Application for Admission

Pre-admission Requirements

Listed below are items required for the Colonial Poplin & Poplin Way Community application process. All information received by Colonial Poplin & Poplin Way Community is considered confidential and is handled as such. If you have any questions or need assistance, please contact the Admissions Department at 603-895-3126. Your application will be processed as quickly as possible.

CHECK LIST

Please send copies only of the items listed below:

____ Social Security Card

____ Medicare Card

____ Medicaid Card (if applicable)

____ Health Insurance cards (Front and Back)

____ Nursing Home Screening Approval Form (For Medicaid Recipients)

____ Current Statements of all bank accounts

____ All current income checks

____ Prepaid Funeral Arrangements Contract (if not prepaid, indicate Funeral Home)

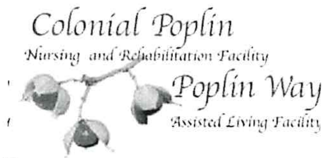
____ Power of Attorney (if applicable)

____ Court Appointed Guardian (if applicable)

____ Trust Agreements (if applicable)

____ Most Recent History & Physical from Primary Care Physician

** **PLEASE NOTE THAT COLONIAL POPLIN & POPLIN WAY COMMUNITY IS A SMOKE-FREE FACILITY****



Colonial Poplin & Poplin Way Community

APPLICATION FOR ADMISSION

DATE: ______________________

APPLICANT INFORMATION

Applicant's Name ____________________ Maiden: ____________ AGE: ______ DOB: __________

Address ______________________ City/Town: ____________ State: ______ Zip: __________

Telephone # ______________ Sex ____ Marital Status: ____________ Religion: __________

Place of Birth: ______________________ Occupation Before Retirement: ______________________

CURRENT STATUS

Applicant is now at: ____ Since: ___/___/_______

Address ______________________ City/Town: ____________ State: ______ Zip: __________

Contact Person: Telephone #

Name of Primary Care Physician: Telephone #

Will you primary care physician continue to provide your medical care at Colonial Po
Poplin Way Community? Yes: ______ No: ____

PERSONAL CARE NEEDS ASSESSMENT

CURRENT MEDICAL DIAGNOSIS: ____

PAST MEDICAL DIAGNOSIS: ____

MEDICATIONS: ____

ALLERGIES: FOOD(S): ______________________ **MEDICATION(S):** ______________________

How is Applicant's appetite? Good _____ Fair ____ Poor __ Explain: ______________________

Does Applicant have difficulty eating or swallowing? Yes ____ **No** ____ Explain: ______________________

Does Applicant have a special Diet? Yes ____ **No** ____ Explain: ______________________

Applicant's Height: ______ Weight: ______ Recent Weight Gain or Loss? ______________________

How is Applicant's Vision? Good ____ Fair ____ Poor ____ Other __________ **Glasses?** Yes ____ **No** ____

How is Applicant's Skin? Dry ______ Rashes _____ Pressure Sores ______ Other: ______________

Does Applicant receive any home visiting services? If so, Explain: ______________________

<u>Applicant Needs Assistance with</u>: (Circle Yes or No)			<u>Mental Status/Behavior</u>: (Circle Yes or No)			<u>Mental Status/Behavior</u>: (Circle Yes or No)		
Grooming	Y	N	Alert	Y	N	Cooperative	Y	N
Bathing	Y	N	Oriented	Y	N	Combative	Y	N
Dressing	Y	N	Confused	Y	N	Threatening	Y	N
Toileting	Y	N	Forgetful	Y	N	Strikes Out	Y	N
Walking	Y	N	Depressed	Y	N	Wanders	Y	N
Eating	Y	N	Anxious	Y	N	Agitated	Y	N

Is Applicant Agreeable to Placement? Y N

Is Applicant Bedridden? Y N

Does Applicant use:			**Is Applicant Continent?**			**Does Applicant Have:**		
Cane	Y	N	Bowel	Y	N	Catheter	Y	N
Walker	Y	N	Bladder	Y	N	Colostomy	Y	N
Wheelchair	Y	N				Ileostomy	Y	N

Does Applicant Need Assist with Wheelchair? Y N

APPENDIX D

ASSET ASSESSMENT FORM

BANK ACCOUNTS

Name on Account	Name of Banking Institution	Account Number	Account Type	Balance as of Date of Admission to Medical Institution

LIFE INSURANCE

Name of Insured	Insurance Company	Policy Number	Face Value

TRUSTS

Name of Trust	Type *	Grantor(s) Donor(s)	Trustee(s)	Beneficiaries	Trust Principal

Type: I = Irrevocable R = Revocable

How much income do you and/or your spouse receive from the trust(s)? $_________How often? _______

REAL ESTATE: Real estate includes your home, vacation property, rental property, time- sharing property, vacant lots, and business property, whether in New Hampshire or out of state. (Ownership of real estate includes joint ownership, tenancy by the entirety, tenants in common, and a life estate).

Name on Ownership Papers	Description and Location	Fair Market Value
		$
		$

MOTOR VEHICLES: Motor vehicles include cars, vans, trucks, mobile homes, and boats.

Name of Owner	Year/Make/Model	Fair Market Value	Amount Owed
		$	$
		$	$

STOCKS/BONDS/OTHER: Theses include stocks, bonds, savings bonds, mutual funds, securities and assets held in safe-deposit box.

Name of Owner	Description & Location	Value	#Shares
		$	
		$	

ANNUITIES

Name of Owner	Name of Annuitant	Beneficiary upon Death of Annuitant	Income Received	How Often?
			$	
			$	

Living Expenses of the Spouse and Family Members in the Community:

Your community spouse may be able to keep some of your income. Complete the following information about your spouse's current living expenses. How much does your spouse pay each month for:

Rent: $____________ Mortgage (principal & interest): $____________

Taxes: $____________ Homeowner's/Tenant's Insurance: $____________

Required Maintenance Charge for a Condo or Co-Op: $__________

Does your spouse pay for heat? ___ Does your spouse pay for utilities?___

If a child, parent, brother, and/or sister live with your spouse, a deduction may be allowed for their maintenance needs. There persons must be related to you or your spouse and one of you must claim them as a dependent on income tax

Name	Social Security Number	Relationship	Date of Birth	Monthly Income Amount

Transfer of Assets

Please complete this section of the form if there has been any transfer of assets at less than fair market value within a five (5) year period preceding the date of admission to the nursing facility or date on which a Medicaid application has or will be filed.

Asset Type *1	Estimated $ Value of Transfer *2	Date Transferred	Name of Person who Receive Asset

*1 Cash, bonds, stocks, mutual funds, 401 Ks, IRAs, real estate, other personal property

*2 In the case of real estate or other personal property, the estimated value of the transfer is equal to the fair market value of the property at time of transfer less the proceeds received for the transfer.

Signatures

I certify that I have read or have had read to me the asset assessment form. I further certify that the information provided on this assessment form is correct and complete to the best of my knowledge.

If you are completing or are assisting in the completion of this form on behalf of someone who is unable to complete this assessment form because of a physical or mental condition, you must be sufficiently aware of his or her circumstances to assume responsibility for the accuracy of the statements made. By signing this document, you are attesting to the accuracy of the statements made.

____ _______________
Signature of Resident or Person Seeking Admission Date

____ _______________
Signature of Legal Representative (if applicable) Date

____ _______________
Signature of Responsible Party (if applicable) Date

Medical info needed:

History and Physical

Notes from last 3 MD visits

Diagnosis List

Medication List

Immunization Records