ROCKINGHAM COUNTY
Rehabilitation and Nursing Center

Thank you for your interest in Rockingham County Rehabilitation & Nursing Center. 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:
603-679-9456
Email:
admissions@co.rockingham.nh.us

Mailing Address:
Rockingham County Nursing Home
Attn: Admissions
117 North Road
Brentwood, NH 03833

Required Documentation:

- Authorization to use and/or Disclose Health Information (included in this document). This must be signed by Resident or if POA has been Activated/Invoked, by the Legal Representative.
- Medicare /Medicaid Cards
- Insurance Cards, including Med D
- Social Security Card
- Covid Vaccination Card
- Life Insurance Policy
- POA/Guardianship papers
    - If Applicable: Medical Provider's letter stating that POA has been Activated/Invoked
- Current Bank Statements (6 mos.)
- Trust, Real Estate & Other Financial Asset Information
- Pre-paid Burial
- DHHS Release Form ONLY if NH Medicaid is in place (including in this document). This must be signed by Resident or if POA has been Activated/Invoked, by the Legal Representative

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

ROCKINGHAM COUNTY
Rehabilitation and Nursing Center

Application for Admission

Applicant's Name: _____
Primary Address: _____
Home Phone: _____ Mobile Phone: _____
Email: _____
Other Address (if living with someone): _____
Hospital/Rehab Hospital being referred by: _____
Telephone No./Social Worker @ Hospital: _____

Personal Information Regarding Applicant:
Male ◯ Female ◯ DOB: _____
Marital Status: Single ◯ Married ◯ Widowed ◯ Separated ◯ Divorced ◯
US Citizen: Yes ◯ No ◯

Primary Language:
English: ◯ Other: _____
Any special needs required: _____

Contact Person Regarding this Application:
Name: _____ Relationship: _____
Address: _____
_____
Home Phone: _____ Mobile Phone: _____
Email: _____
2nd Contact: _____ Relationship: _____
Address: _____
_____
Home Phone: _____ Mobile Phone: _____
Email: _____

Responsible Person/Legal Guardian/DPOA:
Yes ◯ No ◯ Legal Guardian Name: _____
Yes ◯ No ◯ Durable POA (Health) Name: _____
Yes ◯ No ◯ Durable POA (Finances) Name: _____

Name: _____ Relationship: _____
Address: _____
_____
Home Phone: _____ Mobile Phone: _____
Email: _____
Is DPOA for health activated? Yes ◯ No ◯

Copies of these document(s) required if applicable

Advanced Directives in Place:

Yes ◯ No ◯ Living Will
Yes ◯ No ◯ Do Not Resuscitate
Yes ◯ No ◯ Do Not Hospitalize
Yes ◯ No ◯ Organ Donor
Yes ◯ No ◯ Feeding Restrictions Current diet: _____
Yes ◯ No ◯ Medication/Treatment Restrictions
(Explain): _____
_____
_____

Living Arrangements:

Lives alone: Yes ◯ No ◯ With others: Yes ◯ No ◯
Current living arrangements: _____
_____

Prior Hospitalizations/In-home Services:

Yes ◯ No ◯ Rehabilitation Services agency: _____
Yes ◯ No ◯ Home Health Services agency: _____
Yes ◯ No ◯ VNA Services agency: _____
Yes ◯ No ◯ Mental Health Services agency: _____
Yes ◯ No ◯ Private Duty/Other agency: _____
other_____

Assets:	**Value:**
Yes ◯ No ◯ Real Estate:	$_____
Yes ◯ No ◯ Savings Account:	$_____
Yes ◯ No ◯ Checking Account:	$_____
Yes ◯ No ◯ Retirement Account:	$_____
Yes ◯ No ◯ Stocks/Bonds:	$_____
Yes ◯ No ◯ IRA/CD:	$_____
Yes ◯ No ◯ Trust:	$_____

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

Copy of last 6 months of statements required

Insurance Information for Nursing Home Stay:

Yes◯ No◯ Private Funds **(advance payment required)**
Yes◯ No◯ Medicaid No_____
Yes◯ No◯ Medicare No _____
Yes◯ No◯ Medicare Replacement Carrier _____
Yes◯ No◯ Social Security No _____
Yes◯ No◯ VA No _____

Supplemental Insurance

Yes◯ No◯ Insurance. I.D. Number _____Group Number_____
Name/Address Supplemental Insurance/phone number:

_____
_____
_____

Yes◯ No◯ **Enrolled in Medicare "D" Prescription Drug Program:**
Name: _____

Provide copies of all cards; front and back

Monthly Income Source(s)/Assets:

Yes◯ No◯ Social Security check $_____
Yes◯ No◯ Pension check $_____
Name/Address of Pension Company: _____
Yes◯ No◯ Other income $_____

Diagnoses (list all below or attach list):

_____
_____
_____
_____
_____

Medications (list all below or attach current medication list)

_____
_____
_____
_____
_____
_____
_____

COVID-19 Vaccination Status:

Covid 19 Vaccination Received: Yes ◯ No ◯

☐ Pfizer Date of First Dose:_____ Date of Second Dose: _____

☐ Moderna Date of First Dose:_____ Date of Second Dose: _____

☐ Johnson & Johnson Date of Dose:_____

☐ Other (specify manufacturer): _____

Date of Dose(s): _____

Provide Copy of Covid Vaccine card front and back

Comments/pertinent information explaining why this person needs to be placed in a nursing home:

_____

_____

_____

_____

_____

PRIMARY PHYSICIAN:

_____

_____

_____

ADDRESS & TEL. NO. _____

_____

_____

ANY HISTORY OF MENTAL HEALTH SERVICES (INPATIENT OR OUTPATIENT) IN THE LAST TWO YEARS? ◯ YES ◯ NO

Where / who were you seen by: _____

_____

_____

_____

ADDRESS & TEL. NO. _____

_____

_____

_____

Signature of Person Completing Application

_____

Date of Application

Rockingham County Rehabilitation and Nursing Center
117 North Road, Brentwood, New Hampshire 03833
Phone 603-679-5335 • Fax 603-679-9456

ROCKINGHAM COUNTY
Rehabilitation and Nursing Center

AUTHORIZATION TO USE AND / OR DISCLOSE HEALTH INFORMATION

I, the undersigned, hereby voluntarily authorize that information (including psychiatric) from the medical record of:

_____ _____ _____
Name of Person D.O.B. Social Security #

be exchanged (including facsimile) between Rockingham County Rehabilitation and Nursing Center and:

_____
Name of Agency

_____
Address

_____
Telephone Fax Number

Information to be released covers the treatment dates of: _____

The following checked items are being _____ released _____ requested:

_____ Adm. H & P _____ Discharge Summary _____ Immunization Record

_____ Consults _____ Treatment Plans _____ Laboratory Reports _____ X-Rays

_____ Progress Notes _____ Physician Orders _____ Other – Specify _____

_____

_____ Information from other providers received after May 1982

_____ Psychotherapy notes (if this authorization is for the use and /or disclosure of psychotherapy notes, then it cannot be combined with any other authorization.)

INITIAL if you wish the following information to be released (if present)

_____ Alcohol and /or Drug Abuse treatment: (I understand that all related information is protected under Federal Regulation 42CFR and that I have the right to refuse the release.)

_____ HIV Related Information: (I understand I have the right to refuse the release.)

The purpose of the release is: _____ Evaluation for Admission
_____ Treatment Planning
_____ Other – (specify): _____

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.

I also understand that, if the person or entity receiving this information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release expires one year from the signature date below unless a shorter period is specified here: _____.

_____ _____

Signature of Resident or Resident's Legal Representative | Date

_____ _____

Print name of Resident or Legal Representative | Relationship of Legal Representative to Resident

ROCKINGHAM COUNTY

Rehabilitation and Nursing Center

Long Term Care Admissions Department

Telephone: 603-679-5335 • Fax: 603-679-9456

Email: admissions@co.rockingham.nh.us

AUTHORIZATION FOR THE RELEASE OF INFORMATION

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

the Health Care Facility Rockingham County Rehabilitation and Nursing Center
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