Application for Admission

St. Luke's Home
242 10th Street West
Dickinson, ND 58601
(701) 483-5000 Phone
(710) 456-8293 Fax

APPLICANT INFORMATION			
First Name:	**Middle Initial**:	**Last:**	**Preferred Name:**
SEX: ☐female ☐male ☐other_____	**Date of Birth:**		**SOCIAL SECURITY #**:
Placement needed: ☐immediate ☐within 6 months ☐unknown		Anticipated stay: ☐short term ☐long Term ☐unknown Type of Room Preferred: ☐ Shared ☐ Private ($20/day extra)	
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	Primary	Policy #:	
	Secondary	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 Is your spouse a veteran ☐Yes ☐ No		
BILLS TO BE MAILED TO	Name:	Phone #:	
	Address:		
PHYSICIAN:		**CLINIC:**	
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:**

***Email Address for Covid-19/Facility Updates*:**

APPLICANT INFORMATION

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

Height	**Current Weight**	Usual Weight
List Any Known Drug/Food Allergies	Do you Smoke/Use Chewing tobacco/VAPE □ Yes □ No	
Dentures: □ Yes □ No	Eye Glasses: □ Yes □ No	Hearing Aides: □ Right □ Left □ None
Mental Status: □alert □confused □forgetful □depressed □irritable	Do you have a Substance Use Disorder(Alcohol/drugs) □Yes □ No	
List Prior Surgeries in last 100 Days		

Does Applicant : □wander □Hit or Strike Out □Undress □Dress in layers □Yell □ Up frequently at night □ Fall # Falls in last 6 months_____
(mark all that apply)

Language(s) Spoken by Applicant:	Have you ever been convicted of or pled guilty to a sexual offense in a court of law? □ Yes □ No State/County:

Hobbies/Interests(past or present):

List Any Clubs/Organizations applicant belongs to (past/present):

Highest level of education completed:	Has the Applicant Voted 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/Applicant's Spouse:_____ Date:_____

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

Signature of Person completing Application:_____ Date:_____

APPLICATION CONTINUED ON NEXT PAGE

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

FINANCIAL INFORMATION: Tell Us About the Assets You or Your Spouse Own:

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

1. List all transfers or gifts of assets within <u>the past five years</u> 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/Recipient Name	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.)

Description of Asset	Owner of the Asset	Balance/Value
Checking Account		
Savings Account		
CDs/IRAS/Annuities		
Stocks/Bonds/Mutual Funds		
Life Insurance (cash surrender value)		
Real property (Home, Land, Rental Property)		
Life Estate(s)		
Vehicles (car, truck, motor home, snowmobile, motorcycle, boat, etc.)		
Trusts (own or are a beneficiary of)		
Mineral Rights (oil, gas, coal, etc.)		

APPLICATION CONTINUED ON NEXT PAGE

Applicant's Name:

Future Income:

Do you or your spouse have any pending legal action from which you may receive money, including an inheritance or a settlement? ☐ Yes ☐ No If yes, please describe:

Employment:

Are you or your spouse employed by another?

☐ Yes ☐ No If yes, provide the name of the employer, hours worked, and the wage or salary earned:

Are you or your spouse self-employed?

☐ Yes ☐ No If yes, list who, nature of business, and date business started:

Are you or your spouse actively engaged in farming? ☐ Yes ☐ No

Do you or your spouse have an ownership interest in a business?

☐ Yes ☐ No If yes, please describe the nature of the business and extent of ownership:

List all Debts Owed by You or your Spouse: This includes medical bills, mortgages, credit cards, vehicles, personal loans, etc.

Descriptions of Debt and To Whom Owed	Owner of Debt	Approximate Amount of Debt

This questionnaire complies with section 50-10.2-05 of the North Dakota Century Code. By my signature below, I hereby authorize the nursing home to contact the county and/or state social services office for information regarding my Medicaid application and eligibility, and I hereby release and authorize the county and/or state social services office 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:*_____