



*Our Family Caring for Yours*

# Admission Application

**Assisted Living**  
4006 24<sup>th</sup> Avenue S  
Grand Forks, ND 58201  
Phone 701.787.7621  
Fax 701.787.7589

**Basic Care**  
3300 Cherry Street  
Grand Forks, ND 58201  
Phone 701.787.7600  
Fax 701.787.7589

**Skilled Nursing & Transitional Care**  
2900 14<sup>th</sup> Avenue S  
Grand Forks, ND 58201  
Phone 701.787.7900  
Fax 701.787.7959

**Skilled Nursing & Memory Care**  
4004 24<sup>th</sup> Avenue S  
Grand Forks, ND 58201  
Phone 701.787.7500  
Fax 701.787.7959

[www.valleyseniorliving.org](http://www.valleyseniorliving.org)

# VALLEY SENIOR LIVING

## Application for Admission

FOR OFFICE USE ONLY

File No. \_\_\_\_\_

Room No. \_\_\_\_\_

Rental Date: \_\_\_\_\_

Move In 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	<input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced If Married, please list name of spouse: _____		
Background 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 _____		
How did you hear about us? Media _____ Word of Mouth _____ Heathcare Provider _____ Other – Explain _____			
<b>Decision Making Authorization:</b>	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: _____		
<b>Legal Documents:</b> Copies are <b>REQUIRED</b>	<input type="checkbox"/> Durable Power of Attorney Finances or Conservatorship <input type="checkbox"/> Durable Power of Attorney Healthcare or Guardianship <input type="checkbox"/> Health Care Directive or Living Will		
MEDICAL INFORMATION			
Primary Physician: _____		Eye Doctor: _____	
Dentist: _____		Funeral Home: Address: _____	
Pharmacies used by VSL tenants/residents must provide 24/7 service. Please choose one.		<input type="checkbox"/> Thrifty White Drug <input type="checkbox"/> Wall's Medicine Center <input type="checkbox"/> Altru Clinic Pharmacy	
<b>Skilled Nursing Residents Only:</b> Thrifty White Drug will be utilized when you are covered by Medicare A.		Do you currently use medications from the VA? Yes _____ No _____	

**BILLING \*\*MUST BE COMPLETED\*\****List where you would like any mail sent and/or who will be managing financial affairs of applicant*

Billing Party	Relationship to Applicant	Address	Phone Numbers
Name: _____		_____	H: _____
E-Mail Address: _____		_____	W: _____
			C: _____

**EMERGENCY NOTIFICATION** *List in the order of whom you prefer we contact first*

Contact	Relationship to Applicant	Address	Phone Numbers
1. Name: _____		_____	H: _____
E-Mail Address: _____		_____	W: _____
			C: _____
2. Name: _____		_____	H: _____
E-Mail Address: _____		_____	W: _____
			C: _____
3. Name: _____		_____	H: _____
E-Mail Address: _____		_____	W: _____
			C: _____

**INSURANCE INFORMATION**

Are you, the applicant, currently employed part-time or full-time? Yes _____ No _____	Are you, the applicant, currently covered by an employer's group health insurance? Yes _____ No _____ Company Name: Policy Holder Name: Policy #:
Medicare Number:	Medical Assistance/Medicaid Number/County:
Medicare Supplemental Insurance Company: Policy #: Telephone #:	Have you, the applicant, ever applied for Medical Assistance/Medicaid? Yes _____ No _____  Date Applied: _____ County and State: _____
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? Yes\_\_\_\_\_ No\_\_\_\_\_

If YES, please explain the nature of the transaction; such as who completed the transaction and the date it occurred.

Trust Account - Date Created \_\_\_\_\_, Revocable \_\_\_\_ Irrevocable \_\_\_\_

Life Estate - Date Created \_\_\_\_\_

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	
Pre-Paid Burial Account	
Stocks or Bonds	
IRA's or Annuities	
Life Insurance - Cash Surrender Value	
Home(s)	
Vehicle(s)	

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
Applicant Social Security Benefit	Monthly	
Applicant Retirement/ Pension/Other Income		
Spouse Social Security Benefit	Monthly	
Spouse Retirement/ Pension/Other Income		

**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\_\_\_\_\_