ROCKINGHAM COUNTY
Rehabilitation and Nursing Center
Assisted Living Community

Thank you for your interest in Rockingham County Rehabilitation & Nursing Center. Please complete the admission application, release forms and permissions form included. 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:
603-679-4997
Email:
svachon@co.rockingham.nh.us

Mailing Address:
Ernest P. Barka Assisted Living Community
Attn: Admissions
117 North Road
Brentwood, NH 03833

Required Documentation to be submitted with Application:

- Insurance Cards: Medicare, Medicaid Card, Supplemental, Private Insurance, Prescription Plan
- Social Security Card
- Covid Vaccination Card
- Life Insurance Policy (if applicable)
- Durable Power of Attorney (DPOA) Healthcare & Financial and/or Guardianship papers
  - If Applicable: Medical Provider's letter stating that DPOA has been Activated/Invoked
- Current Bank Statements (6 mos.)
- Trust, Real Estate, Long Term Care Insurance Policy & Other Financial Asset Information + Statements
- Pre-paid Burial/Funeral/Cremation documents

Authorization & Consent forms:
The following forms are to be signed by the applicant if able to make their own medical decisions OR by the Primary Durable Power of Attorney for Healthcare (DPOA) & Primary Durable Power of Attorney for Financial with a letter from Medical Provider stating DPOA has been invoked/activated.

- Authorization to Use and/or Disclose Health Information
  - Page 1: Initialed in the 3 yellow highlighted spaces
  - Page 2: Signed
- DHHS Release

Please Note: the application will be considered open and active when:
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 Ernest P. Barka Assited Living Admissions Team

ROCKINGHAM COUNTY

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ADMISSION APPLICATION

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

Applicant's Name: _____ Preferred Name: _____

Primary Address: _____

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

If Yes, Who: _____

Home Phone: _____ Mobile Phone: _____

Email: _____

Hospital/Rehab Hospital being referred by: _____ Contact & PH#: _____

Personal Information of Applicant:

DOB: _____ **Social Security Number:** _____

☐ **Male** ☐ **Female** Gender Identity: _____ Preferred Pronoun(s): _____

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

Do Not Hospitalize ☐ Yes ☐ No

Organ Donor ☐ Yes ☐ No

Prepaid Funeral/Burial ☐ Yes ☐ No

Copies of these document(s) required if applicable

Payment Source for Assisted Living or Nursing Home Stay:

Private Funds ☐ Yes ☐ No **(advance payment required)**

NH Medicaid ☐ No ☐ Yes: Policy / MID#:_____

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

Company Name:_____

Address:_____ Phone#:_____

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:_____

Insurance Information:

Private Funds: ☐ No ☐ Yes

NH Medicaid: ☐ No ☐ Yes: Policy / MID#:_____

Medicare: ☐ No ☐ Yes: Policy / 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 $_____ Policy #_____

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

Prior Hospitalizations/In-Home Services/Community Services:

Hospitalizations within last calendar year: ☐ No ☐ Yes:

Facility Name: _____

Date (s): _____

Have you used any of the following services in the past two years?

Rehabilitation Services: ☐ No ☐ Yes: agency: _____ Dates: _____

Home Health Services: ☐ No ☐ Yes: agency: _____ Dates: _____

VNA Services: ☐ No ☐ Yes: agency: _____ Dates: _____

Mental Health Services ☐ No ☐ Yes: agency: _____ Dates: _____

Private Duty/Other ☐ No ☐ Yes: agency: _____ Dates: _____

Adult Medical Daycare ☐ No ☐ Yes: agency: _____ Dates: _____

Homemaker ☐ No ☐ Yes: agency: _____ Dates: _____

Meals on Wheels ☐ No ☐ Yes: how many times a week? _____

Other: _____ Dates: _____

Doctors:

Primary Care Physician: _____

Address: _____

Phone#: _____

Specialist: _____

Address: _____

Phone#: _____

Specialist: _____

Address: _____

Phone#: _____

Specialist: _____

Address: _____

Phone#: _____

Specialist: _____

Address: _____

Phone#: _____

Allergies

Food ☐ No ☐ Yes:_____

_____

Medications ☐ No ☐ Yes: _____

_____

Environmental: ☐ No ☐ Yes:_____

_____

Other ☐ No ☐ Yes:_____

_____

Nutrition:

Current Diet:_____

Diet Restrictions: ☐ No ☐ Yes: Explain:_____

_____

Height:_____ Weight:_____

Diagnoses (list all below or attach a list)

_____

_____

_____

_____

_____

_____

_____

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

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

_____

_____

_____

_____

_____

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:_____

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:

_____

_____

_____

_____

_____

_____

_____

Additional Information about Applicant:

Education:_____

Previous Occupation:_____ Last Place of Employment:_____

Religion:_____ Active Church Member? ☐ Yes ☐ No

Church Name:_____ Pastor:_____

Mother (Maiden Name):_____ Father:_____

Pets (Past and Present):_____

Interests/Hobbies (Past & Present):_____

_____

_____

Children	Address & Phone#

Brothers & Sisters (Please include all, whether living or deceased)	

_____ _____

Signature of Person Completing Application Date of Application

ROCKINGHAM COUNTY
Rehabilitation and Nursing Center
Assisted Living Community

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
Assisted Living Community

Assisted Living Admissions Department

Telephone: 603-679-5335 • Fax: 603-679-9385

Email: svachon@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 Ernest P. Barka Assisted Living Community
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