

**VALLEY MEMORIAL HOMES**  
Admission Application

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**IDENTIFICATION:**

Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
First Name: \_\_\_\_\_  
Address (Street, City, State, Zip): \_\_\_\_\_ Phone: \_\_\_\_\_

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**PERSONAL INFORMATION:**

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Sex: \_\_\_\_\_ Race: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Spouse Name: \_\_\_\_\_  
Previous Occupation: \_\_\_\_\_ Education: \_\_\_\_\_  
Religion: \_\_\_\_\_  
Church (Name, Address, City, Phone): \_\_\_\_\_  
Birthplace: \_\_\_\_\_  
Military Veteran: \_\_\_\_\_  
Resident: Yes \_\_\_\_\_ No \_\_\_\_\_ Branch: \_\_\_\_\_  
Spouse (name): \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Branch: \_\_\_\_\_  
Have you ever been convicted of or plead guilty to a sexual offense in a court of law? Yes \_\_\_\_\_ No \_\_\_\_\_

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**MEDICAL DESIGNATIONS:**

Local Physician: \_\_\_\_\_ Phone No: \_\_\_\_\_  
Local Optometrist/Ophthalmologist: \_\_\_\_\_ Phone No: \_\_\_\_\_  
Local Dentist: \_\_\_\_\_ Phone No: \_\_\_\_\_

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**PHARMACY PREFERENCE:**

\* These pharmacies provide 24/7 service

VMH utilizes the following pharmacies. Please select one:

\_\_\_\_\_ Thrifty White Drug \_\_\_\_\_ Medicap  
\_\_\_\_\_ Altru Clinic \_\_\_\_\_ Walls

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**NOTIFY IN EMERGENCY:**

1.) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address (Street, City, State, Zip): \_\_\_\_\_  
Phone No: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_  
Email Address: \_\_\_\_\_  
2.) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address (Street, City, State, Zip): \_\_\_\_\_  
Phone No: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_  
Email Address: \_\_\_\_\_  
3.) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address (Street, City, State, Zip): \_\_\_\_\_  
Phone No: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_  
Email Address: \_\_\_\_\_

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**BILLING PARTY:** (who we send the billing statement to)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone No: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

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**ADVANCED DIRECTIVES:**

Please list Power of Attorney (POA) as described in legal document\*

POA for Financial: \_\_\_\_\_ POA for Healthcare: \_\_\_\_\_

OR POA for Both: \_\_\_\_\_

If no legally designated Power of Attorney, please list appointed decision makers:

Medical Decision Maker: \_\_\_\_\_ Financial Decision Maker: \_\_\_\_\_

\*Please provide Valley Memorial Homes with a copy of these documents\*

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**FUNERAL HOME PREFERENCE:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone No: \_\_\_\_\_

Prepaid Burial? \_\_\_\_ Yes \_\_\_\_ No      Amount: \$ \_\_\_\_\_

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**INSURANCE INFORMATION:**

Medicare Number: \_\_\_\_\_ Part A: \_\_\_\_ Effective Date: \_\_\_\_\_

Part B: \_\_\_\_ Effective Date: \_\_\_\_\_

Medicare Supplement Ins: \_\_\_\_\_ Policy No: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Phone No: \_\_\_\_\_

Do you have a Medicare Replacement policy? \_\_\_\_ Yes \_\_\_\_ No

If yes, Name: \_\_\_\_\_ Policy No: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Phone No: \_\_\_\_\_

Medicaid ID No. (If applicable): \_\_\_\_\_ County: \_\_\_\_\_

Pending: \_\_\_\_ Approved: \_\_\_\_ Approved Date: \_\_\_\_\_

Have you previously applied for Medicaid? \_\_\_\_ Yes \_\_\_\_ No

If yes, provide the date and county of the application: Date: \_\_\_\_\_ County: \_\_\_\_\_

Long Term Care Ins.: \_\_\_\_\_ Policy No.: \_\_\_\_\_

Address: \_\_\_\_\_

Phone No.: \_\_\_\_\_

Do you have a Medicare D (prescription drug) Plan? \_\_\_\_ Yes \_\_\_\_ No Effective Date: \_\_\_\_\_

Plan Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Other Insurance: \_\_\_\_\_

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Resident/Legal Agent/Responsible Party)

**VALLEY MEMORIAL HOMES**  
**Basic Care Financial Intake Questionnaire**

*Information provided in this section will assist with financial planning. Attach additional pages if needed.*

Except for personal affects, list all assets owned by **you** and **your spouse**, with the value as of the date of application.

| Owner(s) of Asset | Description of Asset                                    | Approximate Value |
|-------------------|---|-------------------|
|                   | Checking  |                   |
|                   | Savings - Passbook                                      |                   |
|                   | Certificate(s) of Deposit                               |                   |
|                   | Stocks, Bonds, etc.                                     |                   |
|                   | Life Insurance, Cash Surrender Value                    |                   |
|                   | Home(s)   |                   |
|                   | Land  |                   |
|                   | Vehicles  |                   |
|                   | Life Estates  |                   |
|                   | Trust                                      Year created |                   |
|                   | Other (describe)  |                   |

List all debts owed by you and your spouse, with outstanding balance as of the date of application. (This includes mortgages, credit cards, vehicle or personal loans. Not routine daily expenses.)

| Debtor | Description of Debt | Amount of Debt |
|--------|---------------------|----------------|
|        |                     |                |
|        |                     |                |
|        |                     |                |
|        |                     |                |

List all transfers of cash and/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/Relationship | Value of Asset |
|------------------|----------------------|------------------------|----------------|
|                  |                      |                        |                |
|                  |                      |                        |                |
|                  |                      |                        |                |
|                  |                      |                        |                |

Did the agent or attorney-in-fact listed under your financial power of attorney assist you with making any of the transfers or gifts referenced above, or benefit or receive any of the assets transferred or gifted? If yes, please explain.

Were any of the assets described above transferred to or from a trust? If yes, explain the nature of the transaction and identify the trust involved.

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 benefits, and employment income.

| Description of Income   | Date or Frequency of Payment<br>(i.e. monthly, annually, etc) | Amount of Payment |
|-------------------------|---|-------------------|
| Social Security Benefit | Monthly   |                   |
|                         |   |                   |
|                         |   |                   |
|                         |   |                   |
|                         |   |                   |
|                         |   |                   |
|                         |   |                   |
|                         |   |                   |

Do you or your spouse reside on a farm?  Yes.  No.

Are you actively engaged in farming or any other trade or business? If yes, describe the nature of the business.

Are you or your spouse employed by another or self-employed? If yes, provide the name of the employer or the nature of the self-employment, the hours worked and the wage or salary earned.

Are you or your spouse the beneficiary of any trust?  Yes.  No.

Do you have any pending legal action from which you may receive money or medical benefits, including inheritance?  Yes.  No. If yes, describe.

*This questionnaire complies with section 33-03-24.1 of the North Dakota Century Code. By signing my signature below, I hereby authorize the Basic Care facility 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 Basic Care facility. I also authorize the Basic 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 institutions to release any information to the Basic Care facility. I further authorize the Basic Care facility 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: \_\_\_\_\_



## **Mission Statement**

**Valley Memorial Homes provides compassionate care and service from a Christian perspective to enhance the quality of life for those we serve.**



OFFICE USE ONLY:

Admit date: \_\_\_\_\_ Facility: \_\_\_\_\_ Room: \_\_\_\_\_

Admitted from: \_\_\_\_\_ Referred by: \_\_\_\_\_

Medical Record number: \_\_\_\_\_

Payment status: \_\_\_\_\_ Private \_\_\_\_\_ Medicare \_\_\_\_\_ Medicaid  
\_\_\_\_\_ Medicare replacement policy \_\_\_\_\_ Major medical insurance  
\_\_\_\_\_ Worker's compensation

\_\_\_\_\_ Staff initials