

Bethany on University
 Valerie Peterson, SNF Admissions
 201 University Drive South, Fargo ND 58103
 701.239.3525 Fax: 701.239.3255
 vpeterson@bethanynd.org



Bethany on 42nd
 Stephanie Sinner, Housing/Admissions Mgr
 4255 30 Avenue South, Fargo ND 58104
 701.478.8910 Fax: 701.478.8920
 ssinner@bethanynd.org

APPLICANT INFORMATION

First Name:			Initial:			Last:		
SEX: <input type="checkbox"/> female <input type="checkbox"/> male		Date of Birth:			SOCIAL SECURITY #:			
Placement needed: <input type="checkbox"/> immediate <input type="checkbox"/> within 6 months <input type="checkbox"/> unknown					Anticipated stay: <input type="checkbox"/> short term <input type="checkbox"/> long Term <input type="checkbox"/> unknown			
CIVIL STATUS: <input type="checkbox"/> married <input type="checkbox"/> never married <input type="checkbox"/> widowed <input type="checkbox"/> divorced <input type="checkbox"/> separated					Name of Spouse Date of Death (if applicable):			
Applicant's present address:								
Applicant's present phone #:								
Applicant's prior occupation:						Hometown:		
MEDICARE		Number: <i>Note: Copy of Medicare card needed upon admission.</i>			<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part A and Part B			
OTHER INSURANCE		Primary			Policy #:			
		Secondary			Policy #:			
PRESCRIPTION DRUG COVERAGE		Name:			ID #			
COUNTY ASSISTANCE		Do you receive any county assistance? <input type="checkbox"/> Yes - County: # <input type="checkbox"/> No <input type="checkbox"/> No, but information regarding application needed:						
SSI	Do you receive any SSI or SSDI (supplemental / disability) income? <input type="checkbox"/> Yes <input type="checkbox"/> No							
VA	Is the applicant a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the applicant the spouse of a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, contact the VA to determine eligibility for nursing home benefits. Do you receive any VA benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No							
FINANCIAL STATEMENTS TO BE MAILED TO		Name:			Phone #:			
		Address:						
PHYSICIAN:						CLINIC:		
HOSPITAL PREFERENCE: <input type="checkbox"/> Sanford <input type="checkbox"/> Essentia <input type="checkbox"/> VA (If VA, will need to be co-managed, choose 2 nd option) <input type="checkbox"/> Other:								
ADVANCED DIRECTIVES (check applicable boxes, provide copies of applicable paperwork upon admission.)			<input type="checkbox"/> Power of Attorney (POA) <input type="checkbox"/> Durable Power of Attorney (DPOA)					
			<input type="checkbox"/> Power of Attorney for Healthcare					
			<input type="checkbox"/> Guardian <input type="checkbox"/> Living Will <input type="checkbox"/> Advanced Directives					
Name/Address of DPOA/POA/Guardian:								

APPLICATION CONTINUED ON NEXT PAGE

EMERGENCY AND FAMILY/REPRESENTATIVE NUMBERS AND ADDRESSES

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

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 irritable

Special Needs: wanders away emotional issues behavioral issues incontinence issues
terminal care skin concerns dialysis chemotherapy
radiation history of falls other bariatric equipment

Hobbies/Interests(past or present):

Highest level of education completed:

SPIRITUAL - Church OR Affiliation:

(Name/Address/Phone#)

FUNERAL HOME PREFERENCE:

(Name/Address/Phone#)

PHARMACY PREFERENCE: White Drug at Bethany on 42nd Medical Pharmacy (name/city/phone #)

*Must use a 24 hour pharmacy

VA

Previous Pharmacy _____

(name/city/phone#)

SPECIAL DIET:ASSISTANCE NEEDED WITH: walking eating toileting bathing/grooming

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

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