Bethany on University
201 University Drive South, Fargo ND 58103
701.239.3525 Fax: 701.239.3255

Facility Preferenc: ____42nd St Campus
____University Campus
Memory Care Unit University Campus:_____

Bethany retirement living

Bethany on 42nd
4255 30 Avenue South, Fargo ND 58104
701.478.8910 Fax: 701.478.8920

Room Preference:_____Private (additional charge)
_____Double
_____First Available

APPLICANT INFORMATION		
First Name:	***Initial:***	***Last:***
SEX: ☐*female* ☐*male*	***Date of Birth:***	***SOCIAL SECURITY #:***
Placement needed: ☐*immediate* ☐*within 6 months* ☐*unknown*		*Anticipated stay:* ☐*short term* ☐*long Term* ☐*unknown*
CIVIL STATUS: ☐*married* ☐*never married* ☐*widowed* ☐*divorced* ☐*separated*		***Name of Spouse:***
Applicant's present address:		
Applicant's present phone #:		
Applicant's prior occupation:		*Hometown:*
MEDICARE	*Number:* <u>Note</u>: *Copy of Medicare card needed upon admission.*	☐*Part A* ☐*Part B* ☐*Part A and Part B*
OTHER INSURANCE	*Primary*	*Policy #:*
	Secondary	*Policy #:*
PRESCRIPTION DRUG COVERAGE	*Name:*	*ID #*
COUNTY ASSISTANCE	*Do you receive any county assistance/Medicaid?* ☐*Yes - County: #* ☐*No* ☐*No, but information regarding application needed:*	
SSI	*Do you receive any SSI or SSDI (supplemental / disability) income?* ☐*Yes* ☐*No*	
VA	*Is the applicant a Veteran?* ☐*Yes* ☐*No* *Is the applicant the spouse of a Veteran?* ☐*Yes* ☐*No* *If yes, contact the VA to determine eligibility for nursing home benefits. Do you receive any VA benefits?* ☐*Yes* ☐*No*	
FINANCIAL STATEMENTS TO BE MAILED TO	*Name:*	*Phone #:*
	Address:	
PHYSICIAN:		***CLINIC:***
HOSPITAL PREFERENCE: ☐*Sanford* ☐ *Essentia* ☐*VA* *(If VA, will need to be co-managed, choose 2nd option)* ☐*Other:*		
ADVANCED DIRECTIVES *(check applicable boxes, provide copies of applicable paperwork upon admission.)*	☐*Power of Attorney (POA)* ☐*Durable Power of Attorney (DPOA)* ☐*Power of Attorney for Healthcare*	
	☐*Guardian* ☐*Living Will* ☐*Advanced Directives*	
	Name of DPOA/POA/Guardian:	

APPLICATION CONTINUED ON NEXT PAGE

Side 2 of Bethany Retirement Living Application for Admission APPLICANT NAME: *MR#*

EMERGENCY AND FAMILY/REPRESENTATIVE NUMBERS AND ADDRESSES

Name: *Address:*	***Relationship:***	*PHONE: Home ( )* *Work ( )* *Cell ( )*
Name: *Address:*	***Relationship:***	*PHONE: Home ( )* *Work ( )* *Cell ( )*
Name: *Address:*	***Relationship:***	*PHONE: Home ( )* *Work ( )* *Cell ( )*
Name: *Address:*	***Relationship:***	*PHONE: Home ( )* *Work ( )* *Cell ( )*

APPLICANT INFORMATION

Reason applicant needs skilled care: *☐dementia/memory care ☐physical condition*

REFERRAL SOURCE: ☐physician ☐social worker ☐family/friend ☐other

Applicant's feelings regarding placement:

Has applicant been a resident in another nursing home? ☐No ☐Yes - (where & dates)

Has applicant received prior home health services? ☐No ☐Yes - (agency & dates)

Mental Status: ☐alert ☐confused ☐forgetful ☐depressed ☐irritable

Special Needs: ☐wanders away ☐emotional issues ☐behavioral issues ☐incontinence issues
☐terminal care ☐skin concerns ☐dialysis ☐chemotherapy
☐radiation ☐history of falls ☐other ☐bariatric equipment

Hobbies/Interests(past or present):

Highest level of education completed:

SPIRITUAL - *Church OR Affiliation:*
(Name/Address/Phone#)

FUNERAL HOME PREFERENCE:
(Name/Address/Phone#)

PHARMACY PREFERENCE: *☐White Drug at Bethany on 42nd ☐Medical Pharmacy (name/city/phone #)*

**Must use a 24 hour pharmacy ☐VA Previous Pharmacy_____*
(name/city/phone#)

SPECIAL DIET:

ASSISTANCE NEEDED WITH: ☐walking ☐eating ☐toileting ☐bathing/grooming

DESCRIBE MEDICAL CONDITION(S) CONTRIBUTING TO NEED FOR CARE:

PERSON COMPLETING APPLICATION:

Phone # of person to contact re: application and/or openings:	*HOME ( )* *WORK: ( )*	*May we contact you at work? ☐Yes ☐No*

ADDRESS OF PERSON COMPLETING APPLICATION : -OR- see above