Wentz Living Center
555 Lake Ave East
PO Box 90
Napoleon, ND 58561
701-754-2381

Date Received: ______/______/________

APPLICATION FOR ADMISSION

In order for us to process the application, it will be necessary for you to fill in all the blanks with the information requested.

Name of applicant: ___________________________________ Sex: _________ D.O.B.: ______/______/________

Present address: ____

Permanent address: ____

Home Town: ________________________ Birthplace: ______________________ Phone #:______________________

Citizen of USA: Yes No (Circle one): Married Widowed Divorced Separated Single

Complete the next 4-items whether individuals are living or deceased:

Father's Name: ___________________________________ Mother's Maiden Name: _________________________

Spouse's Name: ___________________________________

Spouse's address if living, or date and cause of death: ____

Years of Education: ______________________________ Previous Occupation: ______________________________

Military Service: __________________________________

Funeral Home Preference (Name & Address): ____

Home Church (Name & Address): ____

Minister Name: ___________________________________

Doctor (Name, Clinic, Phone): ____

Hospital Preference: ____________________ Pharmacist: ___________________ Dentist: ___________________

Optometrist (Name, Address, Phone): ____

Social Security #: ______/______/________ Medicare #: _________/_________/_________

Medicaid #:______/______/________ Medicare Part D (Drug Plan): ____________________________________

Medicare Advantage Plan (If Applicable): Humana Secure Horizon Other ___________________________

Supplemental Insurance: ___________________________________ Policy Number: _________________________

Long Term Care Insurance: ________________________________ Policy Number: _________________________

Advanced Directive:

Living Will ______________ DPOA for Healthcare ______________ POA for Financial ______________

Guardian's Name: _______________________________

Is this person authorized to make medical decision? Yes No

When do you anticipate nursing home care needed: ____

Family members or friends to be contacted in case of emergency:

Name	Address	Telephone Number Home/Work	Relationship

Source of Payment: Private Assistance

Person Responsible for Payment (Name, Address, Phone):

____

Do you receive any medical assistance? Yes No

In what county do you receive this? ___________________________________

Have you ever applied for medical assistance? Yes No

Will you need to apply for medical assistance in the near future? Yes No

Primary Medical Problems:

Allergies: ____

Height: ____ Weight: ____

Name of Medications (Prescribed and Over-The-Counter): ____

____

____

Personal Care (Circle if Assistance is Needed):

Leave Home

Stairs

Transfer from Bed to Chair

Bath/Shower

Taking Medications

Eating

Dress/Undress

Getting to Bathroom

Personal Care (Circle if Applicable):

Walks Independently	Needs Assistance to Propel W/C	Lack of Bladder Control
Walks with Device: Cane Walker Crutch	Confined to Bed/Wheelchair	Lack of Bowel Control
Walks with Help of: One Two	Hearing: Good Fair Poor	Colostomy/Catheter
Propels W/C per Self	Hearing Aids	Vision: Good Fair Poor
	Falls Frequently	Glasses

Treatments:

On Oxygen or other Respiratory Care? No Yes – Explain: ______________________________________

Skin Conditions: Good Bruises/Sores – Explain: ____

Diets:

Special Diet? No Yes – Explain: ______________________________________

Appetite: Good Fair Poor

Lab-Work & X-rays:

Has your physician informed you of any abnormal findings? No Yes – Explain: ____________________

Mental Condition (Circle when Applicable):

Oriented to Time	Recent Memory	Able to Communicate
Oriented to Place	Recognizes People	Confused
Distant Memory Confused	Clear	Makes Judgement

Emotional Status (Circle when Applicable):

Feeling Lonely	Sleeping Problems	Irritable Easily Suicidal Talk
Medication Abuse	Drinking Problem	Worried/Anxious
Smokes	Loss of Interest in Things	Combative Behavior/Upset

Any psychiatric treatment over the past two-years? No Yes – Explain: __________________________

____ _______/_________/__________

Person Completing this Application **Date**