INDEPENDENT & ASSISTED LIVING COMMUNITY

SECTION 1: APPLICATION & MEDICAL INFORMATION REQUEST

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55 RIVERGLEN LANE ▲ LITTLETON, NEW HAMPSHIRE 03561 ▲ *t* 888.24.4873 ▲ *f* 877-202-2997
www.riverglenhouse.com *info@riverglenhouse.com*

Application for Admissions

Application for: ☐ Assisted Living ☐ Independent Living Date: ______________________

How did you learn about Riverglen House? ____

I. General Information

Name ____ Social Security # _______-____-_______

Age ______ Date of Birth __________ Gender M / F Marital Status ______________________

Home Address ____

Phone Numbers: Home ____________________________ Work _____________________________

Spouse's Name ____

Age _______ Date of Birth _____________ Gender M / F Social Security # _______-____-_______

Does applicant currently own or rent their home? ☐ Own ☐ Rent

Is applicant responsible for managing their own finances? ☐ Yes ☐ No

If no, please provide the name of responsible party:

Name ____ Relationship __________________

Address ____

Phone Numbers: Home ______________________________ Work ____________________________

Does applicant have Power of Attorney (POA)? ☐ Yes ☐ No

If yes, please provide the name of POA:

Name ____ Relationship __________________

Address ____

Phone Numbers: Home ______________________________ Work ____________________________

Does applicant have a durable Power of Attorney for healthcare? ☐ Yes ☐ No

If yes, please provide the name of POA for healthcare:

Name ____ Relationship __________________

Address ____

Phone Numbers: Home ______________________________ Work ____________________________

Does applicant have a living will or advanced directives? ☐ Yes ☐ No

If these documents exist, please provide copies to the facility upon application acceptance. If applicant has not completed these documents, they should see their personal physician to do so.

In case of an emergency, we should contact:
Name ______________________________ Relationship ______________

Address ____

Phone Numbers: Home ____________________ Work ____________________

Name ______________________________ Relationship ______________

Address ____

Phone Numbers: Home ____________________ Work ____________________

II. Medical Information
Primary Physician Name ______________________________________

Address ______________________________Phone Number______________

Current medical condition(s)__________________________________

____

Past medical condition(s)____________________________________

____

Specialist ____

Optometrist____

Dentist____

Funeral Home:____

Does applicant have any allergies including reactions to drugs? ☐ Yes ☐ No
If yes, please provide details__________________________________

____

Please list all medications used ______________________________

____

____

Applicants physical mobility: ☐ Walks unassisted ☐ Uses a cane ☐ Uses a walker
☐ Uses a wheelchair: can wheelchair applicant transfer unassisted? ☐ Yes ☐ No

Please place a check mark to indicate applicant's level of ability in the following areas:

Task	Can handle alone	Needs some assistance	Total assistance
Grooming/Shaving	☐	☐	☐
Dressing	☐	☐	☐
Bathing	☐	☐	☐
Mouth/ Skin Care	☐	☐	☐
Toileting	☐	☐	☐
Medication Management	☐	☐	☐
Escort/Mobility	☐	☐	☐
Housekeeping/Clothing Management	☐	☐	☐

Other daily needs ____

Does applicant have colosteomy/ileostomy? ☐ Yes ☐ No   Prosthesis? ☐ Yes ☐ No

Is applicant continent of bladder? ☐ Yes ☐ No   Of bowel? ☐ Yes ☐ No

Does applicant have difficulty seeing? ☐ Yes ☐ No   Require Oxygen? ☐ Yes ☐ No

Applicant's **mental status**:

Is applicant alert? ☐ Yes ☐ No   Oriented to time/place? ☐ Yes ☐ No

Is applicant: ☐ Forgetful ☐ Anxious ☐ Confused

Has applicant been diagnosed with: ☐ Dementia ☐ Alzheimer's Disease

Has applicant been diagnosed as mentally ill or mentally retarded? ☐ Yes ☐ No

Does applicant have need for a handicapped accessible apartment? ☐ Yes ☐ No

III. Health Insurance: *(Please provide a copy of all insurance cards.)*

Medicare Number ____________________________ Medicaid Number _________________________

Private Insurance Company ___________________________ Policy Number ____________________

IV. Social History:

Current or prior occupation(s) ____

____

Hobbies/Special Interests ____

____

____

Religious Affiliations: (OPTIONAL) ____

Social groups that applicant belongs to or has belonged to in the past:_____________________________

____

V. Financial Information

Cash Assets: *(If more than one bank, please attach another page).*

Bank ____

Address ____

Checking Account Balance $ ____________ Savings Account Balance $ ____________

Certificates of Deposit Balance $ ______________________________

Does applicant have stocks and bonds? ☐ Yes ☐ No

Approximate value of securities $ ______________________________

Other assets $ ______________________________

Does applicant own a home? ☐ Yes ☐ No Approximate Value $ ________

Does applicant own additional property? ☐ Yes ☐ No Approximate Value $ ________

Income:

Social Security $ __________/month Interest/Dividend Income $ ________

Disability $ __________/month Life Insurance Benefits $ ________

Annuity Income $ __________/month Other $ ________

Rental Income $ __________/month

Pension $ __________/month **Total Monthly Income $ ________**

Does applicant have Long Term Care Insurance? ☐ Yes ☐ No

List the value of any assets applicant has disposed of in the last two years:

$ ______________ $ ______________ $ ______________

$ ______________ $ ______________ $ ______________

I understand and agree that this application is neither a contract nor a reservation for residency. Nothing contained in this document is legally binding on either myself or Riverglen House, until a Residency Agreement has been signed and approved by both parties. I certify that the information I have given in this application is true and correct. I understand that any false statements or misrepresentations of omissions may result in the cancellation of my application or nullification of my residency agreement. I authorize Riverglen House to conduct a review of my financial status and obtain information necessary to verify my ability to pay for residency. I further agree to notify Riverglen House in writing of any substantial change in my (applicant's) financial or medical condition. Riverglen House agrees to keep this information strictly confidential.

Applicant's Signature ______________________________ Date ____________

If this form is being completed by someone other than the applicant for residency, please print the name of the person completing the information, their relationship to the applicant and sign on the line below. Please attach a copy of the Power of Attorney or other documentation authorizing a person to act on the applicant's behalf.

Name ______________________________ Relationship ____________

Signature ______________________________ Date ____________

PHYSICIAN HEALTH ASSESSMENT

To accommodate the needs of your patient at Riverglen House, the following information is required. Thank you in advance for your prompt assistance.

PERTINENT BACKGROUND INFORMATION

PATIENT NAME ______________________________ DATE OF ASSESMENT _____/_____/_____

DATE OF BIRTH _____/_____/_____

PHYSICIAN __________________________________ ADDRESS_____________________________
TELPHONE __________________________________ _____________________________

Vital Signs

WT._______ HT._______ T._______ P._______ R._______ B/P_____/_____

Medical History - Please provide brief medical history

____
____
____
____

Diagnoses
Primary____________________________________ Secondary _________________________________
Other Diagnoses/Problems____
____
____

Procedures – Please list surgical procedures & approximate dates

____
____

Allergies ____

Medications – Please list current medications and/or attach a separate page

____
____
____

Vaccinations – Please document dates of last:

Flu Vaccine _____/_____/_____ Pneumovax _____/_____/_____
Tetanus Toxoid _____/_____/_____ Tuberculin Test _____/_____/_____ Result ________

Routine Diagnostic Testing – Please attach photocopy of most recent report

Dietary Requirements – Please identify all that apply

_____Regular Diet
______No Added Salt (NAS)
______No Concentrated Sweets (NCS)
______Vegetarian
______Low Fat
______Low Cholesterol
______Mechanical Soft
______Pureed

______Diabetic Diet
______Low Sodium
______Other
____

May patient consume alcoholic beverages?
□ Yes □ No
Limitations on alcohol use:_______________
____

Functional Capabilities/Limitations **I= Independent** **A=Needs Assistance**

If Independent the resident may self administer medications without supervision and store the medications in their room in a locked container*

_____ Ambulation
_____ Light Housekeeping
_____ Reading
_____ Verbal Communication
_____ Bathing
_____ **Medication Administration***
_____ Toileting
_____ Written Communication
_____ Following Directions
_____ **Medication Management***
_____ Transfers
_____ Dressing/Grooming
_____ Personal Laundry
_____ Writing
_____ Handling Finances
_____ Preparing Light Meals
_____ Using Telephone
_____ Other(specify)____

Appliances used (if applicable)____

Orientation Person__________ Place__________ Time__________

Memory Good_______ Fair_______ Poor_______

Judgment Good_______ Fair_______ Poor_______

Explain need for supervision and/or assistance__________________________________
____
____

Communicable Diseases None ______
If known, please specify ____

DNR Status Attempt Resuscitation? □ Yes □ No

Additional Comments____
____
____

Completed by____________________________________ **Date**_____________________
(Signature)

Please mail or fax completed form to: **Executive Director** (or)
Resident Care Supervisor
Riverglen House
55 Riverglen Lane
Littleton, NH 03561

Fax Number: 877-202-2997
Tel: 888-424-4873

55 Riverglen Lane
Littleton, NH 03561
Phone: (888)424-4873
Fax: (877)202-2997

RELEASE OF MEDICAL RECORDS

I, ____ ____________________________
(Name) (DOB)

____
(Address)

Authorize ____
(Name of person or agency to disclose information)

____
(Address)

To Release to: **Director of Nursing Services** or **Executive Director**
Riverglen House of Littleton
55 Riverglen Lane
Littleton, NH 03561

_______ All medical records _______ Only records pertaining to:__________________

____

Please initial if you do not wish HIV, drug and alcohol information to be released____________

_______ This consent will expire 60 days from the date signed unless otherwise specified by me in writing.

_______ This consent shall remain in effect for the duration of my residency at Riverglen House.

I understand that I cannot withdraw already disseminated information

____ ______________________
(Name) **(Date)**

____ ______________________
(Parent, Guardian, Legal Representative) (Date)

____ ______________________
(Witness) (Date)

This facsimile contains privileged and confidential information intended only for use by the individual or department to which it is addressed. If you are not the intended recipient, please notify sender at the number listed above.