Valley Senior Living

Our Family Caring for Yours

Admission Application

Assisted Living
4006 24th Avenue S
Grand Forks, ND 58201
Phone 701.787.7621
Fax 701.787.7589

Basic Care
3300 Cherry Street
Grand Forks, ND 58201
Phone 701.787.7600
Fax 701.787.7589

Skilled Nursing & Transitional Care
2900 14th Avenue S
Grand Forks, ND 58201
Phone 701.787.7900
Fax 701.787.7959

Skilled Nursing & Memory Care
4004 24th Avenue S
Grand Forks, ND 58201
Phone 701.787.7500
Fax 701.787.7959

www.valleyseniorliving.org

VALLEY SENIOR LIVING

Application for Admission

FOR OFFICE USE ONLY
File No. _____
Room No. _____
Rental Date: _____
Move In Date: _____

DEMOGRAPHIC INFORMATION

(Please put the **applicant's** information on this page. There will be space later for family/responsible party information)

Applicant's Legal Name	First: MI:	Last:	Preferred Name:	
Applicant's Current Address	Street Address:	City:	State:	Zip Code:
Applicant's Phone Numbers:	Home:	Cell:		
Applicant's Email Address:				
Date of Birth:	Social Security Number: *Required*	Gender:		
Race:	Ethnicity:	Religion:		
Language:	Do you need an interpreter? Yes ____ No ____ What language? _____			
Marital Status	___ Married ___ Widowed ___ Never Married ___ Separated ___ Divorced *If Married, please list name of spouse:* _____			
Veteran Status	Are you a Veteran? Yes _____ No _____ What Branch? _____ Is/was your spouse a Veteran? Yes _____ No _____			
Background	Have you ever been convicted of or plead guilty to a sexual offense in a court of law? Yes _____ No _____ State _____ County _____			
	Mother's Maiden Name:	Birthplace:		

OUTSIDE PROVIDERS/FACILITIES

Primary Physician:	Pharmacy: Pharmacies used by VSL tenants/residents must provide 24/7 service.
Dentist:	Please choose one: ____ Thrifty White Drug ____ Wall's Medicine Center ____ Altru Clinic Pharmacy
Eye Doctor:	
Funeral Home: City:	Do you currently use medications from the VA? Yes ____ No ____
Church: City:	*Skilled Nursing Residents Only:* Thrifty White Drug will be utilized while you are covered by Medicare A.

BILLING PARTYMUST BE COMPLETED**** *List where you would like any mail sent and/or who will be managing financial affairs of the applicant*			
Billing Party Name: E-Mail Address:	Relationship to Applicant POA Healthcare? Y / N POA Finances? Y / N Guardian? Y / N Conservator? Y / N	Address:	Phone Numbers: H: W: C:

CONTACTS			
Do you, the applicant, make your own decisions for healthcare & financial matters? Yes _____ No _____			
Please list 2 primary contacts in the order of whom you prefer we contact first:			
Name: E-Mail Address:	Relationship to Applicant: POA Healthcare? Y / N POA Finances? Y / N Guardian? Y / N Conservator? Y / N	Address:	Phone Numbers: H: W: C:
Name: E-Mail Address:	Relationship to Applicant: POA Healthcare? Y / N POA Finances? Y / N Guardian? Y / N Conservator? Y / N	Address:	Phone Numbers: H: W: C:
Copies of any Power of Attorney, Guardianship/Conservatorship, and/or Health Care Directives/Living Will are required			

INSURANCE INFORMATION		
Employment: Are you currently employed? ___ Yes ___ No Is your spouse currently employed? ___ Yes ___ No	Are you currently covered by an employer's group health insurance? ___ Yes ___ No	Insurance Company: Policy Holder: Policy #:
Medicare Number:	**Medical Assistance/Medicaid** Have you ever applied for Medical Assistance/Medicaid? Yes ____ No ____ Date Applied: _____ County and State: _____ Medicaid Number: _____ County: _____	
Medicare Supplemental Insurance Company: Policy #: Telephone #:		
Medicare Replacement Policy Company: Policy #: Telephone #:	**Health Insurance – Other** Company: Policy #: Telephone #:	
Medicare D (prescription) Plan Company: Policy #: Telephone #:	**Long Term Care Insurance** Company: Policy #: Telephone #:	Daily benefit amount: $_____ Elimination period (if any): _____

FINANCIAL INFORMATION

Information in this section will assist with financial planning. Please attach additional information if needed.

In the past 5 years have you or your acting Financial Power of Attorney sold, traded, transferred, or gifted any cash or assets to you or from you, or to or from a trust account? Yes_____ No_____

If YES, please explain the nature of the transaction; such as who completed the transaction, the amount, and date it occurred: _____

Trust Account – Yes _____ No _____
Date Created _____ Value $_____
Revocable _____ Irrevocable _____
Description:

Life Estate – Yes _____ No _____
Date Created _____
Value $_____
Description:

Except for personal effects, list all assets owned by YOU and YOUR SPOUSE, with the value as of the date of application.

DESCRIPTION OF ASSETS	APPROXIMATE VALUE OF ASSETS
Land	
Checking	
Savings – Passbook	
Certificates of Deposit	
Stocks or Bonds	
IRA's or Annuities	
Pre-Paid Burial Account	
Life Insurance - Cash Surrender Value	
List Home(s)	
List Vehicle(s)	

List all debts owed by you and your spouse, with outstanding balance as of the date of application.
This includes mortgages, credit cards, vehicles or personal loans.
Include any garnishments from Social Security or other income (tax lien, student loans, child support, etc.)

DESCRIPTION OF DEBT	APPROXIMATE AMOUNT OF DEBT

List all sources of income for YOU and YOUR SPOUSE, including but not limited to: rental payments, CRP income, long term care insurance benefits, Social Security Benefits, Veteran Benefits, alimony, and employment income.

DESCRIPTION OF INCOME	FREQUENCY OF INCOME	AMOUNT OF INCOME
Applicant Social Security Benefit	Monthly	$
Applicant Retirement/Pension/Other Income		$
Spouse Social Security Benefit	Monthly	$
Spouse Retirement/Pension/Other Income		$

SIGNATURE LINE

The undersigned represent that all of the above statements are true and complete. *The application complies with section 50-10.2-05 of the North Dakota Century Code, and I hereby authorize the long term care facility 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 long term care facility. I further authorize the long term care facility to release to its attorneys any information regarding my application for admission.*

Signature _____ Date _____

Name of person filling out this application: _____ Relationship to applicant: _____