BETHEL LUTHERAN NURSING & REHABILITATION CENTER

ADMISSION APPLICATION FOR RESIDENCY

Background Information

Name: _____ Preferred name _____

Address: _____ Telephone #: _____

Birthdate: _____ Birthplace: _____

Marital Status: ( ) Single ( ) Widowed ( ) Married ( ) Divorced Maiden Name: _____

Name of Spouse: _____

Veteran: ( ) Yes ( ) No Spouse of a veteran: ( ) Yes ( ) No Branch: _____

Past Occupation: _____ Years of Education: _____

Local Physician: _____ Pharmacy: _____

Dentist: _____ Eye Doctor/Eye Clinic: _____

Religion: _____ Name of Church: _____ Mortuary: _____

Children	Address	Home Phone	Cell Phone	Work Phone
1.				
2.				
3.				
4.				

Siblings	Address	Home Phone	Cell Phone	Work Phone
1.				
2.				
3.				
4.				

Emergency Contacts

1. Name: _____ Relationship: _____

   Address: _____

   Phone Number: (H) _____ (W) _____ (C) _____

   E-Mail: _____

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Emergency Contacts: (continued)

2. Name:_____ Relationship: _____

Address: _____

Phone Number: (H) _____ (W) _____ (C) _____

E-Mail: _____

Advance Directives

Healthcare Directive: ( ) Yes ( ) No
Copy Required

Code Level Directive: ( ) Yes ( ) No
Copy Required

Authorization to Release Information:

If requested, Bethel Lutheran Nursing & Rehabilitation Center is authorized to release health care information to the following person (s):

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Financial Information

Payment source: Medicare _____ Medicare Advantage _____ Applying for Medicaid _____

Self Pay _____ Nursing Home Insurance _____ Medicaid _____

Social Security #: _____ Medicare: _____ Medicaid#: _____
Copy Required Copy Required Copy Required

Medicare Advantage Company: _____ Policy #: _____
Copy Required

Health Insurance Company: _____ Policy #: _____
Copy Required

Health Insurance Company Address: _____

Health Insurance Company Phone Number: _____

BETHEL LUTHERAN NURSING & REHABILITATION CENTER

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Financial Information (continued)

Nursing Home Insurance Company: _____ Policy #: _____

Nursing Home Insurance Address: _____

Nursing Home Insurance Phone Number: _____

Medicare Part D Prescription Plan: _____ Policy #: _____
Copy Required

Have you and/or your spouse transferred and/or gifted any assets to anyone (family, friends, etc.) during the past five (5) years? ( ) Yes ( ) No
If yes, please explain: _____

_____

Do you have a trust? ( ) Yes ( ) No
If yes, Date: _____
Do you have a prepaid funeral arrangement? ( ) Yes ( ) No

Have you previously applied for Medicaid: ( ) Yes ( ) No
If yes, Date: _____ Approved: ( ) Yes ( ) No County: _____

Do you have the following:

Financial POA (Power of Attorney): ( ) Yes ( ) No

Name: _____ Relationship: _____

Address: _____

Phone Number: (H) _____ (W) _____ (C) _____

E-Mail Address: _____

Durable POA (Power of Attorney) For Healthcare: ( ) Yes ( ) No

Name: _____ Relationship: _____

Address: _____

Phone Number: (H) _____ (W) _____ (C) _____

E-Mail Address: _____

Guardian: ( ) Yes ( ) No

Name: _____ Relationship: _____

Address: _____

Phone Number: (H) _____ (W) _____ (C) _____

E-Mail Address: _____

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Do you have the following:

Conservator: ( ) Yes ( ) No

Name: _____ Relationship: _____

Address: _____

Phone Number: (H) _____ (W) _____ (C) _____

E-Mail Address: _____

Person Responsible for Billing:

Name: _____ Relationship: _____

Address: _____

Phone Number: (H) _____ (W) _____ (C) _____

E-Mail Address: _____

If you have:

Transferred or gifted assets, have a Trust, Life estate, or have granted someone financial POA will you:

1. Apply for Medicaid Assistance and/or an Asset Assessment through the County Social Services?
   ( ) Yes ( ) No
2. Will you authorize the County Social Services to release information to Bethel Lutheran Nursing & Rehabilitation Center regarding your application, eligibility, and reasons for denial, etc?
   ( ) Yes ( ) No

_____ _____
Signature of Applicant Date

_____ _____
Signature of Legal Representative/Responsible Party Date

_____ _____
Witness Date

NOTE: Please provide copies of the following: (Copy Front and Back of Cards)

1. Social Security Card
2. Medicare Card
3. Medicaid Card
4. Insurance Card
5. Authorization papers for Power of Attorney (Financial and/or Healthcare), Guardianship, Conservatorship, Living Will, Life Estate, etc.
6. Medicare Part D Card
7. Photo ID

BETHEL LUTHERAN NURSING & REHABILITATION CENTER

RESIDENT NAME: _____

I DO /I DO NOT Request routine hair care to be done by Bethel Lutheran Nursing & Rehabilitation Center staff at no cost.

I DO/I DO NOT There is a $30.00 charge for a permanent and a $25.00 charge for hair coloring.

_____ _____

Signature **Date**

MEDIA CONSENT/CHAPLAIN RELEASE

I hereby authorize Bethel Lutheran Nursing & Rehabilitation Center to use my name and/or picture for:

_____ Website
_____ Photograph for Medical Purposes
_____ Bethel Beacon
_____ Church Social/Organization
_____ Everbridge notification
_____ Birthday board
_____ Bethel Radio Broadcast
_____ Door Sign with your name on it
_____ Other: Radio/TV/Newspaper
_____ Resident Directory
_____ Social Media and Facebook

Bethel's Chaplain may contact my own Pastor:

_____ Upon Admission _____ Upon Hospitalization _____ Upon Death

Such consent is granted freely, and without obligation. This consent shall remain in effect until a written request for withdrawal is provided to Bethel Lutheran Nursing & Rehabilitation Center.

_____ _____

Signature **Date**

RESIDENT TRUST FUND

I have been informed Bethel Lutheran Nursing & Rehabilitation Center will handle my personal funds if I so choose, by signing the following authorization:

I hereby authorize Bethel Lutheran Nursing & Rehabilitation Center to hold, safeguard, and Account for my personal funds. The following person(s) have permission to withdraw money from the trust fund on my behalf:

_____ _____

_____ _____

Signature **Date**

BETHEL LUTHERAN NURSING & REHABILITATION CENTER
SIGNATURE SHEET-- RESIDENT INFORMATION SIGNATURE RECEIPT VERIFICATION

Name: _____

I have been orally informed and have received copies of the following information and agree to abide by this information.

1. The Resident Bill of Rights and Ombudsman Program.
2. Resident Conduct Rules and Responsibilities that govern the facility.
3. The Smoking Policy
4. Daily Charge Information and the Bed Hold Policy.
5. Services available in the facility and charges for those services, including charges not covered by Medicare or this facilities per diem rate.
6. Information regarding Medicare and Medicaid applications (including asset assessment information) and how these programs may assist in paying for long-term care.
7. The facility's grievance procedure and how to file a grievance.
8. Information regarding Advance Directives and the Self-Determination Act.
9. Billing, Credit and Collection Policy.
10. Bethel Lutheran Nursing & Rehabilitation Center's Notice of Privacy Practice.
11. Information on Expectations of a Nursing Home Stay.

_____ _____
SIGNATURE DATE

RESIDENT'S CLINIC APPOINTMENTS

Each family plays an important role in the care of our residents. We need your assistance in accompanying your loved one to their appointment. Please list the person or persons who will be available to be with the resident while at an appointment. Bethel Lutheran Nursing & Rehabilitation Center will provide the transportation as needed.

NAME	TELEPHONE NO.	ADDRESS
NAME	TELEPHONE NO.	ADDRESS

We thank you for your willingness to help.

Bethel Lutheran Nursing & Rehabilitation Center

1515-2nd Avenue West ~ Williston, ND 58801 (701) 572-6766 (701) 572-7579 (Fax)

ASSIGNMENT OF MEDICARE/INSURANCE BENEFITS AUTHORIZATION TO RELEASE AND OBTAIN CLINICAL INFORMATION

_____ _____

Beneficiary **Medicare Number**

I authorize Bethel Lutheran Nursing & Rehabilitation Center to submit claims to Medicare and/or any secondary or third-party payer. I request that payment of authorized Medicare and/or any secondary or third-party insurance benefits be paid to Bethel Lutheran Nursing & Rehabilitation Center on my behalf for any services furnished me by Bethel Lutheran Nursing & Rehabilitation Center. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits for related services. **I ACKNOWLEDGE THAT I WILL BE RESPONSIBLE FOR ANY SERVICES NOT COVERED BY MEDICARE AND/OR ANY SECONDARY OR THIRD-PARTY INSURANCE.**

I, _____, hereby authorize Bethel Lutheran Nursing & Rehabilitation Center to furnish or request copies of my clinical records regarding any sickness or injury, treatment or consultation as may be needed by Bethel Lutheran Nursing & Rehabilitation Center, other medical facility, or insurance company for the continuity of my care, treatment or payments for the same. Information will only be released that originates at Bethel Lutheran Nursing & Rehabilitation Center.

I understand that I may revoke this consent at any time by notifying the facility releasing the information in writing of my revocation.

_____ _____

Beneficiary's Signature **Beneficiary's Name (Print)**

_____

Date

By: _____ _____

Responsible Party's Signature **Relationship to Beneficiary**

_____

Date