



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:	<input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No What Branch? _____	
	Is your spouse a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No What Branch? _____	
Background Status:	Have you ever been convicted of or pled guilty to a sexual offense in a court of law? <input type="checkbox"/> Yes <input type="checkbox"/> No State/County: _____	
Decision Making Authorization:	Do you make your own decisions for healthcare and financial matters? <input type="checkbox"/> Yes <input type="checkbox"/> No If applicant is unable to make own decisions, who is designated to make decisions on their behalf?	
	Healthcare: _____	Phone: _____
Legal Documents: (Copies are Required)	Financial: _____ Phone: _____	
	<input type="checkbox"/> Durable Power of Attorney (POA) Finances or Conservatorship <input type="checkbox"/> Durable Power of Attorney (POA) Healthcare or Guardianship <input type="checkbox"/> Health Care Directive or Living Will <input type="checkbox"/> 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 Nelson Manor (NM)/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:		
<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicare Advantage (Medicare part C)	<input type="checkbox"/> Self Pay
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Applying for Medicaid	<input type="checkbox"/> Nursing Home Insurance

**Insurance Information:**

Are you, the applicant, currently covered by an employer's group health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date Applied: _____ County/State: _____
If yes, were you approved? <input type="checkbox"/> Yes <input type="checkbox"/> 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 Nelson Manor/BLNRC 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 Nelson Manor (NM)/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 NM/BLNRC. I also authorize NM/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 NM/BLNRC. I further authorize NM/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



Nelson Manor - Basic Care

## RESIDENT CONSENT RELEASE

RESIDENT NAME: \_\_\_\_\_

### HAIR CARE

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

I hereby authorize BLNRC/Nelson Manor (NM) to use my name and/or picture for:

- |  |   |
|--|---|
| <input type="checkbox"/> Website                                       | <input type="checkbox"/> Birthday board                 |
| <input type="checkbox"/> Photograph for Medical Purposes               | <input type="checkbox"/> Bethel Radio Broadcast         |
| <input type="checkbox"/> Bethel Beacon (Bethel Foundation Publication) | <input type="checkbox"/> Door Sign with your name on it |
| <input type="checkbox"/> Church Social/Organization                    | <input type="checkbox"/> Other: Radio/TV/Newspaper      |
| <input type="checkbox"/> Everbridge notification*                      | <input type="checkbox"/> Resident Directory             |
|  | <input type="checkbox"/> Facebook/Social Media          |

\*Please note: this information goes to the designated Healthcare POA by default.

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### RESIDENT TRUST FUND

I have been informed BLNRC/NM will handle my personal funds if I so choose, by signing the following authorization: ***I hereby authorize BLNRC/NM 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



Nelson Manor - Basic Care

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

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**Beneficiary**

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**Medicare Number**

I authorize Nelson Manor @ Bethel Lutheran Nursing & Rehabilitation Center (NM/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 NM/BLNRC on my behalf for any services furnished me by NM/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 NM/BLNRC to furnish or request copies of my clinical records regarding any sickness or injury, treatment or consultation as may be needed by NM/BLNRC, 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 Nelson Manor @ 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.

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Beneficiary's Signature

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Beneficiary's Name (Print)

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Date

By: \_\_\_\_\_  
Responsible Party's Signature

---

Relationship to Beneficiary

---

Date



Nelson Manor - Basic Care

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. BLNRC/Nelson Manor's Notice of Privacy Practice.
10. Information on Expectations of a Basic Care 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/Nelson Manor will provide the transportation as needed. We thank you for your willingness to help.

NAME

TELEPHONE NO.

ADDRESS

NAME

TELEPHONE NO.

ADDRESS