800 South Main Avenue
Rugby, ND 58368
Phone: (701) 776-5261
Fax: (701) 776-5448
TDD: (701) 776-5043

NURSING HOME INTAKE APPLICATION

This information must be accurately and honestly completed in full for processing of the proposed resident's Application for the facility's nursing home services. ***If any information required is non-applicable please write "N/A" or "NONE" in the field. Failure to complete this Application in full shall be grounds for denial of admission to the facility.***

Last name, First Name, Middle Initial (Proposed Resident)			
Date of Birth:		Medicare/Social Security Number:	
Mailing Address:		City, State, Zip:	
Phone Number:	Cell Phone Number/ email address:	How to Reach You:	
Spouse's Last name, First Name, Middle Initial:			
Spouse's Date of Birth:		Medicare/Social Security Number:	
Spouse's Mailing Address:		City, State, Zip:	
Spouse's Phone Number:	Spouse's Cell Phone Number:	Spouse's Work Number:	Spouse's Fax Number:
Spouse's E-mail Address:		Best Method and Time to Reach Your Spouse:	
Person Providing information	Person Providing Information's Address, City, State, Zip:		
Contact's Phone Number:	Contact's Cell Phone Number:	Contact's Work Number:	Contact's Fax Number:

1. Please list all liquid assets:

	FINANCIAL INSTITUTION	VALUE AND MATURITY DATES IF APPLICABLE
CHECKING		
SAVINGS		
CD'S		
CASH ON HAND		

Revised 10-10-17

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2. Except for personal effects, list all real and personal property currently owned by you and your spouse or that you own with a third party or parties, including real property currently owned by you or your spouse and a third party or parties, the cash surrender value of life insurance, stocks, bonds, vehicles, life estates, antiques, collectibles, and pensions currently held by you or your spouse with their value as of the date of this Application (Attach additional pages if needed.)

*IF YOU DO NOT KNOW WHETHER YOU OR YOUR SPOUSE OWN A PARTICULAR PIECE OF REAL OR PERSONAL PROPERTY PLEASE LIST THAT PROPERTY AND PUT A QUESTION MARK BEHIND THE DESCRIPTION.

Current owner of property	Description of Asset including date of transfer or sale if transferred or sold	Value of property (if sold or transferred at time sold or transferred
a.		
b.		
c.		
d.		
e.		
f.		
g.		
h.		
i.		

3. List all debts owed by you and your spouse, with amount due as of the date of this Application.

Debtor	Description of Debt (what the debt is and who it is owed to)	Amount of Debt
a.		
b.		
c.		

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4. List all transfers or gifts of real or personal property, and other property have a cash value in excess of $3,000 made by you or your spouse within the past six years, including transfers of a remainder interest in real property where you retained a life estate or other interest in the property.

Date of Transfer	Description of Asset	Recipient	Value of Asset
a.			
b.			
c.			
d.			
e.			
f.			

5. List all pre-paid burial contracts, burial accounts, and pre-paid burial or funeral items owned by you or your spouse or by a third party for the benefit of you or your spouse at the time of this Application.

Description	Owner	Value
a.		
b.		
c.		
d.		
e.		

6. 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's benefits, pensions and employment income at the time of this Application.

Description of Income	Date or Frequency of Payment	Amount of Payment
a.		
b.		
c.		
d.		
e.		
f.		

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7. List all health and pharmacy insurance currently available to you and your spouse.

Name of Insured	Name of Insurer	Type of and Provider of Insurance	Monthly Premium Amount
a.			
b.			
c.			
d.			
e.			
f.			

8. Do you have a financial power of attorney?_____. Is it currently being used by the person as your power of attorney?_____. If you have a financial power of attorney a copy of that power of attorney must be attached to this Application.

Name, address, and telephone number of your financial power of attorney.

9. Do you have a health care power of attorney? Is it currently being used by the person named as your power of attorney? If you have a health care power of attorney a copy of that power of attorney must be attached to this Application.

Name, address, and telephone number of your health care power of attorney.

10. Did the agent or attorney-in-fact listed under your financial power of attorney assist you with making any of the transfers or gifts referenced in section number 3 above, or benefit or receive any of the assets transferred or gifted? If yes, please describe the transfer or gift including the date of transfer.

11. Were any of the assets described in section number 3 above transferred or gifted to or from a trust? If yes, explain the nature of the transaction and identify the trust and trustee involved.

12. Have you ever applied for Medicaid? If yes, provide the date and county in which application was made.

13. Do you or your spouse reside on a farm?

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

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

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16. Are you or your spouse currently a named beneficiary under any will or trust?

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

This questionnaire complies with section 50-24.1-22 of the 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.

Applicant Signature:_____ Date:_____

Person Assisting with this Application _____ Date:_____