VALLEY SENIOR LIVING

Application for Admission

www.valleyseniorliving.org

FOR OFFICE USE ONLY
File No. _____
Room No. _____
Rental Date: _____
Move In Date: _____

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

DEMOGRAPHIC INFORMATION
(Please put the **applicant's** information on this page. There will be space later for family/responsible party information)

Applicant's Legal Name	First: MI:	Last:	Preferred Name:	
Applicant's Current Address	Street Address:	City:	State:	Zip Code:
Applicant's Phone Numbers:	Home:	Cell:		
Applicant's Email Address:				
Date of Birth:	Social Security Number: *Required*	Gender:		
Race:	Ethnicity:	Religion:		
Language:	Do you need an interpreter? Yes ___ No ___ What language? _____			
Marital Status	___ Married ___ Widowed ___ Never Married ___ Separated ___ Divorced *If Married, please list name of spouse:* _____			
Veteran Status	Are you a Veteran? Yes ___ No ___ What Branch? _____ Is/was your spouse a Veteran? Yes ___ No ___			
Background	Have you ever been convicted of or plead guilty to a sexual offense in a court of law? Yes ___ No ___ State _____ County _____			
	Applicant's Birthplace:	Applicant's Previous Occupation:	Mother's Maiden Name:	

OUTSIDE PROVIDERS/FACILITIES

Primary Physician: _____
Dentist: _____
Eye Doctor: _____
Funeral Home: _____
City: _____
Church: _____
City: _____

Pharmacy:
Pharmacies used by VSL tenants/residents must provide 24/7 service.

You must choose one of the following:
___ Thrifty White Drug
___ Wall's Medicine Center
___ Altru Clinic Pharmacy

Do you currently use medications from the VA? Yes ___ No ___

Skilled Nursing Residents Only:
Thrifty White Drug will be utilized while you are covered by Medicare A.

DECISION MAKING			
Do you, the applicant, make your own decisions for healthcare & financial matters? Yes ____ No ____			
Do you have any of the following? **copies required**	☐ Healthcare Power of Attorney ☐ Financial Power of Attorney	☐ Guardianship ☐ Conservatorship	☐ Health Care Directive ☐ Living Will

CONTACTS			
Please list 2 primary contacts in the order of whom you prefer we contact first:			
Name: E-Mail Address:	Relationship to Applicant: POA Healthcare? Ⓨ / Ⓝ POA Finances? Ⓨ / Ⓝ Guardian? Ⓨ / Ⓝ Conservator? Ⓨ / Ⓝ	Address:	Phone Numbers: H: W: C:
Name: E-Mail Address:	Relationship to Applicant: POA Healthcare? Ⓨ / Ⓝ POA Finances? Ⓨ / Ⓝ Guardian? Ⓨ / Ⓝ Conservator? Ⓨ / Ⓝ	Address:	Phone Numbers: H: W: C:

BILLING PARTY **MUST BE COMPLETED** *List where you would like any mail sent and/or who will be managing financial affairs of the applicant*			
Billing Party Name: E-Mail Address:	Relationship to Applicant POA Healthcare? Ⓨ / Ⓝ POA Finances? Ⓨ / Ⓝ Guardian? Ⓨ / Ⓝ Conservator? Ⓨ / Ⓝ	Address:	Phone Numbers: H: W: C:

INSURANCE INFORMATION		
Employment: Are you currently employed? ☐ Yes ☐ No Is your spouse currently employed? ☐ Yes ☐ No	Are you currently covered by an employer's group health insurance? ☐ Yes ☐ No	Insurance Company: Policy Holder: Policy #:
Medicare Number:	**Medical Assistance/Medicaid** Have you ever applied for Medical Assistance/Medicaid? Yes ☐ No ☐ Date Applied: _____ County and State: _____ Medicaid Number: _____ County: _____	
Medicare Supplemental Insurance Company: Policy #: Telephone #:		
Medicare Replacement Policy Company: Policy #: Telephone #:	**Health Insurance – Other** Company: Policy #: Telephone #:	
Medicare D (prescription) Plan Company: Policy #: Telephone #:	**Long Term Care Insurance** Company: Policy #: Telephone #:	Daily benefit amount:$_____ Elimination period (if any): _____

FINANCIAL INFORMATION **MUST BE COMPLETED**

Information in this section will assist with financial planning. Please attach additional information if needed.

Do you have a Trust Account? – Yes ☐ No ☐ Date Created _____ Value $_____ Revocable ☐ Irrevocable ☐ Description: _____	**Do you have a Life Estate?** – Yes ☐ No ☐ Date Created _____ Value $_____ Description:_____

In the past 5 years 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, the amount, and date it occurred: _____

Except for personal effects, list all 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	
Stocks or Bonds	
IRA's or Annuities	
Pre-Paid Burial Account	
Life Insurance - Cash Surrender Value	
List Home(s)	
List 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 50-10.2-05 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 _____

Signature required for application to be processed

Name of person filling out this application: _____ Relationship to applicant: _____