



**Grafton County Nursing Home**  
**RESIDENT ADMISSION APPLICATION**

3855 Dartmouth College Highway \* North Haverhill, NH 03774 - 4909  
Phone: 603.787.6971 FAX: 603.787.2035

Date of application \_\_\_\_\_

Name: \_\_\_\_\_  
(Last) (First) (Middle)

**GENERAL INFORMATION**

Sex: M F DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Prefers to be called: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: H: \_\_\_\_\_ C: \_\_\_\_\_ County: \_\_\_\_\_

Birthplace: \_\_\_\_\_ SS #: \_\_\_\_\_

Religion: \_\_\_\_\_ Citizen: Y N Nationality: \_\_\_\_\_

Military service: Y N Branch of service: \_\_\_\_\_

Primary language: \_\_\_\_\_ Previous occupation: \_\_\_\_\_

Education level (*last grade completed*): \_\_\_\_\_

**PHYSICIAN / MEDICAL INFORMATION**

Resident's choice of physician at GCNH: \_\_\_\_\_

Primary community care physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Have there been any home health or community services involved? Y N If yes, please explain:

\_\_\_\_\_

Has the prospective resident been in a nursing home or used any skilled care in the past year?

Y N If yes, explain: \_\_\_\_\_

Allergies: Y N If yes, please list: \_\_\_\_\_

Intolerance to medication(s)/food(s): Y N If yes, please list below:

\_\_\_\_\_

Date of last flu shot: \_\_\_\_\_ Date of Pneumovax (*pneumococcal pneumonia*): \_\_\_\_\_

History of positive tuberculin skin test: Y N

Have you received the COVID -19 Vaccine? Y N If yes, which vaccine did you receive? \_\_\_\_\_

**RESIDENT'S FAMILY**

Marital status: \_\_\_\_\_ Date of marriage: \_\_\_\_\_

Spouse's name: \_\_\_\_\_ If spouse is deceased, date of expiration: \_\_\_\_\_

Number of siblings: \_\_\_\_\_ Number of children: \_\_\_\_\_ Number of grandchildren: \_\_\_\_\_

**CONTACT INFORMATION**

*FIRST CONTACT: name & address*

\_\_\_\_\_  
\_\_\_\_\_  
Relationship: \_\_\_\_\_  
Home #: \_\_\_\_\_  
Work #: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Cell #: \_\_\_\_\_

*SECOND CONTACT: name & address*

\_\_\_\_\_  
\_\_\_\_\_  
Relationship: \_\_\_\_\_  
Home #: \_\_\_\_\_  
Work #: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Cell #: \_\_\_\_\_

*THIRD CONTACT: name & address*

\_\_\_\_\_  
\_\_\_\_\_  
Relationship: \_\_\_\_\_  
Home #: \_\_\_\_\_  
Work #: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Cell #: \_\_\_\_\_

**RESIDENT’S INTERESTS**

Special interests (*past & present*):

\_\_\_\_\_  
Community involvement (*clubs/organizations, church, volunteerism*):

**LEGAL REPRESENTATION**    \*\* Please provide copy of documents (POA - Power of Attorney)

POA for healthcare: Y N    POA for finances: Y N    Organ donor: Y N  
Guardianship: Y N    Living Will: Y N    Autopsy: Y N

**PAYMENT / INSURANCE INFORMATION**    \*\* Please provide copies of insurance cards

Private pay: Y N  
Medicaid: Y N    Medicaid #: \_\_\_\_\_    Effective date: \_\_\_\_\_  
Medicare: Y N    Medicare #: \_\_\_\_\_    Effective date: \_\_\_\_\_  
Other medical insurance: Y N    Policy holder: \_\_\_\_\_  
\* Name of Insurance: \_\_\_\_\_    Insurance #: \_\_\_\_\_  
Long Term Care insurance: Y N  
Prescription Drug Plan: Y N    If yes, explain: \_\_\_\_\_

**INCOME & OTHER INFORMATION**

**PLEASE NOTE: THIS INFORMATION MUST BE COMPLETED PRIOR TO ADMISSION**  
The following information is required in order to determine if you are eligible to apply for  
Medicaid benefits now or in the future

Social Security income: \$ \_\_\_\_\_ Retirement income: \$ \_\_\_\_\_ Other income: \$ \_\_\_\_\_

Checking account: Y N Account balance \$ \_\_\_\_\_

Bank: \_\_\_\_\_

Savings account: Y N Account balance \$ \_\_\_\_\_

Bank: \_\_\_\_\_

Life insurance company: \_\_\_\_\_

Amount of cash value: \$ \_\_\_\_\_

List property owned: \_\_\_\_\_

Have you transferred, sold, or given away property or monetary assets (\$500 or more) in the last 5 years?

Y N If yes, explain: \_\_\_\_\_

Other assets(examples include: stocks, IRA, 401K, bonds, mutual funds, CDs, trusts, annuity): \_\_\_\_\_

**BILLING INFORMATION**

Please send bills to:

\_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_ Cell #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_ Work #: \_\_\_\_\_

**FUNERAL SERVICES**

Funeral Home preference: \_\_\_\_\_ Prepaid: Y N

Location: \_\_\_\_\_ Phone #: \_\_\_\_\_

**I UNDERSTAND THAT MISREPRESENTATION OF THE ABOVE INFORMATION OR FAILURE TO ANSWER ALL THE QUESTIONS RELATIVE TO FINANCES, ASSETS, ETC., WILL CONSTITUTE CAUSE OF REJECTION OF THIS APPLICATION OR DISCHARGE FROM GRAFTON COUNTY NURSING HOME.**

\_\_\_\_\_  
Signature of Applicant or Responsible Party

\_\_\_\_\_  
Date

REV: 03/08/22

**If you have questions, please contact JESSICA KAMINSKI,  
Social Service Director, at (603) 787-6971, EXT 4008**