Admission Application

Assisted Living
4006 24th 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 14th Avenue S
Grand Forks, ND 58201
Phone 701.787.7900
Fax 701.787.7959

Skilled Nursing & Memory Care
4004 24th Avenue S
Grand Forks, ND 58201
Phone 701.787.7500
Fax 701.787.7959

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	___Married ___Widowed ___Never Married ___Separated ___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 __________________________			
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 Finances or Conservatorship ____ Durable Power of Attorney Healthcare or Guardianship ____ 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. **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_____

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: ___________________________ E-Mail Address: ___________________________			H: W: C:

EMERGENCY NOTIFICATION *List in the order of whom you prefer we contact first*			
Contact	**Relationship to Applicant**	**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:

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______________________