

**North Dakota Veterans Home  
1600Veterans Drive /PO Box 673  
Lisbon, ND 58054-0673**

**Admissions Telephone number: (701) 683-6540 Fax number (701) 683-6550**

Thank you for your interest in the ND Veterans Home. Your application will be given immediate attention. You can help the application process by submitting the following documents or information with your application.

**1. Application-** fully completed

**2. Medical/Physical**

***Basic Care:*** The Veterans Home will be using the VA Form 10-10SH for the medical certificate which needs to be completed in its entirety. Results of a chest x-ray of applicant within the past 6 months are required. We are unable to process an application without the 10-10SH form completed.

***Skilled Care/Nursing Home:*** Medical certificate form 10-10SH, current information from the current nursing home or hospital. Level of screening for nursing home care

**3. Additional Documents**

Copy of DD214 (Report of Separation, Military Record of Service)

If applicable:

Widow(er) needs to submit veteran's death certificate

Award letter from Veterans Affairs - verifying veteran pension / compensation

Guardianship papers, conservatorship paper, Power of Attorney, Durable Power of Attorney

Copy of current Drivers License

**4. Insurance Information**

Copies of insurance cards, including Medicare and secondary insurance if applicable

Copy of current vehicle insurance if applicable

**5. Financial Information**

Verification of income and assets:

Copy of last bank statement, IRA's, etc.

**6. Back Ground Check**

All applicants will have a back ground check completed before admission

After the application is received, it is reviewed for completeness, eligibility and level of care. The applicant or interested party will receive a call from the Admission's Office to schedule an admission date and time, indicate placement on waiting list, or advise you if we are unable to meet the needs required. A letter will follow the phone call.

**Thank you for your cooperation. If you have any questions or wish to know the status of your application, please call (701) 683-6540.**

ND VETERANS HOME APPLICATION FOR ADMISSION Name: \_\_\_\_\_

NORTH DAKOTA VETERANS HOME Basic Care Unit/Skilled Unit (nursing home)  
PO Box 673, Lisbon, ND 58054 -Please circle one of the above-  
Phone: (701) 683-6540 Marketing Coordinator  
Fax: 701-683-6550

**Personal Information:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
(Last, First, Middle Initial)

Current Address: \_\_\_\_\_

\_\_\_\_\_  
City County State and Zip Code

Gender:  Male  Female Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Place of Birth: \_\_\_\_\_ Mothers Maiden Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

What is your race? (Please circle) White, American Indian, Black or African American, Asian

Where else have you lived in the past 2 years? (Address, City, County, State)  
\_\_\_\_\_

Have you been a member of the ND Veterans Home?  Yes  No

Reason for leaving: \_\_\_\_\_

Previous Occupation: \_\_\_\_\_ last date of employment: \_\_\_\_\_

Marital Status:  Married  Divorced  Single  Widowed  Separated

\_\_\_\_\_  
Name of Spouse Address, include zip code Phone Number

Health Care Agent  Yes  No attach copy

Guardian  Yes  No attach copy

Who would you like notified in case of an emergency?  
Name Mailing Address/Phone Relationship  
\_\_\_\_\_

Do you have a police or criminal record:  Yes  No

Have you been convicted of a felony: If yes briefly describe: \_\_\_\_\_

Do you own your own vehicle?  Yes  No \_\_\_\_\_  
Year Make

Do you have auto insurance?  Yes  No \_\_\_\_\_

**ND VETERANS HOME APPLICATION FOR ADMISSION Name:** \_\_\_\_\_

Company Name Policy Number

Do you have a driver's license?  Yes  No \_\_\_\_\_  
 Driver's License # Exp. Date Vehicle License #

**Financial Information:**

Do you handle your own funds?  Yes  No  
 Name, Address and Phone: \_\_\_\_\_

**Financial Agent**  Yes  No **Please attach copy**

INCOME			ALLOWABLE EXPENSES		
	MONTHLY	ANNUAL		MONTHLY	ANNUAL
VA PENSION			MEDICINE		
VA COMPENSATION			HOSPITAL INSURANCE		
SOCIAL SECURITY			MEDICARE		
RR RETIREMENT			FARM TAXES		
FARM INCOME			GLASSES		
INTEREST			DENTAL		
OTHER			HOSPITALIZATION		
			DOCTOR BILLS		
			COURT ORDER		
			CHILD SUPPORT		
<b>TOTAL</b>					

Type of assets: Please provide verification	Amount:
Checking Account	\$
(Name & Address of Bank)	
Savings Account/CD, IRA accounts	\$
(Name & Address of Bank)	
Automobile	\$
Real Estate	\$
(Describe)	
Other Property	\$
(Describe)	

**Insurance Information:** Please provide a copy of all current insurance cards

Are you eligible for Medicare?  Yes  No \_\_\_\_\_  
 Medicare Number

Part A effective date Part B effective date Part D effective Date

Are you covered by Medicaid?  Yes  No \_\_\_\_\_  
 Medicaid Number

Do you have other health insurance?  Yes  No  
 Name & Address of Insurance Company \_\_\_\_\_

Insurance Numbers \_\_\_\_\_

**Military Information:**

**Service in the Armed Forces:**  Self  Spouse (Provide copy of your DD214)

If you're the spouse provide veteran information

Dates of Service: \_\_\_\_\_ to \_\_\_\_\_

**Please circle:** WWII, Korean, Viet Nam, Lebanon Service, Panama Service, Persian Gulf, or Peacetime

_____	_____	_____
Type of discharge	Branch of Service	Rank
_____	_____	_____
Serial Number	Claim Number	Service organization with Power of Attorney

Are you a Purple Heart recipient?  **Yes**  **No**

Are you a former Prisoner of War?  **Yes**  **No**

Do you have a VA Service Connected Rating?  **Yes**  **No**  
If yes, what is your percentage \_\_\_\_\_ and what is the condition: \_\_\_\_\_

Did you serve in combat?  **Yes**  **No**

Was your discharge from military for a disability incurred or aggravated in the line of Duty?  
 **Yes**  **No**

Are you receiving disability retirement pay instead of VA compensation?  **Yes**  **No**

Were you exposed to environmental contaminants while serving in SW Asia during Persian Gulf?  
 **Yes**  **No**

Were you exposed to Agent Orange while serving in Vietnam?  **Yes**  **No**

Were you exposed to radiation while in the military?  **Yes**  **No**

Did you receive nose and throat radium treatments while in the service?  **Yes**  **No**

Do you have a spinal cord injury?  **Yes**  **No**

Do you use the Fargo VA system for medical care?  **Yes**  **No**

Do you pay co-pay for medications at the VA?  **Yes**  **No**

I understand that under the Title VII of Civil Rights Act of 1964, I can not be discriminated against based on race, color, religion, national origin, sex, or on the basis of age, physical, or mental handicap.



Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Signature of Applicant



CERTIFICATION OF RESIDENCY

This is certify that \_\_\_\_\_ has been a resident of North Dakota for 30 days and a resident of \_\_\_\_\_ County prior to date of this application and is personally known as the individual whose name appears on this application.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Title