Merrimack County New Hampshire

Nursing Home / Assisted Living

Thank you for your interest in Merrimack County Nursing Home. Please complete the admission application and medical records release included in this document. For us to complete a proper evaluation, all questions must be answered to the best of your ability, especially those pertaining to financial assets. Please review the list below and email, fax or mail copies of the required documentation to:

Admissions Fax: 603-796-2880

Email: jstevens@mcnhome.net
lgattermann@mcnhome.net

Mailing Address:
Merrimack County Nursing Home
Attn: Admissions
325 Daniel Webster Highway
Boscawen, NH 03303

Required Documentation with Application:

- Birth Certificate
- Authorization to use and/or Disclose Health Information (included in this document).
  - This must be signed by the Applicant or if Durable Power of Attorney (DPOA) has been Activated/Invoked, by the Legal Representative of the Applicant.
- Insurance Cards: Medicare, Medicaid Card (NH Health Families, Wellsense, ETC.) Supplemental, Private Insurance, Prescription Plan
- Social Security Card/Annual Social Security Award Letter
- Covid Vaccination Card
- Life Insurance Policy (if applicable)
- Durable Power of Attorney (DPOA) Healthcare & Financial, Living Will, and/or Guardianship papers
  - If Applicable: Medical Provider's letter stating that DPOA has been Activated/Invoked Current
- Bank Statements (6 mos.) & Current Pension Stub
- Trust, Real Estate & Other Financial Asset Information + Statements
- Pre-paid Burial/Funeral documents/Agreements
- Organ Donor Card, Pacemaker ID, Hearing Aid Prescription and Lens Implant Card
- DHHS Release Form (included in this document)
  - **Fill out only if:** NH Medicaid is in place or is in the process of being applied for. This must be signed by the Applicant or if Durable Power of Attorney (DPOA) has been Activated/Invoked, by the Legal Representative of the Applicant.

Please Note: you will not be added to our wait list until:

1. Application is received without omissions

2. All required documentation noted above is received.

Should you have any questions regarding the application process, forms, or questions about the facility, please do not hesitate to contact the admissions office for assistance.

Thank You,
The Long-Term Care Admissions Team

Merrimack County
New Hampshire

Nursing Home / Assisted Living

ADMISSION APPLICATION

☐ **Assisted Living** ☐ **Long Term Care**

Applicant's Name: _____

Primary Address: _____

Does applicant Live Alone? ☐ Yes ☐ No Does Applicant Live with Others? ☐ Yes ☐ No

Current Location: ☐ Hospital ☐ Home ☐ Other _____ If Yes, Who: _____

Home Phone: _____ Mobile Phone: _____

Email: _____

Other Address (if living with someone): _____

Hospital/Rehab Hospital being referred by: _____

Telephone No./Social Worker @ Hospital: _____

Personal Information of Applicant:

☐ **Male** ☐ **Female** **DOB:** _____ **Social Security Number:** _____

Military Service? ☐ Yes ☐ No Military Branch: _____

US Citizen: ☐ Yes ☐ No Place of Birth: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Never Married

If Applicable:

Spouse Name: _____ Date of Marriage: _____

Divorce (Date): _____ Widowed (date): _____

Primary Language:

☐ English ☐ Other: _____

Special Language Needs Required: _____

Contact Person Regarding this Application:

Name: _____ Relationship: _____

Address: _____

_____

Home Phone: _____ Mobile Phone: _____

Email: _____

2nd Contact: _____ Relationship: _____

Address: _____

_____

Home Phone: _____ Mobile Phone: _____

Email: _____

Guardianship/Durable Power of Attorney

Legal Guardianship: ☐ No ☐ Yes:

☐ of Person: Guardian Name:_____ Relationship:_____

Home Phone:_____ Mobile Phone:_____

☐ of Estate: Guardian Name:_____ Relationship:_____

Home Phone:_____ Mobile Phone:_____

Durable POA (Health) ☐ No ☐ Yes: Name:_____ Relationship:_____

Home Phone:_____ Mobile Phone:_____

Durable POA (Finance) ☐ No ☐ Yes: Name:_____ Relationship:_____

Home Phone:_____ Mobile Phone:_____

Is DPOA Healthcare activated/invoked? ☐ Yes ☐ No

Activation letter required from medical professional if activated/invoked

Copies of these document(s) required if applicable

Advanced Directives/Advanced Care Planning:

Living Will ☐ Yes ☐ No

Do Not Resuscitate ☐ Yes ☐ No

PORT/POLST ☐ Yes ☐ No

Do Not Hospitalize ☐ Yes ☐ No

Organ Donor ☐ Yes ☐ No

Prepaid Funeral/Burial ☐ Yes ☐ No

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

Copies of these document(s) required if applicable

NH Medicaid:

Have you applied for NH Medicaid for Community Services (CFI) and/or Nursing Home Benefits?

☐ **No** ☐ **Yes:** MID#:_____

Re-Determination Date:_____

Case Manager:_____ Phone:_____

Email:_____

Payment Source for Assisted Living or Nursing Home Stay:

Private Funds ☐ Yes ☐ No

NH Medicaid ☐ No ☐ Yes: MID#:_____

Long Term Care Insurance ☐ No ☐ Yes: Policy #:_____

Long Term Care Insurance Company Name:_____

Address:_____

Phone#:_____

Insurance Information:

Private Funds: ☐ No ☐ Yes

NH Medicaid: ☐ No ☐ Yes MID#:_____

Case Manager:_____ Phone#:_____

Email:_____

Medicare: ☐ No ☐ Yes: MBI#:_____

Medicare Replacement (Medicare Advantage Plan): ☐ No ☐ Yes:

Medicare Replacement Company:_____

Medicare Replacement Policy#:_____

VA Benefit: ☐ No ☐ Yes: Policy#:_____

Supplemental Insurance ☐ No ☐ Yes: Insurance Company Name:_____

Policy#:_____ Group Number:_____

Address:_____

Phone#:_____

Enrolled in Medicare "D" Prescription Drug Program ☐ No ☐ Yes:

Company Name:_____

Policy #:_____

Provide copies of all cards; front and back

Assets:

Real Estate ☐ No ☐ Yes: Value $_____

Savings Account: ☐ No ☐ Yes: Value $_____

Checking Account ☐ No ☐ Yes: Value $_____

Retirement Account(s) ☐ No ☐ Yes: Value $_____

Stocks/Bonds ☐ No ☐ Yes: Value $_____

IRA/CD ☐ No ☐ Yes: Value $_____

Trust(s) ☐ No ☐ Yes: Value $_____

Life Insurance ☐ No ☐ Yes: Value $

Have you transferred/gifted assets within last 5 years? ☐ Yes ☐ No

Monthly Income Source(S)/Assets:

Social Security Check: ☐ No ☐ Yes: $_____ / Frequency:_____

Pension Check: ☐ No ☐ Yes: $_____/ Frequency:_____

Name/Address of Pension Company:_____

_____

Other Income: ☐ No ☐ Yes: $_____/ Frequency:_____

Copy of last 6 months of statements required

Doctors:

Primary Care Physician: _____

Address: _____

Phone#: _____

Specialist: _____

Address: _____

Phone#: _____

Specialist: _____

Address: _____

Phone#: _____

Specialist: _____

Address: _____

Phone#: _____

Specialist: _____

Address: _____

Phone#: _____

Hospital Resident Prefers for Treatment: ☐ Concord Hospital, Concord ☐ Concord Hospital, Franklin

Additional Information about Applicant:

Previous Occupation: _____

Last Place of Employment: _____

Highest Level of Education Completed: _____

Religion: _____ Active Church Member? ☐ Yes ☐ No

Church Name: _____ Pastor: _____

Allergies

Food: ☐ No ☐ Yes: _____

_____

Medications: ☐ No ☐ Yes: _____

_____

Environmental: ☐ No ☐ Yes: _____

_____

Other: ☐ No ☐ Yes: _____

_____

Medications (list all below or attach current medication list):

Who Sets-up Daily Medications?_____ Who administers Daily Medications?_____

Nutrition:

Current Diet:_____

Diet Restrictions: ☐ No ☐ Yes: Explain:_____

Height:_____ Weight:_____

Diagnoses (list all below or attach a list)

COVID-19 Vaccination Status:

Covid 19 Vaccination Received: ☐ No ☐ Yes

☐ Pfizer Date of Dose(s):_____

☐ Moderna Date of Dose(s):_____

☐ Johnson & Johnson Date of Dose(s):_____

☐ Other (specify manufacturer):_____

Date of Dose(s):_____

Provide Copy of Covid Vaccine card front and back

Permissions:

Permission to Receive Annual Flu Vaccine: ☐ No ☐ Yes Date Last Received: _____

Permission to Receive Pneumococcal Vaccine: ☐ No ☐ Yes Date Last Received:

Permission to Receive COVID-19 Vaccine: ☐ No ☐ Yes Date Last Received: _____

Provide Copy of Immunization History

Mental Health and Counseling Services:

Inpatient Services in the Last Two Years? ☐ No ☐ Yes

Facility Name:_____

Facility Ph#:_____

Facility Address:_____

Date(s) of Admission:_____

Outpatient Services in the Last Two Years? ☐ No ☐ Yes

Facility Name:_____

Provider Name:_____

Provider Ph#:_____

Provider Address:_____

How long has applicant been seeing this provider:_____

Comments/Pertinent Information explaining why applicant needs to be placed in Assisted Living or Nursing Home:

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Person Completing Application

Date of Application

Merrimack County Nursing Home

325 Daniel Webster Highway, Boscawen, NH 03303

Phone 603-796-2165 Fax 603-796-2880

Authorization To Obtain, Use or Disclosure of Protected Health Information

Name of Resident (type or print)_____ Date of Birth:_____

I hereby authorize the Merrimack County Nursing Home to Obtain, Use and Disclose my health information as indicated below. I understand that this release is voluntary and that I may revoke this authorization at any time except to the extent that action has been taken in reliance on this authorization. I also understand that if the individual or organization authorized to receive this information is not required to comply with current privacy regulations, my health information may be disclosed to others and no longer protected by current state and federal privacy regulations.

I hereby authorize the obtaining/release or use of the information checked and/or listed below for the time period beginning on _____and ending on _____:
or upon the completion of the use of the information for the purpose it was intended, whichever is earlier

Facility/Agency/Physician	Address	Phone	Fax
Facility/Agency/Physician	Address	Phone	Fax
Facility/Agency/Physician	Address	Phone	Fax
Facility/Agency/Physician	Address	Phone	Fax

[ ] Billing Statements	[ ] Laboratory Reports	**[X] Progress Notes**
[X] Care Plans	**[X] Medical / Treatment Records**	[ ] Social Info
[ ] Complete health care record(s)	[ ] Minimum Data Set	[ ] Transcribed Reports
[ ] Consults	[ ] Nurses' Notes	[ ] X-Ray Reports
[ ] Dental Records	[ ] Ophthalmic Records	**[X] Other – Immunization Hx**
[ ] Discharge Summary	[ ] Pathology Reports	[ ] Other
[ ] Emergency Care Records	[ ] Patient Care Referral forms 1&2	
[X] History & Physical Examination	[ ] Photographs, or other images	

The information checked and/or listed above is to be released to: Merrimack County Nursing Home
for the purpose(s) of Pre-Admission Screening

I understand that I may revoke this request at anytime by providing the facility with my written notice of such revocation.

I understand that I may inspect and copy any information used or disclosed under this authorization. I understand that a fee may be charged for such copying services

Date:_____ Signature of Resident:_____

Printed Name of Resident:_____

Date:_____ Signature of Authorized Representative:_____

Printed Name of Authorized Representative:_____

Relationship to Resident:_____

Date:_____ Signature of Witness:_____

Printed Name of Witness:_____

A copy of this record must be provided to the person making the request and a copy must be filed in the medical record.

State of New Hampshire
Department of Health and Human Services
Division of Family Assistance

Authorization to Release of Information (t)
Long Term Care
November 2011

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I, _____ the undersigned, understand that from time to time
Print Your Name

the Health Care Facility Merrimack County Nursing Home
Health Care Facility

May require certain information about assistance I am applying for or receiving from the NH Department of Health and Human Services, Division of Family Assistance (DFA). I hereby authorize DFA to release the following information to the Health Care Facility for the specific purposes outlined below:

Type of Information	Purpose for Requesting this Information
Date of DFA application(s), expected date of eligibility, what my patient liability is and the begin date.	Basic administration of my long-term care/nursing home assistance.
Date my Medicaid case opened and my Medicaid Identification Number(s)	Processing of Medicaid reimbursements for payment to the long-term care facility for my care.
Sharing eligibility information, which can be used to determine eligibility such as income and resources.	Processing the initial and redetermination application for Medicaid assistance.
Reason for the denial of my application such as income or resources, transfers, failed to provide information, ect.	Basic administration of my long-term care/nursing home assistance.

I understand that I have the option to provide any or all of the requested information myself.

I understand that any use of the above information inconsistent with these purposes is forbidden.

I understand that the long-term care facility may not release information provided under this authorization to any other person without my written permission.

_____ _____
Signature Date

If the signature above is not that of the person to whom the requested information pertains, the relationship of the signer to that person must be indicated, the signature must be witnessed, and verification that the signer has the authority to represent the person in these matters with DFA must be provided upon DFA request.

_____ _____ _____
Relationship to You Witness Date