North Dakota Veterans Home
1600 Veterans Drive
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 dedicated to serving Veterans and their spouses in a warm, supportive environment that provides the highest standards of quality care for both basic and skilled care services.

The decision to transition out of one's home can be emotionally difficult for individuals and their loved ones. Please take comfort in the words that several of our residents have spoken; "I wish I would have moved here sooner." Residents can partake in activities they enjoy without the day-to-day stress of managing their households, medications, appointments, and more. Our experienced team is eager to assist you throughout the admission process.

As you prepare to apply, there are criteria that we want to make you aware of:

- The NDVH is unable to accept residents who are receiving dialysis treatment.
- The NDVH requires that applicants who have a diagnosis of alcohol or substance abuse have nine to twelve months of documented sobriety before being accepted to NDVH.
- The NDVH skilled care campus is smoke-free (including e-cigarettes.)
- Applicants who apply for admission and are denied are eligible to reapply after 12 months unless otherwise stated in a denial letter.

Prior to admission, residents may need to apply for all monetary benefits to which they may be entitled from both the state and federal governments. (Including but not limited to: Aid and Attendance, Medicaid, etc.)

A tour of the facility greatly assists the Admissions Board in determining admission. Please get in touch with the Admission Coordinator at 701-683-6540 to schedule a tour.

The Admissions Coordinator will gather medical, social, and financial information about a potential resident from the applicant, family, and/or the referral source. Once this information is completed in full, it will be forwarded to the Admissions Team for review and vote. Upon completion of the voting process, the Admissions Coordinator will contact the applicant.

Please feel free to contact us if you have any questions. We look forward to working with you on placement to our beautiful facility.

Sincerely.

Susie Schlecht
Admissions/Marketing Coordinator
701-683-6540
sjschlecht@nd.gov

Ashley Olson
Director of Social Services
701-683-6530
a2olson@nd.gov

NORTH DAKOTA VETERANS HOME
Caring for America's Heroes

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
- ☐ Unsteady
- ☐ Powerchair
- ☐ Uses wheelchair independently
- ☐ Uses wheelchair with assistance
- ☐ Uses cane or walker without assistance
- ☐ Uses cane or walker with assistance
- ☐ Uses gait belt
- ☐ 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 VETERAN'S HOME
Form # 16 (Rev.12/20/2011)

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

1. **I Hereby Authorize:**			
Name of Person/Facility:			
Street Address:	City:	State:	Zip Code:

2. **To Release Information To:**			
Name of Person/Facility To Receive Information: **ND Veterans Home**			
Street Address: **1600 Veterans Drive**	City: **Lisbon**	State: **ND**	Zip Code: **58054**

3. The Following Information is Requested: (Be specific – include dates where appropriate)

X Nurses Notes X Activity Notes X Physician Orders
X Dietary Notes X Immunization Record X Physician's Progress Notes
X Care Plans X Discharge Summary X Medication List
X Mental Health Records X All Drug/Alcohol Related Information
X History and Physical
X Laboratory Results
X Consultation Reports from (doctor's names) _____
X Other Social History _____
X Entire Record

4. The Information Identified Above Will Be Used For: (List Each Purpose)
Admission and On-Going Care

5. This Authorization to Disclose Information Remains in Effect Until: (Date) **three months following admission**

OR: (Specific Event Terminating Operation of the Release) **resident revokes consent**

RESIDENT CONSENT:

This authorization is voluntary and remains in effect until the above date or event, unless specifically revoked by written notice to the facility by the resident. 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 of this authorization is as effective as the original. 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:
Signature of Witness (if needed):	Date:

___ CHECK IF APPLICABLE – NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING ADDICTION RECORDS: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

NOTICE: Except for information subject to 42 CFR Part 2, information disclosed to another entity may potentially be redisclosed, in which case it may not be protected by state or federal law.

DISTRIBUTION: _____ Resident _____ Resident Refused Copy _____ Addiction Chart if Applicable
_____ Requesting Person/Facility _____ Other

AUTHORIZATION TO DISCLOSE INFORMATION

NORTH DAKOTA VETERAN'S HOME
Form # 16 (Rev.12/20/2011)

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

1. **I Hereby Authorize:**			
Name of Person/Facility: **VA Medical Center**			
Street Address: **2101 Elm Street**	City: **Fargo**	State: **ND**	Zip Code: **58102**

2. **To Release Information To:**			
Name of Person/Facility To Receive Information: **ND Veterans Home**			
Street Address: **1600 Veterans Drive**	City: **Lisbon**	State: **ND**	Zip Code: **58054**

3. The Following Information is Requested: (Be specific – include dates where appropriate)

X Nurses Notes	X Activity Notes	X Physician Orders
X Dietary Notes	X Immunization Record	X Physician's Progress Notes
X Care Plans	X Discharge Summary	X Medication List
X Mental Health Records	X All Drug/Alcohol Related Information	
X History and Physical		
X Laboratory Results from		

X Consultation Reports from (doctor's names) _____
X Other Social History _____
X Entire Record

4. The Information Identified Above Will Be Used For: (List Each Purpose)
Admission and On-Going Care

5. This Authorization to Disclose Information Remains in Effect Until: (Date) **three months following admission**

OR: (Specific Event Terminating Operation of the Release) **resident revokes consent**

RESIDENT CONSENT:

This authorization is voluntary and remains in effect until the above date or event, unless specifically revoked by written notice to the facility by the resident. 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 of this authorization is as effective as the original. 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:
Signature of Witness (if needed):	Date:

___ CHECK IF APPLICABLE – NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING ADDICTION RECORDS: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

NOTICE: Except for information subject to 42 CFR Part 2, information disclosed to another entity may potentially be redisclosed, in which case it may not be protected by state or federal law.

DISTRIBUTION: _____ Resident _____ Resident Refused Copy _____ Addiction Chart if Applicable
_____ Requesting Person/Facility _____ Other

PERSONAL AUTHORIZATION FOR CRIMINAL HISTORY RECORD INFORMATION

OFFICE OF ATTORNEY GENERAL
BUREAU OF CRIMINAL INVESTIGATION
SFN 51156 (07-2023)

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

Mail to Attention of			Telephone Number/Extension
Name/Company			
Address	City	State	ZIP Code

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	Date

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