

FOR OFFICE USE ONLY

Contact Date _____ Type of Admission Sought _____ Type of Residence _____
Arrival Time _____ M P S _____ Acct # _____
Date of Admit _____ Admitted From _____ Floor _____ Room _____

MERRIMACK COUNTY NURSING HOME
APPLICANT'S PERSONAL & FAMILY INFORMATION

_____ MALE/FEMALE
FIRST NAME MIDDLE INITIAL LAST NAME (Circle One)

SOCIAL SECURITY # _____ MEDICARE # _____

A _____ B _____
MED D PRESCRIPTION PLAN _____ MED D # _____

MEDICAID # _____ VA FILE # _____

OTHER HEALTH INSURANCE # _____

PERMANENT ADDRESS _____

LENGTH OF TIME AT THIS ADDRESS _____

WHO RESIDES WITH APPLICANT? _____ LENGTH OF STAY _____

APPLICANT'S PRIOR ADDRESS _____

LENGTH OF TIME AT THIS ADDRESS _____

DATE OF BIRTH _____ AGE _____ BIRTHPLACE _____
Month/Day/Year

MARITAL STATUS: NEVER MARRIED MARRIED SEPARATED DIVORCED WIDOWED
(Circle One)

CITIZEN OF U.S. YES NO

VETERAN STATUS YES NO MILITARY BRANCH _____

RELIGION _____ CHURCH/LOCATION _____

PASTOR'S NAME/ADDRESS/TEL _____

RACE: _____ LANGUAGES SPOKEN/UNDERSTOOD _____
(Caucasian, African American, Hispanic, Oriental, East Indian, Other)

EDUCATION(HIGHEST LEVEL COMPLETED): _____ PREVIOUS OCCUPATION: _____

NAME OF SPOUSE (MAIDEN NAME OF WIFE): _____

FIRST CONTACT PERSON (Circle one if applicable & provide copy of document)
POWER OF ATTORNEY ~ FINANCIAL OR MEDICAL, GUARDIAN ~ PERSON OR ESTATE

NAME _____ DAY TELEPHONE # _____

STREET _____ CELL # _____

EVENING TELEPHONE # _____

CITY _____ EMail Address _____

Relationship to Applicant _____

SECOND CONTACT PERSON (Circle one if applicable & provide copy of document)

POWER OF ATTORNEY ~ FINANCIAL OR MEDICAL, GUARDIAN ~ PERSON OR ESTATE

NAME _____ DAY TELEPHONE # _____
CELL # _____
STREET _____ EVENING TELEPHONE # _____
Email Address _____
CITY _____ Relationship to Applicant _____

THIRD CONTACT PERSON

NAME _____ DAY TELEPHONE # _____
CELL # _____
STREET _____ EVENING TELEPHONE # _____
Email Address _____
CITY _____ Relationship to Applicant _____

HEALTH CARE PROVIDERS WITH WHOM APPLICANT IS ESTABLISHED:

REFERRING PHYSICIAN'S NAME	ADDRESS	DATE OF LAST VISIT
MENTAL HEALTH	ADDRESS	DATE OF LAST VISIT
DENTIST	ADDRESS	DATE OF LAST VISIT
OPTOMETRIST/OPHTHAMOLOGIST	ADDRESS	DATE OF LAST VISIT
HOSPITAL	ADDRESS	DATE OF LAST VISIT

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

Name of Hospital you prefer for Treatment _____
(In the event of an emergency, residents will be taken to the nearest facility.)

Funeral Home you prefer us to call in the event of death _____

Please indicate if you have a pre-paid/pre-arranged burial contract and supply us with a copy of the document _____

Name/Location of Family Burial Lot _____

Name of Person completing this information _____

Relationship to applicant _____

Application Date _____