**Basic Care Intake Questionnaire**

***Please complete this form in its entirety. Attached additional documentation if necessary.***

**Applicant’s Information:**

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| --- | --- | --- |
| Last Name, First Name, Middle Initial: | | |
| Date of Birth: | | Social Security Number: |
| Gender: | | E-mail: |
| Mailing Address: | | |
| City, State, Zip: | | |
| Home Phone: | | Cell Phone: |
| Marital Status: | € Married € Widowed € Never Married € Separated € Divorced | |
| Veteran Status: | Are you a Veteran? € Yes € No What Branch?  Is your spouse a Veteran? € Yes € No € N/A | |
| Background Status: | Have you ever been convicted of or pled guilty to a sexual offense in a court of law?  € Yes € No State/County: | |
| Decision Making Authorization: | Do you make your own decisions for healthcare and financial matters?  € Yes € No  If applicant is unable to make own decisions, who is designated to make decisions on their behalf?  Healthcare: Phone:  Financial: Phone: | |
| Legal Documents:  (Copies are Required) | € Durable Power of Attorney Finances or Conservatorship  € Durable Power of Attorney Healthcare or Guardianship  € Health Care Directive or Living Will | |

**Spouse’s Information (if applicable):**

|  |  |
| --- | --- |
| Last Name, First Name, Middle Initial: | |
| Date of Birth: | Social Security Number: |
| E-mail: | |
| Mailing Address: | |
| City, State, Zip: | |
| Home Phone: | Cell Phone: |

**Billing Party:** Please list where you would like any mail sent and/or who will be managing the financial affairs of the applicant.

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| --- | --- |
| Name: | |
| Relationship to Applicant: | |
| Mailing Address: | |
| City, State, Zip: | |
| E-mail: | |
| Home Phone: | Cell Phone: |

**Insurance Information:**

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| Are you, the applicant, currently covered by an employer’s group health insurance? € Yes € No  Company Name:  Policy Holder Name:  Policy Number: |
| Medicare Number (Part A, B, or C): |
| Medicare D (prescription) Plan Company:  Policy: Phone: |
| Medicare Supplemental Insurance Company:  Policy: Phone: |
| Medical Assistance/Medicaid Number/County: |
| Have you, the applicant, ever applied for Medical Assistance/Medicaid? € Yes € No  Date Applied: County/State: |
| Health Insurance – Other Company:  Policy: Phone: |
| Long-Term Care Insurance Company:  Policy: Phone: |

**Tell Us About the Assets You or Your Spouse Own:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Description of Asset** | **Owner(s) of Asset** | **Value of Asset** | **Location of Asset** |
| Checking/Savings/Credit Union/Money Market Accounts |  |  |  |
| Annuities/CDs |  |  |  |
| Retirement Funds (IRA/401K/KEOGH) |  |  |  |
| Stocks/Bonds/Mutual Funds |  |  |  |
| Life Insurance (cash surrender value) |  |  |  |
| Real property (Home, Land, Rental Property) |  |  |  |
| Life Estate(s) |  |  |  |
| Vehicles (car, truck, motor home, snowmobile, motorcycle, boat, etc.) |  |  |  |
| Trusts (own or are a beneficiary of) |  |  |  |
| Mineral Rights (oil, gas, coal, etc.) |  |  |  |
| Pre-Paid Burial Account(s) |  |  |  |

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| **Transfer of Assets** |
| Have you or your spouse sold, transferred, or gifted anything of value including cash, real property, vehicles, or any other asset within the past 5 years?  € Yes € No If yes, list the item(s), to whom, & date(s): |

**Tell Us About the Income/Money You or Your Spouse Receive:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of Income or Other Money Received** | **Recipient** | **How Often Received** | **Amount** |
| Employment/Workers Compensation |  |  |  |
| Oil/Mineral Rights/Royalties |  |  |  |
| Income from CRP or Farmland |  |  |  |
| Pension/Retirement Benefits |  |  |  |
| Trust Income |  |  |  |
| Social Security Benefits |  |  |  |
| Supplemental Security Income (SSI or SSDI) |  |  |  |
| **Type of Income or Other Money Received** | **Recipient** | **How Often Received** | **Amount** |
| Contract Sale or Rental Income |  |  |  |
| Veteran’s/Military Benefits |  |  |  |
| Other: (list) |  |  |  |

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| **Future Income** |
| Do you or your spouse have any pending legal action from which you may receive money, including an inheritance or a settlement?  € Yes € No If yes, please describe: |
| Are you or your spouse the beneficiary of any trust?  € Yes € No If yes, please describe: |

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| **Transfer of Income** |
| Have you or your spouse transferred or given away any income within the past 5 years?  € Yes € No If yes, list the amount(s), date(s), and to whom it was given to: |

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| **Employment** |
| Are you or your spouse employed by another?  € Yes € No If yes, provide the name of the employer, hours worked, and the wage or salary earned: |

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| **Self-Employment** |
| Are you or your spouse self-employed?  € Yes € No If yes, list who, nature of business, and date business started: |

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| **Farming** |
| Are you or your spouse actively engaged in farming?  € Yes € No |

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| **Business Ownership** |
| Do you or your spouse have an ownership interest in a business?  € Yes € No If yes, please describe the nature of the business and extent of ownership: |

**List all Debts Owed by You or your Spouse:** This includes medical bills, mortgages, credit cards, vehicles, personal loans, etc.

|  |  |  |
| --- | --- | --- |
| **Description of Debt**  **& To Whom Owed** | **Owner of Debt** | **Approximate Amount of Debt** |
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**This questionnaire complies with section 50-10.2-05 of the North Dakota Century Code. By my signature below, I hereby authorize the basic care facility to contact the county and/or state social services office for information regarding my Medicaid application and eligibility, and I hereby release and authorize the county and/or state social services office to release any information to the basic care facility. I also authorize basic care facility 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 basic care facility. I further authorize basic care facility 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 herein are true and correct to the best of my knowledge and information.**

Signature: Date:

Printed Name: