Financial Intake Questionnaire

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

Applicant's Information:

<table>
<tr><td colspan="6">Last Name, First Name, Middle Initial:</td></tr>
<tr><td colspan="3">Date of Birth:</td><td colspan="3">Social Security Number:</td></tr>
<tr><td colspan="3">Gender:</td><td colspan="3">E-mail:</td></tr>
<tr><td colspan="6">Mailing Address:</td></tr>
<tr><td colspan="6">City, State, Zip:</td></tr>
<tr><td colspan="3">Home Phone:</td><td colspan="3">Cell Phone:</td></tr>
<tr><td>Marital Status:</td><td>☐ Married</td><td>☐ Widowed</td><td>☐ Never Married</td><td>☐ Separated</td><td>☐ Divorced</td></tr>
<tr><td rowspan="2">Veteran Status:</td><td>Are you a Veteran?</td><td>☐ Yes</td><td>☐ No</td><td colspan="2">What Branch?</td></tr>
<tr><td colspan="2">Is your spouse a Veteran?</td><td>☐ Yes</td><td>☐ No</td><td>☐ N/A</td></tr>
<tr><td rowspan="2">Background Status:</td><td colspan="5">Have you ever been convicted of or pled guilty to a sexual offense in a court of law?</td></tr>
<tr><td>☐ Yes</td><td>☐ No</td><td colspan="3">State/County:</td></tr>
<tr><td rowspan="2">Decision Making Authorization:</td><td colspan="3">Do you make your own decisions about healthcare and financial matters?</td><td>☐ Yes</td><td>☐ No</td></tr>
<tr><td colspan="5">If the applicant is unable to make their own decisions, who is designated to make decisions on their behalf?
Healthcare: Phone:
Financial: Phone:</td></tr>
<tr><td>Legal Documents:
(Copies are Required)</td><td colspan="5">☐ Durable Power of Attorney Finances or Conservatorship
☐ Durable Power of Attorney Healthcare or Guardianship
☐ Health Care Directive or Living Will</td></tr>
</table>

Emergency Contact:

Last Name, First Name, Middle Initial:	
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.

Name:			
Relationship to Applicant:	☐ Self	☐ Spouse	☐ Other
Mailing Address:			
City, State, Zip:			
E-mail:			
Home Phone:		Cell Phone:	

Insurance Information: Please include copies of card(s) (Front & Back)

Medicare Number Part A Part B:	
Medicare Supplemental or Medicare Advantage Plan Insurance Company: Policy:	 Phone:
Medicare D (prescription) Plan Company: Policy:	 Phone:
Have you, the applicant, ever applied for Medical Assistance/Medicaid? Yes No Date Applied:	 County/State:
Medical Assistance/Medicaid Number/County:	
Health Insurance – Other Company Name: Policy Holder Name: Policy Number:	
Long-Term Care Insurance Company: Policy:	 Phone:

FINANCIAL INFORMATION: (*Information in this section will assist with financial planning. Please attach additional information if needed.)*

1. Have you or your acting Financial Power of attorney sold, traded, transferred, or gifted any cash or assets to you or from you, or to or from a trust account? If YES, please explain the nature of the transaction, such as who completed the transaction and the date it occurred.

2. Have you or your spouse sold, transferred, or gifted anything of value including income, cash, real property, vehicles, or any other asset within the past 5 years? If YES, please explain.

3. Are you or your spouse actively engaged in farming or any other business activities? If YES, please explain.

List all the assets owned by YOU and YOUR SPOUSE, with the values as of the date of application.

Description of Asset	Value of Asset
Land	
Checking	
Savings-Passbook	
Certificates of Deposit	
Pre-Paid Burial Accounts	
Stocks or Bond	
IRA’s or Annuities	
Life Insurance-Cash Surrender Value	
Home(s)	
Vehicles(s)	
Trusts (own or are a beneficiary of)	

List all debts owed by YOU and YOUR SPOUSE, with outstanding balance as of the date of application. This includes mortgages, credit cards, vehicles or personal loans.
Include any garnishments from Social Security or other income (tax lien, student loans, child support, etc.)

Description of Debt	Approximate Amount of Debt
Description of Debt	**Approximate Amount of Debt**

List all sources of income for YOU and YOUR SPOUSE, including but not limited to rental payments, CRP income, long term care insurance benefits, Social Security Benefits, Veteran Benefits, alimony, and employment income.

Type of Income or Other Money Received	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	**How Often Received**	**Amount**
Contract Sale or Rental Income		
Veteran's/Military Benefits		
Other: (list)		

This questionnaire complies with section 50-10.2-05 of the North Dakota Century Code. By my signature below, I hereby authorize the 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 facility. I also authorize the 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 the facility. I further authorize the 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: ____