Coös County Nursing Hospital
P.O. Box 10
West Stewartstown, NH
(603) 246-3321 / Fax (603) 246-8117

Application for Admission

Applicant Name: _____ Date: _____

Present Address: _____ Sex: ☐ Male or ☐ Female

Phone Number: _____ Primary Language: ☐ English ☐ French ☐ Spanish ☐ Other:

Age: _____ Birth Date: _____ Place of Birth: _____ US Citizen: ☐ YES or ☐ NO

Social Security #: _____-_____-_____ Previous Occupation: _____

Military Service: ☐ NO ☐ YES: Branch: _____ Year(s) Served: _____

Father's Name: _____ Mother's Maiden Name: _____

Reason For Admission: _____

Primary Care Physician: _____ Phone Number: _____

Address: _____

Last Hospitalization at : _____ Admission Date: _____ Discharge Date: _____

Pending Medical Appointments: _____

Health Care: ☐ DPOAH (Health Agent) **OR** GUARDIAN: ☐ over Person (Health) ☐ over Estate (Finances)

Name: _____ Relationship: _____

Address: _____

Home Phone Number: _____ Work/Cell: _____

Email Address: _____ ***~Please provide copies of any legal documents~***

Responsible Party for Finances: ☐ DPOA (Financial) OR ☐ Party to assist with Finances/Medicaid Application

Name: _____ Relationship: _____
Address: _____

Home Phone Number: _____ Work/Cell: _____

Email Address: _____ ***~Please provide copies of any legal documents~***

Please list Concerned Relatives:

Name / Relationship	Address	Phone Number
_____	_____	_____

_____	_____	_____
_____	_____	_____

Race / Ethnicity: *(Check only one)*

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian / Pacific Island
- ☐ Unable to determine / unknown
- ☐ White

Customary Routine for the Past at Home or Year Prior to Admission to Health Care Facility: *(Check ALL that apply)*

- ☐ Stays up late at night (e.g., after 9 pm)
- ☐ Naps regularly during day (at least 1 hour)
- ☐ Goes out 1+ days a week
- ☐ Stays busy with hobbies, reading, or daily routine
- ☐ Spends most of time alone or watching TV
- ☐ Moves independently indoors (with appliances, if used)
- ☐ None of above

Education: *(Highest Level Completed)*

- ☐ No schooling
- ☐ 8th grade/less
- ☐ 9-11 grades
- ☐ High school
- ☐ Technical or trade school
- ☐ Some college
- ☐ Bachelor's degree
- ☐ Graduate degree

Behavior: *(Check ALL that apply)*

- ☐ Sleeps all night
- ☐ Awakens often during the night
- ☐ Medications for sleep:
- ☐ Anxious
- ☐ Alert
- ☐ Wanders
- ☐ Confused
- ☐ Noisy
- ☐ Other: _____
- ☐ Quiet
- ☐ Fearful
- ☐ Cooperative
- ☐ Friendly
- ☐ Belligerent

Marital Status: *(Check only one)*

- ☐ Divorced
- ☐ Life Partner (Partner's name: _____)
- ☐ Married (Spouse's name: _____)
- ☐ Never Married
- ☐ Separated
- ☐ Single
- ☐ Widowed

Involvement Patterns: *(Check ALL that apply)*

- ☐ Daily contact with relative/close friends
- ☐ Usually attends church, temple, synagogue (etc.)
- ☐ Finds strength in faith
- ☐ Daily animal companion/presence
- ☐ Involved in group activities
- ☐ None of above

Other Information: *(Check ALL that apply)*

- ☐ Glasses
- ☐ Contacts
- ☐ Cataracts
- ☐ Lens implants
- ☐ Macular degeneration
- ☐ Artificial Eye L or R

Dentures:
☐ Upper ☐ Lower ☐ BOTH

Hearing aids:
☐ Right ☐ Left ☐ BOTH

Height: _____ Weight: _____

Life Style Patterns: *(Check ALL that apply)*

- ☐ History of falls
- ☐ Falls in the past month
- ☐ Falls in the past 2-6 months
- ☐ Falls resulting in fractures within the past 6 months
- ☐ Wakens to toilet all or most nights
- ☐ Has irregular bowel movement pattern
- ☐ Use of alcoholic beverage(s) at least weekly
- ☐ Use of tobacco products in the past*

*Date quit: _____

***CCNH is a non-smoking facility.**

Financial Information

The financial information requested below is required on all residents for the purpose of the Medicaid Pre-Screening Program. Please attach a copy of all cards such as: Social Security, Medicare, Medicaid, Medicare Part D or Other Insurance. Failure to complete this section may jeopardize assistance in the future for Medicaid. *The financial information provided is confidential.*

MEDICARE Information:	MEDICAID Information:
Medicare Number: _____-_____-_____ _____ ☐ Part A Effective Date: _____ ☐ Part B Effective Date: _____ Medicare D Plan: ☐ NO or ☐ Yes (please complete the box below)	Medicaid Number: _____ _____ State: ☐ NH ☐ VT Pending: ☐ NO or ☐ YES Date of Application for Medicaid: _____ Managed Medicaid Provider: (if applicable) ☐ NH Healthy Families ☐ WellSense
MEDICARE Part D: Prescription Drug Coverage Company Name: _____ Plan Name: _____ Effective Date: _____	Other Health Insurance: Insurance Name: _____ Policy Number: _____ Group Number: _____ Is there prescription coverage? ☐ Yes or NO ☐
Nursing Home Insurance: NO ☐ or ☐ Yes Name of Insurance: _____	
Life Insurance Policy: NO ☐ or ☐ Yes Cash/Face Value: _____	
Funeral Arrangements Funeral Home: Jenkins Phone Number: _____ Address: _____ Amount of Irrevocable Trust: _____	

Income/Resources

Retirement/Disability Benefits	Yes	No	Claim Number	Amount
Social Security (SSA)	☐	☐		
Supplemental Security Income	☐	☐		
Veteran's Benefits (VA)	☐	☐		
Military Retirement Pension	☐	☐		
Railroad Retirement	☐	☐		
Other Pensions/Disability/Retirement	☐	☐		
Other Pensions/Disability/Retirement	☐	☐		

Financial Assets (Cash Value) Please Complete

☐ Checking Account ☐ Savings Account ☐ Savings Certificates, CDs ☐ Stocks, Shares

☐ Bonds ☐ Trust Bank Account ☐ Retirement (IRA) ☐ Annuities

Type of Resource	*Names on Account*	*Amount*	*Account# or Certificate#*	*Bank/Financial Institution*

Have you transferred or given away any property or money valued at $500.00 or more over the past 5 years: including Real-estate, vehicles, cash etc.? ☐ NO or ☐ Yes: Please describe: _____

_____

Any other financial information for consideration: _____

_____

Real Estate Information

Location of Real Estate: _____ Assessed Value: _____

Name(s) on Deed of Property: _____

Is property for sale? ☐ No or ☐ Yes: Listing Agent: _____

Other real estate?

☐ No or ☐ Yes: location_____ Assessed Value: _____

Name(s) on Deed of Property: _____

Is property for sale? ☐ No or ☐ Yes: Listing Agent: _____

Additional Properties: _____

I certify, under penalty of perjury, that I have reviewed this information; it is true and complete to the best of my knowledge, including the information concerning citizenship and alien status. I understand that misrepresentation of

the above information or failure to answer all the questions relative to Finances, Assets, etc., will constitute cause for rejection of this application or for discharge from Coös County Nursing Hospital.

Signature: _____ Date: _____
(Applicant or Responsible Party)

Please include the following copies: ☐ Social Security Card ☐ Medicare Card ☐ Medicare Part D Card
☐ Medicaid Card ☐ Other Insurance Cards ☐ Living Will ☐ DPOAH/DPOA/Guardianship papers
☐ VISA/Citizenship Card

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ACKNOWLEDGEMENT REGARDING FINANCIAL RESPONSIBILITY

Applicant Name: ____

1. All resources owned, controlled, or attributable to the person being admitted under this agreement shall be used for payment of nursing home services. This includes Social Security, Pension payments, and Annuities, all of which are to be used for payment of services in addition to Medicaid and/or other payment sources.

2. It is the policy of Coös County Nursing Hospital that Private Pay residents pay their Coös County Nursing Hospital bills on or before the day they are admitted.

3. The agent, representative, attorney-in-fact, fiduciary, or family member of the person being admitted under this agreement is not personally responsible for the cost of care of that person under normal circumstances. However, if that representative party fails to file for Medicaid assistance and/or fails to cooperate with the Medicaid application process, he/she may be found personally liable for the cost of the nursing home care.

4. The agent, representative, attorney-in-fact, fiduciary, or family member of the person being admitted under this agreement must fully and completely disclose the nature and extent of all financial resources for the 5-year period prior to admission and at any time such information is requested by the nursing home.

5. Medicaid regulations prohibit the transfer of money or assets in order to qualify for state medical assistance (Medicaid). Such transfers within a five-year period prior to admission may make the resident ineligible for Medicaid assistance. In such case, the resident is required to pay privately until he/she becomes eligible for Medicaid.

6. If there is a community spouse, the agent, representative, attorney-in-fact, fiduciary, or family member must arrange for a Resource Assessment to be completed by the Medicaid Fiscal Services regardless of payer source. This resource Assessment must be completed within 30 days of admission to the nursing home.

7. Private Pay customers are subject to any and all collection efforts provided by law for collection of fees for services rendered.

I acknowledge that I have reviewed and understand all the above information, and that Coös County Nursing Hospital will be sharing this information with the party identified in the Admission Application as assisting the resident with his/her finances.

_____ _____

Applicant Signature Date

Financial/Responsible Party Signature Date

Print Applicant Name

Print Responsible Party Name