Maplewood
OF CHESHIRE COUNTY
YOUR HOME... YOUR FAMILY

Resident Admission Application

201 River Road Westmoreland, NH 03467
(P) 603-399-4912 (F) 603-399-4300

Please check the facility you are interested in

☐ Nursing Home ☐ Both
☐ Assisted Living

Application Date:_____

*Please be sure to complete the application in full. Must return to admission coordinator before being placed on the waitlist.

Last	**First**	**Middle Initial**	**Maiden Name**
Address	**City/State**	**Zip Code**	**County**
Date of Birth **Social Security #**	**Birthplace**	**US Citizen:** Yes No **Registered Voter:** Yes No **What county were You registered in:** _____ **Would you like to continue voting:** Yes No	
Phone Number **H:** **C:**	**Race** **Hispanic or Not Hispanic**		
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Widowed	☐ Male ☐ Female ☐ Prefer not to answer	**Religion** **Military Service** ☐ Yes ☐ No	**Languages Spoken**
Spouse's Name	**Spouse's Address**		**Spouse's Phone** H: C:
Primary Care Provider	**PCP Address/Location**	**Home Health or Community Services?** **If yes, who?**	
In the past year has the potential resident been in a nursing home or received skilled care?			
Desired Funeral Home	**Prepaid Burial Plan** ☐ Yes ☐ No *if **No,** arrangements are recommended*		

Contact information

*~ Please Provide **COPIES** of all legal Documents, including POAs (Power of Attorney) & Guardianships~*

Health Care POA Name: Relationship: Email:	**Phone Numbers** H: C: W:	**Mailing Address**
Financial POA Name: Relationship: Email:	**Phone Numbers** H: C: W:	**Mailing Address**
Legal Guardian Name: ☐ Over Person (Health Care) ☐ Over Estate (Finances) ☐ Both	**Phone Numbers** H: C: W:	**Mailing Address** **Email:**
Please designate who is responsible to receive bills not covered by insurance Name: Relationship: Email:	**Phone Numbers** H: C: W:	**Mailing Address**
Emergency Contact other than those listed above Name: Relationship: Email:	**Phone Numbers** H: C: W:	**Mailing Address**
Emergency Contact other than those listed above Name: Relationship: Email:	**Phone Numbers** H: C: W:	**Mailing Address**

Payment & Insurance Information

*~ Please Provide **COPIES** of all insurance cards~*

Medicare ☐ Yes ☐ No

Part A ☐ Yes ☐ No
Effective Date:

Part B ☐ Yes ☐ No
Effective Date:

ID#:

Medicare Supplemental
☐ Yes ☐ No
Insurance Company:

Effective Date:

Phone number for providers:

ID#:
Monthly Premium: $

Medicare Advantage Plan
☐ Yes ☐ No
Insurance Company:

Effective Date:

Phone Number for Providers:

ID#:
Monthly Premium: $

NH Medicaid

☐ Yes
☐ No

Effective Date:

ID#:

NH Healthy Families
ID#:

Well Sense
ID#:

AmeriHealth
ID#:

Medicaid Status - Select one of the following:
☐ N/A I already have Medicaid see above for policy information
☐ Application has been submitted
☐ Application process has been started but not submitted
☐ I would like help or more information regarding the Medicaid process
☐ I do not plan to apply for Medicaid

Long Term Care Insurance
Insurance Company:

Policy #:

Policy Holder:

Monthly Premium: $

Phone Number for Providers:

Prescription Drug Plan
Insurance Company:

Policy #:

Policy Holder:

Monthly Premium: $

Life Insurance
Insurance Company:

Policy #:

Policy Holder:

Cash Value: $

☐ Whole Life
☐ Term Policy

Other Medical Insurance
Insurance Company:
Policy #:

Policy Holder:

Monthly Premium: $

Phone Number for Providers:

Income & Other information

~ Please provide the following info regarding your monthly income as well as all other finances and assets owned. If necessary, this info will be used to determine whether you are eligible to receive or to apply for Medicaid benefits now or in the future~

If the applicant is married, please also provide your spouse's income and asset information on pg. 5.

All income and asset info must be completed prior to admission

Social Security Income ☐ Yes ☐ No Amount: $_____ ☐ Monthly – When: _____ ☐ Annually – When: _____	**Pension/Retirement Income** ☐ Yes ☐ No Amount: $_____ ☐ Monthly – When: _____ ☐ Annually– When: _____ Company Name:	**Other income** ☐ Yes ☐ No Amount: $_____ ☐ Monthly – When: _____ ☐ Annually – When: _____ Source:
Other income ☐ Yes ☐ No Amount: $_____ ☐ Monthly – When: _____ ☐ Annually – When: _____ Source:	**Other income** ☐ Yes ☐ No Amount: $_____ ☐ Monthly – When: _____ ☐ Annually – When: _____ Source:	
Checking Account(s) ☐ Yes ☐ No Current Balance: $_____ Name of Bank(s):	**Savings Account(s)** ☐ Yes ☐ No Current Balance: $_____ Name of Bank(s):	
Real Estate Owned: ☐ Yes ☐ No Type of property: Monthly Mortgage amount: $_____ Principle Balance:	**Is there a home in a trust:** ☐ Yes ☐ No **If yes,** please consult with your lawyer to ask if this house is protected for the purpose of Medicaid eligibility.	
Other Assets ☐ Stocks $_____ ☐ 401K $_____ ☐ Bonds $_____ ☐ IRA $_____ ☐ CDs $_____ ☐ Trusts $_____ ☐ Annuity$_____ ☐ Mutual Fund $_____	**Have you transferred, sold, or given away property or monetary assets totaling $500 or more within the last 5 years?** ☐ Yes ☐ No If **yes**, please explain:	

Income & Other information

~ Please provide the following info regarding your monthly income as well as all other finances and assets owned. If necessary, this info will be used to determine whether you are eligible to receive or to apply for Medicaid benefits now or in the future~

All income and asset info must be completed prior to admission

Spouse's Name:_____

Social Security Income ☐ Yes ☐ No Amount: $_____ ☐ Monthly – When: _____ ☐ Annually – When: _____	**Pension/Retirement Income** ☐ Yes ☐ No Amount: $_____ ☐ Monthly – When: _____ ☐ Annually– When: _____	**Other income** ☐ Yes ☐ No Amount: $_____ ☐ Monthly – When: _____ ☐ Annually – When: _____ Source:
Other income ☐ Yes ☐ No Amount: $_____ ☐ Monthly – When: _____ ☐ Annually – When: _____ Source:		**Other income** ☐ Yes ☐ No Amount: $_____ ☐ Monthly – When: _____ ☐ Annually – When: _____ Source:
Checking Account(s) ☐ Yes ☐ No Current Balance: $_____ Name of Bank(s):		**Savings Account(s)** ☐ Yes ☐ No Current Balance: $_____ Name of Bank(s):
Real Estate Owned: ☐ Yes ☐ No Type of property: Monthly Mortgage amount: $_____ Principle Balance:		**Is there a home in a trust:** ☐ Yes ☐ No **If yes,** please consult with your lawyer to ask if this house is protected for the purpose of Medicaid eligibility.
Other Assets ☐ Stocks $_____ ☐ 401K $_____ ☐ Bonds $_____ ☐ IRA $_____ ☐ CDs $_____ ☐ Trusts $_____ ☐ Annuity$_____ ☐ Mutual Fund $_____		**Have you transferred, sold, or given away property or monetary assets totaling $500 or more within the last 5 years?** ☐ Yes ☐ No If **yes**, please explain:

Maplewood
OF CHESHIRE COUNTY
YOUR HOME... YOUR FAMILY

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

_____	_____
Applicant or Responsible Party Signature	**Witness Signature**
_____	_____
Print Name of Party Signing	**Date**