FOR OFFICE USE ONLY

File No.: ________________

Room No.: ________________

Room Charge: ________________

Admit Date: ________________

Admit From: ________________

H & P Date: ________________

Acute Days: ________________

Application for Admission

Personal Information

Date of Application________________________

Applicant Name: ____
Last (include maiden) First Middle Nickname

Current Address: ____
Street City State Zip Code

Phone Numbers: ____
Home Cell Work Other phone no. you can be reached

E-Mail Address: ____

Social Security No.: ________________ Birth Date: ____________ Birth Place: ________________

Gender: ________________ Mother's Maiden Name: ________________

Education: ____________________________ Previous Occupation: ________________

Home Church\Religion: ____________ Ethnicity: ❑ Hispanic ❑ Not Hispanic Race: ____________

Marital Status: ❑ Married ❑ Widowed ❑ Never Married ❑ Separated ❑ Divorced

If married, please list spouse's name: ____

Veteran Status: Are you a Veteran? ❑ Yes ❑ No What Branch? ____________________________

Is your spouse a Veteran? ❑ Yes ❑ No What Branch? ____________________________

Criminal Status: Have you ever been convicted of or plead guilty to a crime in a court of law (including sexual offense)?

❑ Yes ❑ No State ____________________ County ____________________________

Preferred Language:____

Medical Information

Primary Physician: ____________________________________ Phone No.: ____________________

Dentist: ____________________________________ Phone No.: ____________________

Optometrist: ____________________________________ Phone No.: ____________________

Funeral Home: ____

Address: ____________________________________ Phone No.: ____________________

Pharmacy: ____________________________________ Phone No.: ____________________

Skilled Nursing Resident: Aasen Drug and Pharmacy will be utilized when you are covered by Medicare A.

Do you currently use medications from VA? ❑ Yes ❑ No

Advanced Directives

Advanced Directives – check all that apply (**copies required upon admission**):

❑ Durable Power of Attorney Finances Name of Responsible Party ____________________________

❑ Durable Power of Attorney Healthcare Name of Responsible Party ____________________________

❑ Guardian Name of Responsible Party ____________________________

❑ Living Will Name of Responsible Party ____________________________

❑ Healthcare Directive Name of Responsible Party ____________________________

Emergency Notification – list in order of whom you prefer we contact first

	Contact Name	Relationship	Mailing Address	Phone No.
1.				H:
	Email Address:			W:
				C:
2.				H:
	Email Address:			W:
				C:
3.				H:
	Email Address:			W:
				C:
4.				H:
	Email Address:			W:
				C:

Billing

	Billing Party	Relationship	Address	Phone No.
1.				H:
	Email Address:			W:
				C:

Billing Information

Are YOU or YOUR SPOUSE currently employed part-time or full-time? ❑ Yes ❑ No

Are YOU or YOUR SPOUSE currently covered by an employer's group health insurance? ❑ Yes ❑ No

If yes, name and policy number: ____

Have you ever applied for Medical Assistance/Medicaid: ❑ Yes ❑ No

If yes, date and county applied: ____

Medical Assistance/Medicaid number: ______________________ / ______________________

Insurance (Please provide cards)	Policy No.	Company	Phone No.
Medicare (MBI#)			
Medicare Co-Insurance			
Medicare Replacement Policy			
Medicare D (prescription) Plan			
Long Term Care Insurance			
Health Insurance - Other			
VA			

Financial Information

Information in this section will assist with financial planning. Please attach additional information if needed.

Have you or your acting Financial Power of Attorney sold, traded, transferred, or gifted any cash or assets to you or from you, or to or from a trust account? ☐ Yes ☐ No If yes, please explain the nature of the transaction and date it occurred.

____

____

____

Have you or your spouse resided on a farm in the past 5 years? ☐ Yes ☐ No

Except for personal effects, list all the assets owned by YOU and YOUR SPOUSE, with the value as of the date of this application.

Description of Assets	Approximate Value of Assets
Land	
Checking	
Savings – Passbook	
Certificates of Deposit	
Stock, Bonds, IRA, Annuities, etc.	
Life Insurance – Cash Surrender Value	
Home(s)	
Vehicle(s)	
Life Estate(s)	
Trust – Year Created ________ Revocable ☐ Irrevocable ☐	
Prepaid Funeral/Other	

List all debts owed by YOU and YOUR SPOUSE, with outstanding balances as of the date of this application. This includes mortgages, credit cards, vehicles or personal loans. Include any garnishments from Social Security or other income (tax lien, student loans, child support, etc.)

Description of Debt	Approximate Amount of Debt

List all sources of income for YOU and YOUR SPOUSE, including but not limited to rental payments, CRP income, long term care insurance benefits, Social Security benefits, Veteran's benefits, alimony, and employment income.

Description of Income	Frequency of Income	Amount of Income
Social Security benefit	Monthly	
Retirement / Pension		
VA Benefit		
Other (please include any monthly insurance payments)		

The undersigned represent that all of the above statements are true and complete. The application complies with section 50-24, 1-22 of the North Dakota Century Code, and I hereby authorize the long term care facility to contact any and all of the above identified financial institutions to obtain information regarding my assets and income, and I hereby release and authorize the financial institution to release any information to the long term care facility I further authorize the long term care facility to release to its attorneys and information regarding my application for admission.

Signature: ____ Date: __________________________