LUTHERAN SUNSET HOME

SKILLED NURSING FACILITY ADMISSION APPLICATION

333 Eastern Avenue
Grafton, ND 58237
Telephone (701) 352.1901
Fax (701) 352.1926

Lutheran Sunset Home Admission Application

IDENTIFICATION:

Last Name:_____ Preferred Nickname:_____
First Name:_____ Middle Initial:_____
Address (Street, City, State, Zip):_____
_____ Phone:_____

PERSONAL INFORMATION:

Birth Date:_____ Age:_____ Social Security Number_____-_____-_____
Sex:_____ Race:_____ Marital Status:_____ Spouse Name:_____
Previous Occupation:_____ Education:_____
Religion:_____
Church: (Name, Address, City, Phone):_____
Birthplace:_____
Military Veteran:
Resident: Yes_____ No_____ Branch:_____
Spouse (Name):_____ Yes_____ No_____ Branch_____
Have you ever been convicted of or pled guilty to a sexual offense in a court of law? Yes_____ No_____

MEDICAL DESIGNATIONS:

Local Physician:_____ Phone No:_____
Local Optometrist/Opthalmologist:_____ Phone No:_____
Local Dentist:_____ Phone No:_____
Local Pharmacy:_____ Phone No:_____
If outside of Grafton, Primary MD:_____ Phone No:_____

NOTIFY IN EMERGENCY:

1) Name:_____ Relationship:_____
Address (Street, City, State, Zip):_____
Phone No: (H)_____ (W)_____ (C)_____
Email Address:_____
2) Name:_____ Relationship:_____
Address (Street, City, State, Zip):_____
Phone No: (H)_____ (W)_____ (C)_____
Email Address:_____
3) Name:_____ Relationship:_____
Address (Street, City, State, Zip):_____
Phone No: (H)_____ (W)_____ (C)_____
Email Address:_____

BILLING PARTY: (who we send the billing statement to)

Name:_____ Relationship:_____
Address:_____
City, State, Zip:_____
Phone No: (H)_____ (W)_____ (C)_____

Along with your completed application, please include copies of the following cards/documents (if applicable):

- Social Security Card
- Medicare Card
- Medicare Supplement Insurance Card
- Medicaid Card
- Prescription Drug Plan (Medicare Part D) Card
- Photo ID/Driver's License
- Power of Attorney
- Advanced Health Care Directives/Living Will
- Nursing Home Insurance Policy

ADVANCED DIRECTIVES:

Please list Power of Attorney (POA) as described in legal document*

POA for Financial:_____ POA for Healthcare:_____

OR POA FOR BOTH:_____

If no legally designated Power of Attorney, please list appointed decision makers:

Medical Decision Maker:_____ Financial Decision Maker:_____

Please provide Lutheran Sunset Home with a copy of these documents

FUNERAL HOME PREFERENCE:

Name:_____

Address:_____

Phone No:_____

Prepaid Burial? Yes_____ No_____ Amount: $_____

INSURANCE INFORMATION:

Medicare Number:_____ Part A:_____ Effective Date:_____

Part B:_____ Effective Date:_____

Medicare Supplement Ins:_____ Policy No.:_____

Address_____

_____ Phone No:_____

Do you have a Medicare Replacement policy: Yes_____ No_____

If yes, Name:_____ Policy No:_____

Address:_____

_____ Phone No:_____

Is Applicant currently receiving Medicaid? Yes_____ No_____

Medicaid ID No. (If Applicable)_____ County:_____

Pending:_____ Approved:_____ Approved Date:_____

If no, will financial assistance be needed? Yes_____ No_____

Has an application been submitted for Medical Assistance? Yes_____ No_____

If yes, what county?_____

Long Term Care Ins:_____ Policy No:_____

Address:_____

Phone No:_____

Long Term Care Ins:_____ Policy No:_____

Address:_____

Phone No:_____

Do you have a Medicare D (prescription drug) Plan? Yes_____ No_____ Effective Date:_____

Plan Name:_____ Policy No:_____

Other Insurance:_____

Signature:_____ Date:_____

(Resident/Legal Agent/Responsible Party)

LUTHERAN SUNSET HOME
FINANCIAL INTAKE QUESTIONNAIRE

Lutheran Sunset Home requests detailed financial information prior to admission, as permitted by the regulations detailed below:

North Dakota Century Code:
50-24.1-22. Long-term care facility information. A long-term care facility may request that an applicant for admission, a resident of the facility, or the applicant's or residents legal representative furnish financial information regarding income and assets, including information regarding any transfers or assignments of income or assets. A long-term care facility may deny admission to an applicant for admission who is unable to verify a viable payment source.

We recognize that the completion of this form is time-consuming and that the confidentiality of this information is the paramount concern. Thank you for your understanding of our need to request this information.

Nursing Home Financial Intake Questionnaire

Information provided in this section will assist with financial planning. Attach additional pages if needed.

Except for personal affects, list all assets owned by you and your spouse, with the value as of the date of application.

Owner(s) of Asset	Description of Asset	Approximate Value
	Checking	
	Savings-Passbook	
	Certificate(s) of Deposit	
	Stocks, Bonds, etc.	
	Life Insurance, Cash Surrender Value	
	Home(s)	
	Land	
	Vehicles	
	Life Estates and Trusts	
	Annuities & Retirement Funds (401(k), IRA, Roth)	
	Prepaid Burial	
	Other (describe)	

List all debts owed by you and your spouse, with outstanding balance as of the date of application.

Debtor	Description of Debt	Amount of Debt

List all transfers of cash and/or gifts of assets within the past five years, by you and your spouse, including transfers of a remainder interest in real property.

Date of Transfer	Description of Asset	Recipient/Relationship	Value of Asset

Did the agent or attorney-in-fact under your financial power of attorney assist you with making any of the transfers or gifts referenced above, or benefit or receive any of the assets transferred or gifted? If yes, please explain.

_____

_____

Were any of the assets described transferred to or from a trust? If yes, explain the nature of the transaction and identify the trust involved.

_____
_____
_____

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, and employment income.

Description of Income	**Date of Frequency of Payment (i.e. Monthly, annually, etc.**	**Amount of Payment**
Social Security Benefit	Monthly	

Do you or your spouse reside on a farm? Yes_____ No_____

Are you actively engaged in farming or any other trade or business? If yes, describe the nature of the business.

_____
_____
_____

Are you or your spouse employed by another or self-employed? If yes, provide the name of the employer or the nature of self-employment, the hours worked and the wage or salary earned.

_____
_____
_____

Are you or your spouse the beneficiary of any trust? Yes_____ No_____

Do you have any pending legal action from which you may receive money or medical benefits, including inheritance? Yes_____ No_____ If yes, describe.

_____
_____
_____

This questionnaire complies with section 50-24.1-22 of North Dakota Century Code. By my signature below, I hereby authorize the nursing home to contact the county social services for information regarding my Medicaid application and eligibility, and I hereby release and authorize the county social services to release any information to the nursing home. I also authorize the nursing home 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 nursing home. I further authorize the nursing home 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:_____ Date:_____

OFFICE USE ONLY:

Admit date:_____ Room:_____
Admitted from:_____ Referred by:_____
Medical Record Number:_____
Payment status: Private_____ Medicare_____ Medicaid_____
Medicare replacement policy_____ Major medical insurance_____
Worker's compensation_____
Three day qualifying stay:_____ - _____
If Medicare, reason for coverage:_____
Staff initials_____

ADDITIONAL INFORMATION