ROCKINGHAM COUNTY

Rehabilitation and Nursing Center
Assisted Living Community

Greetings!

Thank you for your interest in becoming a resident at one of our communities, Rockingham County Rehabilitation and Nursing Center, and Ernest P. Barka Assisted Living. We know making the decision to move into a senior living community can be difficult and we are grateful you have chosen to place your trust in us.

To ensure a smooth application process, we ask that all prospective residents and/or their representatives complete the Admissions Application in full. We understand that gathering all the necessary documentation may seem tedious, but it's essential in helping us determine qualification for residency and ensuring that we can provide the appropriate level of care.

In addition to providing the requested personal and medical information, please **be sure to sign all required release forms and permissions**. These forms allow our team to obtain the most up-to-date clinical information from healthcare providers, which provides a clear understanding of all prospective residents' medical history and current needs. We have enclosed a checklist which outlines the required documentation that must be submitted with your application.

If you're unsure about any of the language used within the application, you can find a glossary of commonly used terms on the last page of this packet.

Completed applications can be mailed, faxed, emailed or dropped off to:

Long-Term Care:
Fax: 603-679-9456
Email: admissions@co.rockingham.nh.us
Mailing Address:
117 North Road
Attn: RCRNC Admissions
Brentwood, NH 03833

Assisted Living:
Fax: 603-679-9385
Email: ebassistedliving@co.rockingham.nh.us
Mailing Address:
117 North Road
Attn: ALF Admissions
Brentwood, NH 03833

If you have any questions or need assistance with the application, please do not hesitate to reach out. We look forward to the opportunity to welcome you to our community!

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Required Documentation Checklist

☐ ***1. Admission Permissions Form***

Gives us permission to speak with designated individuals regarding the Resident Application and applicant information

☐ ***2. Durable Power of Attorney (DPOA)/Guardianship***

Healthcare and Financial and/or Guardianship papers. If applicable, a medical provider's letter stating that the DPOA has been activated/invoked

☐ ***3. Advance Directives*** *(if applicable)*

Documents including: Living Will, Do Not Resuscitate, and any prepaid funeral/burial expenses

☐ ***4. Insurance and ID Cards***

Social Security Card, Medicare and/or Medicaid Card, Supplemental and/or Private Insurance, Prescription Plan, and Life Insurance Policy

☐ ***5. Financial/Assets Information***

Bank statements from the last six (6) months, trust(s), real estate, retirement accounts, and other financial asset information and statements such as stocks/bonds, social security, pension checks, and life insurance policy value

☐ ***6. Authorization to Use and Disclose Health Information Form***

This allows us to contact applicant's physicians and specialists and authorizes us to review psychiatric, mental health, and drug and alcohol treatments if applicable

117 North Road, Brentwood, New Hampshire 03833
Phone 603-679-5335 Fax 603-679-9456

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PRE-ADMISSION PERMISSIONS

Resident/Client Name: _____

I grant permission to the following responsible individuals to discuss and/or release information regarding my Admission Application, Financial and Medical Records

Date	Name & Relationship	Address & Cell#	Permission Type:
			☐ Admission Application **Initial:** _____ ☐ Financial Information **Initial:** _____ ☐ Release of Medical Info. **Initial:** _____
			☐ Admission Application **Initial:** _____ ☐ Financial Information **Initial:** _____ ☐ Release of Medical Info. **Initial:** _____

_____ **Signature of Authorized Representative**

_____ **Date**

_____ **Printed Name**

☐ **Self** ☐ **DPOA** ☐ **Guardian**
Relationship (select one)

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ADMISSION APPLICATION

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

Applicant's Name: _____ Preferred Name: _____

Primary Address: _____

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

If Yes, With Whom: _____

Home Phone: _____ Mobile Phone: _____

Email: _____

Personal Information of Applicant:

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

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

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

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

If Applicable: Spouse Name: _____

Primary Language:

☐ English ☐ Other: _____

Special Language Needs Required: _____

Decision Making:

Is Applicant able to make their own Medical Decisions? ☐ Yes ☐ No

Advanced Directives/Advanced Care Planning:

Durable Power of Attorney	☐ Yes ☐ No	☐ Healthcare	☐ Financial	☐ General
Guardianship	☐ Yes ☐ No	☐ Person	☐ Estate	
Living Will	☐ Yes ☐ No			
Do Not Resuscitate	☐ Yes ☐ No			
Prepaid Funeral/Burial	☐ Yes ☐ No			

Copies of these document(s) required (if applicable)

117 North Road, Brentwood, New Hampshire 03833
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Payment Source & Insurance Information:

Private Funds: ☐ No ☐ Yes

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

NH Medicaid: ☐ No ☐ Pending ☐ Yes Policy#: _____

NH Medicaid Case Manager Name & Phone#: _____

Medicare: ☐ No ☐ Yes Policy#: _____

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

Company & Policy#: _____

VA Benefit: ☐ No ☐ Yes Policy#: _____

Supplemental Insurance: ☐ No ☐ Yes

Company & Policy#: _____

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

Company & Policy#: _____

Provide copies of all cards (front and back)

Financial/Asset Information:

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: _____

Required: Copies of last six (6) months of statements

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Primary Care Doctor:

Primary Care Physician: _____

Address: _____

Phone: _____

Mental Health and Counseling Services:

Inpatient Services in the last two years? ☐ No ☐ Yes

Facility Name: _____

Address: _____

Phone: _____

Outpatient Services in the last two years? ☐ No ☐ Yes

Facility & Provider Name: _____

Address: _____

Phone: _____

Comments or Additional Information (optional):

_____

_____

_____

_____

_____

_____

_____

Disclosure Statement

I, the undersigned applicant or authorized representative, certify that the information provided in this application is accurate, complete, and truthful to the best of my knowledge. I understand that any omission, misrepresentation, or falsification of information may affect eligibility for admission or services.

I acknowledge that completion of this application does not guarantee admission and that placement is subject to facility availability, medical and financial eligibility, and compliance with applicable policies and regulations.

I authorize the facility to verify the provided information, including but not limited to medical records, financial documents, and legal authorization forms, as necessary to determine eligibility for admission and appropriate care. I also understand that additional documentation may be required to complete the admission process.

If applying for Medicaid assistance, I understand that the facility may conduct a review of financial records and past asset transfers to determine Medicaid eligibility. I acknowledge that failure to disclose gifts or asset transfers within the Medicaid look-back period may result in a penalty or delay in coverage.

By signing below, I acknowledge that I have read, understand, and agree to the terms outlined in this disclosure statement.

_____ _____

Signature of Authorized Representative Date

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Glossary of Commonly Used Terms

Activated/Invoked (as related to a DPOA or Healthcare Proxy) –A DPOA becomes "activated/invoked" when a medical provider has determined that the individual lacks the capacity to make their own medical decisions. Once activated/invoked, the designated agent is now authorized to act on behalf of the individual in making medical and/or financial decisions, depending on the scope of the document.

Authorized Representative - An individual who has legal authority to act on behalf of an applicant, including completing paperwork, making decisions, and accessing personal or medical information. This may include a legal guardian, power of attorney, or someone designated by the individual through written consent.

Advance Directive – A legal document outlining a person's healthcare wishes if they become unable to make decisions.

Durable Power of Attorney (DPOA) – A legal document that grants a designated individual the authority to make financial and/or healthcare decisions on behalf of another person.

Gift/Asset (as defined by Medicaid) – A transfer of money, property, or other assets for less than fair market value to family, friends or charities. **Examples of gifts include:** giving large sums of money, deeding or selling a home and/or real estate for less than market value, gifting a car, moving money to someone else's account, or paying for someone else's expenses. Medicaid has a look-back period (typically five years) to review financial transactions. If a gift is made during this period, it may result in a penalty period during which the individual is ineligible for Medicaid benefits.

Guardianship (Person and/or Estate)– A court-appointed role granting someone the authority to make medical and/or financial decisions for an individual who is unable to do so.

Long-Term Care Insurance – A privately purchased policy that helps cover the cost of long-term care services.

Medicaid – A state and federally funded program offering healthcare coverage and/or financial assistance for senior living communities for eligible low-income individuals. Example: Help pay for the cost of living in a Long-Term Care or Assisted Living Community.

Medicare – A federal health insurance program primarily for individuals 65+ and those with certain disabilities.

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Authorization to Request Protected Health Information

I authorize the following individual or entity to release the protected health information of the patient named below. I acknowledge that any information disclosed under this authorization may be subject to redisclosure by the recipient, unless otherwise restricted by law.

Name of Applicant	Applicant D.O.B.	Social Security Number

Name of facility or person that now holds the records:

Facility Name: _____

Address: _____ City: _____ State: _____Zip Code: _____

Phone: _____ Fax: _____

PLEASE SEND REQUESTED RECORDS TO:

☐ **Rockingham County Rehabilitation & Nursing Center**
117 North Rd., Brentwood, NH 03833
FAX: 603-679-9456

☐ **Ernest Barka Assisted Living Community**
117 North Rd., Brentwood, NH 03833
Fax: 603-679-9385

RECORDS REQUESTED:

☐ History & Physical
☐ Immunization Record
☐ Medication List
☐ Treatment Plans and Progress Notes
☐ Hospital Discharge Summaries
☐ Other _____
☐ ALL OF THE ABOVE

HIGHLY CONFIDENTIAL INFORMATION REQUESTED:

☐ Mental Health Treatment Records
☐ Psychotherapy Notes
☐ Alcohol and Drug Treatment Records
☐ HIV Related Information
☐ Other _____
☐ ALL OF THE ABOVE

PURPOSE OF DISCLOSURE: ☐ Evaluation for Admission ☐ Medical Care

NOTE: this request will expire one year from the request date, unless otherwise noted

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Authorization to Request Protected Health Information

Acknowledgment & Consent:

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:

_____ _____

Signature of Authorized Representative | Date

_____ _____

Name of Legal Representative | Relationship to Patient

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