Memorial Hospital
Merriman House
A MaineHealth Member

Application For Residency

Making decisions about nursing home care is not always easy. We are pleased that you are interested in the Merriman House and hope that we can assist you during this time. We would appreciate it if you could complete the following application. The information you provide will help us to understand your needs and concerns. Please fill out this form to the best of your ability. If you have any questions please contact Michelle Lato at mlato@memorialhospitalnh.org or 603-356-0635.

Applicant Name:	Sex: ☐ M ☐ F	Age:	Date of Birth:
Applicant Address:		Place of Birth:	
Phone number:	Primary Care Provider: Address:		Phone #:
Current living arrangement: ☐ Private home/apartment Who do you currently live with? ☐ Home Health Services (name of company): ☐ Nursing home (name of facility): ☐ Assisted living (name of facility):			
Marital status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single	Name of Spouse: Date of marriage:		
Name of Father:	Name of Mother (Maiden name):		
Level of education: ☐ 8th grade or less ☐9th-11th grade ☐ High school ☐ Some college ☐ Bachelor's degree ☐ Graduate degree	Military service/Branch:	Occupation:	
Religious Preference/ Church Affiliation:		US Citizen: ☐ Yes ☐ No	
Primary Language:	Secondary Language:		
Advance Directives: ☐ Durable Health Care Power of Attorney ☐ Living Will ☐ Organ donor	Has the Durable Power of Attorney for Health Care been activated by a physician: ☐ Yes ☐ No **When the DPOA has been activated, the physician has determined that the applicant is no longer of competent mind to make safe decisions for him/her self.**		
Does the applicant have a Durable Health Care Power of Attorney: ☐ Yes ☐ No	Name: Address: Phone #: (H) (C) (W) E-mail:		
Does the applicant have a Durable Power of Attorney for Finances: ☐ Yes ☐ No	Name: Address: Phone #: (H) (C) (W) E-mail:		
Does the applicant have a guardian: ☐ Yes ☐ No	Name: Address: Phone #: (H) (C) (W) E-mail:		
Present Illnesses/diagnoses:			

Memorial Hospital
Merriman House
A MaineHealth Member

Application For Residency

Surgical procedures with dates:

Reason for nursing home placement:

Does the applicant know you are applying for residency: ☐ Yes ☐ No
Are you applying for permanent or temporary residency: ☐ Permanent ☐ Temporary ☐ Respite care (10 days)

Does the applicant have a history of mental illness, intellectual disability, or developmental disability: ☐ Yes ☐ No
If yes, please explain:

Does the applicant see any other physicians routinely? (Cardiologist Neurologist, Orthopedist etc.)

Name of physician: Address: Phone #:

Name of physician: Address: Phone #:

Name of physician: Address: Phone #:

Height	Weight	Last flu vaccine	Last pneumonia vaccine	Last PPD	Last tetanus shot

Allergies:

Code status: ☐ DNR (Do Not Resuscitate) ☐ Full Code

Medications

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Is there a concern that the applicant is:
☐ Not taking their medications on time ☐ Refusing to take their medication ☐ Affected by side-effects
☐ Not taking the proper medication ☐ Forgetting to take their medication ☐ other:

Treatments (current or past history)
☐ Alcohol/Drug treatment program ☐ Chemotherapy ☐ Radiation therapy ☐ Dialysis ☐ IV meds/transfusions
☐ Pain management ☐ Tracheostomy care ☐ Oxygen therapy ☐ Physical therapy/occupational therapy
☐ Speech therapy ☐ Ventilator/respirator ☐ BiPAP/CPAP ☐ suctioning ☐ Hospice care ☐ Tube feeding
☐ Other:

Memorial Hospital
Merriman House
A MaineHealth Member

Application For Residency

Please indicate the type of assistance needed for the applicant

Dressing/undressing:

☐No help needed ☐ Supervision or reminders needed ☐ Some physical help needed ☐ A lot of physical help needed ☐ needs someone else to perform entire task

Bathing:

☐No help needed ☐ Supervision or reminders needed ☐ Some physical help needed ☐ A lot of physical help needed ☐ needs someone else to perform entire task

Bed mobility: (How well the applicant moves up or around in bed)

☐No help needed ☐ Supervision or reminders needed ☐ Some physical help needed ☐ A lot of physical help needed ☐ needs someone else to perform entire task

Transferring: (How well the applicant moves in and out of bed or chair)

☐No help needed ☐ Supervision or reminders needed ☐ Some physical help needed ☐ A lot of physical help needed ☐ needs someone else to perform entire task

Mobility: (How well the applicant moves around/walks)

☐No help needed ☐ Supervision or reminders needed ☐ Some physical help needed ☐ A lot of physical help needed ☐ needs someone else to perform entire task

Adaptive Devices:

☐ Cane ☐ Walker ☐ Crutches ☐ Wheelchair ☐ Brace

Eating:

☐No help needed ☐ Supervision or reminders needed ☐ Some physical help needed ☐ A lot of physical help needed ☐ needs someone else to perform entire task ☐ Needs adaptive devices

Eating habits:

☐Regular diet ☐Soft food ☐ Diabetic diet ☐ No/Low salt diet ☐ Puree diet ☐ Renal diet

☐ Thickened liquids ☐ Swallowing issues

☐ Snacks between meals ☐ Recent weight loss ☐ Recent weight gain ☐ Drinks alcoholic beverages

Sleeping habits:

☐ Sleeps all night ☐ awakens often ☐ Wanders at night ☐ naps during the day ☐Needs medications to sleep

☐ awakens often to use the bathroom Usual bed time: usual arising time:

Routines:

☐ Resists help with daily activities (bathing, dressing, eating) ☐ Uses tobacco products

☐ Physically aggressive (hits/swings/pushes at others) ☐ Wanders away from home

☐ Repeatedly asks the same questions/makes the same statements ☐ goes out once or more a week

☐ spends most of the time alone or watching TV

☐ Stays busy with hobbies/interests (Please list):

Memorial Hospital
Merriman House
A MaineHealth Member

Application For Residency

As Part of the process of consideration for admission to the Merriman House, we will assess your financial resources. The information is designed to provide us with certain basic financial data that is integral to this assessment. Therefore, it is extremely important that you provide us with accurate and comprehensive information when completing this form.

Financial/Insurance Information	
Social Security #	Medicare # Part A effective date: Part B effective date:
Medicaid # Date of application for Medicaid (if pending):	Medicare D Plan name (Medication plan): ID #
Are you paying by private pay: ☐ Yes ☐ No	How long will you be private pay before applying for Medicaid?
Other health insurance/Long term care insurance: Policy # Group # What is the elimination period (this is the time frame that the insurance will not pay): Does this plan also cover prescriptions ☐ Yes ☐ No	
Financial Assets (Cash value)	
Social security	Checking account
Life insurance policies	Pensions, VA, Railroad etc.
Savings account	Cash, Bonds, CDs, Annuities
Real estate (assessed value)	Does the applicant receive rental income ☐ Yes ☐ No If yes, how much:
Revocable living trust Name of Trust(s) Are you the trustee of the trust? ☐ Yes ☐ No Are you the beneficiary of the trust? ☐ Yes ☐ No Does the trust provide payment towards your monthly living expenses ☐ Yes ☐ No	
Does the applicant have a prepaid burial ☐ Yes ☐ No Name of funeral home: Address: Phone #:	

Have you transferred any assets within the last 5 years? (60 months from the date of this application? ☐ Yes ☐ No

If yes, please explain:

Do you anticipate any significant change in your financial situation, income, other support or expenses during the next 18 months? ☐ Yes ☐ No

If yes, please explain:

Do you anticipate making any gifts of money of more than $10,000 or incurring any direct or indirect obligation to provide financial assistance to another during the next 18 months? ☐ Yes ☐ No

If yes, please explain:

Thank you for filling out this application. You will be contacted by the Merriman House upon receipt of this application.