate or birth certificate, whichever is appropriate, is required (spouse or widow of veteran  marriage certificate; parent of veteran  birth certificate of veteran). Guardianship and/or conservatorship papers MUST BE PROVIDED as well, when applicable. All applicants may be required to provide true copies of marriage certificates, divorce decrees, and birth certificates. These must be made available at the time of admission.

ENLISTMENT DATE	PLACE OF ENLISTMENT	RESIDENCE AT TIME OF ENLISTMENT
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SEPARATION DATE	PLACE OF DISCHARGE
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VETERANS ORGANIZATION HOLDING POWER OF ATTORNEY RE: V.A. RECORDS

### INSURANCE INFORMATION

<b>MEDICARE COVERAGE</b>	PART A HOSPITAL <input type="checkbox"/> YES	PART B MEDICAL <input type="checkbox"/> YES
	EFFECTIVE DATE _____	EFFECTIVE DATE _____
OTHER MEDICAL INSURANCE <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME OF COMPANY NAME OF INSURANCE CARRIER ADDRESS	
PRESCRIPTION COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME OF COMPANY NAME OF INSURANCE CARRIER ADDRESS	
DENTAL COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME OF COMPANY NAME OF INSURANCE CARRIER ADDRESS	

VISION COVERAGE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	NAME OF COMPANY
			NAME OF INSURANCE CARRIER
			ADDRESS

## APPLICANT'S FINANCIAL DATA

This financial statement must be completed and signed by applicant, spouse, guardian or responsible person.  
**All questions must be answered. If the answer is none, put none.**

### PERSON HAVING FINANCIAL RESPONSIBILITY IF OTHER THAN APPLICANT

NAME (Last, First, Middle)		Phone (      )	
ADDRESS (Street & Number)	CITY	STATE	ZIP

PLEASE CHECK APPROPRIATE BOX:    **NOTE: You must provide documented proof for each box checked.**  
 FINANCIALLY RESPONSIBLE     LEGAL GUARDIAN     CONSERVATOR     DPOA     POA     PATIENT ADVOCATE

OCCUPATION OF APPLICANT	LAST DATE WORKED	
FORMER EMPLOYER	YEARS OF SERVICE	
FORMER EMPLOYER	YEARS OF SERVICE	
AUTOMOBILE(S) - YEAR AND MAKE	PARKED AT GRHV? <input type="checkbox"/> YES <input type="checkbox"/> NO	
MONTHLY INCOME	GROSS	NET
V.A. PENSION OR COMPENSATION	\$	\$
SOCIAL SECURITY	\$	\$
OTHER RETIREMENT INCOME (source: _____)	\$	\$
PLEASE LIST OTHER INCOME BELOW	\$	\$
1.	\$	\$
2.	\$	\$
3.	\$	\$
4.	\$	\$
5.	\$	\$
RENTAL PROPERTY INCOME	\$	\$
LAND CONTRACT INCOME	\$	\$
DIVIDENDS	\$	\$
INTEREST	\$	\$
NAME AND ADDRESS OF BANKS, SAVINGS & LOAN, CREDIT UNIONS	TYPE OF ACCOUNT Please list: SAVINGS; CERT. OF DEPOSIT (CD); CHECKING; IRA; OTHER	AMOUNT
1.		\$
2.		\$

3.		\$
4.		\$
5.		\$

APPLICANT'S FINANCIAL DATA continued

NAME OF LIFE INSURANCE COMPANIES	BENEFICIARIES	AMOUNT
1.		\$
2.		\$

Are you or your dependents receiving, or will be receiving, nursing care insurance payments?  Yes  No

LOCATION OF REAL ESTATE Street	City	State	Zip	VALUE
1.				\$
2.				\$

OTHER INVESTMENTS - IDENTIFY	VALUE
1.	\$
2.	\$
3.	\$
4.	\$
5.	\$
6.	\$
7.	\$
8.	\$

# FINANCIAL STATEMENT FOR DEPENDENTS

## FOR VETERANS OR APPLICANTS WITH DEPENDENTS ONLY

Applicants **WITHOUT** dependents, go on to page 9

This financial statement must be completed and signed by applicant, spouse, or conservator.

**All questions must be answered. If the answer is none, put none.**

SPOUSE: \_\_\_\_\_

(NAME)

SOCIAL SECURITY NUMBER

DATE LAST WORKED \_\_\_\_\_

INCOME SPOUSE AND/OR MINOR CHILDREN	MONTHLY INCOME	
	GROSS	NET
WAGES (source: _____)	\$	\$
SOCIAL SECURITY	\$	\$
OTHER RETIREMENT INCOME (indicate source below)		
1.	\$	\$
2.	\$	\$
3.	\$	\$
4.	\$	\$
RENTAL PROPERTY INCOME	\$	\$
LAND CONTRACT INCOME	\$	\$
DIVIDENDS	\$	\$
INTEREST	\$	\$
OTHER INCOME (indicate source below)		
1.	\$	\$
2.	\$	\$
3.	\$	\$
4.	\$	\$

NAME AND ADDRESS OF BANKS, SAVINGS AND LOAN, OR CREDIT UNIONS	TYPE OF ACCOUNT - Please list: SAVINGS; CERT. OF DEPOSIT (CD); CHECKING; IRA; OTHER	AMOUNT
1.		\$
2.		\$
3.		\$
4.		\$
5.		\$
6.		\$

AUTOMOBILE(S) - YEAR AND MAKE

FINANCIAL STATEMENT FOR DEPENDENTS continued

NAME OF LIFE INSURANCE COMPANIES		BENEFICIARIES		AMOUNT
1.				\$
2.				\$
LOCATION OF REAL ESTATE STREET	CITY	STATE	ZIP	VALUE
1.				\$
2.				\$
OTHER INVESTMENT - IDENTIFY				VALUE
1.				\$
2.				\$
<b>LIVING EXPENSES AND INDEBTEDNESS</b> MONTHLY EXPENSES				MONTHLY AMOUNT
FOOD AND CLOTHING				\$
TELEPHONE				\$
ELECTRICITY				\$
WATER & SEWAGE				\$
HEAT				\$
TAXES				\$
HOME INSURANCE				\$
HEALTH INSURANCE (OTHER THAN MEDICARE)				\$
LIFE INSURANCE				\$
CAR PAYMENTS				\$
CAR EXPENSE				\$
RENT - MORTGAGE PAYMENT				\$
OTHER EXPENSES AND DEBTS (indicate source below)				AMOUNT
1.				\$
2.				\$
3.				\$
4.				\$
5.				\$
6.				\$
7.				\$

DEPENDENT CHILDREN

DEPENDENT CHILDREN INCLUDE THOSE UNDER 18 YEARS OF AGE AND THOSE WHO, BECAUSE OF A DISABILITY, ARE STILL CONSIDERED DEPENDENTS

NAME	SOCIAL SECURITY NUMBER	AGE	SOURCE OF INCOME (IF ANY)	AMOUNT
1.				\$
2.				\$
3.				\$
4.				\$

MEDICAL EXPENSES

LIST ALL MEDICAL EXPENSES	AMOUNT	REIMBURSEMENT EXPECTED	MEDICAL COSTS NOT REIMBURSED FOR
(indicate source below)			
1.	\$	\$	\$
2.	\$	\$	\$
3.	\$	\$	\$
4.	\$	\$	\$
5.	\$	\$	\$

I AGREE TO NOTIFY THE GRAND RAPIDS HOME FOR VETERANS OF INCREASES AND DECREASES OF INCOME, ASSETS AND EXPENSES PRIOR TO THE ADMISSION OF THIS INDIVIDUAL, AND AFTER HIS/HER ADMISSION TO THE GRAND RAPIDS HOME FOR VETERANS.

SIGNED BY: (PLEASE CHECK ONE)     SPOUSE     GUARDIAN     OTHER RESPONSIBLE PERSON

NAME (PRINTED) \_\_\_\_\_

\_\_\_\_\_ SIGNATURE

\_\_\_\_\_ DATE



REVIEW OF SYSTEMS			
	NORMAL	ABNORMAL	COMMENT
EENT	<input type="checkbox"/>	<input type="checkbox"/>	
CARDIOVASCULAR	<input type="checkbox"/>	<input type="checkbox"/>	
PULMONARY	<input type="checkbox"/>	<input type="checkbox"/>	
GASTROINTESTINAL	<input type="checkbox"/>	<input type="checkbox"/>	
GENITOURINARY	<input type="checkbox"/>	<input type="checkbox"/>	
ENDOCRINE	<input type="checkbox"/>	<input type="checkbox"/>	
CENTRAL NERVOUS SYSTEM	<input type="checkbox"/>	<input type="checkbox"/>	
SKELETAL	<input type="checkbox"/>	<input type="checkbox"/>	
B.P.	TEMP.	PULSE	RESP.
	NORMAL	ABNORMAL	COMMENT
DERMAL/EENT	<input type="checkbox"/>	<input type="checkbox"/>	
HEART	<input type="checkbox"/>	<input type="checkbox"/>	
LUNGS	<input type="checkbox"/>	<input type="checkbox"/>	
ABDOMEN	<input type="checkbox"/>	<input type="checkbox"/>	
GENITOURINARY/PELVIC	<input type="checkbox"/>	<input type="checkbox"/>	
NEUROLOGIC	<input type="checkbox"/>	<input type="checkbox"/>	
MUSCULOSKELETAL	<input type="checkbox"/>	<input type="checkbox"/>	

**ALL APPLICANTS MUST SUPPLY THE RESULTS OF A CHEST X-RAY TAKEN WITHIN 30 DAYS PRIOR TO ADMISSION AND A HISTORY AND PHYSICAL COMPLETED WITHIN THE LAST 90 DAYS.**

EXAMINING PHYSICIAN		
SIGNATURE	DATE	PHONE (     )
NAME (PRINTED)		
ADDRESS	CITY	ZIP

# APPLICANT'S MEDICAL INFORMATION

Please  appropriate box

SELF-CARE STATUS		INDEPENDENT	NEEDS ASSISTANCE	UNABLE TO DO
PERSONAL HYGIENE	BATHING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	SHAVING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	ORAL HYGIENE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DRESSING	UPPER EXTREMITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	TRUNK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	LOWER EXTREMITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FEEDING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MOBILITY	SITTING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	STANDING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	TRANSFERRING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	WHEELCHAIR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	WALKING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	STAIRS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COMMUNICATION ABILITY	CAN SPEAK	<input type="checkbox"/> YES <input type="checkbox"/> NO	English <input type="checkbox"/> YES <input type="checkbox"/> NO	
	CAN WRITE	<input type="checkbox"/> YES <input type="checkbox"/> NO		
	UNDERSTANDS SPEAKING	<input type="checkbox"/> YES <input type="checkbox"/> NO	English <input type="checkbox"/> YES <input type="checkbox"/> NO	
	UNDERSTANDS GESTURES	<input type="checkbox"/> YES <input type="checkbox"/> NO		
	UNDERSTANDS WRITING	<input type="checkbox"/> YES <input type="checkbox"/> NO		
BOWELS	<input type="checkbox"/> CONTINENT <input type="checkbox"/> INCONTINENT			
BLADDER	<input type="checkbox"/> CONTINENT <input type="checkbox"/> INCONTINENT			
SPECIAL NEEDS	<input type="checkbox"/> CATHETER <input type="checkbox"/> COLOSTOMY <input type="checkbox"/> TRACHEOSTOMY			
APPLIANCES	<input type="checkbox"/> PROSTHESIS <input type="checkbox"/> DENTURES <input type="checkbox"/> GLASSES <input type="checkbox"/> HEARING AID <input type="checkbox"/> OTHER _____			
BEHAVIOR/ORIENTATION	<input type="checkbox"/> FRIENDLY <input type="checkbox"/> DISORIENTED <input type="checkbox"/> ANXIOUS <input type="checkbox"/> COOPERATIVE <input type="checkbox"/> DEPRESSED <input type="checkbox"/> FEARFUL <input type="checkbox"/> QUIET <input type="checkbox"/> DESPONDENT <input type="checkbox"/> SUSPICIOUS <input type="checkbox"/> ALERT <input type="checkbox"/> DEMANDING <input type="checkbox"/> WITHDRAWN <input type="checkbox"/> CONFUSED <input type="checkbox"/> ANGRY <input type="checkbox"/> WANDERS <input type="checkbox"/> NOISY			
	<input type="checkbox"/> DELUSIONS <input type="checkbox"/> INAPPROPRIATE <input type="checkbox"/> HALLUCINATIONS <input type="checkbox"/> SPECIAL PSYCHOSOCIAL NEEDS <input type="checkbox"/> AGGRESSIVE <input type="checkbox"/> COMBATIVE ADDITIONAL COMMENTS REGARDING BEHAVIOR _____ _____			

SIGNATURE OF PERSON COMPLETING FORM \_\_\_\_\_ PHONE \_\_\_\_\_

NAME (PRINTED) \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

Applicant's Medical Information, continued

Does the applicant have a PEG?  YES  NO If yes, size \_\_\_\_\_

Does the applicant have a G-tube?  YES  NO

Does the applicant have a Dobhoff?  YES  NO

Does the applicant have a trach?  YES  NO If yes, size \_\_\_\_\_

What type of feeding does the applicant receive? \_\_\_\_\_

Does the applicant have a shunt for dialysis?  YES  NO

Does the applicant have a prosthesis?  YES  NO If yes, type \_\_\_\_\_

Will the applicant have a Foley catheter?  YES  NO  Suprapubic  
If yes, for what reason? \_\_\_\_\_ Insertion date: \_\_\_\_\_

Does the applicant have an ostomy?  YES  NO If yes, what type of appliance? \_\_\_\_\_

Will the applicant require oxygen?  YES  NO If yes, what concentration? \_\_\_\_\_

Are restraints in use?  YES  NO If yes, what type? \_\_\_\_\_

Is the applicant combative?  YES  NO  
If yes, describe: \_\_\_\_\_

Is there a history of active infectious disease?  YES  NO If yes, explain: \_\_\_\_\_

Is there a history of latex allergy?  YES  NO If yes, explain: \_\_\_\_\_

Has an influenza vaccine been given this year?  YES  NO

Has a pneumococcal vaccine been given?  YES  NO

Tuberculin test received?  YES  NO If yes, date and result: \_\_\_\_\_

History of actual/suspected infection/infectious disease:

Tuberculosis  YES  NO If yes, date: \_\_\_\_\_

Resistant Organism (any site)  YES  NO If yes, date: \_\_\_\_\_

Other \_\_\_\_\_  YES  NO If yes, date: \_\_\_\_\_

Does the applicant have an open wound?  YES  NO

If yes, what type?  Pressure Ulcer  Surgical Wound  Stasis Ulcer  Other

Current Treatment Modality/Special Mattress: \_\_\_\_\_

While in acute care, did applicant receive any antibiotics?  YES  NO

If yes, please list name, dosage, date: \_\_\_\_\_

SIGNATURE OF PERSON COMPLETING FORM \_\_\_\_\_ PHONE \_\_\_\_\_

NAME (PRINTED) \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

Have you ever been arrested or convicted of a felony?  YES  NO

If yes, please list all arrests and/or convictions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MICHIGAN FELONY STATUTE  
FALSE PRETENSES

Michigan Compiled Laws Annotated Section 750.218 provides:

"Any person who shall by any false token or writing obtain from this State Institution care and services, the value of which exceeds \$100 by intentional fraudulent misrepresentations or false signature before a notary shall be guilty of a felony punishable by imprisonment in the state prison for a period not to exceed ten (10) years ..."

It is unfortunate that a minority of veterans make false representations concerning their income and assets upon admission to this facility. This detracts from the services we are able to provide and increases the monthly costs to the honest veterans.

## NOTICE AGREEMENT

For and in consideration of my admission to the Grand Rapids Home for Veterans, I hereby agree payment to the Board of Managers of the Grand Rapids Home for Veterans of any balance of money accumulated while a member of the Facilities, or due to me or on deposit with any bank, trust company, corporation or with any individual, at the time of my death; provided all such sums shall first be expended to pay for residual maintenance costs attributable to the deceased individual, and shall then be paid to the wife, minor children, or dependent mother or father in the order named.

If no such relative shall be found within a period of two years, or if no claim for the sums has been made within a period of two years, the balance of the money shall be paid into a fund in the hands of the Board of Managers of the Facilities to be expended by the Board of Managers to improve the service of the Facilities, pursuant to MCLA 36.61 as amended, P.A. 1905, No. 313.

