

**North Dakota Veterans Home
1400 Rose St. /PO Box 673
Lisbon, ND 58054-0673**

Admissions Telephone number: (701) 683-6530 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.

Application- fully completed

Medical

Basic Care: The Veterans Home will be using the VA Form 10-10SH for the medical certificate. This needs to be completed in its entirety. Results of a chest x-ray of applicant within the past 6 months. 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

Documents

Copies of the following

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

Insurance Information

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

Copy of current vehicle insurance if applicable

Financial Information

Verification of income and assets:

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

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) 683-6530

ND VETERANS HOME APPLICATION FOR ADMISSION Name: _____

NORTH DAKOTA VETERANS HOME

Basic Care Unit/Skilled Unit (nursing home) (Please circle)

PO Box 673, Lisbon, ND 58054

Phone: (701) 683-6530, Admissions Coordinator Fax: 701-683-6550

Personal Information:

Name: _____ Phone: _____

(Last, First, Middle Initial)

Current Address: _____

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

Permanent Address	City	County	State and Zip Code
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Where have you lived in the past 2 years? (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
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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
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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 _____

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 Source:	Monthly	Annual	Expenses	Monthly	Annual
VA Pension	\$	\$	Medicare	\$	\$
VA Compensation	\$	\$	Medical Insurance	\$	\$
Social Security	\$	\$	Medications	\$	\$
Social Security Disability	\$	\$	Child Support	\$	\$
RR Retirement	\$	\$	Doctor Bills	\$	\$
Retirement	\$	\$	Dental	\$	\$
Interest Income	\$	\$	N. H. Insurance	\$	\$
			Taxes	\$	\$

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 _____



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

Application explained and witnessed by



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