KNIFE RIVER CARE CENTER
APPLICATION FOR ADMISSION

118 22nd ST NE BEULAH, ND 58523
Phone 701-873-4322 Fax 701-873-3182

Person to Notify for Bed Opening _____ **Phone #** _____

Date of Application_____ **Desired Date of Admission** _____

Name of Applicant _____ **Social Security Number** _____

Address_____ **City** _____ **State** ____ **Zip Code** _____

Date of Birth _____ **Birthplace** _____ **Ancestry** _____

Language _____ **Religion** _____ **Military Service (Branch)** _____

Highest Grade Completed _____ **Former Occupation** _____

Marital Status M S W D **Spouse Living Y N** **Name of Spouse** _____

Date of Marriage _____ **Place of Marriage** _____

Name of Father_____ **Age** _____ **Cause of Death** _____

Name of Mother (maiden) _____ **Age** ____ **Cause of Death** _____

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

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

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

Primary Physician _____

Number of Children _____ **Grandchildren** _____ **Great Grandchildren** _____

Living Children/Significant Others:

	Name	Address	Phone Day/Eve/Cell	Relationship
1				
2				
3				
4				

Please List Three Emergency Contact People: **(If different than above)**

	Name	Address	Phone
1			
2			
3			

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

Medical (Supplemental) Insurance _____
Address _____
Policy # _____

Nursing Home Insurance Company _____
Address _____
Policy # _____

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

Medicaid # _____ **Medicare #** _____

Financial Power of Attorney? Y N **Name** _____
Address _____
Phone # _____

Health Care Power of Attorney? Y N **Name** _____
Address _____
Phone # _____

Living Will Y N

Legal Guardian Y N Name _____
Address _____

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

Do you and/or spouse have a trust? Yes _____ **No**_____
If yes: type of trust: _____ **Date established:**_____
What is in it? _____ **What is not?** _____
Trustee: _____ **Address:** _____

If you have transferred or gifted assets, have a Trust, Life Estate, or have granted someone financial POA; will you apply for Medicaid assistance and/or an asset assessment through the County Social Services and will you authorize the County Social Services to release information to the Knife River Care Center regarding your application, eligibility, and resons for denial, etc.?

Y _____ **N** _____ **Signature** _____

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Complete this section as accuratly as possible. Your physician or their nurse can provide assistance if needed.

Diagnosis and History of illness: _____

Circle all that apply

Cognitive	**Bathing**	**Devices**	**Dressing**
Alert	Indpendent	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			

Transfers	**Toileting**
Wheelchair	Independent
Cane	Assist 1 or 2
Walker	Continent
Independent	Incont of bowel/bladder
Assist 1 or 2	Uses pad/brief

Appetite : Poor / Fair / Adequate / Good

Meal needs	**Special Diet:**
Independent	
Set up help	
Needs supervision	
Totally fed	

Other concerns: _____
_____

Please provide copies of the following:

1. **Social Security Card**
2. **Medicare Card**
3. **Medicaid Notification**
4. **Insurance Card(s)**
5. **Authorization papers for Power of Attorney (Financial and/or Healthcare), Guardianship, Living Will, Life Estate, Conservatorship, etc.**
6. **Medicare Prescription Drug Plan Card**

For KRCC use: Date application received _____ By:_____

Revised 6/08