Application for Admission

IN ORDER FOR US TO REVIEW THIS APPLICATION, IT MUST BE COMPLETED IN FULL. **Please do not leave any blanks**

5 Nursing Home Drive
Unity, NH 03743
P: (603) 542-9511
F: (603) 542-6020

Sullivan County Health Care

Last	First	Middle Initial	Maiden Name
Address	City/State	Zip Code	County
Date of Birth	Birthplace	Where is the applicant now? If at home, do you have home health services?	
Phone Number	Race	US Citizen: Yes No Registered Voter? Yes No Where: Would like to continue to vote: Yes No	
Social Security #	Hispanic or not Hispanic		
Mother's full maiden Name	Father's name	Date Naturalized	Place
Religion	Church	Languages spoken:	

Marital Status		Spouse's name	
Date of marriage	Years of Marriage / Previous Marriages	Spouse's Address	
Community Primary Physician		Address/Phone	
Community Dentist	Community Optometrist	Community Podiatrist	Community Psychiatrist

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

#1 Emergency Contact: Relationship:	Mailing Address:	Home Phone:	Work or Cell Phone:
#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 prior to 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: Yes No	Organ Donor Y N Body Donor Y N Autopsy request Y N
	Cemetery:	Prepaid lot Y N
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?		

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 #

APPLICANT'S CONFIDENTIAL FINANCIAL INFORMATION

List all income

Social Security Amount $ How paid:	Pension Amount $ From Where: How paid:	Other Income $ From Where: How paid:

Do you own: ☐ a home ☐ a business ☐ a farm

Are any of your assets in a trust? If yes, please list details.

_____
_____
_____
_____

Do you have a financial manager? If yes, please list Name, address and phone number.

Name: Address
Phone Number: City, State, Zip Code

Have you transferred any assets or property in the last five years? If yes, please list details.

_____
_____
_____

#1 Property type: Location: Value: Jointly owned? Yes No	#2 Savings Account: Bank: Account Number: Balance: Jointly owned? Yes No	#3 Checking Account Bank: Account Number: Balance: Jointly owned? Yes No
#1a Property type: Location: Value: Jointly owned? Yes No	#2a Savings Account: Bank: Account Number: Balance: Jointly owned? Yes No	#3a Checking Account Bank: Account Number: Balance: Jointly owned? Yes No
#4 Other accounts: Jointly owned? Yes N	#5 Investments (specify): Jointly owned? Yes No	#6 Life Insurance Face Value: Cash Value: Jointly owned? Yes No
#7Other accounts: Jointly owned? Yes N	#8 Investments (specify): Jointly owned? Yes No	#9 Life Insurance Face Value: Cash Value:

Designate who is responsible for bills not covered by insurance:

SOCIAL DATA: The following information will assist Sullivan County Health Care to meet the total needs of the resident.

Residential history of last 5 years: check all that apply ❑ Lived alone ❑ Home with family or caregivers ❑ Prior stay at this nursing home ❑ Another nursing home ❑ Residential facility (group home, assisted living) ❑ Psychiatric facility	Lifetime occupation: How many years:
Highest level of education: Where:	Other occupations held:

Did applicant serve Yes No in US Armed Forces?	Branch	Dates of service (mm/dd/yy) / / to / /	Final Rank
VA Number:	Type of Discharge:	Receiving VA Disability? Amount:	

What is the applicant's sleeping pattern?
Stays up late at night?
Restless?

Appetite/Special diet: Distinct food preferences? Snacks between meals?	Use of alcohol: Drugs: Tobacco:
Interests? Hobbies?	Likes to socialize? Has the applicant been involved in group activities? Or is a Loner?
Prefers baths or showers?	Does/ did applicant have a pet? What: Name:
Finds strength in spiritual/ religious faith? Attended church services regularly?	Where is the pet now?

Did the applicant have daily contact with relatives/ close friends?

Will he/she have regular visitors at Sullivan County Home?

Daily Care (please check off one to the best of your knowledge)	Independent	With Assist	Unable
Transfers bed to chair			
Walks			
Toileting			
Dressing			
Grooming/Hygiene			

Does applicant have any history of mental illness or mental retardation?	Is applicant combative, agitated, anxious?	Is applicant oriented, confused, forgetful?	Does applicant physically wander?

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?

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 Responsible Party **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 Department at (603) 542-9511 ext: 292. A tour and informational meeting can be arranged by appointment.

_____ _____

Applicant or Responsible Party Signature Date

If someone other than applicant is completing this form, please sign above and indicate relationship to the Applicant.

_____ _____

Relationship Are you the DPOA or Guardian