Application for Admission
Rockingham County Rehabilitation & Nursing Center

Applicant's Name: _____
Primary Address: _____
Other Address (if living with someone): _____
*H*ospital/Rehab Hospital being referred by: _____
Telephone No./Social Worker @ Hospital: _____

Personal Information Regarding Applicant:
Male ☐ Female ☐ DOB: _____
Marital Status:
US Citizen:

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

Contact Person Regarding this Application:
Name: _____
Address: _____
_____
Relationship: _____ Tel. No.: _____
Email: _____

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

Responsible Person/Legal Guardian/DPOA:
Legal Guardian ☐
Durable POA (Health) ☐
Durable POA (Finances) ☐
Name: _____
Address: _____
Relationship: _____ Tel. No.: _____
Email: _____
Is DPOA for health activated? Yes ☐ No ☐
(Provide copies of above documents)

Advanced Directives in Place:
Living Will ☐
Do Not Resuscitate ☐
Do Not Hospitalize ☐
Organ Donor ☐
Feeding Restrictions ☐
Medication/Treatment Restrictions ☐
(Explain): _____

Living Arrangements:
Lives alone ☐ or Other: _____

Prior Hospitalizations/In-home Services:
Rehabilitation Services ☐
Home Health Services ☐
VNA Services ☐
Mental Health Services ☐
Private Duty/Other ☐

Insurance Information for Nursing Home Stay:
Private Funds (advance payment required) ☐
Medicaid No._____ ☐
Medicare No._____ ☐
Medicare Replacement Carrier:_____
_____ ☐
Social Security No. _____ ☐
VA No. _____ ☐
Supplemental Insurance:
Ins. I.D. No.: _____
Name/Address Supplemental Insurance:
_____
_____
_____
Enrolled in Medicare "D" Prescription Drug Program: Yes ☐ No ☐
Name: _____
(Provide copies of all cards; front and back)

Monthly Income Source(s)/Assets:
Social Security check $_____
Pension check $_____
Name/Address of Pension Company:
_____
_____
_____

Assets:	**Value:**
Real Estate:	$
Savings Account:	$
Checking Account:	$
Retirement Account:	$
Stocks/Bonds:	$
IRA/CD:	$

Have you transferred/gifted assets within last 5 yrs?
Yes ☐ No ☐
(Copies of most recent statements required)

Diagnoses (list all):

Medications (list all):

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

PRIMARY PHYSICIAN:	**ANY HISTORY OF MENTAL HEALTH IN THE LAST TWO YEARS?** no
	Where /who were you seen by:
ADDRESS & TEL. NO.	ADDRESS & TEL NO.

Signature of Person Completing Application

Date of Application

12/20

Email to Admissions | Scan documents to attach

Print

Submission instructions:
Please email, fax, mail, or drop off application and additional documents as requested.
email: admissions@co.rockingham.nh.us
fax: 603-679-9456
Address: 117 North Rd, Brentwood, NH 03833