



Skilled Nursing Facility Admission Application

VALLEY ELDERCARE CENTER
2900 14th Avenue South
(701) 787-7900

WOODSIDE VILLAGE
4004 24th Avenue South
(701) 787-7500

Grand Forks, North Dakota 58201

VALLEY MEMORIAL HOMES
Admission Application

IDENTIFICATION:

Last Name: _____ Preferred Nickname: _____

First Name: _____ Middle Initial: _____

Address (Street, City, State, Zip): _____

Phone: _____

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 _____

MEDICAL DESIGNATIONS:

Local Physician: _____ Phone No: _____

Local Optometrist/Ophthalmologist: _____ Phone No: _____

Local Dentist: _____ Phone No: _____

If outside of Grand Forks, Primary MD: _____ Phone No: _____

PHARMACY PREFERENCE:

* These pharmacies provide 24/7 service

VMH utilizes the following pharmacies. Please select one:

_____ Thrifty White Drug _____ Medicap

_____ Altru Clinic _____ Walls

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: _____

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

Name: _____ Relationship: _____

Address: _____

City, State, Zip: _____

Phone No: (H) _____ (W) _____ (C) _____

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

FUNERAL HOME PREFERENCE:

Name: _____

Address: _____

Phone No: _____

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

Has applicant lived in a nursing facility before? _____ Yes _____ No

If so, where and when? _____

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: _____

Do you have a building preference? _____ Valley Eldercare Center _____ Woodside Village _____ Either
_____ Semi-Private Room _____ Private Room

Signature: _____ Date: _____

(Resident/Legal Agent/Responsible Party)

VALLEY MEMORIAL HOMES
Nursing Home Financial Intake Questionnaire

Please read the following questions as listed below. If you answer "No" to all of the questions, then you have completed this application after you sign below. If you answer "Yes" to any of the questions, please proceed with completing the entire application. Thank you.

1. Did the agent or attorney-in-fact listed under your financial power of attorney assist you with making any of the transfers or gifts or benefits or receive any assets transferred or gifted? If yes, please explain.
2. Have you transferred or gifted to or from a trust? If yes, explain the nature of the transaction and identify the trust involved.
3. Have you previously applied for Medicaid? If yes, provide the date and county in which application was made.
4. Do you or your spouse reside on a farm in the past five years? Are you actively engaged in farming or any other trade or business? If yes, describe the nature of the business.
5. 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.

**IF IT IS A POSSIBILITY THAT YOUR ADMISSION COULD BE A LONG TERM PLACEMENT,
THEN PLEASE COMPLETE THE ENTIRE APPLICATION.
THIS WILL ASSIST WITH FINANCIAL PLANNING. THANK YOU.**

By my signature below, I hereby state that the above information is true and correct to the best of my knowledge. I understand that if I become a long term resident that I will be obligated to complete the final page of this application.	
Signature: _____	Date: _____

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 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 (i.e. monthly, annually, etc)	Amount of Payment
Social Security Benefit	Monthly	

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 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.

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

Three day qualifying stay: _____ - _____

If Medicare, reason for coverage: _____

_____ Staff initials