Mountain View Community

Center for Rehabilitation and Transitional Living

93Water Village Rd.

Ossipee, NH 03864-7200

Tel: (603) 539-7511

Fax: (603) 539-4233

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 Director of Social Services and Admissions. 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 Social Service Coordinators, they can be reached by:

Call our main line 603-539-7511 and ask for Susan Gelinas or Debra Thomas

Or Email: sgelinas@mtnview.org / dthomas@mtnviewnh.org

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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

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: _____

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_____
_____
_____

ADMISSION INFORMATION

Primary Physician Name and Address:
_____

_____

Medical Diagnosis:
_____

_____

_____

Past Surgeries:
_____

_____

Allergies:
_____

Dietary Information/Food Allergies:
_____
_____

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:
_____

_____

Is the applicant a smoker? ___Yes ___No

Additional information:
_____

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_____

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:
_____
_____
_____

Able to read/write: Yes / No

Understands/responds: Yes / No

Verbal Ability: Good / Fair / Poor

Can communicate needs: Yes / No

Communication Problems/Deficits:

_____

_____

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:

_____

_____

_____

_____

Applicant's Name and Date

EDUCATION/MILITARY & OCCUPATIONAL HEALTH

Schools attended:
_____

_____

Highest Grade completed: _____ Veteran: Yes____ No____ Branch: _____

Previous occupation(s)/specialized training:
_____

RELIGIOUS BACKGROUND/INTERESTS

Religious Preference: _____ Church: _____

Name and Phone # of involved Clergy:
_____

RECREATION ASSESSMENT/INTEREST (Hobbies or Talents)

Applicant's present/past interests:
_____

_____

_____

Musical Preferences:
_____

Independent Pursuits:
_____

Community Involvement:
_____

Describe your typical day at home_____

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

_____

Applicant's Name and Date

Contact Information

Primary Contact Person: _____ Relationship to applicant: _____

Address:
_____

City/State/Zip:
_____

Home Phone: _____ Work Phone: _____
Ext. _____

Email Address:
_____

Check all that apply: ___Guardian -Person ___Guardian -Estate ___POA-Financial

___ POA-Medical

Alternate contact: _____Relationship to applicant: _____

Address:
_____
_____

City/State/Zip:
_____

Home Phone: _____ Work Phone: _____
Ext. _____

Email Address:
_____

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: _____