Grafton County Nursing Home
3855 Dartmouth College Highway * North Haverhill, NH 03774 - 4909
Phone: 603.787.6971 FAX: 603.787.2035

RESIDENT ADMISSION APPLICATION

Date of application _____

Name: _____ _____ _____
(Last) *(First)* *(Middle)*

GENERAL INFORMATION

Sex: ❑ M ❑ F DOB: _____ Age: _____ Prefers to be called: _____
Address: _____
Phone number: _____ County: _____
Birthplace: _____ SS #: _____
Religion: _____ Citizen: ❑ Y ❑ N Nationality: _____
Military service: ❑ Y ❑ N Branch of service: _____
Primary language: _____ Previous occupation: _____
Education level (*last grade completed*): _____ Does applicant live alone? ❑ Y ❑ N If no, who does applicant currently live with? _____

PHYSICIAN / MEDICAL INFORMATION

Medical Providers: Lili Cargill, APRN
Primary community care physician: _____ Phone #: _____
Have there been any home health or community services involved? ❑ Y ❑ N If yes, 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: _____
_____
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

Has DPOA for healthcare been activated/invoked? ❑ 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: $_____ If no cash value, what is the face value? _____
Who is listed as the beneficiary? _____
Are there any current promissory notes? ❑ Y ❑ N If yes, to whom and what is their contact information? ____
_____
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 #: _____
_____ 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
Phone Number(s): **H**: ( ) _____-_____ **C:** ( ) _____-_____ **W:** ( ) _____-_____
REV: 09/17/24

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