Bethel Lutheran Nursing & Rehabilitation Center

ADMISSION APPLICATION FOR RESIDENCY

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

Applicant's Information:

Last Name, First Name, Middle Initial:			
Preferred Name:		Social Security Number:	
Date of Birth:		Birthplace:	
Gender:		E-mail:	
Mailing Address:			
City, State, Zip:			
Home Phone:		Cell Phone:	
Marital Status:	☐ Married ☐ Widowed ☐ Never Married ☐ Separated ☐ Divorced		
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 If applicant is unable to make own decisions, who is designated to make decisions on their behalf? Healthcare: _____ Phone: _____ Financial: _____ Phone: _____		
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		

Spouse's Information (if applicable):

Last Name, First Name, Middle Initial:	
Date of Birth:	Social Security Number:
E-mail:	
Mailing Address:	
City, State, Zip:	
Home Phone:	Cell Phone:

Emergency Contacts:

Name:	
Relationship to Applicant:	
E-mail:	
Mailing Address:	
City, State, Zip:	
Home Phone:	Cell Phone:

Name:	
Relationship to Applicant:	
E-mail:	
Mailing Address:	
City, State, Zip:	
Home Phone:	Cell Phone:

Authorization to Release Information: If requested BLNRC is authorized to release health care information to the following person(s):

Name:	
Relationship to Applicant:	
Home Phone:	Cell Phone:

Name:	
Relationship to Applicant:	
Home Phone:	Cell Phone:

Name:	
Relationship to Applicant:	
Home Phone:	Cell Phone:

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:	
City, State, Zip:	
E-mail:	
Home Phone:	Cell Phone:

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: _____

Children's Information (if applicable):

Last Name, First Name, Middle Initial:	
E-mail:	
Mailing Address:	
City, State, Zip:	
Home Phone:	Cell Phone:

Last Name, First Name, Middle Initial:	
E-mail:	
Mailing Address:	
City, State, Zip:	
Home Phone:	Cell Phone:

Last Name, First Name, Middle Initial:	
E-mail:	
Mailing Address:	
City, State, Zip:	
Home Phone:	Cell Phone:

Last Name, First Name, Middle Initial:	
E-mail:	
Mailing Address:	
City, State, Zip:	
Home Phone:	Cell Phone:

Last Name, First Name, Middle Initial:	
E-mail:	
Mailing Address:	
City, State, Zip:	
Home Phone:	Cell Phone:

Sibling's Information (if applicable):

Last Name, First Name, Middle Initial:	
E-mail:	
Mailing Address:	
City, State, Zip:	
Home Phone:	Cell Phone:

Last Name, First Name, Middle Initial:	
E-mail:	
Mailing Address:	
City, State, Zip:	
Home Phone:	Cell Phone:

Last Name, First Name, Middle Initial:	
E-mail:	
Mailing Address:	
City, State, Zip:	
Home Phone:	Cell Phone:

Last Name, First Name, Middle Initial:	
E-mail:	
Mailing Address:	
City, State, Zip:	
Home Phone:	Cell Phone:

Last Name, First Name, Middle Initial:	
E-mail:	
Mailing Address:	
City, State, Zip:	
Home Phone:	Cell 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

Bethel Lutheran Nursing & Rehabilitation Center

RESIDENT CONSENT RELEASE

RESIDENT NAME: _____

I DO /I DO NOT	Request routine hair care to be done by Bethel Lutheran Nursing & Rehabilitation Center (BLNRC) staff at no cost.
I DO/I DO NOT	There is a $30.00 charge for a permanent and a $25.00 charge for hair coloring.

_____ _____

Signature Date

MEDIA CONSENT/CHAPLAIN RELEASE

I hereby authorize BLNRC to use my name and/or picture for:

_____ Website
_____ Photograph for Medical Purposes
_____ Bethel Beacon (Bethel Foundation Publication)
_____ Church Social/Organization
_____ Everbridge notification
_____ Birthday board
_____ Bethel Radio Broadcast
_____ Door Sign with your name on it
_____ Other: Radio/TV/Newspaper
_____ Resident Directory
_____ Facebook/Social Media

Bethel's Chaplain may contact my own Pastor:

_____ Upon Admission _____ Upon Hospitalization _____ Upon Death

Such consent is granted freely, and without obligation. This consent shall remain in effect until a written request for withdrawal is provided to BLNRC.

_____ _____

Signature Date

RESIDENT TRUST FUND

I have been informed BLNRC will handle my personal funds if I so choose, by signing the following authorization: ***I hereby authorize BLNRC to hold, safeguard, and account for my personal funds. The following person(s) have permission to withdraw money from the trust fund on my behalf:***

_____ _____

_____ _____

Signature Date

Bethel Lutheran Nursing & Rehabilitation Center

ASSIGNMENT OF MEDICARE/INSURANCE BENEFITS
AUTHORIZATION TO RELEASE AND OBTAIN CLINICAL INFORMATION

_____ _____

Beneficiary **Medicare Number**

I authorize Bethel Lutheran Nursing & Rehabilitation Center (BLNRC) to submit claims to Medicare and/or any secondary or third-party payer. I request that payment of authorized Medicare and/or any secondary or third-party insurance benefits be paid to Bethel Lutheran Nursing & Rehabilitation Center on my behalf for any services furnished me by BLNRC. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits for related services. ***I ACKNOWLEDGE THAT I WILL BE RESPONSIBLE FOR ANY SERVICES NOT COVERED BY MEDICARE AND/OR ANY SECONDARY OR THIRD-PARTY INSURANCE.***

I, _____, hereby authorize Bethel Lutheran Nursing & Rehabilitation Center to furnish or request copies of my clinical records regarding any sickness or injury, treatment or consultation as may be needed by Bethel Lutheran Nursing & Rehabilitation Center, other medical facility, or insurance company for the continuity of my care, treatment, or payments for the same. Information will only be released that originates at Bethel Lutheran Nursing & Rehabilitation Center.

I understand that I may revoke this consent at any time by notifying the facility releasing the information in writing of my revocation.

_____ _____

Beneficiary's Signature Beneficiary's Name (Print)

_____

Date

By: _____ _____

Responsible Party's Signature Relationship to Beneficiary

_____

Date

Bethel Lutheran Nursing & Rehabilitation Center

RESIDENT INFORMATION RECEIPT VERIFICATION

Name: _____

I have been orally informed and have received copies of the following information and agree to abide by this information:

1. The Resident Bill of Rights and Ombudsman Program.
2. Resident Conduct Rules and Responsibilities that govern the facility.
3. Daily Charge Information and the Bed Hold Policy.
4. Services available in the facility and charges for those services, including charges not covered by Medicare or this facility's per diem rate.
5. Information regarding Medicare and Medicaid applications (including asset assessment information) and how these programs may assist in paying for long-term care.
6. The facility's grievance procedure and how to file a grievance.
7. Information regarding Advance Directives and the Self-Determination Act.
8. Billing, Credit and Collection Policy.
9. Bethel Lutheran Nursing & Rehabilitation Center's Notice of Privacy Practice.
10. Information on Expectations of a Nursing Home Stay.

_____ _____

SIGNATURE DATE

RESIDENT'S CLINIC APPOINTMENTS

Each family plays an important role in the care of our residents. We need your assistance in accompanying your loved one to their appointment. Please list the person or persons who will be available to be with the resident while at an appointment. Bethel Lutheran Nursing & Rehabilitation Center will provide the transportation as needed. ***We thank you for your willingness to help.***

NAME	TELEPHONE NO.	ADDRESS
_____	_____	_____
_____	_____	_____