

**CHESHIRE COUNTY/MAPLEWOOD NURSING HOME & ASSISTED LIVING APARTMENTS**

201 River Road, Westmoreland, NH 03647  
(Tel) 603-399-4912 (Admissions Fax) 603-399-4300

**RESIDENT ADMISSION APPLICATION**

Applying for:  ASSISTED LIVING APTS,  NURSING HOME,  BOTH

Application Date: \_\_\_\_\_

Name: \_\_\_\_\_  
*(Last) (First) (Middle)*

**GENERAL INFORMATION ABOUT PROSPECTIVE RESIDENT**

Gender: \_\_\_ M/ \_\_\_ F Age: \_\_\_ DOB: \_\_\_ Prefers to be called: \_\_\_\_\_

Home Address: \_\_\_\_\_

Cell/Home Phone: \_\_\_\_\_

SS#: \_\_\_\_\_ Military Service: \_\_\_ Yes / \_\_\_ No

Marital Status: \_\_\_ Single / \_\_\_ Married / \_\_\_ Partnered / \_\_\_ Divorced / \_\_\_ Widowed

Married Spouse name/address: \_\_\_\_\_

Married Spouse phone: \_\_\_\_\_ DOB: \_\_\_\_\_

**PHYSICIAN / MEDICAL INFORMATION**

Primary Care Physician & location: \_\_\_\_\_

Have any home health or community services been involved? \_\_\_ Yes / \_\_\_ No

If yes, explain: \_\_\_\_\_

In the past year, has the prospective resident been in a nursing home or used any skilled care? \_\_\_ Yes / \_\_\_ No. If yes, explain: \_\_\_\_\_

**FUNERAL ARRANGEMENTS**

Funeral Home & Location: \_\_\_\_\_

Phone: \_\_\_\_\_ Prepaid contract is in place: \_\_\_ Yes / \_\_\_ No

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~ Please provide Copies of all Legal Documents

**CONTACT INFORMATION**

including POAs (Powers of Attorney) & Guardianships ~

**Health Care POA:** \_\_\_\_\_ Relationship: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone(H/C): \_\_\_\_\_ Phone(W): \_\_\_\_\_ email: \_\_\_\_\_

[Office Note for ECS: \_\_\_\_\_]

**Financial POA:** \_\_\_\_\_ Relationship: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone(H/C): \_\_\_\_\_ Phone(W): \_\_\_\_\_ email: \_\_\_\_\_

[Office Note for ECS: \_\_\_\_\_]

**Legal Guardian:** \_\_\_ Over Person (Health Care) \_\_\_ Over Estate (Finances) \_\_\_ Both

Name: \_\_\_\_\_ Title (eg: Atty, OPG): \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone(H/C): \_\_\_\_\_ Phone(W): \_\_\_\_\_ email: \_\_\_\_\_

**Financial Contact & Party to Assist w/ Medicaid Application:** \_\_\_ Finc'l POA \_\_\_ Guardian

Other: \_\_\_\_\_ Relationship: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone(H/C): \_\_\_\_\_ Phone(W): \_\_\_\_\_ email: \_\_\_\_\_

**Emergency Contact:** \_\_\_ HC-POA, \_\_\_ F-POA, \_\_\_ Guardian, \_\_\_ Financial Contact

Other: \_\_\_\_\_ Relationship: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone(H/C): \_\_\_\_\_ Phone(W): \_\_\_\_\_ email: \_\_\_\_\_

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**PAYMENT / INSURANCE INFORMATION** ~Please provide Insurance Cards~

**Medicare:** \_\_\_ Yes \_\_\_ No

Medicare ID#: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**NH Medicaid:** \_\_\_ Yes \_\_\_ No

Effective Date: \_\_\_\_\_

\_\_\_ NH Healthy Families ID# \_\_\_\_\_

\_\_\_ Well Sense ID#: \_\_\_\_\_

\_\_\_ NH Medicaid ID#: \_\_\_\_\_

**Other Medical Insurance:** \_\_\_ Yes \_\_\_ No

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Policyholder: \_\_\_\_\_ Monthly Premium: \$ \_\_\_\_\_

**Prescription Drug Plan:** \_\_\_ Yes / \_\_\_ No.

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Policyholder: \_\_\_\_\_ Monthly Premium: \$ \_\_\_\_\_

**Long Term Care Insurance:** \_\_\_ Yes / \_\_\_ No

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Policyholder: \_\_\_\_\_ Monthly Premium: \$ \_\_\_\_\_

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**INCOME & OTHER INFORMATION**

**Applicant Name:** \_\_\_\_\_

Please provide the following information regarding your monthly income as well as all other finances and assets owned. If necessary, this information will be used to determine whether you are eligible to receive or to apply for Medicaid Benefits now or in the future. ***THIS SECTION MUST BE COMPLETED PRIOR TO ADMISSION.***

**If the Applicant is married, please also provide your spouse's income and asset information on p.5. *THIS SECTION MUST BE COMPLETED PRIOR TO ADMISSION.***

Social Security income: \$ \_\_\_\_\_ Monthly / \_\_\_ Yearly

Retirement income: \$ \_\_\_\_\_ Monthly / \_\_\_ Yearly

Other income (source) \_\_\_\_\_: \$ \_\_\_\_\_ Monthly / \_\_\_ Yearly

Checking Account(s): \_\_\_ Yes / \_\_\_ No Current balance(s): \$ \_\_\_\_\_

Bank(s): \_\_\_\_\_

Savings Account(s): \_\_\_ Yes / \_\_\_ No Current balance(s): \$ \_\_\_\_\_

Bank(s): \_\_\_\_\_

Life Insurance: \_\_\_ Yes / \_\_\_ No Company: \_\_\_\_\_

Policyholder: \_\_\_\_\_ Cash Value: \$ \_\_\_\_\_

Real Estate owned: \_\_\_\_\_

Monthly mortgage amount: \$ \_\_\_\_\_ Principle balance: \$ \_\_\_\_\_

Have you transferred, sold, or given away property or monetary assets totaling \$500 or more within the last 5 years? \_\_\_ Yes / \_\_\_ No. If yes, explain: \_\_\_\_\_

\_\_\_\_\_

Other Assets, including stocks, bonds, mutual funds, IRA, 401K, CDs, trusts, annuities:

\_\_\_\_\_

**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 MAPLEWOOD NURSING HOME.**

\_\_\_\_\_  
Applicant or Responsible Party Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Print Name of Party Signing

\_\_\_\_\_  
Date

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**INCOME & OTHER INFORMATION**

**Spouse's Name:** \_\_\_\_\_

Please provide the following information regarding your spouse's monthly income as well as all other finances and assets owned by your spouse. If necessary, this information will be used to determine whether the Applicant is eligible to receive or to apply for Medicaid Benefits now or in the future.

**Where items are joint accounts/ownership, you may write "joint" or "shared". THIS SECTION MUST BE COMPLETED PRIOR TO ADMISSION.**

Social Security income: \$ \_\_\_\_\_ Monthly / \_\_\_ Yearly

Retirement income: \$ \_\_\_\_\_ Monthly / \_\_\_ Yearly

Other income (source) \_\_\_\_\_: \$ \_\_\_\_\_ Monthly / \_\_\_ Yearly

Checking Account(s): \_\_\_ Yes / \_\_\_ No Current balance(s): \$ \_\_\_\_\_

Bank(s): \_\_\_\_\_

Savings Account(s): \_\_\_ Yes / \_\_\_ No Current balance(s): \$ \_\_\_\_\_

Bank(s): \_\_\_\_\_

Life Insurance: \_\_\_ Yes / \_\_\_ No Company: \_\_\_\_\_

Policyholder: \_\_\_\_\_ Cash Value: \$ \_\_\_\_\_

Real Estate owned: \_\_\_\_\_

Monthly mortgage amount: \$ \_\_\_\_\_ Principle balance: \$ \_\_\_\_\_

Have you transferred, sold, or given away property or monetary assets totaling \$500 or more within the last 5 years? \_\_\_ Yes / \_\_\_ No. If yes, explain: \_\_\_\_\_

\_\_\_\_\_

Other Assets, including stocks, bonds, mutual funds, IRA, 401K, CDs, trusts, annuities:

\_\_\_\_\_

**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 MAPLEWOOD NURSING HOME.**

\_\_\_\_\_  
Applicant or Responsible Party Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Print Name of Party Signing

\_\_\_\_\_  
Date