KNIFE RIVER Care Center

118 22nd ST NE
Beulah, ND 58523
(701)873-4322
FAX (701)873-3182

Application for Admission

Family member to notify for bed opening: _____ **Phone Number**: _____

Name of Applicant: _____ **What date would you like admission?** _____

Social Security Number: _____ **Address**: _____

City: _____ **State**: _____ **Zip Code**: _____

Brief reasoning for admission, and current living arrangements (home, hospital, nursing home, basic care, assisted living, etc.):

_____

Date of Birth: _____ **Age**: _____ **Birthplace**: _____ **Ancestry**: _____

Sex: M or F or Other _____ **Language**: _____ **Religion**: _____
Military Service (Branch): _____ **Highest Grade Completed**: _____

Former Occupation: _____

Race (Circle one): White | Black or African American | American Indian or Alaska Native | Asian Indian | Chinese | Filipino | Japanese | Korean | Vietnamese | Other Asian | Native Hawaiian | Guamanian or Chamorro | Samoan | Other Pacific Islander | Resident Unable to respond | Resident declines to respond | None of the above

Ethnicity (Circle one): No, not of Hispanic, Latino/a, or Spanish origin | Yes, Mexican, Mexican American, Chicano/a | Yes, Puerto Rican | Yes, Cuban | Yes, another Hispanic, Latino/a or Spanish origin | Resident unable to respond | Resident declines to responds

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? (Circle one): Yes, it has kept me from medical appointments or from getting my medications | Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need | No | Resident is unable to respond | Resident declines to respond

Marital Status: M, S, W, D, or Other _____ **Spouse Living**: Y or N
Name of Spouse: _____ **Date of Mariage:** _____

Name of Father: _____ **Age of Father:** _____ **Living:** Y or N (Cause of death_____)

Name of Mother: _____ **Age of Father:** _____ **Living:** Y or N (Cause of death_____)

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Pharmacy: _____ **Dentist:** _____ **Optometrist:** _____

Podiatrist: _____ **Hospital:** _____ **Funeral Home:** _____

Church: _____ **Pastor:** _____ **Psychiatrist:** _____

Primary Physician: _____

Number of Children: _____ **Number of Grandchildren:** _____

Number of Great Grandchildren: _____

Living Children and significant others (please list together):

Name(s)	Address	Phone: Home/Cell/Work	Relationship to Applicant
1.			
2.			
3.			
4.			

Emergency Contacts (if different from above) list in order of priority:

Name(s)	Address	Phone: Home/Cell/Work	Relationship to Applicant
1.			
2.			
3.			
4.			

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Payment Source (Circle all that apply)? Private Pay Insurance Medicare Medicaid

Medical (supplemental) Insurance: Company Name: _____

Policy Number: _____

Company Address: _____ (Copy of Card)

Nursing Home (LTC) Insurance: Company Name: _____

Policy Number: _____

Company Address: _____ (Copy of Card)

Have you previously applied for Medicaid? Y or N **Date Applied**: _____ **County**: _____

Medicaid Number: _____ (Copy of card)

Medicare Number: _____ (Copy of card)

Financial Power of Attorney? Y or N **POA Finance Name: _____**

******* provide copy of paperwork **Address: _____**

Phone Number: _____

Health Care Power of Attorney? Y or N **POA Health Care Name: _____**

******* provide copy of paperwork **Address: _____**

Phone Number: _____

If you have transferred or gifted assets, have a trust, life estate, or have granted someone financial POA; will you apply for NDMA and/or an asset assessment through the State NDMA LTC Unit (701-328-1180) and will you authorize the State NDMA LTC Unit to release information to Knife River Care Center regarding your application, eligibility, and reasons for denial, etc.?

Yes or No Signature: _____

**** If consenting fill out the Authorization to Disclose Information from the North Dakota Department of Human Services Legal Services. KRCC will have this form on admission. (Form: SFN 1059 (9-2019))*

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Living Will? Y or N (Provide copy) **Advanced Directive? Y or N (Provide copy)**

Legal Guardian? Y or N (Provide copy) **Physician Statement of incapacity *if applicable*? (Provide copy)**

Conservatorship? Y or N (Provide copy)

Have you or your spouse transferred and/or gifted any assets to anyone (family, friends, etc.) Y or N, If Yes, explain:

_____

_____

Do you and/or spouse have a trust? Y or N

If yes, what type of trust? _____ Date Established: _____

What is in it? _____ What is not? _____

Trustee? _____ Address? _____

Complete this section as accurately as possible. Your physician or their nurse can provide assistance.

Diagnosis(s) and history of Illness: _____

Circle all that apply:

Cognitive	Bathing	Devices	Dressing
Alert	Independent	Hearing Aid R/L	Independent
Confused	Assist 1 or 2	Glasses	Assist 1 or 2
Wanders	Set up with assist	Has own teeth	Set up assist
Forgetful	Showers	Dentures: Upper/Lower	Needs Supervision
Paces	Bathes		
Agitated/Depressed			

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Complete this section as accurately as possible. Your physician or their nurse can provide assistance.

Circle all that apply:

Transfers	Toileting	Meal Needs	Special Diet (List):
Wheelchair	Independent	Independent	1.
Cane	Assist 1 or 2	Set up Help	2.
Walker	Continent	Needs Supervision	3.
Independent	Incontinent of bowel/bladder	Totally assist	4.
Assist 1 or 2	Uses pad/brief		

Appetite (circle one): Poor | Fair | Adequate | Good

Other Concerns, or care needs: _____

_____

_____

Please provide copies of the following:

1. Social Security Card
2. Medicare Card
3. Insurance Card(s)
4. Authorization papers for power of attorney (financial, and healthcare), guardianship, living will, life estate, conservatorship, physician statement of incapacity (if applicable), advance directive (if applicable)
5. Medicare Prescription Drug Plan Card

FOR KRCC USE: Date application received _____ By: _____

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