

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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Complete this section as accurately 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	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			

Transfers

Wheelchair
Cane
Walker
Independent
Assist 1 or 2

Toileting

Independent
Assist 1 or 2
Continent
Incont of bowel/bladder
Uses pad/brief

Appetite : Poor / Fair / Adequate / Good

Meal needs

Independent
Set up help
Needs supervision
Totally fed

Special Diet:

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