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: ____________________ Religion: ____________

Father's Name: ____________________ Mother's Maiden Name: ____________________

Reason For Admission: ____

Present Physician: ______________________________ Phone Number: ____________________

Address: ____

Last Hospitalization at: ____________________ Admission Date: _________ Discharge Date: _________

Pending Medical Appointments:

Health Care Agent or Guardian

Name: ______________________________ ☐ DPOAH ☐ GUARDIAN (court appointed)
(Relationship) (Health Agent)

Address: ____

Home Phone Number: ____________________ Work/Cell: ____________________

Email Address: ____________________ May we email you: ☐ YES or ☐ NO

Responsible Party for Finances

Name: ______________________________ ☐ DPOA ☐ Guardian over Estate ☐ Same as Above
(Relationship)

Address: ____

Home Phone Number: ____________________ Work/Cell: ____________________

Email Address: ____________________ May we email you: ☐ YES or ☐ NO

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	☐ Quiet
☐ Alert	☐ Fearful
☐ Wanders	☐ Cooperative
☐ Confused	☐ Friendly
☐ Noisy	☐ Belligerent

- ☐ Other:___________________________

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: ________-_____-__________ ____	Medicaid Number:_________________________ ___
☐ Part A Effective Date: __________________ ☐ Part B Effective Date: __________________	State: ☐ NH ☐ VT ☐ Other:_____________ Pending: ☐ YES or ☐ NO
Medicare D Plan: ☐ NO or ☐ Yes (please complete the box below)	Date of Application for Medicaid:__________________
MEDICARE Part D: Prescription Drug Coverage	Other Health Insurance:
Company Name:____________________________________	Insurance Name:__________________________________
Plan Name: ____	Policy Number:___________________________________
Effective Date: ________________________	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:____ 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				

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? _________ Listing Agent:____

Other real estate?

☐ No or ☐ Yes: location_____________________________ Assessed Value:______________

Name(s) on Deed of Property:____

Is property for sale? _________ Listing Agent:____

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