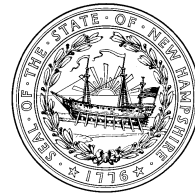


Glenclyff Home

PO Box 76, 393 High Street, Glenclyff 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 ☐ NDoes 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 Glenclyff 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 cemetery: _____

Does the applicant have a preference to be cremated? ☐ Y ☐ N

Please list details: _____

Name of person completing form _____

Signature _____

Date _____