Application for Admission
Ernest P. Barka Assisted Living Facility

Applicant's Name: ______________________________
Primary Address: ______________________________
Other Address (if living with someone): ______________________________

Room Preference:	**Private** ☐	**Suite (Semi)** ☐	**Shared** ☐

(Age Requirements: 65 & over)

Personal Information Regarding Applicant:
Male ☐ Female ☐ DOB: ______________
Marital Status: **S**☐ **M**☐ **W**☐ **Sep.**☐ **Div.**☐
Primary Physician: ______________________________
____
Specialist: ______________________________
____
(Address and Tel. No.)

Living Arrangements:
Lives alone ☐ or Other: ______________________________

Prior Hospitalizations/In-home Services:
Rehabilitation Services ☐
Home Health Services ☐
VNA Services ☐
Mental Health Services ☐

Primary Language:
English: ☐ Other: ______________
Any special needs required: ______________

Contact Person Regarding this Application:
Name: ______________________________
Address: ______________________________
____
Relationship: ________ Tel. No.: ______________

2nd Contact: ______________________________
Address: ______________________________
____
Relationship: ________ Tel. No.: ______________

Responsible Person/Legal Guardian/DPOA:
Legal Guardian ☐
Durable POA (Health) ☐
Durable POA (Finances) ☐
Name: ______________________________
Address: ______________________________
Relationship: ________ Tel. No.: ______________
Is DPOA for health activated? Yes ☐ No ☐
(Provide copies of above documents)

Advanced Directives in Place:
Living Will ☐
Do Not Resuscitate ☐
Do Not Hospitalize ☐
Organ Donor ☐
Feeding Restrictions ☐
Medication/Treatment Restrictions ☐
(Explain): ______________________________

Insurance Information for Assisted Living Stay:
Private Funds (advance payment required) ☐
Medicaid No. ______________ ☐
Medicare No. ______________ ☐
Medicare Replacement Carrier: ______________
______________________________ ☐
Social Security No. ______________ ☐
VA No. ______________ ☐
Supplemental Insurance:
Ins. I.D. No.: ______________
Name/Address Supplemental Insurance:
____
____
____

Enrolled in Medicare "D" Prescription Drug Program: Yes ☐ No ☐
Name: ______________________________
(Provide copies of all cards; front and back)

Monthly Income Source(s)/Assets:
Social Security check $______________
Pension check $______________
Name/Address of Pension Company:
____
____
____

Assets:	**Value:**
Real Estate:	$
Savings Account:	$
Checking Account:	$
Retirement Account:	$
Stocks/Bonds:	$
IRA/CD:	$

(Copies of most recent statements required)

Diagnoses (list all):

____

____

____

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____

____

____

____

Medications (list all):

____

____

____

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____

Comments/pertinent information explaining why this person needs to be placed in a assisted living:

____

____

____

PICTURE RELEASE

I hereby give designated staff of Ernest P. Barka Assisted Living Facility permission to take:

1. Photographs for identification purposes — Yes ☐ No ☐
2. Photographs for the purpose of publication in local newspapers and possible display in the facility. — Yes ☐ No ☐

____
Signature of Person Completing Application

____
Date of Application

5/09 - BM

ERNEST P. BARKA ASSISTED LIVING COMMUNITY
DEMOGRAPHIC INTAKE

NAME: ______________________ PRESENT ADDRESS: ______________________
PREVIOUS ADDRESS: ______________________ LENGTH OF STAY: __________
DOB: __________ AGE: __________ PLACE OF BIRTH: ______________________ CITIZEN: __________
MOTHER (MAIDEN NAME): ______________________ FATHER: ______________________
MARITAL STATUS: __________ SPOUSE (MAIDEN NAME): ______________ DATE OF MARRIAGE: ______________
IF WIDOWED (DATE): __________

CHILDREN	ADDRESS

BROTHERS & SISTERS-PLEASE INCLUDE ALL, WHETHER LIVING OR DECEASED

PRESENT LIVING CONDITIONS: ______________________
EDUCATION: ______________________ PREVIOUS OCCUPATION: ______________________
LAST PLACE OF EMPLOYMENT: ______________________ LANGUAGE SPOKEN/UNDERSTOOD: ______________
RELIGION: ______________ ACTIVE CHURCH MEMBER/CHURCH: ______________________
PASTOR: ______________ MILITARY SERVICE: ______________ BRANCH: ______________
INTERESTS/HOBBIES/PETS: PAST/PRESENT: ______________________
COMMUNITY SERVICES: VNA, HOME HEALTH AIDE, MEALS ON WHEELS, HOMEMAKER, PT/OT, AMDC: ______________
DOCTORS/SPECIALISTS/HOSPITALS THAT MAY HAVE RECORDS:
____

____

ALLERGIES/IMMUNIZATIONS: ______________________

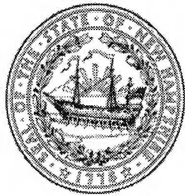
DURING HIS/HER TIME AT THE ERNEST P. BARKA ASSISTED LIVING COMMUNITY, ______________________
Does ☐ or Does Not ☐ **HAVE PERMISSION TO RECEIVE THE ANNUAL FLU VACCINATION** AS DEEMED MEDICALLY APPROPRIATE.

IN ADDITION TO THE YEARLY FLU VACCINATIONS, RESIDENTS SHOULD RECEIVE THE PNEUMOCCOAL VACCINE ONCE IF INDICATED DURING THEIR RESIDENCY AT THE ERNEST P. BARKA ASSISTED LIVING COMMUNITY.

______________________ HAS ALREADY RECEIVED THE PNEUMOCCOAL VACCINE ON

______________ AT ______________________________.

______________________ Does ☐ or Does Not ☐ HAVE PERMISSION TO RECEIVE THE PNEUMOCCOAL VACCINE.



STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH & HUMAN SERVICES
DIVISION OF COMMUNITY BASED CARE SERVICES
BUREAU OF ELDERLY & ADULT SERVICES

Form 3540
01/2012

APPENDIX A to He-E 605
STANDARD DISCLOSURE SUMMARY

For an electronic form contact beas@dhhs.state.nh.us

ADD FACILITY LOGO (optional)

FACILITY: Ernest P. Barka Assisted Living

This form is a summary. Please see the "Residential Services Agreement" for a full description of the most current costs, services, rules and policies.

Base Rate: $__________ [X] Monthly [ ] Weekly

[X] Deposit/Advance Payment $__________ (50% of monthly fee)
[X] Refundable [ ] Non-Refundable [ ] Partially Refundable

SERVICES INCLUDED IN THE BASE RATE:
Meals: (check all that apply): Daily number of Meals: 21

[X] Breakfast [X] Lunch [X] Dinner [X] Special Diets [X] Snacks

Housekeeping:

[X] Times per week: 1 [X] Hours per visit: 30 min [X] Other: TRASH/BATHROOM DAILY

Laundry Services:

[X] Personal (ON UNIT) [X] Loads per week 2 [X] Linens: SENT TO MAIN LAUNDRY

Personal Assistance (provided according to the resident's plan of care):

[X] Bathing [X] Dressing [ ] Eating [X] Grooming [ ] Toileting
[X] Medication Administration [ ] Mobility [X] Supervision of medications
[ ] Supervision of residents who wander (describe):__________
[X] Other: MOBILITY- GENERAL OVERSIGHT, TOILETING-LIMITED ASSIST PRN, MEALS SET UP AND SUPERVISION

Personal Living Unit Amenities: (check all that apply) If amenities are located in common areas and shared with other residents, put "X" in the box provided.

[X] Basic Cable TV
[X] Emergency Call System
[ ] Local phone service
[ ] Mini-refrigerator
[X] Refrigerator/freezer
[X] Stove/oven
[X] Window treatment
[ ] Cable Hookup
[X] Fully furnished unit -if needed
[X] Lockable door
[ ] Off-site storage
[X] Shower/bathtub
[X] Telephone hookup
[X] Internet Connection
[X] Carpeting
[X] Gas/Electric/Water
[X] Microwave Oven
[ ] Pets allowed
[ ] Stove-top burner
[X] Toilet & sink
[ ] Other__________

Staff Coverage (check all that apply):
"On-site hours" means the specific period of time when staff is awake, alert and on duty at the facility location. **"On-call hours"** means a specific period of time where the staff member is not present at the facility location, but can be reached to come in to work at the facility if requested to do so by management.

	Staff	On-site hours	On-call hours
[x]	Building maintenance staff	24/7	
[x]	Housekeeping staff	7A-3P	0
[x]	Licensed Nurse	7A-3P	24/7
[x]	Licensed Nursing Asst. (LNA)	24/7	
[ ]	Personal care attendant		
[ ]	Other:		

Transportation:

Assist with arranging for transportation

- [x] Car
- [ ] Scheduled route only
- [x] Resident parking available
- [ ] Van/mini bus with lift
- [ ] Unscheduled/on call
- [ ] Mileage limitations: ___
- [ ] Daily
- [x] Times per week 1
- [ ] Geographic limitations (specify): ___
- [ ] Available destination (if limited): ___

Recreation and Leisure (indicate activity and schedule):
Please note that this section includes activities provided at the facility free of charge, but does not include elective outing outside the facility (for example, going out to lunch or to a concert). Such elective outings will be at the resident's own expense unless otherwise specified by the facility.
Activities are scheduled 2-3 times per day

Other Services Included in Base Rate: ___

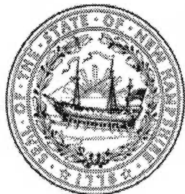
Services not included in Base Rate, but available for an extra charge.
Please include cost and unit of service. You may attach a separate sheet if additional space is needed. TELEPHONE, CABLE TV, HAIRDRESSER, MEDICATIONS, MEDICAL SUPPLIES, ON-SITE DENTAL CLINIC, ON-SITE PODIATRY, ON-SITE MENTAL HEALTH
PT, OT, AND SPEECH THERAPY AVAILABLE ON-SITE AND OFF CAMPUS

Regulatory Oversight (Please check if applicable):
- [x] Licensed/Certified Health Facility (RSA 151) Type: 805 SUPPORTED RESIDENTIAL HEALTHCARE FACILITY
- [ ] Other ___

Additional Comments (if any) by Facility: ___

Signature of Prospective Resident ___ **Date** ___

Signature of Facility Staff Completing Form ___ **Date** ___



STATE OF NEW HAMPSHIRE
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Instructions For Completing Form 3540, "Standard Disclosure Summary"

PURPOSE

Form 3540 is completed in accordance with RSA 161-J and He-E 605, the rule adopted by the Bureau of Elderly and Adult Services on the Standard Disclosure Summary. Form 3540 enables prospective residents of assisted living facilities, independent living retirement communities or other housing for older persons to make informed choices about residential services and costs.

Form 3540 is a summary only. A full description of the most current costs, services, rules and policies pertaining to the assisted living facility, independent living retirement community or other housing for older persons is contained in the Residential Services Agreement required under RSA 161-J.

FORM COMPLETION

Form 3540 is completed with the prospective resident by the staff member from the assisted living facility, independent living retirement community or other housing for older persons. The staff member enters the base rate (monthly or weekly) that is charged, and then reviews with the prospective resident the services listed on Form 3540, indicating which services are provided. The facility staff member signs the form in the space provided and gives it to the prospective resident for his/her review. If the prospective resident decides to pursue admission to the facility, he/she needs to sign Form 3540 when the Residential Services Agreement is completed.

RETENTION

A copy of the completed Form 3540 is given to the prospective resident and a copy is retained by the assisted living facility, independent living retirement community or other housing for older persons.

He-E 605.04 Completion of the Standard Disclosure Summary.
Adopted Rule Effective 1/1/12

(a) Each resident, prospective resident or his/her representative shall be given a standard disclosure summary by the residence in accordance with RSA 161-J: 4 prior to beginning residency in an assisted living residence, independent living retirement community, or other housing for older persons.

(b) Residences and independent living retirement communities shall utilize Form 3540 entitled "Standard Disclosure Summary" (January 2012) provided by the department in accordance with RSA 161-J: 4, II(j), and:

(1) The Standard Disclosure Summary form shall be the cover sheet for the residential services agreement described in RSA 161-J: 4(j); and

(2) No alteration or amendment shall be made to the content of the Standard Disclosure Summary form with the exception of the insertion of the logo of the residence.