Applicant/Resident Information

First Name	Middle Initial	Last Name
AKA, Maiden Name, Former Name	Telephone Number	County
Address	City	State / Zip Code

Date of Birth	Age	Gender	Birth Place	Social Security Number
		Male ☐ Female ☐		

Marital Status
Single ☐ Married ☐ Seperated ☐ Divorced ☐ Widowed ☐

Name of Spouse

Placement Needed
Immediate ☐ *Within 6 Months* ☐ *Unknown* ☐

Anticipated Stay
Short Term ☐ *Long Term* ☐ *Unknown* ☐

Race
White ☐ American Indian ☐ Black or African American ☐ Asian ☐ Other (specify)

Primary Language

Insurance Information: Please provide a copy of all current insurance cards

Are you eligible for Medicare Yes ☐ No ☐	Medicare Number:	
Part A Effective Date	Part B Effective Date	Part D Effective Date
Are you eligible for Medicaid? Yes ☐ No ☐	Medicaid Number:	

Do you have any other health insurance or a Medicare Replacement Plan? Yes ☐ No ☐
If yes, plase list including the name and address of insurance company

Primary Insurance Company	Policy Number
Secondary Insurance Company	Policy Number

SSI Do you receive any SSI or SSDI (supplemental/disability) income? Yes ☐ No ☐

VA Is the applicant a veteran? Yes ☐ No ☐ Is the applicant the spouse of a Veteran? Yes ☐ No ☐
If yes, contact the VA to determine eligibility for nursing home benefits. Do you recieve any VA benefits? Yes ☐ No ☐

FINANCIAL STATEMENTS TO BE MAILED TO

Name: Phone #:

Address:

ADVANCED DIRECTIVES
(Check applicable boxes, Provide copies of applicable paperwork upon admission)

Power of Attorney (POA) ☐ Durable Power of Attorney (DPOA) ☐
Powe of Attorney for Healthcare ☐

Guardian ☐ Living Will ☐ Advanced Directives ☐

Name and Address of DPOA/POA/ Guardian

Primary Physician	Physician Telephone Number	Date Last Seen by Physician
Choose Primary Physician while at Maryhill	Dr. Buhr	Dr. Sheets-Olson

HOSPTITAL PREFERENCE:	Sanford (Fargo)	Essentia (Fargo)	VA
	CHI (Lisbon)	Mercy (Valley City)	Other:
PHARMACY PREFERENCE:	Nucara		Thrifty White

SPECIAL DIET (Including Food Allergies):

Assistance Needed With:	Walking	Eating	Toileting	Bathing

DESCRIBE MEDICAL CONDITION(S) CONTRIBUTING TO NEED FOR CARE:

CURRENT PHYSICAL HEALTH PROBLEMS/ SPECIAL NEEDS

Alzheimer's, Dementia	Hallucinations	Hypertention
Bowel Incontinence	Fracture	Pain
Urine Incontinencce	CVA/Stroke	Smoker
Infections (UTI, Respiratory, etc.)	Arthritis	Insomnia
Emotional Issues	Behavioral issues	Chemotherapy
Skin concerns	Dialysis	Bariatric equipment
history of falls	radiation	wanders away
Alcohol Consumption	Obesity	Cancer
Decubitus Ulcer	Parkinsons	Paralysis
Heart Disease	Contractures	Catheter Use
Seizure Disorder	Respiratory; Using O2 @_____Liters	Kidney Disease

Allergies- List:

HOSPITALIZATION

Have you been hospitalized in the last 12 months? Yes No If yes, complete the following information

Acute Hospital Name: (most recent)	Admit Date:	Discharge Date:
Skilled Nursing Facility Name: (most recent)	Admit Date:	Discharge Date:
Applicant/Resident is currently resideing at	Admit Date:	

Any other information that you feel may be important

PERSON COMPLETING THE APPLICATION

Phone # of person to contact reguarding application and/or openings:	HOME ( )
	WORK ( )
	May we contact you a work? Yes No

ADDRESS OF PERSON COMPLETEING APPLICATION: