MEMBER APPLICATION

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Step 1:

To make application to the At Home By Hunt Program, please submit the following items to your sales counselor.

- ☐ A completed Confidential Data Financial Application
- ☐ A completed Monthly Expense Worksheet
- ☐ Last year's Federal Income Tax Return
- ☐ A copy of your Long Term Care Policy, if applicable
- ☐ A completed Personal Health Questionnaire
- ☐ A signed authorization of medical release. Please leave "Practice Name" blank on one of the two forms. We will use this form for any specialists you have.

Additional medical and/or financial information may be requested.

Please submit a non-refundable application fee of $300 for one person or $350 for a couple. Please make the check payable to Hunt Community.

Step 2:

The Personal Care Coordinator will be in touch with you set up the following:

- ☐ A home review with the At Home By Hunt Care Coordinator
- ☐ A personal medical discussion and review with the At Home By Hunt Care Coordinator

Additional medical and/or financial information may be requested.

Confidentiality Statement

Hunt Community, At Home By Hunt and The Huntington at Nashua shall hold confidential data information in strictest confidence and agree that it shall be used only for the contemplated purposes of approval and continued residency/membership in any of our programs and shall not be used for any other purpose, or disclosed to any third party.

I affirm that the information and documents provided are a true statement of facts known to me.

_____ _____

Signature Date

_____ _____

Signature Date

ACKNOWLEDGMENT

Applicant Name(s): _____/_____

I understand that completion of the requested forms does not guarantee my admission to At Home By Hunt.

I understand that admission is subject to a satisfactory review of my financial and health status.

I understand that if accepted as a member of the At Home By Hunt program, the membership fee is due within 30 days of acceptance.

I understand that I will be required to provide certain financial records, to authorize the release of medical records, and to complete a medical and cognitive assessment.

I specifically authorize a representative of At Home By Hunt to discuss the results of the assessment(s) and medical record review with my personal physician(s) for the purpose of determining my eligibility for admission to At Home By Hunt.

_____ _____

Date Applicant Signature

_____ _____

Date Applicant Signature

At Home
BY HUNT

Confidential Data Financial Application

NAME: FIRST PERSON _____ TELEPHONE #: _____
DATE OF BIRTH: _____
ADDRESS: _____
STREET CITY STATE ZIP
MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED
SOCIAL SECURITY # __ __ __ - __ __ - __ __ __ __

NAME: SECOND PERSON _____ RELATIONSHIP TO _____
DATE OF BIRTH: _____ FIRST PERSON
MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED
SOCIAL SECURITY # __ __ __ - __ __ - __ __ __ __

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

	First Person	Second Person
1. Equity in Residence (Estimated Value less Mortgage)	$ _____	$ _____
2. Checking, Savings & CD's	$ _____	$ _____
3. Stocks & Bonds	$ _____	$ _____
4. Trusts & Estate Equities Available for use	$ _____	$ _____
5. Other Real Estate Equities	$ _____	$ _____
6. Other_____ (Please define)	$ _____	$ _____
TOTAL ASSETS	$ _____	$ _____
Less Total Member 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 ____

7. Social Security	$ _____	$ _____
8. Pension/Retirement Income	$ _____	$ _____
9. Interest	$ _____	$ _____
10. Dividends	$ _____	$ _____
11. Other_____ (Please define)	$ _____	$ _____
12. Other _____ (Please define)	$ _____	$ _____
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 FINANACIAL INFORMATION LISTED.

(PLEASE IDENTIFY LINE ITEM #)

_____
_____
_____
_____

	1ST PERSON		2ND PERSON	
DO YOU HAVE LONG TERM CARE INSURANCE?	YES	NO	YES	NO

IF YES, PLEASE PROVIDE A COPY OF POLICY.
PLEASE GIVE NAME, ADDRESS AND TELEPHONE OF CHILDREN OR NEAREST RELATIVES.

1. _____
2. _____
3. _____

I understand that prior to accepting this application; the Approval Committee may request additional information concerning my finances. I hereby declare that all statements made herein and other information provided are true according to my best knowledge and belief, in witness thereof I have hereto set my hand to this application this day _____ of _____, _____ (Year).

_____ _____
First Person Second Person

Monthly Expense Worksheet

Name(s) of Applicant: _____

Address of residence: _____

	Present Monthly Expenses
Housing	
Monthly Mortgage/Rent	$
Homeowner's/Tenant Insurance	$
Property Taxes	$
Condo Fee	$
Home Security System Fees	$
Housing Total	$
Utilities	
Heat/Oil/Gas	$
Electricity/Lights/AC	$
Water & Sewer	$
Telephone – Home and Cell	$
Cable / Internet	$
Utilities Total	$

Home Maintenance	
General Maintenance and Servicing	$
Major Repairs and Replacement	$
Trash Collection, Yard Care, Snow Removal	$
Housekeeping	$
Redecoration/Updates/Replacement	$
Home Maintenance Total	$
Transportation	
Auto Payment	$
Auto Insurance/Registration	$
Fuel	$
Auto Servicing and Repairs	$
Other	$
Transportation Total	$
Other Spending	
Food and Groceries	$
Dining Out	$
Credit card payments/loan payments	$
Life Insurance monthly premium	$
Long-Term Care Insurance premium	$
Clothing	$
Travel/Vacations	$
Other entertainment	$
Other Total	$

Health Care Expenses	
Medicare Premium	$
Supplemental Insurance Premium	$
Prescription Costs (insurance premiums & co-payments)	$
Health Care Total	$
Other Personal Expenses	
	$
	$
Other Personal Expenses Total	$
TOTAL MONTHLY EXPENSES	**$**

I/we affirm that the information shared above provide a true statement of facts known to me.

Signature of Applicant:_____Date:_____

Signature of co-applicant: _____Date: _____

At Home
BY HUNT

PERSONAL HEALTH QUESTIONNAIRE

GENERAL INFORMATION

Name: _____ DOB: _____

Street Address: _____ City: _____ State: _____

Home Ph #:_____ Cell Ph #: _____

E-Mail Address: _____ Sex: _____ Male ____ Female

Veteran Status: _____YES _____ NO If Yes, Branch: _____

Social Security #: _____ Marital Status: ___ S ___ M ___ W ___D

Spouse's Name: _____ Age: _____ If deceased, date: _____

MEDICAL INFORMATION

Medicare #: _____ Medicare Part _____A _____ B

Medicare Part D #: _____ Part D Insurance Name: _____

Supplemental Insurance: _____

Policy #: _____ Group #: _____

Primary Care Provider

Name: _____

Address:_____

City, State, Zip:_____

Phone # : _____

Fax #:_____

Specialty Physician *

Name:_____

Address:_____

City, State, Zip:_____

Phone # : _____

Fax#:_____

***Please attach a list of other specialty physicians you see regularly**

Emergency Contact:

Name: _____ Relationship: _____

Address: _____

Home Phone #: _____ Cell Phone #: _____

Alternate Emergency Contact (1):

Name: _____ Relationship: _____

Address: _____

Home Phone #: _____ Cell Phone #: _____

Alternate Emergency Contact (2):

Name: _____ Relationship: _____

Address: _____

Home Phone #: _____ Cell Phone #: _____

List All Medications and Supplements You Take on a Regular Basis:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

***Attach additional page for continued list of medications if needed**

Hospital Preference: _____

List hospitalizations (year and date) in the past 2 years:

_____

_____

_____

Emergency Room visits in the past year: _____ YES _____ NO Number of Visits: _____

Reason for ER visit(s):_____

Falls in the past year: _____ YES _____ NO

Reason for fall(s): _____

_____

List Allergies (food, medication, other sources): _____

_____

Tobacco Use: _____ YES _____ NO If YES, type and amount per day: _____

Alcohol Consumption: _____ YES _____ NO

If YES, type and amount per week: _____

Do you exercise? _____ YES _____ NO

If YES, type and frequency: _____

Advance Directives:

Power of Attorney for Healthcare: _____ YES _____ NO

Name/Relationship of person appointed: _____

Address:_____

Home Ph #: _____ Cell Ph #: _____

Power of Attorney for Finances: _____ YES _____ NO

Name/Relationship of person appointed: _____

Address: _____

Home Ph #: _____ Cell Ph #: _____

Have you ever been diagnosed with the following? Check all that apply:

___ Kidney Disease	___ COPD	___ Depression
___ High Blood Pressure	___ Asthma/Emphysema	___ Diabetes
___ Alzheimer's Disease/Dementia	___ Mental Illness	___ Arthritis
___ Stroke/TIA	___ Parkinson's Disease	___ Heart Disease
___ Osteoporosis	___ Frequent Falls	___ Cancer

Are you currently being treated for any items checked above? ____ YES ___ NO

PERSONAL BACKGROUND/SOCIAL HISTORY

Birthplace: _____

Education: _____

Primary Language: _____ Second Language: _____

Religious Denomination (if applicable): _____

Occupation (if retired, previous occupation): _____

Family/Significant Others:

Siblings (Name, Age, Location)	**Children (Name, Age, Location)**
_____	_____
_____	_____
_____	_____
_____	_____

Who do you consider your Support System?

___ Spouse ___ Child/Children ___ Sibling(s)

___ Significant Other/Partner ___ Relative ___ Neighbor(s)

___ Other: _____

How do you spend your Holidays: _____

_____

How do you keep busy? (Hobbies, Group/Community Activities, etc.): _____

_____

Significant Life Events: _____

_____

Significant Losses: _____

_____

Additional Comments: _____

_____

Funeral Arrangements Made? ___ YES ___ NO

If YES, Contact Info: _____

_____

_____

_____ _____

Signature of Applicant **Date**

_____ _____

Signature of Interviewer (if applicable) **Date**

Authorization to Release Protected Health Information

Patient Name:_____ Date of Birth:_____ Age:_____

Address:_____

I authorize (*Practice Name*):_____

To use, disclose or release my protected health information (medical records) described below to:

_____
(Name of person or entity*)*

10 Allds St., Nashua, NH 03060
Address, City, State, Zip *Code*

For the following purpose: (at patient's request is sufficient): _____

Dates of service requested:_____

Specific description of information that may be used/disclosed:

All records for 2 years including Labs, X-rays, all tests, TB, Shingles, Pneumovax, Flu Vaccine

If my initials appear here_____, I specifically authorize release of drug, alcohol abuse and/or psychiatric records. Federal law 42 CFR Part 2 prohibits those receiving information on drugs or alcohol treatment from re-disclosing it unless further disclosure is expressly permitted by written consent of the person to whom it pertains, or is otherwise permitted by 42 CFR Part 2.

If my initials appear here _____, I specifically authorize release of my HIV test results for the purpose set forth above. My signature below indicates I have read this from, have asked all the questions I have about the reason for the release of my identity as a test subject, the results of my HIV test and I agree to the release of information to the above named party.

I understand that I may inspect or copy the protected health information described in this authorization.

I understand that this authorization may be revoked in writing and delivered to the originating practice at any time, except to the extent that action has already been taken in reliance on this authorization.

I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I understand that Hunt at Home shall not condition treatment, payment, enrollment in a health plan or eligibility for benefits on my providing authorization for the requested use or disclosure and that I may refuse to sign this authorization.

_____

Signature of Patient *Printed Name of Patient* *Date*

_____

Signature of Representative *Relationship to Patient* *Printed Name of Representative* *Date*

EXPIRATION: *This authorization will expire on (date or event)*: _____

If no date or event is specified, the authorization shall expire six months from the date it was signed. A copy of this authorization shall be provided to the patient or representative when signed.

Authorization to Release Protected Health Information

Patient Name:_____ Date of Birth:_____ Age:_____

Address:_____

I authorize (*Practice Name*):_____

To use, disclose or release my protected health information (medical records) described below to:

_____
(Name of person or entity*)*

10 Allds St., Nashua, NH 03060
Address, City, State, Zip *Code*

For the following purpose: (at patient's request is sufficient): _____

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