



**North Dakota Veterans Home**  
**1600 Veterans Drive**  
**PO Box 673**  
**Lisbon, ND 58054-0673**  
**Phone: (701) 683-6540**  
**Fax: (701) 683-6550**

Dear Applicant,

Thank you for your interest in the North Dakota Veterans Home. Our mission is to provide Veterans and their spouses with high-quality basic and skilled care in a warm, supportive environment.

We understand that transitioning from one's home can be an emotional decision. Our experienced team is here to support you throughout the admission process.

At NDVH, residents can enjoy meaningful activities without the daily stress of managing household responsibilities and care needs. Please review the following admission criteria as you prepare to apply:

- The North Dakota Veterans Home is unable to accept residents who require dialysis treatment.
- The NDVH skilled care campus is smoke-free, including the use of e-cigarettes.
- The use, possession, or storage of marijuana, including medical marijuana, is not permitted in the facility or on the grounds in accordance with federal law and CMS regulations.
- Applicant information will be reviewed to ensure NDVH has the appropriate services, staffing, and capacity to meet the applicant's current mental and physical health needs, as well as those of our existing residents.
- Applicants who are denied admission may reapply after 12 months unless otherwise stated in the denial letter.

Prior to admission, residents may be required to apply for all monetary benefits for which they may be eligible through state and federal programs, including but not limited to Aid and Attendance and Medicaid.

A tour of the facility is strongly encouraged, as it helps applicants become familiar with life at the Veterans Home and assists the Admissions Board in making admission decisions. To schedule a tour, please contact the Admissions Coordinator at **701-683-6540**.

The Admissions Coordinator will gather medical, social, and financial information from the applicant, family members, and/or referral sources. Once all required information is completed, it will be submitted to the Admissions Team for review and vote. Following this process, the Admissions Coordinator will contact the applicant with the decision.

If you have any questions, please do not hesitate to contact us. We look forward to working with you toward placement at our beautiful facility.

Sincerely,

Susie Schlecht  
Admissions/Marketing Coordinator  
701-683-6540  
[sjschlecht@nd.gov](mailto:sjschlecht@nd.gov)

Ashley Olson  
Director of Social Services  
701-683-6530  
[a2olson@nd.gov](mailto:a2olson@nd.gov)



**APPLICATION FOR ADMISSION  
NORTH DAKOTA VETERANS  
HOME** (06-2021)

1600 Veterans Drive  
Lisbon, ND 58054-0673  
Phone: (701) 683-6540  
Fax: (701) 683-6550

**PLACEMENT:**

Basic Care    Skilled Care (Nursing Home)    Placement for:    Veteran    Spouse/Surviving Spouse

NDVH is a smoke free facility. Have you smoked/used a tobacco product (including electronic cigarettes)?

Yes    No    If yes, when was the last time you smoked or used a tobacco product? \_\_\_\_\_

**BASIC INFORMATION:**

Name of Applicant: \_\_\_\_\_

AKA, Maiden Name, Former Name: \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email: \_\_\_\_\_ County: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Birthplace: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

In compliance with the Federal Privacy Act of 1974, the disclosure of the social security number on this form is voluntary. They are not disclosed to the public, the individuals social security number is used for identification purposes and to determine eligibility for residency at the North Dakota Veterans Home pursuant to Administrative Code 86-13-01-02. While voluntary disclosure is requested; failure to do so will prevent this application from being processed.

Marital Status:    Single    Married    Separated    Divorced    Widowed

Race:    White    American Indian    Black or African American    Asian    Other(specify): \_\_\_\_\_

Religion: \_\_\_\_\_

Are you under Guardianship?    Yes    No    Name of Guardian: \_\_\_\_\_

Business Telephone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Do you have a current Drivers License?    Yes    No    Driver's License Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Vehicle License Number: \_\_\_\_\_

Do you have a police or criminal record?    Yes    No    If yes, briefly describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**BASIC INFORMATION:**

Where have you lived the past two years? (City, county, State):

List the states in which you have lived in other than North Dakota (also indicate the years):

Have you ever been a resident of the North Dakota Veterans Home?    Yes    No

Reason for Leaving: \_\_\_\_\_

Previous Occupation: \_\_\_\_\_ Last Date of Employment: \_\_\_\_\_

Current Living Arrangement: \_\_\_\_\_ Since: \_\_\_\_\_

House    Apartment    Assisted Living    Nursing Home    Other(specify): \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Physician Telephone Number: \_\_\_\_\_

Date Last Seen by Physician: \_\_\_\_\_

**MILITARY SERVICE:**

Branch of Service: \_\_\_\_\_ Serial Number: \_\_\_\_\_

Date of Entry: \_\_\_\_\_ Date of Discharge: \_\_\_\_\_ Type of Discharge: \_\_\_\_\_

Please check:                      WWII                      Korean                      Vietnam                      Lebanon Service  
Panama Service                      Persian Gulf                      Peacetime

Are you considered a P.O.W.?    Yes    No    Have you received a Purple Heart?    Yes    No

Do you have a service-connected disability rating?    Yes    No    If yes, what percentage? \_\_\_\_\_

What condition are you service connected for? \_\_\_\_\_

**INSURANCE INFORMATION: provide front and back copies of all current insurance cards.**

Medicare Number: \_\_\_\_\_

Part A Effective Date: \_\_\_\_\_ Part B Effective Date: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Medicaid Number: \_\_\_\_\_

Are you enrolled in a Medicare Advantage plan?    Yes    No    If yes provide information: \_\_\_\_\_

## FAMILY MEMBERS:

Name of Spouse: \_\_\_\_\_ Living Deceased Date of death: \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email: \_\_\_\_\_

Children (if more, list on back of form)

Name of Child: \_\_\_\_\_ Email: \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Name of Child: \_\_\_\_\_ Email: \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Name of Child: \_\_\_\_\_ Email: \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Name of Child: \_\_\_\_\_ Email: \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## HOSPITALIZATION:

Have you been hospitalized in the last 12 months? Yes No

If yes, complete the following information:

Acute Hospital Name: (most recent): \_\_\_\_\_

Admit Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

Have you ever been a resident at a skilled nursing facility? Yes No

If yes, complete the following information:

Skilled Nursing Facility Name: (most recent): \_\_\_\_\_

Admit Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

**CURRENT HEALTH PROBLEMS:**

Alcohol Consumption  
Alzheimer's, Dementia  
Anxiety  
Arthritis  
Bowel Incontinence  
Cancer  
Catheter Use  
Contractures  
CVA/Stroke  
Decubitus Ulcer  
Depression  
Diabetes  
Fracture  
Hallucinations  
Heart Disease  
Hypertension

Infections (UTI, Respiratory, etc.)  
Insomnia  
Kidney Disease  
Obesity  
Pain: Location  
Paralysis  
Parkinson's  
Seizure Disorder  
Smoker  
Speech Impaired  
Urine Incontinence  
Respiratory: Using O2@ \_\_Liters.

Allergies -List:  
\_\_\_\_\_  
\_\_\_\_\_

Other:  
\_\_\_\_\_  
\_\_\_\_\_

Other Mental Illness:  
\_\_\_\_\_  
\_\_\_\_\_

Current Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_  
Special Dietary Needs: \_\_\_\_\_

**Which of the Following Best Describes the Applicants Ability to Walk:**

- |                   |                                        |                                     |
|-------------------|----------------------------------------|-------------------------------------|
| Fully Independent | Uses wheelchair independently          | Uses cane or walker with assistance |
| Unsteady          | Uses wheelchair with assistance        | Uses gait belt                      |
| Powerchair        | Uses cane or walker without assistance | Total assistance with transfers     |

Fall History?    Yes    No    Most Recent Fall Date: \_\_\_\_\_    How many falls in the last month? \_\_\_\_\_

Comments:

\_\_\_\_\_  
Any other information that you feel may be important:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FINANCIALLY RESPONSIBLE PARTY:**

Send Statement /Bill To:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Email: \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

I agree to furnish on request certification as to my assets, income, and sources of income. My spouse and/or resident representative also agree to provide financial information as may be required for application for Medicaid benefits. I agree to pay for my cost of care from my income and assets according to current rates set by the State of North Dakota as long as I am a resident. When my funds are not enough, I agree to comply with eligibility requirements and will apply for State of North Dakota Medicaid acceptance.

**PLEASE PROVIDE A COPY OF THE FOLLOWING WITH THE APPLICATION, IF APPLICABLE:**

DD-214

If Spouse Marriage/Death Certificate

Durable Power of Attorney/Guardianship/Conservator papers

Signed form SFN51156 Personal Authorization for Criminal History

Signed form #16 Authorization to Disclose Information-VA Medical Center

Signed form #16 Authorization to Disclose Information-one for each facility the applicant is seen at.

**THE FOLLOWING WILL NEED TO BE TURNED IN PRIOR TO ADMISSION DATE:**

- Health Care Directive
- Front and back copies of all insurance cards-Medicare, Secondary Insurance, Prescription Plans
- Copies of IDS-Social Security, Driver’s License, VA ID
- Award Letters from Veterans Affairs-verifying Service Connection/Pension/Compensation/ Aid and Attendance/Homebound
- Copy of last bank statement; IRA’s, Bonds, Retirement, Burial

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**Completed application and information can be mailed to:** North Dakota Veterans Home  
Attn: Admissions  
PO Box 673 Lisbon, ND 58054-0673

# AUTHORIZATION TO DISCLOSE INFORMATION

NORTH DAKOTA VETERANS HOME

SFN 62632 (6-2025)

**INSTRUCTIONS:** Provide information as it existed when the service was provided.

Name	Medical Record Number	Date of Birth	
Street Address	City	State	ZIP Code

## CLIENT RELEASE AND SIGNATURE

<b>1. I Hereby Authorize:</b>			
Name of Person/Facility			
Street Address	City	State	ZIP Code

## 2. To Release Information To:

Name of Person/Facility to Receive Information			
Street Address	City	State	ZIP Code

## 3. The following information is requested: (Be specific – include dates where appropriate)

- |                                                                                 |                                                               |                                                     |
|---------------------------------------------------------------------------------|---------------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Nurses Notes                                           | <input type="checkbox"/> Activity Notes                       | <input type="checkbox"/> Physician Orders           |
| <input type="checkbox"/> Dietary Notes                                          | <input type="checkbox"/> Immunization Record                  | <input type="checkbox"/> Physician's Progress Notes |
| <input type="checkbox"/> Care Plans                                             | <input type="checkbox"/> Discharge Summary                    | <input type="checkbox"/> Medication List            |
| <input type="checkbox"/> Mental Health Records                                  | <input type="checkbox"/> All Drug/Alcohol Related Information |                                                     |
| <input type="checkbox"/> History and Physical from (date) _____ to (date) _____ |                                                               |                                                     |
| <input type="checkbox"/> Laboratory Results from (date) _____ to (date) _____   |                                                               |                                                     |
| <input type="checkbox"/> Consultation Reports from (doctor's names) _____       |                                                               |                                                     |
| <input type="checkbox"/> Other _____                                            |                                                               |                                                     |
| <input type="checkbox"/> Entire Record                                          |                                                               |                                                     |

## 4. The Information Identified Above Will Be Used For: (List Each Purpose)

5. This Authorization to Disclose Information Remains in Effect Until: (Date) \_\_\_\_\_

**OR:**  **Resident Revokes Consent**

## RESIDENT CONSENT

This authorization remains in effect until the above date or event, unless specifically revoked by written notice to the facility by the resident or legal representative. Refer to the Notice of Privacy Practices for further description of revocation rights. Any information disclosed prior to written revocation of this authorization shall not be a breach of confidentiality. A photocopy or fax of this authorization is as effective as the original. I understand that this consent is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits. Unless otherwise agreed in writing, information may be disclosed under authorization in any form or medium, including oral, written, or electronic transmission.

Signature of Resident or Legal Representative	Date
If Signed By Legal Representative, Relationship to Resident	Date

**NOTICE:** All information regarding alcohol and/or drug abuse or behavioral health that are part of the records you specified above will be released **unless you restrict** by initialing:

- Do Not** release alcohol and/or drug abuse information       **Do Not** release behavioral health information

**NOTICE:** I understand information disclosed to another entity may potentially be redisclosed, in which case it may not be protected by state or federal law.

**DISTRIBUTION:** I understand upon request, I will receive a copy of this form after I have signed it.

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SFN 62632 (6-2025)

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3. The following information is requested: (Be specific – include dates where appropriate)

- |                                                                                 |                                                               |                                                     |
|---------------------------------------------------------------------------------|---------------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Nurses Notes                                           | <input type="checkbox"/> Activity Notes                       | <input type="checkbox"/> Physician Orders           |
| <input type="checkbox"/> Dietary Notes                                          | <input type="checkbox"/> Immunization Record                  | <input type="checkbox"/> Physician's Progress Notes |
| <input type="checkbox"/> Care Plans                                             | <input type="checkbox"/> Discharge Summary                    | <input type="checkbox"/> Medication List            |
| <input type="checkbox"/> Mental Health Records                                  | <input type="checkbox"/> All Drug/Alcohol Related Information |                                                     |
| <input type="checkbox"/> History and Physical from (date) _____ to (date) _____ |                                                               |                                                     |
| <input type="checkbox"/> Laboratory Results from (date) _____ to (date) _____   |                                                               |                                                     |
| <input type="checkbox"/> Consultation Reports from (doctor's names) _____       |                                                               |                                                     |
| <input type="checkbox"/> Other _____                                            |                                                               |                                                     |
| <input type="checkbox"/> Entire Record                                          |                                                               |                                                     |

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# PERSONAL AUTHORIZATION FOR CRIMINAL HISTORY RECORD INFORMATION

OFFICE OF ATTORNEY GENERAL  
BUREAU OF CRIMINAL INVESTIGATION  
SFN 51156 (12-2024)

## REQUESTER INFORMATION - RESULTS WILL BE MAILED TO INDIVIDUAL OR COMPANY INDICATED IN THIS BLOCK

Mail to Attention of Admissions		Telephone Number/Extension 701-683-6500	
Name/Company North Dakota Veterans Home			
Address 1600 Veterans Drive/ PO Box 673		City Lisbon	State ND
		ZIP Code 58054	

Pursuant to NDCC § 12-60-16.8, I hereby authorize the North Dakota Bureau of Criminal Investigation to release a copy of my criminal history record to the above party, provided; however, that the Bureau may release only that information pertaining to reportable events occurring within the past three years and information regarding any conviction.

## SUBJECT OF RECORD CHECK

Name (please print)	
Signature (electronic or typed name is the legal equivalent of a handwritten signature)	Date

This form should accompany the Public Request for Criminal History Record Information.