



55 Kent Lane Nashua NH 03062

603-598-1440 or 800-298-6608

www.TheHuntingtonAtNashua.org

How to Join the Wait List

- Make an appointment with the Marketing Department to learn about The Huntington at Nashua Life Care Retirement Community.
- Complete and return the Wait List Confidential Data Application. Please include a copy of your last year's Federal Income Tax Return. Additional supporting financial information may be required.
- Have your physician complete the Medical Application. We will also require two years of medical history from your physician and a signed authorization release for additional medical information if required.
- Submit a fee of Two Thousand Seven Hundred and Fifty dollars (\$2,750) which is fully refundable if your application is not accepted.
- If your application is accepted, Seven Hundred and Fifty dollars (\$750.00) is a non-refundable application fee. Two Thousand (\$2,000) is a deposit which is applied to the entrance fee upon move-in. There is no interest paid on the deposit. The \$2,000 deposit is refundable if you submit in writing your desire to withdraw from our Wait List. Please make check payable to The Huntington at Nashua.
- Consider yourself on the Wait List for The Huntington at Nashua upon receiving written notification of your acceptance. Based on your indicated/desired waiting time and apartment choice, you will be notified when an apartment or cottage is available for you to consider. You will have three opportunities to accept an apartment or cottage home, before your name is rotated to the bottom of the list.
- At that time you accept an apartment or cottage, you will be asked to update your application both financially and medically before final approval is established.



Wait List
Number: _____



**Wait List
Applicant(s) General Information**

Date: _____

Applicant Name: _____

Age: _____ **Date of Birth:** _____

Second Applicant's Name: _____

Age: _____ **Date of Birth:** _____

Current Address: _____
(Street) (City) (Zip Code)

Current Telephone Number: _____

Do you plan on bringing a pet? _____ **If so, what type?** _____

Type of Apartment/Cottage Home you are interested in occupying: (number in preference)

1-Bedroom 1 Bath	Large 1-Bedroom 1.5 Baths	2-Bedroom 2 Baths	Cottage
___ ANY	___ ANY	___ ANY	___ Banbury
___ Amberley	___ Gleaston	___ Oxford	___ Newcastle
___ Duffield	___ Kingsland	___ Pembridge	___ Richmond
___ Ellesmere	___ Levington (w/Den)	___ Scarborough	
		___ Windsor	

I prefer:

___ An End Unit ___ A Non-End Unit ___ Either ___ Basement
___ Ground Level ___ Second Level ___ Third Level

I would like to move to the Huntington:

___ As soon as possible ___ 1-2 Years ___ 2-5 Years ___ 5+ Years

Seasonal Information:

Seasonal Address: _____
(Street) (City) (Zip Code)

Seasonal Telephone Number: _____



Authorization Form

For the Use and Disclosure of Individually Identifiable Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

This authorization expires on _____

Persons/organizations authorized to use and/or disclose the information:

Persons/organizations authorized to receive the information:

Specific description of information that may be used/disclosed:

The information will be used/disclosed for the following purposes:

I understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that the Department will not condition treatment, payment or enrollment in a health plan based on this authorization. I understand that I may revoke this authorization at any time by notifying the Department in writing. However, the revocation will not be valid if:

- a. The Department has taken action in reliance on this authorization; or
- b. If this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Please sign below.

Signature

Date

Printed Name

Notary Name & Seal

If the above signature is that of a patient representative, please attach the appropriate legal documentation.

For Department Use Only

If the above signature is that of a patient representative, complete the following:

The Department has verified the identity of the patient representative.

Signature /Title

Date



55 Kent Lane
Nashua, NH 03062
603-598-1440 – Fax: 603-598-1442
www.TheHuntingtonAtNashua.org

Medical Information Form

Dear Physician:

This is a confidential admission physical examination form to be completed for prospective residents of The Huntington at Nashua.

As you are aware, The Huntington at Nashua is a Life Care Retirement Community offering a full spectrum of services to adults 62 and older.

The completion of this document is necessary for the applicant to be considered for residency to The Huntington at Nashua in an independent setting.

The focus of The Huntington at Nashua is to provide a quality living environment, which encourages individuals to maintain healthy, active and self-sufficient life styles by assuring access to on-site health care.

Thank you for providing this necessary information. Should you have further questions about The Huntington at Nashua, please do not hesitate to call.

Sincerely,

Eileen M. Hegarty
Director of Operations

I, the undersigned, authorize the release of the following medical information to the management and the Board on a need to know basis.

Future Resident

Address

Date: _____

To Be Filled Out by Future Resident: Personal Profile

I. Name _____ D.O.B. _____ Age _____ Sex _____

Current Address _____

Responsible Party or Contact in case of an emergency (Include name, address, phone number & relationship)

1. _____

2. _____

Primary Physician _____ Phone (____) _____

Address _____

Medicare Part A [] Part B [] _____ Medicare No. _____

Supplemental Insurance _____ Policy No. _____

Medical History

Attention Practitioner -- Please complete this form in detail

or attach patient's current health & physical report inclusive of lab work and consults.

II. Diet _____

Allergies _____

Immunizations (must be offered)

Flu Vaccine/Date: _____

Pneumovax/Date: _____

Tuberculin Testing _____

Medications: Include dosage & frequency
Medication Usage:

Drug	Dose	Frequency
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1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

Part A.

Indicate all of the following medical conditions which are currently present in the examinee. Check the appropriate box and indicate in space provided under each category the following information:

1) Date of Dx. 2) Is condition current and for how long has condition been under continuous control? 3) Does this condition require constant treatment (If so, specify)? 4) Method of control (i.e. diet, meds, other prescribed medical treatment and specify each). 5) Indicate dates and locations of hospitalizations associated with treatment of condition.

Endocrine:

1. [] Endocrine disorders (specify)

2. [] Diabetes

[] Current Treatment

Gastrointestinal:

- 3. Peptic Ulcer
- Hiatus Hernia
- Other Upper Intestinal Disorder

- 4. Diverticulosis
- Colitis
- Other _____

Current Treatment

Cardiovascular:

- 5. Hypertension
- 7. Post Pacemaker Insertion
- 9. Post Stroke or Post Stroke Syndrome

- 6. Post Myocardial Infarction
- 8. Cardiac Decompensation Arrhythmia
- 10. Arteriosclerotic Heart Disease

Current Treatment

- 11. Rheumatoid Arthritis
- 12. Osteoarthritis

Current Treatment

- 13. Alcoholism and/or
- 14. Drug Dependency

Current Treatment

- 15. Gout

Current Treatment

Part B.

Indicate if examinee currently has any of the following conditions, the date diagnosed, confinement in a hospital or other health related facility within the last 24 months and date/locations of confinements if applicable.

1. Known Active Malignancy: Date Dx: _____ Primary Site _____
 Has condition necessitated confinement in a hospital or other health related facility within 24 months,
 Yes No
 If yes, dates/locations of confinements _____

2. Chronic Liver Disease or Cirrhosis: Date Dx: _____
 Has condition necessitated confinement in a hospital or other health related facility within 24 months,
 Yes No
 If yes, dates/locations of confinements _____

End stage Renal Disease (specify below): Date Dx: _____

3. Amyloidosis

6. Chronic Pyelonephritis

4. Chronic Glomerulonephritis

7. Hydronephritis

5. Chronic Uremia

Has condition necessitated confinement in a hospital or other health related facility within 24 months,

Yes No

If yes, dates/locations of confinements _____

Debilitating Neuromuscular Disease (specify below): Date of Dx: _____

8. Parkinson's Disease

11. Multiple Sclerosis

9. Anterior Horn Cell Disease (Myopathies/neuropathies)

10. Huntington's Chorea

Has condition necessitated confinement in a hospital or other health related facility within 24 months,

Yes No

If yes, dates/locations of confinements _____

Current Treatment

Part C.

Indicate if examinee currently has any of the following medical or psychiatric conditions and the date of original diagnosis.

Chronic Brain Disease (Dementia) (specify below) Date of Dx: _____

1. Chronic Dementia

3. Alcoholic Psychoses

2. OBS associated with drug use

4. Korsakoff's Syndrome

5. Alzheimer's Disease

Mental Disorders:

1. Affective Psychoses Dx: _____ Date of Dx: _____

Current Treatment

Part D.

Indicate if examinee has any medical condition not listed in parts A, B, & C that has:

1) Necessitated treatment, services or prescribed medications during the last 90 days: _____

2) If so, did condition necessitate confinement in a hospital or other health related facility within the last 12 months.

Part E.

Physical Exam and Review Systems. (Use "NL" if normal, where appropriate).

- A. Appearance _____
1. Weight _____ 2. Height _____
3. BP _____ Any postural change? Yes No
4. Pulse _____ regular irregular
5. Eye Glasses? Yes No Fundi _____
- Vision _____
- Eye abnormalities _____ Tension _____ Cataract _____
6. Ears _____
- Impairment? Yes No
- Hearing Aids? Yes No
7. Nose _____
8. Mouth: upper denture: Yes No
- lower denture: Yes No
9. Neck: thyroid _____
- Carotids: (R) _____ (L) _____
- Bruits: (R) _____ Yes No
- (L) _____ Yes No
10. Chest: _____
11. Breasts: _____
12. Axilla: _____
13. Heart: rhythm _____ Chest Pain Edema
- murmurs _____ Palpitations
14. Abdomen
- Liver _____
- Spleen _____
- Masses _____
- Hemic _____
15. Extremities:
- edema: _____
- pulses: post. tibial _____ (R) _____ (L)
- dors. pedis _____ (R) _____ (L)
16. Skin _____
17. Neurological: Seizures Blackout spells Aphasia Diminished memory
- Cranial nerves (II-XII) _____
- Tremor: Yes No
- Motor Strength: symmetrical and strong: Yes No
- symmetrical and weak: Yes No
- asymmetrical: Yes No
- any paralysis: Yes No

Other Comments: _____

Sensory: grossly normal: Yes No

If no, please comment: _____

Please indicate the functional status of examinee today in relation to the following activities of daily living.

	Independent	With Some Assistance	Dependent
Bathing			
Dressing			
Transferring			
Toileting			
Eating			
Mobility			
Medication Administration			

If with assistance or dependent describe: _____

18. Genito-Urinary:

a. Males: hematuria stones venereal disease

Testes _____

Penis _____

Prostate _____

Bladder _____

urgency frequency hesitancy

Comments: _____

b. Female: hematuria stones venereal disease discharge bleeding

Vagina _____

Cervix _____

Ovaries _____

Bladder _____

urgency frequency hesitancy

Comments: _____

c. Bowel Control:

continent selfcare assistance with external device incontinent

d. Bladder Control:

continent selfcare assistance with external device incontinent

19. Provide report if available:

EKG _____ Last Hematocrit _____

Chest X-Ray _____ Hemoglobin _____

Part F.

List all medical or surgical conditions (including all hospitalization(s) associated with conditions) not listed in parts B,C,D & E.

Do you feel that this applicant is an appropriate candidate for participation in independent living at The Huntington at Nashua?

Physician's Signature: _____

Print or Type Name: _____

Address: _____

City/State/Zip Code: _____

Telephone Number (_____) _____

Date: _____

Again, our sincere thanks for your help



Wait List
Confidential Data Application
Financial Information

NAME: First Person Telephone #:
DATE OF BIRTH:
ADDRESS: Street City State Zip

MARITAL STATUS Single Married Widowed SOCIAL SECURITY # Relationship

NAME: Second Person to First Person

DATE OF BIRTH:

MARITAL STATUS Single Married Widowed SOCIAL SECURITY #

ASSETS (Note: If Jointly owned enter under First Person and designate with a "J")

Table with columns for First Person and Second Person assets. Rows include: 1. Equity in Residence, 2. Checking, Savings & CDs, 3. Stocks & Bonds, 4. Trusts & Estate Equities available for use, 5. Other Real Estate Equities, 6. Other, TOTAL ASSETS.

Less Total Entrance Fee \$()

TOTAL COMBINED ASSETS \$

MONTHLY INCOME (Note: If either person has survivor benefits, indicate by entering the percentage after filling in the monthly amount. Does your pension/retirement income allow for annual adjustment of your monthly income based on the Consumer Price Index? Yes No?)

Table with columns for First Person and Second Person income. Rows include: 7. Social Security, 8. Pension/Retirement Income, 9. Interest, 10. Dividends, 11. Trust & Estate Equities, 12. Other, TOTAL INCOME.

TOTAL COMBINED INCOME \$

Please list any Debts (i.e., Mortgage) or Liabilities in excess of \$5,000.

_____	\$ _____
_____	\$ _____
_____	\$ _____

Please include any comments regarding the Financial Information listed.

(Please identify line item #)

	1 st Person	2 nd Person
Do you have Long Term Care Insurance?	Yes No	Yes No

Name(s) of Power of Attorney: _____
(First Person) (Second Person)

Please give name, address and telephone of children or nearest relatives.

1. _____
2. _____

I understand that prior to accepting this application, the Approval Committee may request additional information concerning my finances.

_____ First Person	_____ Second Person
_____ Date	_____ Date

**** PLEASE BRING LAST YEAR'S TAX RETURN TO THE APPOINTMENT.**