

BETHANY HOMES
SKILLED NURSING FACILITY
201 SOUTH UNIVERSITY DRIVE
FARGO ND 58103
(701)239-3525 FAX: (701)239-3255
Email: vpeterson@bethanyhomes.org

FOR OFFICE USE ONLY <input type="checkbox"/> Special Care Unit <input type="checkbox"/> Skilled Nursing
Date Application Received: _____
Admitting on: _____ Arrival Time _____
From: _____ Via: _____
Room: _____ MR#: _____ Laundry#: _____

APPLICANT INFORMATION

First Name: _____ **Initial:** _____ **Last:** _____

SEX: Female Male **Date of Birth:** _____ **SOCIAL SECURITY #:** _____

Placement needed: immediate within 6 months Unknown **Anticipated stay:** Short term Long Term Unknown

CIVIL STATUS: Married Never Married **Name of Spouse:** _____
 Widowed Divorced Separated **Date of Death (if applicable):** _____

Applicant's present address: _____

Applicant's present phone #: _____

Applicant's prior occupation: _____ **Hometown:** _____

MEDICARE **Number:** _____ Part A Part B Part A and Part B
Note: Copy of Medicare card needed upon admission.

OTHER INSURANCE **Primary** _____ **Policy #:** _____
Secondary _____ **Policy #:** _____

PRESCRIPTION DRUG COVERAGE **Name:** _____ **ID #** _____

COUNTY ASSISTANCE **Do you receive any county assistance?** Yes - County: # _____
 No No, but information regarding application needed:

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

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 receive any VA benefits? No Yes

FINANCIAL STATEMENTS TO BE MAILED TO **Name:** _____ **Phone #:** _____
Address: _____

PHYSICIAN: _____ **CLINIC:** _____

HOSPITAL PREFERENCE: MeritCare Innovis Health VA

ADVANCED DIRECTIVES
(check applicable boxes, provide copies of applicable paperwork upon admission.)

Power of Attorney (POA) Durable Power of Attorney (DPOA)
 Power of Attorney for Health care

Guardian Living Will Advanced Directives

Name/Address of DPOA/POA/Guardian: _____

APPLICATION CONTINUED ON NEXT PAGE

EMERGENCY AND FAMILY/REPRESENTATIVE NUMBERS AND ADDRESSES

Name:	Relationship:	PHONE: Home () Work () Cell ()
Address:		
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Address:		
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Address:		
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Address:		

APPLICANT INFORMATIONReason applicant needs skilled care: dementia/memory care physical conditionREFERRAL SOURCE: Physician Social Worker Family/Friend Other

Applicant's feelings regarding placement:

Has applicant been a resident in another nursing home? No Yes - (where & dates)Has applicant received prior home health services? No Yes - (agency & dates)Mental Status: Alert Confused Forgetful Depressed IrritableSpecial Needs: wanders away emotional issues behavioral issues incontinence issues terminal care skin concerns dialysis chemotherapy radiation history of falls Other

Hobbies/Interests:

Highest Level of Education Completed:

SPIRITUAL - Church OR Affiliation:

(Name/Address/Phone#)

FUNERAL HOME:

(Name/Address/Phone#)

PHARMACY PREFERENCE: White Drug at Bethany Previous (name/city/phone #)*Must use a 24 hour pharmacy Medical Pharmacy VA

SPECIAL DIET:

ASSISTANCE NEEDED WITH: Walking Eating Toileting Bathing/Grooming

DESCRIBE MEDICAL CONDITION(S) AND/OR NEEDS:

PERSON COMPLETING APPLICATION:

Phone # of person to contact re: HOME ()

application and/or openings: WORK: ()

May we contact you at work? Yes No

ADDRESS OF PERSON COMPLETING APPLICATION :

-OR- See above