Admission Application

Tufte Manor
Basic Care & Assisted Living
3300 Cherry Street
Grand Forks, ND 58201
Phone 701.775.2581
Fax 701.787.7589

Valley Eldercare Center
Skilled Nursing
2900 14th Avenue S
Grand Forks, ND 58201
Phone 701.787.7900
Fax 701.787.7959

Wheatland Terrace
Assisted Living
4006 24th Avenue S
Grand Forks, ND 58201
Phone 701.787.7621
Fax 701.787.7589

Woodside Village
Skilled Nursing
4004 24th Avenue S
Grand Forks, ND 58201
Phone 701.787.7500
Fax 701.787.7959

VALLEY MEMORIAL HOMES

Application for Admission

FOR OFFICE USE ONLY
File No. _____
Apt/Room No. _____
Rental Date: _____
Admit Date: _____

PERSONAL INFORMATION			
Name of Applicant	First: MI:	Last:	Nickname:
Current Address	Street: City:	State: County:	Zip:
Phone Numbers	Home:	Cell: Work:	
Social Security Number:		Mother's Maiden Name:	
Birthdate:		Education:	
Birthplace:		Previous Occupation:	
Gender:		Religion:	
Race:		Home Church:	
MARITAL STATUS	___Married ___Widowed ___Never Married ___Separated ___Divorced If Married, please list name of spouse:		
CRIMINAL STATUS	Have you ever been convicted of or plead guilty to a sexual offense in a court of law? Yes_____ No_____ State_____ County_____		
VETERAN STATUS	Are you a Veteran? Yes_____ No_____ What Branch? _____ Is your spouse a Veteran? Yes_____ No_____ What Branch? _____		
HOW DID YOU HEAR ABOUT US? Media _____ Word of Mouth _____ Heathcare Provider _____ Other – Explain _____			

MEDICAL INFORMATION		
Primary Physician:	Eye Doctor:	
Dentist:	Funeral Home: Address: Phone:	
Advanced Directives: Please check all that apply. Copies ***REQUIRED*** upon admission.	____ Durable Power of Attorney Finances	Name:_____ Email: _____
	____ Durable Power of Attorney Healthcare	Name:_____ Email: _____
	____ Guardian	Name:_____ Email: _____
	____ Living Will	Name:_____ Email: _____
Pharmacies used by VMH tenants/residents must provide 24/7 service. Please choose one. **Skilled Nursing Residents Only:** Thrifty White Drug will be utilized when you are covered by Medicare A.	____Thrifty White Drug ____Wall's Medicine Center ____Altru Clinic Pharmacy Do you currently use medications from the VA? _____Yes _____ No	

EMERGENCY NOTIFICATION *List in the order of whom you prefer we contact first*			
Contact	**Relationship**	**Address**	**Phone Numbers**
1. Name: _____ E-Mail Address: _____			H: W: C:
2. Name: _____ E-Mail Address: _____			H: W: C:
3. Name: _____ E-Mail Address: _____			H: W: C:

BILLING			
Billing Party	**Relationship**	**Address**	**Phone Numbers**
Name: _____ E-Mail Address: _____			H: W: C:

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:
Medicare Number:	Medical Assistance/Medicaid Number:
Medicare Supplemental Insurance Company: Policy #: Telephone #:	Have you ever applied for Medical Assistance/Medicaid? ____ Yes ____ No If yes, date & county applied:
Medicare Replacement Policy Company: Policy #: Telephone #:	Health Insurance – Other Company: Policy #: Telephone #:
Medicare D (prescription) Plan Company: Policy #:	Long Term Care Insurance Company: Policy #: Telephone #:

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

1. 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? If YES, please explain the nature of the transaction and the date it occurred.
____Yes ____No Explain:

2. 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 application.

DESCRIPTION OF ASSETS	APPROXIMATE VALUE OF ASSETS
Land	
Checking	
Savings - Passbook	
Certificates of Deposit	
Stocks, Bonds, IRAs, Annuities, etc.	
Life Insurance - Cash Surrender Value	
Home(s)	
Vehicle(s)	
Life Estate(s)	
Trust - Year Created_____, Revocable ____Irrevocable____	
Other	

List all debts owed by you and your spouse, with outstanding balance as of the date of 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 Benefits, alimony, and employment income.

DESCRIPTION OF INCOME	FREQUENCY OF INCOME	AMOUNT OF INCOME
Social Security Benefit	Monthly	
Retirement / Pension		

SIGNATURE LINE *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 institutions to release any information to the long term care facility. I further authorize the long term care facility to release to its attorneys any information regarding my application for admission.*

Signature_____Date_____