Application for Admission

St. Luke's Home
242 10th Street West
Dickinson, ND 58601
(701) 483-5000

APPLICANT INFORMATION			
First Name:	**Initial**:	**Last:**	**Preferred Name:**
SEX: ☐female ☐male	**Date of Birth:**	**SOCIAL SECURITY #**:	
Placement needed: ☐immediate ☐within 6 months ☐unknown		Anticipated stay: ☐short term ☐long Term ☐unknown	
CIVIL STATUS: ☐married ☐never married ☐widowed ☐divorced ☐separated		**Name of Spouse:** **Date of Marriage:**	
Applicant's present address:			
Applicant's present phone #:			
Prior occupation/Retirement Date:		**Place of Birth:**	
MEDICARE	Number: Note: Copy of Medicare card needed upon admission.	☐Part A ☐Part B ☐Part A and Part B	
OTHER INSURANCE	Secondary	Policy #:	
	Third	Policy #:	
PRESCRIPTION DRUG COVERAGE	Name:	ID #	
COUNTY ASSISTANCE	Do you receive any county assistance/Medicaid? ☐Yes - County: # _____ ☐No ☐No, but information regarding application needed:		
VA	Is the applicant a Veteran? ☐Yes ☐No Branch of Service_____ War(s) Served In_____ Do you receive any VA benefits? ☐Yes ☐No		
BILLS TO BE MAILED TO	Name:	Phone #:	
	Address:		
PHYSICIAN:		**Pharmacy** (choose 1) ☐White Drug ☐ Clinic Pharmacy	
SPIRITUAL/CHURCH: (Church/religion)		**DENTIST:**	
EYE DOCTOR:		**FUNERAL HOME:**	
ADVANCED DIRECTIVES (check applicable boxes, provide copies of applicable paperwork upon admission.)	☐Power of Attorney (POA) ☐ Durable Power of Attorney (DPOA) ☐Power of Attorney for Healthcare ☐ Living Will ☐ Guardian/Conservator		
	Name of DPOA/POA/Guardian:		

APPLICATION CONTINUED ON NEXT PAGE

Side 2 of St. Luke's Home Application for Admission **APPLICANT NAME:**

EMERGENCY AND FAMILY/REPRESENTATIVE NUMBERS AND ADDRESSES

EMERGENCY CONTACT Name: Address:	**Relationship:**	PHONE: Home ( ) Work ( ) Cell ( ) Email:
Name: Address:	**Relationship**:	PHONE: Home ( ) Work ( ) Cell ( ) Email:
Name: Address:	**Relationship:**	PHONE: Home ( ) Work ( ) Cell ( ) Email:
Name: Address:	**Relationship:**	PHONE: Home ( ) Work ( ) Cell ( ) Email:

APPLICANT INFORMATION

Reason applicant needs skilled care: □ dementia/memory care □ physical condition

Height	**Current Weight**	Usual Weight
List Any Known Drug/Food Allergies		
Dentures: □ Yes □ No	Eye Glasses: □ Yes □ No	Hearing Aides: □ Right □ Left □ None
Mental Status: □alert □confused □forgetful □depressed □irritable		
List Prior Surgeries in last 100 Days	**Any Falls in Last 6 Month/How Many & When**	
Does Applicant : □wander □Hit or Strike Out □Undress □Dress in layers □Yell □ Up frequently at night (mark all that apply)		
Language(s) Spoken by Applicant:		
Hobbies/Interests(past or present):		
List Any Clubs/Organizations applicant belongs to (past/present):		
Highest level of education completed:	Is Applicant Registered to Vote in North Dakota? □ Yes □ No Does Applicant wish to vote? □ Yes □ No	
List of Applicant's Children:		

Applicant Name: ***Date of Birth:***

By my signature below, I hereby authorize St. Luke's Home to exchange and/or release information between the Facility and Medical Information Bureau, governmental agencies and providers of health care (including, without limitation, hospitals, clinics, dentists, physicians and nursing home) for insurance purposes, to provide continuity of care, and as required by applicable laws, rules and regulations.

I understand that providing false information could result in discharge and/or denial of my application. The answers provided herein are true and correct to the best of my knowledge and information.

Signature of Applicant:_____ ***Date:***_____

Signature of Applicant's Spouse:_____ ***Date:***_____

Signature of Health Care/Financial POA:_____ ***Date:***_____

Signature of Person completing Application:_____ ***Date:***_____

You must complete this page UNLESS applicant is full VA Contract or has been Approved for Medicaid

FINANCIAL INFORMATION

First Name: ***Initial***: ***Last*:**

1. List all transfers or gifts of assets within the past five years by you and your spouse, including transfers of a remainder interest in real property.

Date of Transfer	Description of Asset	Recipient of Asset	Value of Asset
a.			
b.			
c.			

2. List all pre-paid burial contracts, burial accounts, and pre-paid burial or funeral items owned by you or your spouse or by a third party for the benefit of you or your spouse.

Description	Owner	Value
a.		
b.		

3. 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, and employment income.

Description of Income	Date or Frequency of Payment	Amount of Payment
a.		
b.		
c.		
d.		
e		

4. Except for personal effects, list all assets owned by you and your spouse, including the cash surrender value of life insurance, stocks, bonds, vehicles, life estates, and pensions, with the value as of the date of admission into the nursing home. (Attach additional pages if needed.)

Owner of Asset	Description of Asset	Balance/Value
a.	***Checking Account***	
b.	***Savings Account***	
c.	***CDs/IRAS etc***	
d.		
e.		
f.		

This questionnaire complies with section 50-24.1-22 of the North Dakota Century Code. By my signature below, I hereby authorize the nursing home to contact the county social services for information regarding my Medicaid application and eligibility, and I hereby release and authorize the county social services to release any information to the nursing home. I also authorize the nursing home 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 institutions to release any information to the nursing home. I further authorize the nursing home to release to its attorneys any information regarding my application for admission.

I understand that providing false information could result in discharge and/or denial of my application. The answers provided herein are true and correct to the best of my knowledge and information.

*Signature:*_____ *Date:*_____