Coös County Nursing Home

PO Box 416
364 Cates Hill Road
Berlin, NH 03570
603-752-2343
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www.cooscountynh.us

Louise J. Belanger, RN, BS
Administrator

Candice Santy
Social Worker

Application for Admission

Background Information

Name:	Sex: ☐ M ☐ F	Age:	Date of Birth:
Address:		Place of Birth:	

Current Living Arrangement:

☐ Private Home/Apartment
☐ Supervised Living

Home Health Services – Specify Organization: _____
Nursing Home – Name of Facility :_____
Date Admitted:_____

Telephone:	Name of Father	Name of Mother (Maiden Name)

Marital Status ☐ S ☐ M ☐ W ☐ D ☐ Sep	Name of Spouse 1.	Date of Marriage	**Level of Education:** ☐ 8th grade or less ☐ 9-11 Grade ☐ High School ☐ Some College ☐ Bachelors ☐ Graduate
	2.		

Military Service/Branch	Occupation	Religious Preference	Church Affiliation

Advanced Directives: ☐ Living Will ☐ Durable Health Care Power of Attorney	Primary Language	**English Speaking Ability:** ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ None

Does Applicant have a Guardian (of Estate)
Name: _____
Address: _____
Tel # (work) _____ (Home) _____

Does Applicant have a Guardian (over person)
Name: _____
Address: _____
Tel # (work) _____ (Home) _____

Does Applicant have a Durable Power of Attorney for Finances
Name: _____
Address: _____
Tel # (work) _____ (Home) _____

Does Applicant have a Durable Health Care Power of Attorney
Name: _____
Address: _____
Tel # (work) _____ (Home) _____

Has Durable Power of Attorney for Health Care been activated by a physician? ☐ Yes ☐ No

When a Durable Health Care Power of Attorney for Health has been Activated, a physician has determined that this person is no longer of competent mind to make safe decisions for him/her self.

OTHER RELATIVES

Relationship	Name	Address	Telephone Home	Telephone Work

Medical Information

Physician / Telephone Number:	Last Office Visit:	Last Hospitalization:

Present Illness/Diagnoses: _____

_____

_____

_____

Surgical Procedures and Dates of Surgery: _____

_____

_____

Reason for Nursing Home Placement: _____

_____

_____

Was Applicant involved with decision of Nursing Home placement? ☐ Yes ☐ No

Does Applicant have a history of mental illness / mental retardation? ☐ Yes ☐ No

If yes, please explain: _____

Height	Weight	Last Flu Shot	Last Pneumonia vaccine	Last PPD (tuberculin test)	Last Tetanus Shot

Allergies _____

Medications:

Medication	Dosage	Medication	Dosage

Is the Applicant able to set up and administer his / her own medication without assistance or supervision? ☐ Yes ☐ N o

If No, who sets up medication for Applicant? ☐ Caregiver ☐ Professional ☐ Other

Does someone other than the applicant administer the Medication? ☐ Yes ☐ N o

Is there concern that the applicant is (check all that apply)

☐ Not taking medication on time
☐ Refusing to take medication
☐ Not taking the proper medication
☐ Forgetting to take medication
☐ Affected by side-effects

Treatments (current or past history of)

☐ Alcohol / Drug Treatment Program
☐ Pain Management
☐ Medical Monitoring (blood pressure)
☐ Chemotherapy
☐ Respirator
☐ Other – Specify:
☐ Radiation Therapy
☐ Tracheotomy Care
☐ Dialysis
☐ Respiratory Therapy (Oxygen)
☐ IV Medication
☐ PT / OT Services

FUNCTIONAL STATUS

Activities of Daily Living

IN THE FOLLOWING SECTION, INDICATE THE TYPE OF ASSISTANCE REQUIRED BY THE APPLICANT FOR EACH ACTIVITY

1. **Dressing and Undressing:**
How is the applicant able to manage dressing? This includes laying out clothes and putting them on, including shoes.

☐ Needs no help at all
☐ Needs a lot of physical help
☐ Needs supervision or reminding
☐ Needs some physical help
☐ Needs someone else to perform the complete task
☐ Prefers to be in bedclothes most of the day

2.. **Bathing**

☐ Needs no help at all
☐ Needs a lot of physical help
☐ Needs supervision or reminding
☐ Needs some physical help
☐ Needs someone else to perform the complete task
☐ Prefers a bath

3. **Grooming / Routine Hair and Skin Care**
How well is the applicant able to manage activities like combing hair, putting on makeup or shaving and brushing teeth?

☐ Needs no help at all
☐ Needs a lot of physical help
☐ Needs supervision or reminding
☐ Glasses/Contacts
☐ Needs some physical help
☐ Needs someone else to perform the complete task
☐ Dentures ☐ Upper ☐ Lower

4. **Bed Mobility**
How well can the applicant manage sitting up or moving around in bed?

☐ Needs no help at all
☐ Needs a lot of physical help
☐ Needs supervision or reminding
☐ Needs some physical help
☐ Needs someone else to perform the complete task
☐ Needs Bed-Rails

5. **Transferring**
How well the applicant can move in and out of bed or chair?

☐ Needs no help at all
☐ Needs a lot of physical help
☐ Needs supervision or reminding
☐ Needs some physical help
☐ Needs someone else to perform the complete task

6a. **Mobility**
How well the applicant moves around the house, whether or not they use a cane, walker, or wheelchair (not including climbing stairs).

☐ Needs no help at all
☐ Needs a lot of physical help
☐ Needs supervision or reminding
☐ Needs some physical help
☐ Needs someone else to perform the complete task

6b. **Adaptive Devices**

☐ Cane ☐ Walker ☐ Crutches ☐ Wheelchair ☐ Brace

7. **Skin Treatments**

☐ Prone to reddened areas
☐ Prone to breakdown of skin
☐ Has a physician prescribed medication?
☐ Has a skin wound / skin ulcer at this time?
Where? _____

8a. **Eating**
How well the applicant manages eating on his or her own. This means drinking and eating, including cutting food without help from anyone.

☐ Needs no help at all
☐ Needs a lot of physical help
☐ Needs supervision or reminding
☐ Needs some physical help
☐ Problem with following diet
☐ Needs someone else to perform the complete task
☐ Needs adaptive devices

8b. **Eating Habits**

DOES THE APPLICANT EAT

☐ Regular food ☐ A Diabetic Diet
☐ Soft food ☐ No Salt Diet

DOES THE APPLICANT

☐ Have recent weight loss ☐ Have distinct food preferences
☐ Eat between meals ☐ Use alcoholic beverages

Activities of Daily Living - continued

9. **Sleeping Habits**

- ☐ Sleeps all night
- ☐ Awakens often
- ☐ Wanders around in the home at night
- ☐ Wanders away from the home at night
- ☐ Retires at _____ p.m.
- ☐ Naps during the day
- ☐ Needs medication to sleep

10. **Resists help with daily activities (bathing, dressing, eating)**

- ☐ Never
- ☐ Resists help rarely
- ☐ Resists help several times weekly
- ☐ Resists help several times daily

11. **Repeatedly asks the same question or makes the same statement**

- ☐ Never
- ☐ Less than once a day
- ☐ More than once a day
- ☐ Every hour or more than 10 times daily

12. **Physically aggressive (hits others / swings at others: pushes others away when they try to assist with personal care or other occasions**

- ☐ Does none of the above
- ☐ Hits others / swings at others more than once a day
- ☐ Pushes others away when they try to dress, feed, or bathe, more than once a week.

13 **Customary routine for past year at home or in other facility** **(**CCNH is a NON-Smoking facility**)**

- ☐ Stays up late at night (after 9 p.m.)
- ☐ Goes out 1+ days a week
- ☐ Stays busy with hobbies, reading and regular routine
- ☐ Spends most of the time alone, watching TV
- ☐ Use of tobacco products daily
- ☐ Use of alcohol
- ☐ Wanders away from the home
- ☐ Moves independently indoors with appliance if necessary

Hobbies and other interests: _____

_____

Financial / Insurance Information

Financial information requested below is required on all residents for the purpose of the Medicaid Pre-Screening Program. Failure to complete this section may jeopardize assistance in the future from Medicaid.

Social Security #	Medicare #:	☐ Part A- Effective date: _____ ☐ Part B- Effective date: _____	
Medicaid #	Date of application for Medicaid (if pending)	Medicare D Plan (Pharmacy Program)	Medicare D ID#
Please bring insurance cards in for copying front and back of cards. If agreeable, cards may be kept on file in business office, after admission to nursing home.			Medicare D Effective Date:
Other Health Insurance / Nursing Home Insurance:	Policy #	Group #	Is this also prescription coverage? ☐ Yes ☐ No

Financial Assets (Cash Value)

Social Security: _____ Pensions, VA, Railroad, etc. _____

Life Insurance Policies _____ Cash, Bonds, CD's, Annuities _____

Savings Account _____ Checking Account _____

Real Estate (assessed value) Does Applicant own other real estate? ☐ Yes ☐ No

Does Applicant receive rental income? ☐ Yes ☐ No If yes, amount: _____

Does Applicant have Prepaid Burial Arrangements? ☐ Yes ☐ No

If yes, Where: _____