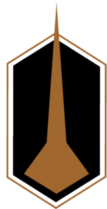

MISSOURI SLOPE

TAILORED CARE. INSPIRED LIVING.

A ministry of Missouri Slope Lutheran Care Center

Dear Applicant:

Thank you for contacting Missouri Slope. Enclosed is an Application for Admission, Admission Orders form and Pre-Entrance Medical Record form. Please complete the Application for Admission and return it to Missouri Slope. The applicant's primary care physician should complete the Admission Orders form and Pre-Entrance Medical Record form and return them to Missouri Slope.

If you have any questions or would like to schedule a tour of the facility, please contact Tina Kellar, Admissions Director, at 701-221-9391.

Thank you again for contacting Missouri Slope.

Enclosure

4916 N Washington Street, Bismarck ND 58503 | 701-223-9407 | missourislope.com

APPLICATION FOR ADMISSION

Along with the completed application please submit a current History and Physical and Medication List from the applicant's Physician.

Date: ____________________

Personal Information

Applicant Name: ____
Last | First | Middle | Nickname/Preferred Name | Pronoun

Current Address: ____
Street | City | State | Zip Code

Phone Number: ____
Home | Cell/Mobile | Work | Email

Social Security No: ________________ Birth Date: ______________ Age: ____ Birth Place: ______________________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If married, please provide:
Spouse's name ________________________
Date of Marriage ______________________

Mother's Name: ______________________________________ Father's Name: ______________________________________
Last (Include Maiden Name) First | Last First

Veteran Status: ☐ Veteran ________________________ ☐ Spouse/Widow of a Veteran ______________________
Military Branch | Military Branch

Has the applicant previously applied to Missouri Slope? ☐ No ☐ Yes ___________________
Date

Religion: ________________________ Church Membership: ____
Name | Address

Medical Information

	Name	*Address*	*Phone No.*
Primary Physician:			
Clinic:			
Hospital:			
Optometrist:			
Dentist:			
Funeral Home:			

Vaccinations (check all vaccinations received by the applicant)

☐ Influenza (Flu) ☐ Pneumococcal (pneumonia) ☐ Respiratory Syncytial Virus (RSV)

☐ Shingrix (Shingles) ☐ SARS-coV-2 (COVID-19)

Physical Condition (check all that apply)

Ambulation	Physical Needs	Mental Condition	Personal Needs
☐ Bedfast	☐ Poor Eyesight	☐ Clear	☐ Dresses Self
☐ Wheelchair	☐ Poor Hearing	☐ Confusion	☐ Bathes Self
☐ Walker/Cane	☐ Control of Bowel/Bladder	☐ Forgetful	☐ Feeds Self
☐ Walks by Self	☐ Special Diet _________	☐ Requires Supervision	Habits
☐ Transfers Self	☐ Oxygen	☐ Behavior Problems	☐ Smokes/Vapes
		☐ Wanders	☐ Chews Tobacco
			☐ Uses Alcohol

Legal Information

Advanced Directives (check all that apply)- copies will be requested at time of admission

☐ Durable Power of Attorney Finances — Name of Responsible Party ________________________________

☐ Durable Power of Attorney Healthcare — Name of Responsible Party ________________________________

☐ Guardian — Name of Responsible Party ________________________________

☐ Living Will/Health Directive — Name of Responsible Party ________________________________

☐ None

Financial Information

Insurance (please provide copies of the front and back of each card)

Insurance	*Policy No.*	*Company*	*Phone No.*
Medicare			
Medicare Advantage Insurance			
Medicare Part D			
Medicaid			
Long-Term Care Insurance			
Health Insurance-other			
Supplement			
VA			
Private Pay			

If Private Pay, provide the Name, Address, and Phone No. of Responsible Party

Has the applicant and/or the applicant's spouse transferred and/or gifted any assets to anyone (family, friends, etc.) in the past 5 years? If yes, explain:______________________ ☐ Yes ☐ No

Does the applicant and/or the applicant's spouse have a trust? ☐ Yes ☐ No

Does the applicant/applicant's spouse have a Life Estate? If yes, provide name:____ ☐ Yes ☐ No

Has the applicant previously applied or will the applicant be applying for Medicaid Assistance and/or be completing an asset assessment through the Long-term Care (LTC) Unit at the ND Department of Human Services (DHS)? Date:_______________________________________ ☐ Yes ☐ No

Will the applicant authorize the LTC/DHS to release information to Missouri Slope regarding this application and eligibility for Medicaid Assistance, including any reason for denial of assistance? ☐ Yes ☐ No

Relatives / Significant Others (List in order of notification)

Name	*Relation*	*Address*	*Phone No.*
1.		Home: Email Address:	Home: Cell: Work:
2.		Home: Email Address:	Home: Cell: Work:
3.		Home: Email Address:	Home: Cell: Work:
4.		Home: Email Address:	Home: Cell: Work:

Signature

_______________________________________ _______________________

Signature of Applicant Date

_______________________________________ _______________________

Signature of Legal Representative/Responsible Party Date

Note - Please provide copies of the following: (front and back of each insurance card)

1. Social Security Card
2. Medicare Card
3. Medicaid Card
4. Health / Supplement Insurance Card
5. Medicare Part D Prescription Drug Plan Card
6. Nursing Home Insurance
7. Power of Attorney (Financial and/or Healthcare), Guardianship, Living Will, Life Estate, Etc.

Please return completed application by mail, email, fax or drop off at one of the Missouri Slope locations:

Washington Campus	Hillview Campus	Email	Fax
4916 N Washington St.	2425 Hillview Ave.	admissions@mslcc.com	701-204-7424
Bismarck, ND 58503	Bismarck, ND 58501		

ADMISSION ORDERS

From: ________________________________ To: Missouri Slope ________________________

Date: __________ Name of Patient: ____

Diagnoses: ____
____
____
____

Code Status at Time of Admission (To be reviewed by accepting facility):

- ❑ Level 1: Total support. Defibrillation, chest compression, artificial respiration, transfer to hospital.
- ❑ Level 2: No defibrillation, no chest compression, no artificial respiration. Transfer to hospital as necessary for treatable conditions.
- ❑ Level 3: Keep comfortable in nursing facility. No defibrillation, no chest compression, no artificial respiration.

Code status discussed with resident or legal representative. ❑ Yes ❑ No

Name and relationship, if other than resident: ______________________________

Advance Directive: ❑ Living Will ❑ Durable Power of Attorney for Healthcare ❑ Guardianship

Allergies: ____

Diet: ____

Restorative or Other Therapy Plan (Describe Specific Type and Frequency): ________________
____
____

Treatments: ____
____
____

Medications: ____
____
____
____
____

Physician to Assume Care: ____
Print Physician's Full Name

Physician's Signature: ____
Signature of Physician Date

Revision Date: 3/05/2024

PRE-ENTRANCE MEDICAL RECORD

Name of Patient: ____
Last First Middle

Date of Birth: ________________ Age:____ Height: ________________ Weight: ________________

Allergies: ____

Past Medical History: ____
____
____
____
____
____

Family History: ____
____
____

Social History: ____
____
____

Review of Systems:

General: ____
HEENT: ____
Gastrointestinal: ____
Genitourinary: ____
Pulmonary: ____
Cardiovascular: ____
Endocrine: ____
Musculoskeletal: ____
Neurological: ____

Has the individual experienced an acute episode of mental illness within the past two (2) years?

☐ Yes ☐ No

Has this individual been prescribed an antipsychotic medication on a regular basis in the last 90 days?

☐ Yes ☐ No
If yes, what is the medication? ____

Does the individual display disturbance in orientation, affect or mood that is not attributable to dementia?

☐ Yes ☐ No

(Rev: 3/06/2024)

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Physical Examination:

General: ______________________________

____

HEENT: ______________________________

____

Skin: ______________________________

____

Neck: ______________________________

____

Heart: ______________________________

____

Lungs: ______________________________

____

Abdomen: ______________________________

____

Extremities: ______________________________

____

Neurological: ______________________________

____

Diagnoses: ______________________________

____

____

Vaccines:

Has the Pneumovax vaccine been given?

☐ Yes ☐ No

If yes, date of vaccination: ______________________________

History of tuberculosis:

☐ Yes ☐ No

TB test and/or last chest x-ray results: ______________________________

Physician's Statement:

☐ I find this individual capable of making medical decisions.

☐ I find this individual incapable of making medical decisions.

____

Physician's Signature Date

(Rev: 3/06/2024)