Sanford Mid Dakota Care Center
300 S. Byron Blvd, Chamberlain, SD 57325
Phone: 605-234-6518

Application for Admission

***** IDENTIFYING INFORMATION *****

Name:	Phone:
Present Home Address:	
Present Living Arrangement	
Type of Admission Sought: LTC: Temporary Placement: Rehab: Other:	
Room Preference: Single: Double: Comments:	

***** SOCIAL INFORMATION *****

Birth date:	Birthplace:
Soc. Sec #:	Race:
Nationality:	Citizen of:
Primary Language:	Past Occupation:
Marital Status:	Date of Marriage:
Is Spouse Living:	Date of Death:
Spouse's Name:	Spouse's Occupation:
Father's Name:	Living/Deceased?
Mother's Maiden Name	Living/Deceased?
Religion:	Church Affiliation:

***** MEDICAL INFORMATION *****

Primary Attending Physician:	Alternate Physician:
Dentist:	Eye Doctor:
Hospital Preference:	Ambulance Preference:
Drugstore:	Allergies:
Are you a smoker? Yes: No:	Previous Admission Date:

Current Diagnosis (if known):

Briefly describe physical condition:

Briefly describe mental condition:

***** INSURANCE INFORMATION *****

Medicare: Part A Coverage: Part B Coverage:	Medicare #:
Other Hospital Insurance: Company:	Policy #:
Address:	Phone:
Long Term Care: Company:	Policy #:
Address:	Phone:

Sanford Mid Dakota Care Center
300 S. Byron Blvd, Chamberlain, SD 57325
Phone: 605-234-6518

Application for Admission

***** FINANCIAL AND BILLING INFORMATION *****

Payment Source: Private (Self) Pay: State Assistance (Medicaid/Title XIX): Other	
Medicaid #: Are you presently receiving SSI at home? Yes: No:	
Are you a veteran: Yes: No: Are you receiving any VA Benefits? Explain:	
Who will be physically paying the bill?	
Name:	Relationship
Address:	Phone:

***** LEGAL INFORMATION *****

Legal Guardian: Name:	Relationship:
Address:	Phone:
Power of Attorney: Name:	Relationship
Address:	Phone:
Does the POA cover Medical Care? Yes: No: (If so please attach copy)	
Have you every given an advanced directives (No use of life sustaining measures) to your physician, next of kin, medical facility, etc?	
Who do you want to help you with making any financial decisions? Name:	
Who do you want to help you with making any medical decisions? Name:	
Name of your Attorney:	

***** FINAL ARRANGEMENTS *****

Do you wish to be an organ donor? Yes: No:	Please specify:
Funeral Home:	Prepaid Burial: Yes: No:
Address	
Responsible Party:	Address

***** PERSONS TO CONTACT REGARDING THIS APPLICATION *****

Name:	Relationship:	
Address		Phone:
Name:	Relationship:	
Address		Phone:

Signature of Applicant

Signature of Person Assisting w/Application

Date

Date