

# ***BASIC CARE APPLICATION FOR ADMISSION***

Please complete this form in its entirety and return it to the Administrator.

<b>1. Applicant</b>			
Last name:	First Name:	Middle Initial:	Maiden:
Date of Birth:	Present Age	Social Security Number:	
Mailing Address:		County	City, State, Zip:
Phone Number:	Cell Phone Number:	Best Method and Time to Reach You:	
<b>2. Spouse's</b>			
Last name:	First Name:	Middle Initial:	Maiden:
Spouse's Date of Birth:		Spouse's Social Security Number:	
Spouse's Mailing Address:		County	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:	
<b>3. Name of all Living children</b>			
Last name: First Name: Middle Initial:			
Contact's Address, City, State, Zip:			
Contact's Phone Number:	Contact's Cell Phone Number:	Contact's Work Number:	Contact's Fax Number:
Last name: First Name: Middle Initial:			
Contact's Address, City, State, Zip:			
Contact's Phone Number:	Contact's Cell Phone Number:	Contact's Work Number:	Contact's Fax Number:
Last name: First Name: Middle Initial:			
Contact's Address, City, State, Zip:			
Contact's Phone Number:	Contact's Cell Phone Number:	Contact's Work Number:	Contact's Fax Number:
<b>4. Name of Emergency Contacts</b>			
Last name: First Name: Middle Initial:			
Contact's Address, City, State, Zip:			
Contact's Phone Number:	Contact's Cell Phone Number:	Contact's Work Number:	Contact's Fax Number:
Last name: First Name: Middle Initial:			
Contact's Address, City, State, Zip:			
Contact's Phone Number:	Contact's Cell Phone Number:	Contact's Work Number:	Contact's Fax Number:

**5.** Except for personal effects, list all assets owned by you and your spouse, including the cash surrender value of life insurance, stocks, bonds, vehicles, life estates, antiques, collectibles, and pensions, with the value as of the date of admission into the Basic Care home. (Attach additional pages if needed.)

Owner of Asset	Description of Asset	Value of Asset
a.		
b.		
c.		
c.		

**6.** List all debts owed by you and your spouse, with values as of the date of admission into the Basic Care home.

Debtor	Description of Debt	Amount of Debt
a.		
b.		
c.		

**7.** List all transfers 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	Value of Asset
a.			
b.			
c.			

**8.** 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.

Description	Owner	Value
a.		
b.		

**9.** 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, and employment income.

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

**10.** List **all** Insurance life, health dental and pharmacy insurance for you and your spouse.

Name of Insured	Name of Insurer	Insurance & policy #	Monthly Premium Amount
a.		Life #	
b.		Health#	
c.		Dental #	
d.		Pharmacy#	
e.		Medicare#	
f.		Medicaid#	
g.		Other	
h.		Other	

**11. Identify your power of attorney. (Please attach a copy hereto.)**

Name, address, and telephone number:

**12. Identify your agent under your financial power of attorney. (Please attach a copy hereto.)**

Name, address, and telephone number:

**13. Identify your agent under your health care power of attorney. (Please attach a copy hereto.)**

Name, address, and telephone number:

**14. 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 number 7 or benefit or receive any of the assets transferred or gifted? If yes, please explain.**

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**15. Were any of the assets described in number 7 transferred or gifted to or from a trust? If yes, explain the nature of the transaction and identify the trust involved.**

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

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**17. Do you or your spouse reside on a farm?**

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

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19. Are you or your spouse 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.

20. Are you or your spouse the beneficiary of any trust?

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

**22. Family History (optional)**

Father Name

Mother Name

Maiden

Number of Brothers

Number of sisters

Names:

Your education Level:

Former Occupation:

Language spoken:

Other Information you think is important

**23. General Information**

Need Assistance with? (check the appropriate item)

Bathing	Dressing	Grooming	Taking medications	Climbing stairs
Toileting	Eating	Walking	Transferring	

Does the applicant use?

Walker	Wheelchair	Cane
Glasses	Dentures	Hearing aids right left both

Special Interests: \_\_\_\_\_

Hobbies: \_\_\_\_\_

Religious Preference: \_\_\_\_\_ Church Attended: \_\_\_\_\_

Pastor's Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

**24. Medical Information**

Physician: \_\_\_\_\_ Clinic: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
Address: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Dentist: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
Address: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Eye Doctor: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
Address: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Psychologist: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
Address: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Psychiatrist: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
Address: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Other Physician: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
Address: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

PAST PLACEMENTS (hospitalizations, placement with relatives, out-patient services, etc.):

Agency Name/address: \_\_\_\_\_ Date of Placement: \_\_\_\_\_ Reason for Placement: \_\_\_\_\_  
Date of Discharge: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Funeral Home Preference: \_\_\_\_\_ City: \_\_\_\_\_

Does Applicant Smoke? \_\_\_\_\_

Does the applicant have any allergies to medications or food? \_\_\_\_\_ If yes, please list: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all of the medications the applicant is presently taking (name, dose, how often, what for), and list all the over the counter medications they are taking (e.g., aspirin, antacids, laxatives, etc.).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is the applicant continent of bowel and bladder? \_\_\_\_\_

Does the applicant have an indwelling Foley catheter? \_\_\_\_\_ When was it put in? \_\_\_\_\_

Is the applicant alert? \_\_\_\_\_

Is the applicant forgetful? \_\_\_\_\_

Is the applicant confused? \_\_\_\_\_

Does the applicant get agitated easily? \_\_\_\_\_

Does the applicant fall often? \_\_\_\_\_

Does the applicant wander? \_\_\_\_\_

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*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.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_