

**SULLIVAN COUNTY HEALTH CARE  
APPLICATION FOR ADMISSION**

5 Nursing Home Drive, Unity, New Hampshire 03743 (603) 542-9511 ext. 292 FAX (603) 542-6020

**IN ORDER FOR US TO REVIEW THIS APPLICATION, IT MUST BE COMPLETED IN FULL  
PLEASE DO NOT LEAVE ANY BLANKS.  
MUST BE RETURNED WITHIN ONE WEEK OF ADMISSION**

Last		First		Middle Initial	Maiden Name
Address		City/State		Zip	Phone
City/Town of Residence		County		Where is the applicant now? If at home, do you have home health services?	
Date of Birth		Birthplace		US Citizen:	Yes      No
Social Security #:				Registered Voter?	Yes      No
Mother's full maiden name		Father's name		Date Naturalized	Place
Religion		Church/Minister		Languages spoken:	
Marital Status:			Spouse's Name		
Date of Marriage	Years of Marriage	Previous Marriages	Spouse's Address		
Primary Physician			Address/Phone		
Other Physicians seen:			Address/ Phone		

**CONTACTS: FAMILY / FRIENDS:** Please provide copies of power of attorney / guardianship upon admission

#1 Emergency Contact:	Mailing Address:	Home Phone:	Work or Cell Phone:
Relationship:			
#2 Emergency Contact:			
Relationship:			
#3 Emergency Contact:			
Relationship:			
Health Care Power of Attorney:			
Durable Power of Attorney ( financial):			
Guardian:      yes      no			

**Office Use ONLY: Primary Diagnosis:**

**ADVANCE DIRECTIVES:**

Check if you have executed these documents:

Please provide copies of your advanced directives upon admission.

- Living Will
- Do Not Resuscitate
- Do not hospitalize
- Intravenous Restrictions: \_\_\_\_\_
- Tube Feeding Restrictions: \_\_\_\_\_
- Medication Restrictions: \_\_\_\_\_
- Other Restrictions: \_\_\_\_\_

Funeral Home Name/Address/Phone	Prepaid Burial Contract:	Organ Donor	Y	N
	Yes                      No	Body Donor	Y	N
		Autopsy request	Y	N
	Cemetery:	Prepaid lot	Y	N

Please provide copies of all your insurance cards with this application.

Medicare #  Part A?    Y    N Effective date: Part B?    Y    N Effective date:	Have you ever used your Medicare benefit for skilled nursing home (snf) placement or rehabilitation?  Yes    No    Don't know	NH Medicaid # or date of application
Health Insurance Company/Address	Long Term Care Insurance Company/Address	Prescription Drug Insurance Company/Address
Policy #  Group #	Policy #  Group #	Policy #  Group #

Briefly explain why this application is being made. Comment on current illnesses, any hospitalizations, pertinent surgical procedures, etc.

Applicant's feelings about nursing home placement?



1.Has the applicant been hospitalized in the last 90 days? Dates?		
2.Has the applicant visited the emergency room without being admitted in the last 90 days? Dates?		
3.Does the applicant have any allergies? (Animals, grass, food, medicine, flowers, latex etc.)		
4a.Last eye exam?	4b. Last dental ex am?	
5.Has the person been evaluated by a mental health specialist in the past 90 days? Dates?		
6a.Last flu vaccine?	6b.Last pneumonia vaccine?	6c.Last Tetanus?

**APPLICANT'S CONFIDENTIAL FINANCIAL INFORMATION  
YOU MAY SUBSTITUTE THIS INFORMATION WITH A MEDICAID APPLICATION**

**List all income**

Social Security Amount \$ How paid:	Pension Amount \$ From Where: How paid:	Other Income \$ From Where: How paid:
Do you own your home?		
Do you own a business or farm?		
Do you have a will?		
Are any of your assets in a trust? Please list details.		
Do you have a financial manager? Please list Name, address and phone number		
Have you transferred any assets or property in the last five years? Please list details.		

<p>#1 Property type:</p> <p>Location:</p> <p>Value:</p> <p>Jointly owned?    Yes    No</p>	<p>#2 Savings Account:</p> <p>Bank:</p> <p>Account Number:</p> <p>Balance:</p> <p>Jointly owned?    Yes    No</p>	<p>#3 Checking Account</p> <p>Bank:</p> <p>Account Number:</p> <p>Balance:</p> <p>Jointly owned?    Yes    No</p>
<p>#1a Property type:</p> <p>Location:</p> <p>Value:</p> <p>Jointly owned?    Yes    No</p>	<p>#2a Savings Account:</p> <p>Bank:</p> <p>Account Number:</p> <p>Balance:</p> <p>Jointly owned?    Yes    No</p>	<p>#3a Checking Account</p> <p>Bank:</p> <p>Account Number:</p> <p>Balance:</p> <p>Jointly owned?    Yes    No</p>
<p>#4 Other accounts:</p> <p>Jointly owned?    Yes    N</p>	<p>#5 Investments (specify):</p> <p>Jointly owned?    Yes    No</p>	<p>#6 Life Insurance Face Value: Cash Value:</p> <p>Jointly owned?    Yes    No</p>
<p>#7 Other accounts:</p> <p>Jointly owned?    Yes    N</p>	<p>#8 Investments (specify):</p> <p>Jointly owned?    Yes    No</p>	<p>#9 Life Insurance Face Value: Cash Value:</p>
<p>Designate who is responsible for bills not covered by insurance:</p>		

**Authorization to Receive and Release Medical Information and to Clinically Assess Prospective Resident**

I, \_\_\_\_\_, authorize Sullivan County Nursing Home to evaluate this application, to receive medical and mental health records and information from any medical or mental health agent, medical or mental health facility, or physician and to release information to same, for purpose of review, as reasonably related to this application.

\_\_\_\_\_  
Signature of Applicant or POA

\_\_\_\_\_  
Date

Sullivan County Health Care bills private pay residents for the coming month. All bills should be paid by the end of the month that the bill is sent out.

Medicaid residents are required to pay their liability amount, determined by New Hampshire Medicaid, directly to Sullivan County Nursing Home. Anyone with less than \$2500 in personal assets MUST apply to the New Hampshire Medicaid program.

This admission packet includes an application, brochure, and pre-admission information letter. Further information regarding policies, resident's rights, and advance directives will be provided prior to or at the time of admission. Any questions regarding the admission process may be addressed to the Admission Coordinator at (603) 542-9511 ext: 292. A tour and informational meeting can be arranged by appointment.

**PLEASE BE ADVISED THAT IN THE EVENT PAYMENT IS NOT RECEIVED OR MEDICAID IS DENIED, SCHC RESERVES THE RIGHT TO LIEN ANY PROPERTY OWNED BY THE RESIDENT.**

Signature of Applicant	Date
If some other than applicant is completing the form, please sign and indicate relationship to the Application.  Relationship: _____ Are you the DPOA? _____	Date