Bethel Lutheran Nursing & Rehabilitation Center

APPLICATION FOR RESIDENCY

Please complete this form in its entirety. Attached additional documentation if necessary.

Applicant's Information:

Full Name:			
Preferred Name:		Social Security Number:	
Date of Birth:		Birthplace:	
Gender:	E-mail:		
Mailing Address:			
Phone #1: H/C		Phone #2: H/C	
Marital Status:	☐ Married ☐ Widowed ☐ Never Married ☐ Separated ☐ Divorced ☐ Other _____		
Maiden Name/Alias:			
Past Occupation:		Years of Education:	
Local Physician:		Pharmacy:	
Dentist:		Eye Dr./Clinic:	
Religion:	Name of Church:	Mortuary:	
Veteran Status:	Are you a Veteran? ☐ Yes ☐ No What Branch? _____ Is your spouse a Veteran? ☐ Yes ☐ No What Branch? _____		
Background Status:	Have you ever been convicted of or pled guilty to a sexual offense in a court of law? ☐ Yes ☐ No State/County:_____		
Decision Making Authorization:	Do you make your own decisions for healthcare and financial matters? ☐ Yes ☐ No		
Legal Documents: (Copies are Required)	☐ Durable Power of Attorney (POA) Finances or Conservatorship ☐ Durable Power of Attorney (POA) Healthcare or Guardianship ☐ Health Care Directive or Living Will ☐ Code Level Directive		
Vaccination:	Have you received a Covid Vaccination? ☐ Yes ☐ No Last dosage: _____		
Spouse's Full Name (if applicable):			
Spouse DOB:		Spouse SS#:	
E-mail:			
Mailing Address:			
Phone #1: H/C		Phone #2: H/C	

Emergency Contacts/Authorization to Release Information: *If requested BLNRC is authorized to release health care information to the following person(s) in this priority order:*

Priority #1:			
Relationship to Applicant:			
E-mail:			
Mailing Address:			
Phone #1:	H/C	Phone #2:	H/C
Priority #2:			
Relationship to Applicant:			
E-mail:			
Mailing Address:			
City, State, Zip:			
Phone #1:	H/C	Phone #2:	H/C
Priority #3:			
Relationship to Applicant:			
E-mail:			
Mailing Address:			
City, State, Zip:			
Phone #1:	H/C	Phone #2:	H/C
Priority #4:			
Relationship to Applicant:			
E-mail:			
Mailing Address:			
City, State, Zip:			
Phone #1:	H/C	Phone #2:	H/C
Priority #5:			
Relationship to Applicant:			
E-mail:			
Mailing Address:			
City, State, Zip:			
Phone #1:	H/C	Phone #2:	H/C

Billing Party: Please list where you would like any mail sent and/or who will be managing the financial affairs of the applicant.

Name:	
Relationship to Applicant:	
Mailing Address:	
E-mail:	
Phone #1: H/C	Phone #2: H/C

Financial Information:

Payment Source:
☐ Medicare ☐ Medicare Advantage (Medicare part C) ☐ Self Pay
☐ Medicaid ☐ Applying for Medicaid ☐ Nursing Home Insurance

Insurance Information:

Are you, the applicant, currently covered by an employer's group health insurance? ☐ Yes ☐ No Company Name: _____ Policy Holder Name: _____ Policy Number: _____
Medicare Number (Part A, B, or C (also known as Medicare Advantage)):
Medicare Advantage Company:
Medicare D (prescription) Plan Company: _____ Policy: _____ Phone: _____
Medicare Supplemental Insurance Company: _____ Policy: _____ Phone: _____
Medical Assistance/Medicaid Number/County:
Have you, the applicant, ever applied for Medical Assistance/Medicaid? ☐ Yes ☐ No Date Applied: _____ County/State: _____ If yes, were you approved? ☐ Yes ☐ No
Health Insurance – Other Company: _____ Policy: _____ Phone: _____
Long-Term Care Insurance Company: _____ Policy: _____ Phone: _____

Tell Us About the Assets You or Your Spouse Own:

Description of Asset	Owner(s) of Asset	Value of Asset	Location of Asset
Checking/Savings/Credit Union/Money Market Accounts			
Annuities/CDs			
Retirement Funds (IRA/401K/KEOGH)			
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.)			
Pre-Paid Funeral/Burial Account(s)			

Transfer of Assets

Have you or your spouse sold, transferred, or gifted anything of value including cash, real property, vehicles, or any other asset within the past 5 years? □ Yes □ No If yes, list the item(s), to whom, & date(s):

If you have transferred or gifted assets or have granted someone financial POA will you:

Apply for Medicaid Assistance and/or an Asset Assessment through the County Social Services? □ Yes □ No

Will you authorize the County Social Services to release information to Bethel Lutheran Nursing & Rehabilitation Center regarding your application, eligibility, and reasons for denial, etc.? □ Yes □ No

Tell Us About the Income/Money You or Your Spouse Receive:

Type of Income or Other Money Received	Recipient	How Often Received	Amount
Employment/Workers Compensation			
Oil/Mineral Rights/Royalties			
Income from CRP or Farmland			
Pension/Retirement Benefits			
Trust Income			
Social Security Benefits			
Supplemental Security Income (SSI or SSDI)			
Type of Income or Other Money Received	**Recipient**	**How Often Received**	**Amount**
Contract Sale or Rental Income			
Veteran's/Military Benefits			
Other: (list)			

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:

Are you or your spouse the beneficiary of any trust?

☐ Yes ☐ No If yes, please describe:

Transfer of Income

Have you or your spouse transferred or given away any income within the past 5 years?

☐ Yes ☐ No If yes, list the amount(s), date(s), and to whom it was given to:

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:

Self-Employment

Are you or your spouse self-employed? ☐ Yes ☐ No If yes, list who, nature of business, and date business started:

Farming

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

Business Ownership

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.

Description of Debt & 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 Bethel Lutheran Nursing & Rehabilitation Center(BLNRC) 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 BLNRC. I also authorize BLNRC 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 BLNRC. I further authorize BLNRC 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 of Applicant Date

_____
Printed Name

_____ _____
Signature of Legal Representative/Responsible Party Date

_____
Printed Name

_____ _____
Witness Date

_____
Printed Name

NOTE: Please provide copies of the following: (A copy of both ***front & back*** of cards is needed)

1. Social Security Card
2. Medicare Card
3. Medicaid Card
4. Insurance Card
5. Authorization papers for Power of Attorney (Financial and/or Healthcare), Guardianship, Conservatorship, Living Will, Life Estate, etc.
6. Medicare Part D Card
7. Photo ID

Please complete the following North Dakota Department of Human Services form:

"AUTHORIZATION TO DISCLOSE INFORMATION"

www.nd.gov/eforms/Doc/sfn01059.pdf