Hatton Prairie VILLAGE

CATERED COUNTRY LIVING

950 Dakota Avenue
Hatton, North Dakota

ADMISSION APPLICATION

Our Mission Statement

"Every time we touch residents' and families' lives, they will feel better."

www.hattonprairievillage.com

Hatton Prairie VILLAGE
CATERED COUNTRY LIVING

Admission Application *Please *Print* Clearly*

Section 1

IDENTIFICATION:

Last Name: _____

First Name:_____ Middle Initial:_____

Address (Street, City, State, Zip): _____

_____

Do you or your spouse reside on a farm? _____ Yes _____ No

PERSONAL INFORMATION:

Birthdate:_____ Age:_____ Birthplace:_____

Sex:_____ Marital Status:_____ Spouse Name:_____

Previous Occupation: _____

Religion: _____

Church:_____

Military Veteran:

Resident: Yes _____ No _____ Branch: _____

Spouse (name):: Yes _____ No _____ Branch: _____

MEDICAL DESIGNATIONS:

Physician: _____ Phone No: _____

Optometrist/Ophthalmologist :_____ Phone No: _____

Dentist:_____ Phone No: _____

Pharmacy: _____ Phone No: _____

DECISION MAKING AUTHORITY

Do you make your own decisions for your healthcare and financial matters? _____ Yes _____ No

If not, who is designated to make decisions on your behalf?

Healthcare: _____ Phone No: _____

Financial: _____ Phone No: _____

LEGAL DOCUMENTS

____ Power of Attorney (Finances) ____ Power of Attorney (Healthcare) ____ Healthcare Directive or Living Will *Copies are required*

NOTIFY IN EMERGENCY:

Name:_____ Relationship:_____

Address (Street, City, State, Zip):_____

Phone No. (H)_____ (W)_____ (Cell)_____

Email Address: _____

Name:_____ Relationship:_____

Address (Street, City, State, Zip):_____

Phone No. (H)_____ (W)_____ (Cell)_____

Email Address: _____

BILLING PARTY:

Name:_____ Relationship:_____

Address (Street, City, State, Zip):_____

Phone No. (H)_____ (W)_____ (Cell)_____

Email Address: _____

FUNERAL HOME PREFERENCE:

Name:_____

Address:_____

Phone No: _____

Prepaid Burial: Yes _____ No _____ Amount: $ _____

Has Applicant lived in a Nursing Facility before? Yes _____ No _____

If so, where and when? _____

Has Applicant received Home Health Care Benefits before? Yes _____ No _____

If so, what Agency and when? _____

INSURANCE INFORMATION:

Social Security Number _____ - _____ - _____

Medicare Number: _____ Part A _____ Effective Date: _____

Part B _____ Effective Date: _____

Medicare Supplement Insurance: _____ Policy No:_____

Medicare Part D Plan:_____ Policy No:_____

Medicaid ID No. (If Applicable):_____ County:_____

Pending:_____ Approved:_____ Approved Date:_____

Have you previously applied for Medicaid? Yes _____ No _____

If yes, provide the date & county in which the application was made. Date:_____ County:_____

Long Term Care Insurance :_____ Policy No:_____

Is your primary health insurance other than Medicare? For example, do you have Humana, Medica, or United Health insurance?

Yes _____ No _____

Note: If you are currently receiving Medicaid assistance or are approved for Medicaid, you do not need to complete Section 2. Go to Section 3 and sign the application.

Section 2

Except for personal affects, list all assets owned by you and your spouse, with the value as of the date of application.

Owner(s) of Asset	Description of Asset	Name of Institution	Approximate Value
	Checking Account		
	Savings-Passbook Account		
	Certificate(s) of Deposit		
	Stocks, Bonds IRAs, etc.		
	Life Insurance, Cash Surrender, Annuities, Trusts		
	Farm Equipment, Livestock, Stored Crops, Burial Plots		
	Home(s)		
	Land		
	Vehicle(s)		
	Life Estates		
	Other (describe)		

Have you created a trust within the last 5 years? Yes _____ No _____

List all debts owed by you and your spouse as of the date of application. **If no debts, write "None" below.**

Debtor	Description of Debt	Amount of Debt

List all transfers of cash, gifts of cash or assets, including transfers of a remainder interest in real property, and sale of property for less than its value, within the past five (5) years, by you or your spouse. If no transfers, write "None" below. **You Must complete this section. Your application can not be considered if this section is left blank.**

Date of Transfer	Description of Asset	Recipient/Relationship	Value of Asset

List all sources of income for you and your spouse.

Description of Income	Date or Frequency of Payment (monthly, annually, etc.)	Amount of Payment
Social Security Benefit	Monthly	
Pension/Retirement Benefit		
Income from CRP or Farmland		
Oil/Mineral Rights Royalties		
Trust Income		
Rental Income		
Veterans'/Military Benefits		
Other (list)		

Section 3

This application complies with Section 50-10.2-05 of the North Dakota Century Code. By my signature below, I hereby authorize Hatton Prairie Village to contact the county and/or state social services office for information regarding my Medicaid application and eligibility, if applicable, and hereby release and authorize the county and/or state social services office to release any information to Hatton Prairie Village. I also authorize Hatton Prairie Village to contact any and all of the above-identified financial institutions to obtain information regarding my assets and income, and I hereby release and authorize the financial institutions to release any information to Hatton Prairie Village. I further authorize Hatton Prairie Village to release to its attorneys any information regarding my application for admission.

I understand that providing false information could result in discharge and/or denial of my application. The answers provided in this application are true and correct to the best of my knowledge and information.

Name:_____
(print)

Signature: _____ Date: _____

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We thank you for choosing Hatton Prairie Village and welcome you to our neighborhood.