

## Mountain View Community

Center for Rehabilitation and Transitional Living



Dear Prospective Resident,

Thank you for interest in Mountain View Community. We take pride in offering the residents of Carroll County quality skilled nursing and long term care. Mountain View is a new modern facility, fully equipped to meet the needs of our Residents, from care and comfort to rehabilitation and recreation. Each resident room is private as well as having a private bathroom equipped with a shower.

### Pre-Admission Process

It is very important that Mountain View meet your rehabilitation or long term care needs; therefore, prior to admission certain information will be requested via the attached pre-admission packet. The pre-admission packet contains the Mountain View Community application and Social History Form and a checklist of needed documentation.

### Admission Process

On the day of admission, certain forms explaining our policies and procedures, resident rights, privacy practices as well as elected services (telephone and cable) will be reviewed with our Social Service Coordinators. The nursing staff will then perform their evaluations and admission assessments. Families are invited to join us for lunch on the day of admission and help personalize the new family member's room.

Mountain View Community is pleased to offer skilled nursing care, onsite rehabilitation with a complete complement of physical, occupation and speech therapist staff. We also offer a registered dietician, social service, activity department, beautician as well as housekeeping and maintenance staff. We feel you will find the staff to be caring, compassionate and professional as well as the environment to be bright, active and friendly. We are both pleased and happy to meet your needs. Please feel free to ask any questions, we are happy to assist you.

To contact the Admissions Director:

Debra Thomas, BSW  
(603)539-7511  
[dthomas@carrollcountynh.gov](mailto:dthomas@carrollcountynh.gov)

## Mountain View Community

Center for Rehabilitation and Transitional Living



93 Water Village Rd.

Ossipee, NH 03864-7200

Tel: (603) 539-7511

Fax: (603) 539-4233

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## Pre-Admission Check List

**Please provide Mountain View Community with the following documentation prior to admission.**

### Resident Application

- Complete and return

### Financial Information

- Copy of Medicare Card
- Copy of Medicaid Card or Date Applied (if applicable)
- Medicare D Plan (prescription payer source)
- Copy of Insurance Cards (if applicable)
- Funeral Home
- Copy of Social Security Card/State with Number
- Copy of DPOA Financial or Guardian over Estate

### Medical Information

- Copy of DPOA-Health Care or Guardian Over Person
- Living Will

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Applicant's Name and Date

# MOUNTAIN VIEW COMMUNITY

## Application & Social History Intake Form

Applicant's First, Middle and Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_

Prefers to be called: \_\_\_\_\_

Sex: Male / Female Place of Birth: \_\_\_\_\_

Telephone number: \_\_\_\_\_

Comments: \_\_\_\_\_

If married, applicant's maiden name: \_\_\_\_\_

### Where is the applicant entering from? Please pick the following below:

- Home/Community (E.g., private home/apartment, board/care, assisted living, group home, transitional living, other residential care arrangements)
- Nursing Home (long-term care facility)
- Skilled Nursing Facility (SNF, swing beds)
- Short-Term General Hospital (acute hospital, IPPS)
- Long-Term Care Hospital (LTCH)
- Inpatient Rehabilitation Facility (IRF, free standing facility or unit)
- Inpatient Psychiatric facility (psychiatric hospital or unit)
- Intermediate Care facility (ID/DD facility)
- Hospice (home/non-institutional)
- Hospice (institutional facility)
- Critical Access Hospital (CAH)
- Home under care of organized home health service organization
- Not listed

Current address: \_\_\_\_\_

If not residing in Carroll County, has the applicant ever lived in Carroll County?  Yes  No

If yes, when and in what town? \_\_\_\_\_

If no, does DPOA/family member currently reside in Carroll County?  Yes  No

DPOA/family member-relation to applicant: \_\_\_\_\_

Has applicant had a Medicare-covered hospital stay in the past 90 days?  Yes  No

If yes, when:

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Has the applicant had a hospital or Nursing Home stay within the last  
year \_\_\_\_\_

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#### **ADMISSION INFORMATION**

Race of Applicant. Check ones that apply:

- White
- Black or African American
- American Indian or Alaska Native
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Native Hawaiian
- Guamanian or Chamorro
- Samoan
- Other Pacific Islander
- Resident unable to respond
- Resident declines to respond
- None of the above

Ethnicity of Applicant, are you Hispanic, Latino/a, or Spanish Origin. Check ones that applies.

- No, not Hispanic, Latino/a, or Spanish origin
- Yes, Mexican, Mexican American, Chicano/a
- Yes, Puerto Rican
- Yes, Cuban
- Yes, another Hispanic, Latino/a, or Spanish origin
- Resident unable to respond
- Resident declines to respond

Does applicant need or want an interpreter to communicate?

- No
- Yes
- Unable to determine
- Not assessed/no information

Primary Physician Name and Address:

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Medical Diagnosis:

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Past Surgeries:

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Allergies:

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Dietary Information/Food Allergies:

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Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Dentures: \_\_\_\_\_

Hearing: \_\_\_\_\_ Hearing Aides: R/L  Both  Audiologist: \_\_\_\_\_

Vision:  Wears glasses  Needs large print  Assistive Devices: \_\_\_\_\_

Is there a history of drug and/or alcohol use?  Yes  No

If yes, please explain:

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Is the applicant a smoker?  Yes  No Additional information:

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Applicant's Name and Date

## COMMUNICATION and COGNITION

Primary Language: \_\_\_\_\_ Other Languages: \_\_\_\_\_

Speech:  Clear  Difficult to understand  Non-verbal

Does the applicant need or want an interpreter to communicate with a doctor or health care staff?

Yes  No, Primary

Language \_\_\_\_\_

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How often does the applicant need to have someone help you when you read instructions, prescriptions, or other written material from your doctor or pharmacy? Please choose below.

- Never
- Rarely
- Sometimes
- Often
- Always
- Resident declines to respond
- Resident unable to respond

Does the applicant participate in their medical decision making? Yes / No

Please explain:

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Able to read/write: Yes / No

Understands/responds: Yes / No

Verbal Ability: Good / Fair / Poor

Can communicate needs: Yes / No

Communication Problems/Deficits:

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Orientation:  Person  Place  Time  None

Memory:  Able to recall recent events  Poor short term memory

Able to recall past events  Poor long term memory

Some recall with cues/reminders  Intact

Has the applicant been evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition?  Yes  No

Condition related to MR/DD Status:

MR/DD with Organic Condition -  Down syndrome  Autism  Epilepsy

Other organic condition related to MR/DD

MR/DD without Organic Condition  No MR/DD

#### APPLICANT / FAMILY INFORMATION

Marital Status:  Married  Divorced  Separated  Widowed  Single

Husband/Wife (Maiden) Name: \_\_\_\_\_ If deceased, date of death: \_\_\_\_\_

Family Information/Relevant Information needed:

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#### EDUCATION/MILITARY & OCCUPATIONAL HEALTH

Schools attended:

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Highest Grade completed: \_\_\_\_\_ Veteran: Yes  No

Branch: \_\_\_\_\_

Previous occupation(s)/specialized training:

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#### RELIGIOUS BACKGROUND/INTERESTS

Religious Preference: \_\_\_\_\_ Church: \_\_\_\_\_

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Name and Phone # of involved Clergy:

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### RECREATION ASSESSMENT/INTEREST (Hobbies or Talents)

Applicant's present/past interests:

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### Musical Preferences:

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## Independent Pursuits:

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### Community Involvement:

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Describe your typical day at home \_\_\_\_\_

Comments/Other Information that is helpful for us to get to know you and for your care

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## Contact Information

Primary Contact Person: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

Address:

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City/State/Zip:

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Ext. \_\_\_\_\_

Email Address:

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Check all that apply:  Guardian -Person  Guardian -Estate  POA-Financial  
 POA-Medical

Alternate contact: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

Address:

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City/State/Zip:

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Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Ext. \_\_\_\_\_

Email Address:

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Check all that apply:  Guardian -Person  Guardian - Estate  POA-Financial.  POA-Medical

Has lack of transportation kept the applicant from medical appointments, meetings, work, or from getting things needed for daily living? Please select below.

- Yes, it has kept me from medical appointments or from getting my medications.
- Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
- No
- Applicant unable to respond:
- Applicant declines to respond

SOURCES OF INCOME:

Social Security #: \_\_\_\_\_

SSI: \_\_\_\_\_

Veterans#: \_\_\_\_\_

Railroad Retirement #: \_\_\_\_\_

Other Income: \_\_\_\_\_

Id#: \_\_\_\_\_

INSURANCE (MEDICAL):

Medicare #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

BC/BS #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Plan #: \_\_\_\_\_

AARP #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Plan #: \_\_\_\_\_

Long-Term Care Insurance #: \_\_\_\_\_ Name: \_\_\_\_\_

Other Insurance #: \_\_\_\_\_ Name: \_\_\_\_\_

Has the applicant applied to Medicaid Services? If so, when was the application submitted?  
\_\_\_\_\_

OTHER INFORMATION:

Funeral Home/Preference:  
\_\_\_\_\_

Address:  
\_\_\_\_\_

Phone:  
\_\_\_\_\_

Phone:  
\_\_\_\_\_

Signature of Applicant or Representative: \_\_\_\_\_

Date: \_\_\_\_\_