Glencliff Home
PO Box 76, 393 High Street, Glencliff NH 03238
Phone (603) 989-3111 Fax (603) 989-3040

Application for Placement

Date: _____

Agency or Individual Making Referral: _____
Address: _____
Telephone: _____ Fax: _____
Email: _____ Relationship: _____

Vital Information

Name of Applicant:_____ DOB: _____
Social Security number: _____
Address: _____
Telephone: _____ Fax: _____
Sex: __ M __ F US Citizen? __Y __ N Birthplace: _____
Occupation: _____Veteran? __Y __ N
Marital status: __Married __Divorced __Widowed __Never married
Spouse's Name (maiden name if applicable): _____
Address: _____
Telephone: _____ Fax: _____
Spouse occupation: _____
Place of Birth: _____
Father's Name: _____ Occupation: _____
Mother's Name (inc. maiden): _____ Occupation: _____

Psychiatric History

Psychiatric and Medical Diagnoses: _____
_____
Previous Psychiatric Hospitalization(s)
Date: _____ Location: _____
Date: _____ Location: _____

Guardian

Does applicant have a guardian over person? __ Y __ N Date obtained: _____
Does applicant have a guardian over estate? __ Y __ N Date obtained: _____
Guardian name: _____ Relationship: _____
Address: _____
Telephone: _____ Fax: _____

Durable Power of Attorney (DPOA)

Does applicant have DPOA for health care? __ Y __ N Activated? ___Y ___N
Does applicant have DPOA for finances? __ Y __ N Activated? ___Y ___N
DPOA name: _____ Relationship: _____
Address: _____
Telephone: _____ Fax: _____

Representative Payee

Who is the Representative Payee for Social Security Benefits? _____

Medications

Medication name	Dose	Frequency taken
Please attach list separately, or copy current Medication Administration Record and submit with application.		

Allergies: _____
Diet: _____

Current Living Situation

Length of time in current living situation? _____
Briefly describe current living situation and reason this is no longer viable:

_____

_____

_____

_____

_____

_____

_____

Social History

Please list names and contact information for all relatives and close friends. Please designate one to be notified re. applicant's needs or changes in condition.

Designated contact person: (Guardian/DPOA for healthcare, or other individual)

Name: _____ Relationship: _____
Address: _____
Telephone: _____

Other relatives and/or friends:

Name: _____ Relationship: _____

Address: _____

Telephone: _____

Name: _____ Relationship: _____

Address: _____

Telephone: _____

Please list additional names/addresses on a separate sheet if necessary

Current relationship with individuals listed above: _____

_____

_____

Past and current hobbies and interests: _____

_____

_____

Realistic goals for this applicant: _____

_____

_____

Previous placements or attempted placements (must have two minimum):

_____

_____

_____

Briefly describe what led to application to Glencliff Home and why we would be the best choice: _____

_____

_____

_____

_____

_____

_____

Financial

Does applicant own property? __ Y __ N
If Yes, please give location and details: _____
_____

Medical Insurance

Medicare Part A (Hospital) # _____ Effective Date ____/____/____
Medicare Part B (Medical) __Y __ N Effective Date ____/____/____
Medicare Part D (Prescription) # _____Effective Date ____/ ____/ ____

NH Medicaid ID# _____ District Office: _____

Other Insurance

Name: _____
Name of policy holder: _____
ID# _____ Group # _____

CHAMPUS (VA Med) __ Y __ N
Please list additional insurance on separate page

Advanced Directives

DNR in place? __ Y __ N Living Will in place? __Y __ N

Religion/Burial Plans

Applicant's religious preference: _____
Does applicant have a prepaid burial plan? __ Y __ N
If yes, with whom: _____
Address: _____
Telephone: _____
How much is the plan/contract? $ _____ Please attach a copy of the contract.
Does the applicant have a plot? __ Y __ N
If yes, under what name is the plot found? _____
Name and location of cemetary: _____
Does the applicant have a preference to be cremated? __Y __ N
Please list details: _____

Name of person completing form_____
Signature _____
Date_____