928 South Street Portsmouth, NH 03801-5475
Admissions Department: 603-766-2310
Admission FAX: 603-766-2306

APPLICATION FOR ADMISSION

Applicant's Name: ____________________

Legal Address: ____________________

Current Location: ☐ Home ☐ Rehab ☐ Assisted Living ☐ Nursing Home

Tell us what type of care you are seeking at this point:

☐ Short-Term Rehab

☐ Long-Term Living

☐ Memory Care

☐ Assisted Living

Tell us about you/your loved one:

Medical History/Diagnoses: ____________________

____

Height: __________ ***Weight:*** __________

Special Needs: ☐ Oxygen ☐ Wheelchair ☐ Specialty Lift ☐ Specialty Mattress

☐ Other: ____________________

Medications: __________ __________

__________ __________

__________ __________

__________ __________

Functional Status:

Ambulation: __________ Assistive Device: __________

Bathing/Dressing/Meals: ____________________

Cognition/Behaviors: ____________________

Skin Issues: __________ Sleep Disturbances: __________

Allergies: ____________________

What are your goals for care:

____

____

Is there anything else that would be helpful for us to know about you/your love one?

____

____

How do you plan on paying for care?

(This can be overwhelming. Please contact our Admissions Department for more information and guidance)

☐ Private Funds ☐ Medicaid ☐ Long Term Care Insurance

How can we contact you?

Your name: ____________________________________

Your Address: ____________________________________

____

Your Phone Number: ____________________________________

Your email: ____________________________________

Your relationship to Applicant: ____________________________________

Signature: ______________________________ Date: ____________________

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CONFIDENTIAL
APPLICANT FINANCIAL DISCLOSURE

All information provided on this form shall remain confidential in accordance with applicable law. The Edgewood Centre Initial Admission Application cannot be processed without the information requested on this form. Copies of Medicare, Medicaid, Insurance Cards, Living Will, Appointment of Health Care Representative, Power of Attorney, Appointment of Conservator and Health Care Agent documents (as applicable) should accompany this form. *(We would be pleased to copy these documents if you so desire.)*

Applicant's Name (Last, First, Middle Initial): ______________________________

Social Security Number: ______________________________

PAYMENT INFORMATION

How will the applicant's stay be financed? (Check all that apply)

☐ Private Funds ☐ Long-Term Care Insurance ☐ Medicaid

* ***Please provide copies of Medicare, Medicaid and other Insurance Cards***

APPLICANT'S LEGAL REPRESENTATIVES

Please provide the name(s), telephone number(s), and address(es) (street, P.O. Box and email addresses) of any individual(s) legally authorized to make financial and/or medical care decisions on behalf of the Applicant and anyone who otherwise exercises control over, or who has the authority to manage or dispose of the income and/or assets listed in this form. (For example, individuals designated as Conservator of the Person and/or of the Estate; Durable Power of Attorney, Durable Power of Attorney for Health Care Decisions; Health Care Representative or Health Care Agent, or the Trustee of a trust.)

Name: ______________________ Designation: ______________________
Address: ______________________________
Telephone Number: ______________________ Email: ______________________

Name: ______________________ Designation: ______________________
Address: ______________________________
Telephone Number: ______________________ Email: ______________________

Name: ______________________ Designation: ______________________
Address: ______________________________
Telephone Number: ______________________ Email: ______________________

* ***Please provide a copy of all legal documents that authorize the above individuals to act in their designated capacities on behalf of the applicant.***

* ***If applicant has a Conservator of the Estate, please provide a copy of the accounting with the Probate Court.***

Applicant's Assets	**Applicant's Monthly Income**	
Real Estate: ________	Social Security: ________	Source: ________
Investments: ________	Pension/Retirement: ________	Source: ________
Annuities: ________	Annuities: ________	Source: ________
Dividends: ________	Investments: ________	Source: ________
Cash: ________	Dividends: ________	Source: ________
Trust Balance: ________	Trust: ________	Source: ________
(Checking/Savings): Other: ________	Other: ________	Source: ________
Total Assets: ________	**Total Monthly Income:** ________	

Spouse's Assets	**Spouse's Monthly Income**	
Real Estate: ________	Social Security: ________	Source: ________
Investments: ________	Pension/Retirement: ________	Source: ________
Annuities: ________	Annuities: ________	Source: ________
Dividends: ________	Investments: ________	Source: ________
Cash: ________	Dividends: ________	Source: ________
Trust Balance: ________	Trust: ________	Source: ________
(Checking/Savings): Other: ________	Other: ________	Source: ________
Total Assets: ________	**Total Monthly Income:** ________	

If the Applicant and/or spouse receive income from, or have interest in trust? Please provide a copy of the trust instrument.

Are any of the Applicant's assets subject to co-ownership or any claim that might affect the availability of the assets to pay for care and services provided by Edgewood Centre? ☐ Yes ☐ No

Has the applicant been a part to any actual or threatened litigation (arbitration, demand or lawsuit) in the last 60 months?

☐ Yes ☐ No If yes, please describe, include how the case was resolved, if applicable, and provide copies of pertinent pleadings:

____

Has the Applicant, or any representative on behalf of the Applicant, sold or gifted any assets, including any cash gifts valued at $500 or more to any person or transferred assets into a trust, in the last 60 months? ☐ Yes ☐ No

If yes, please explain: ____

Are there any liens or encumbrances of any kind on any of the assets or income listed above? ☐ Yes ☐ No

If yes, please explain: ____

Are all of the assets listed on this form available to pay for the services and care provided by the Edgewood Centre?

☐ Yes ☐ No If no, explain which assets and income are not available: ______________________

____

PARTY RESPONSIBLE FOR PAYMENT OF BILL

Name: ____

Daytime Phone: ____________________ Evening Phone: ____________________

Street Address (physical): ____________________ P.O. Box (if applicable): __________

City: ____________________ State: ______________ Zip Code: ____________

Email Address: ____

Relationship to Applicant: ____________________

(For example: Conservator of the Estate, Holder of Durable Power of Attorney)

REPRESENTATION

I represent as true, complete and accurate all of the information contained in this application and the supporting documents that I have given or will give to the Edgewood Centre. I further represent and agree that I will notify the Edgewood Centre as soon as possible of any changes to such information or if I become aware of any inaccuracy, incompleteness or falsity in the information. I understand that the Edgewood Centre is considering the Applicant for admission, and may admit the Applicant in reliance on the information provided and this presentation.

Name of person completing application (please print): ______________________________

______________________	______________________	______________
Signature of Person Completing Application	Relationship to Applicant	Date

NOTICE OF PROGRAM PARTICIPATION

We are required by law to obtain from each prospective resident prior to admission a signed statement showing the prospective resident's understanding as to whether this Assisted Health Care Center participates in the Medicaid and Medicare programs; and of our policies regarding advance payments and deposits. This notice must be signed and returned to us before we can admit any resident. The prospective resident must sign the notice if he or she is capable of understanding it. If a Conservator of the Person has been appointed for the prospective resident; the Conservator should sign this document. If the prospective resident is not capable of understanding this notice and no Conservator has been appointed, anyone authorized to act for the prospective resident under a Power of Attorney or the person acting as the responsible relative of the prospective resident should sign this document.

The Edgewood Centre participates in the Medicaid (Title XIX) Program and has a Provider agreement with the State of New Hampshire to provide care and services to Medicaid assisted residents. The State Medicaid agency based on each patient's financial resources determines eligibility for Medicaid Services.

The Edgewood Centre also participates in the Medicare (Title XVIII) program and has a Provider agreement with the United States Department of Health and Human Services to provide care and services to residents who are eligible for Medicare benefits. Eligibility for Medicare benefits is determined according to rules established by the Secretary of Health and Human Services, based on the type of care that is needed and whether other requirements, such as prior three-day hospital stay are met.

NOTICE OF ADVANCE PAYMENT REQUIREMENT

PRIVATE PAY

If the patient is paying for their care from their own funds, we require and advance payment equal to one month's per diem rate. The Edgewood Centre also requires a prorated amount of the total per diem rate to cover care provided from the admission date to the end of the month. In addition, when a resident is admitted within the last fifteen (15) days of any month, the resident agrees to pay at the time of admission the total per diem rate for the next succeeding month's services. Thereafter, the resident will be billed in advance on or about the 15th of each month for per diem charges for the following month, and any accrued ancillary charges.

MEDICARE

If Medicare will cover the patient's care, there is NO required advance payment of deposit. The Edgewood Centre will bill the patient at the end of each month for any coinsurance charges that have become due and any items or services not covered by Medicare.

MEDICAID

If the resident is eligible for Medicaid Assistance at this time, there is NO required advance payment or deposit. The Edgewood Centre will bill the patient, or charge their personal account, for the items and services not covered under Medicaid at the end of each month for any such charges accrued during that month.

MEDICAID PENDING

If the patient has an application for Medicaid Assistance filed with the State Medicaid Agency prior to admission, they will be billed charges at the end of each month until their application is approved. If Medicaid Assistance is approved retroactively for any care and services for which the patient has been billed, an appropriate adjustment or refund will be made promptly. If the patient is admitted in a Medicaid Pending status the personal income must be paid at the time of admission and then again at the beginning of every month thereafter.

BILLING

All bills from the Edgewood Centre are due and payable upon receipt. If the patient has made an advance payment and is entitled to a refund for any reason, refunds will be in accordance with applicable law.

I have read this notice and understand that the Inn at Edgewood does not participate in both Medicaid or Medicare programs. I also understand the Inn at Edgewood policies regarding advance payments.

Signed: ______________________________ or ______________________________

Applicant Representative of Applicant

Relationship to Applicant: ______________ Print Name: ________________ Date: __________