Good Shepherd Home
709 4th Ave NE
Watford City, ND 58854
701.444.2331 Fax 701.444.2339

McKenzie County Healthcare Systems, Inc.

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* ☐*widowed* ☐*divorced* ☐*separated*		***Name of Spouse:***	
Applicant's present address:			
Applicant's present phone #:			
Applicant's prior occupation:		*Birthplace:*	
MEDICARE	*Number:* <u>*Note*</u>*: Copy of Medicare card needed upon admission.*	☐*Part A* ☐*Part B* ☐*Part A and Part B*	
OTHER INSURANCE	*Primary*	*Policy #:*	
	Secondary	*Policy #:*	
PRESCRIPTION DRUG COVERAGE	*Name:*	*ID #*	
COUNTY ASSISTANCE	*Do you receive any county assistance/Medicaid?* ☐*Yes – Medicaid #* ☐*No* ☐ *Pending*		
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 receive any VA benefits?* ☐*Yes* ☐*No*		
FINANCIAL STATEMENTS TO BE MAILED TO	*Name:*	*Phone #:*	
	Address:		
PHYSICIAN:		***CLINIC:***	
HOSPITAL PREFERENCE: ☐*MCHS* ☐ *Sanford* ☐*VA* *(If VA, will need to be co-managed, choose 2nd option)* ☐*Other:*			
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 Healthcare*		
	☐*Guardian* ☐*Living Will* ☐*Advanced Directives*		
	Name of DPOA/POA/Guardian:		

APPLICATION CONTINUED ON NEXT PAGE

EMERGENCY AND FAMILY/REPRESENTATIVE NUMBERS AND ADDRESSES

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

APPLICANT INFORMATION

Reason applicant needs skilled care: ☐*dementia/memory care* ☐*physical condition*

REFERRAL 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: ☐*wandering* ☐*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: ☐ *Larsen Service Drug* ☐ *Barrett's Pharmacy*
☐*VA* *Previous Pharmacy*_____

SPECIAL DIET*:*

ASSISTANCE NEEDED WITH: ☐*walking* ☐*eating* ☐*toileting* ☐*bathing/grooming* ☐ *transferring*

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

APPLICATION CONTINUED ON NEXT PAGE

APPLICANT INFORMATION	***Reason applicant needs skilled care:*** ☐*dementia/memory care* ☐*physical condition*

VACCINE/IMMUNIZATION HISTORY:

☐*COVID-19, dates:*

☐*Pneumonia, dates:*

☐*Shingles, dates:*

☐*Flu, most recent date:*

ALLERGIES*:*

PERSON COMPLETING APPLICATION:

Phone # of person to contact re: application and/or openings:	*HOME ( )* *WORK: ( )* *May we contact you at work?* ☐*Yes* ☐*No*

ADDRESS OF PERSON COMPLETING APPLICATION : *-OR-* *see above*

FINANCIAL INTAKE

Billing Party: Please list where you would like any mail sent and/or who will be managing the financial affairs of the applicant.

Name:	
Relationship to Applicant:	
Mailing Address:	
City, State, Zip:	
E-mail:	
Home Phone:	Cell Phone:

Insurance Information:

Are you, the applicant, currently covered by an employer's group health insurance? ☐ Yes ☐ No Company Name: Policy Holder Name: Policy Number:
Medicare Number (Part A, B, or C):
Medicare D (prescription) Plan Company: Policy: _____ Phone: _____
Medicare Supplemental Insurance Company: Policy: _____ Phone: _____
Medical Assistance/Medicaid Number/County:
Have you, the applicant, ever applied for Medical Assistance/Medicaid? ☐ Yes ☐ No Date Applied: County/State:
Health Insurance – Other Company: Policy: _____ Phone: _____
Long-Term Care Insurance Company: Policy #: _____ Phone: _____

Tell Us About the Assets You or Your Spouse Own:

Description of Asset	Owner(s) of Asset	Value of Asset	Location of Asset
Checking/Savings/Credit Union/Money Market Accounts			
Annuities/CDs			
Retirement Funds (IRA/401K/KEOGH)			
Stocks/Bonds/Mutual Funds			
Life Insurance (cash surrender value)			
Real property (Home, Land, Rental Property)			
Life Estate(s)			
Vehicles (car, truck, motor home, snowmobile, motorcycle, boat, etc.)			
Trusts (own or are a beneficiary of)			
Mineral Rights (oil, gas, coal, etc.)			
Pre-Paid Burial Account(s)			

Transfer of Assets

Have you or your spouse sold, transferred, or gifted anything of value including cash, real property, vehicles, or any other asset within the past 5 years?

☐ Yes ☐ No If yes, list the item(s), to whom, & date(s):

Tell Us About the Income/Money You or Your Spouse Receive:

Type of Income or Other Money Received	Recipient	How Often Received	Amount
Employment/Workers Compensation			
Oil/Mineral Rights/Royalties			
Income from CRP or Farmland			
Pension/Retirement Benefits			
Trust Income			
Social Security Benefits			
Supplemental Security Income (SSI or SSDI)			

Type of Income or Other Money Received	Recipient	How Often Received	Amount
Contract Sale or Rental Income			
Veteran's/Military Benefits			
Other: (list)			

Future Income

Do you or your spouse have any pending legal action from which you may receive money, including an inheritance or a settlement?

☐ Yes ☐ No If yes, please describe:

Are you or your spouse the beneficiary of any trust?

☐ Yes ☐ No If yes, please describe:

Transfer of Income

Have you or your spouse transferred or given away any income within the past 5 years?

☐ Yes ☐ No If yes, list the amount(s), date(s), and to whom it was given to:

Employment

Are you or your spouse employed by another?

☐ Yes ☐ No If yes, provide the name of the employer, hours worked, and the wage or salary earned:

Self-Employment

Are you or your spouse self-employed?

☐ Yes ☐ No If yes, list who, nature of business, and date business started:

Farming

Are you or your spouse actively engaged in farming?

☐ Yes ☐ No

Business Ownership

Do you or your spouse have an ownership interest in a business?
□ Yes □ No If yes, please describe the nature of the business and extent of ownership:

List all Debts Owed by You or your Spouse: This includes medical bills, mortgages, credit cards, vehicles, personal loans, etc.

Description of Debt & To Whom Owed	Owner of Debt	Approximate Amount of Debt

This questionnaire complies with section 50-10.2-05 of the North Dakota Century Code. By my signature below, I hereby authorize the nursing home to contact the county and/or state social services office for information regarding my Medicaid application and eligibility, and I hereby release and authorize the county and/or state social services office 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:_____

Printed Name: _____