HANOVER HILL
HEALTH CARE CENTER

Application for Admission

"Family Owned and Operated"

Please return completed application to:

Lori McIntire, NHA, Administrator
700 Hanover Street
Manchester, NH 03104
Telephone: 603/627-3826
Fax: 603/626-6310

Personal and Confidential

Application for Admission
Financial Disclosure

Date: _____

If you or a loved one is in need of care and services, please complete the Admissions Application. Upon receipt of the application, a member of our Admissions Team will contact the designated person to schedule a meeting and a tour.

I. GENERAL INFORMATION:

A. Customer's Name _____ Home Phone _____

Birth Date _____ Age _____ Place of Birth (Country/State) _____

Home Street Address _____

City _____ State _____ Zip _____

Marital Status _____ Spouse's Name (if applicable) _____

Previous Occupation _____

Referred to Hanover Hill by _____

Customer is now at ❑ Home ❑ Hospital ❑ Nursing Home

❑ Other, specify _____

Has the customer been admitted to the hospital within the last 30 days? ❑ Yes ❑ No

If yes, please list the hospital name _____

Has the customer ever been in another nursing home? ❑ Yes ❑ No

If yes, name of the nursing home _____ Dates of stay _____

Primary Physician Name _____

Address _____ Telephone _____

B. Individual Responsible for Paying Bill:

Name _____ Relationship _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

C. Legal Representative:

Has anyone been appointed Power of Attorney or Guardian? ❑ Yes ❑ No

If so, who? _____

Relationship to Customer _____

II. INSURANCE INFORMATION:

A. Social Security # _____ Medicare # _____ ❑ Part A ❑ Part B

Medicare Supplemental Insurance _____ Policy # _____

Long Term Care Insurance _____ Policy # _____

Medicaid # _____ Part D Plan Name _____ # _____

B. Assets:	Yes	No	Account Balance	Authorized Signatures
Checking Accounts	❑	❑	$_____	_____
Bank Name and Address: _____				
Savings Accounts	❑	❑	$_____	_____
Bank Name and Address: _____				
Certificate of Deposit	❑	❑	$_____	_____
Annuities	❑	❑	$_____	_____
Bank Name and Address: _____				
Life Insurance	❑	❑	$_____ Cash Value	_____
Name and Address of Insurance Co.: _____				
Promissory/Mrtg. Notes	❑	❑	$_____	_____
Name and Address of Maker: _____				
Trusts (attach copy)	❑	❑	$_____	_____
Life Estates	❑	❑	$_____	_____
Address of Real Estate: _____				
Investments: (Stocks, Bonds, IRAs)	❑	❑	$_____	_____

Investment Company Name: _____

C. CUSTOMER INCOME:

	Amount	Frequency: Monthly/Other
Social Secuity		
Social Secuity Supplement (SSI)		
Veteran's Benefits		
Retirement/Pension		
Rents, Dividends, Interest		
Royalties		
Other		
TOTAL INCOME		

D. REAL ESTATE ASSETS: Does the customer own their home? ❑ No ❑ Yes Value $ _____

Is the property owned jointly? ❑ No ❑ Yes

Name or Names of Co-owners _____

Does the customer own other real estate? ❑ No ❑ Yes Value $ _____

Address of Real Estate _____

E. MEDICAID/TITLE XIX (19)

Has the customer applied, or will the customer be applying, for Medical Assistance? ❑ No ❑ Yes

If the customer has applied, what was the date? _____ County _____

I hereby certify that, to the best of my knowledge, the above stated information is correct and complete. Hanover Hill Health Care Center will keep all of the information confidential.

Signature of Customer (optional) _____ Date _____

Signature of Responsible Party _____ Date _____

Hanover Hill Health Care Center complies with all governing acts to ensure that admissions to the facility are implemented through a fair and impartial practice. Policies and procedures apply to all residents admitted to the facility, without regard to religion, race, color, creed, national origin, disability, age, veteran status, and/or payment source.