Bel~Air Nursing & Rehab Center
29 Center St.
Goffstown, NH 03045
(603) 497-4871 – Fax: (603) 497-2936

ADMISSION APPLICATION

All references herein to "Resident" mean the prospective or potential resident of Bel-Air Nursing and Rehab Center, Inc. (the "Facility"). Such references are not intended to imply and do not mean that the resident shall be considered admitted or accepted for admission upon completion of this admission application..

Applicant's Name: _____

Primary Address: _____

Hospital/Rehab Hospital being referred by: _____

Telephone No./Case Manger making referral:_____

Personal Information Regarding Applicant:

Male ( ) Female ( ) DOB: _____
Marital Status: S M W Sep. Div.
Primary Physician: _____
Specialist: _____
_____

Address and Telephone Number

Primary Language:

English: ( ) Other: _____
Any Special Needs required: _____

Contact Person Regarding this Application:

Name: _____
Address: _____
Relationship: _____
Tel. No._____ Cell: _____
Email: _____

2nd Contact:
Name: _____
Address: _____
Relationship: _____
Tel. No: _____ Cell: _____
Email: _____

Responsible Person/Legal Guardian/DPOA

Name: _____
Legal Guardian ( )
Durable POA Health ( )
Durable DPOA Finance ( )
Is DPOA Activated: Yes: ( ) No: ( )

Provide copies of documents

Living Arrangements:

Lives Alone ( ) Other: ( )

Prior Hospitalization/In-home Services

Hospitalization ( )
Rehabilitation ( )
Home Health ( )
VNA Services ( )
Mental Health ( )

Insurance Information

Private: ( )
Medicaid: ( ) Number:_____
Medicare: ( ) Number: _____
Managed: ( ) Number: _____
Carrier: _____
VA: ( )
Supplemental: ( ) _____
LTC Insurance: ( ) _____
Prescription Plan ( ) _____
_____

Provide copies of all cards front & back:

Advanced Directives in Place:

Living Will: ( )
Do Not Resuscitate : ( )
Do Not Hospitalize: ( )
Organ Donor: ( )
Medication Restrictions: ( )
Other: _____
_____

Bel-Air Nursing & Rehab Center Admission Application page 2

Financial Income		Asset Values:
Social Security Amount: _____		Real Estate: _____
Pension: _____		Savings: _____
Annuities: _____		Checking: _____
VA: _____		Retirement Account: _____
Long Term Care Ins: _____		Stocks/Bonds: _____
Other: _____		Investments: _____
		Other: _____
Medicaid		

Have you applied for Medicaid: Yes ( ) No ( ) Has Medicaid been denied: Yes ( ) No ( )
If so is Medicaid pending: Yes ( ) No ( ) Medicaid application date:_____
Has there been any gifting of assets during the last 5 years: Yes ( ) No ( )

Physician Services		Physician Contact Information:
Do you have a Primary Physician: Yes: ( ) No: ( )		Name: _____
Are you seeing a specialist Yes:( ) No: ( )		Address: _____
Area of Specialty: _____		_____
		_____

Diagnoses (list all):		Medications (list all):

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

Everything stated in this Application (and any attachments hereto) is true, correct and complete. I understand that the Facility may check bank references and Resident's credit history and I hereby authorize this activity. I also understand that the Facility considers this Application as a continuing statement of financial condition and agree to notify the Facility, in writing, of any substantial change in the above financial condition. All of this information will be kept confidential by the Facility.
I further understand, acknowledge and agree that the Facility shall reasonably rely upon the statements made herein in considering Resident for admission.

Signature of Person Completing Application	Date of Application