



Garvey Manor

Our Lady of the Alleghenies Residence

Carmelite Sisters for the Aged and Infirm • Diocese of Altoona Johnstown

128 Logan Boulevard • Hollidaysburg, Pennsylvania 16648 • Phone: 814-695-5571
 Fax: 814-695-8516

TO BE COMPLETED BY STAFF
 Date complete application received
 by O.L.A.R. staff

_____ by _____

APPLICATION FOR ADMISSION

Please provide all information as requested. Additional information may be required as the application is processed. Please inform the Admission Coordinator if information changes significantly after the application is submitted.

Date application completed: _____

Applicant's Name: _____ Maiden Name: _____

Current Address: _____ City: _____ State: _____ Zip: _____

Contact person regarding application if not applicant: _____ Relation: _____

Contact person's address: _____ City _____ State: _____ Zip: _____

Contact person's Home Phone: _____ Cell Phone: _____ Work Phone: _____

Demographic Information

Date of Birth: _____ Place of Birth: _____ If not born in USA, how long in USA _____

U.S. Citizen: ___ Yes ___ No If NO Citizen of: _____ PA Resident: ___ Yes ___ No How long in PA: _____

Religious Affiliation: _____ Church: _____

Current marital status: ___ Single (never married) ___ Currently Married ___ Separated ___ Divorced ___ Widowed

Date of Marriage: _____ Spouse's Name: _____ Date of Spouse's Death: _____

Military Service: Branch: _____ Rank: _____ Dates of Service: _____ Eligible for VA Benefits: ___ Yes ___ No

Spouse's Military Service: Branch: _____ Date of Service: _____

Education: Highest grade attended: _____ Graduated High School: _____ College Degree Achieved: _____

Work History – Profession/Line of Work: _____

Main Employer: _____ Year Retired: _____

Medical Insurance Information

Medicare #: _____ Social Security Number: _____

Supplemental Health Insurance: Type: _____ Company: _____ Group ID #: _____

Other Supplemental Insurance: Type: _____ Company: _____ Group ID #: _____

Other Supplemental Insurance: Type: _____ Company: _____ Group ID #: _____

Such as long term care insurance

Financial Resources Information

Monthly Social Security: \$ _____ Monthly Pension: From: _____ Amount: \$ _____

Other Monthly Income: From: _____ Amount: \$ _____

Amount in Savings: \$ _____ Amount in Checking: \$ _____ Amount in Stock: \$ _____

Home/Real Estate approximate value: describe: _____ Approximate Value: \$ _____

Other Assets: Type: _____ Value: \$ _____ Type: _____ Value: \$ _____ Type: _____ Value: \$ _____

Family Members/Personal Contacts

PRIMARY CONTACT – Person to be contacted first regarding the applicant

Name: _____ Relationship: _____ POA Yes No

Include spouse first name

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Place of Work: _____ Work Phone: _____

Person Responsible for Managing Applicant's Financial Affairs (If different from Primary Contact name above)

Name: _____ Relationship: _____ POA Yes No

Include spouse first name

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Place of Work: _____ Work Phone: _____

Other Family Members/Personal Relations:

Name: _____ Relationship: _____ POA Yes No

Include spouse first name

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Place of Work: _____ Work Phone: _____

Name: _____ Relationship: _____ POA Yes No

Include spouse first name

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Place of Work: _____ Work Phone: _____

HEALTH CARE DECISION INFORMATION

Does Applicant have a **Living Will**? **Yes** **No** If YES, when was it signed: _____
Does Applicant have a person named as **Health Care Proxy** (Durable Power of Attorney for Health Care) **Yes** **No**
If YES, Name of **Health Care Proxy**: _____ Date Document Signed: _____

Physician's Name: _____ How long has (s)he been your physician _____
Name of Dentist: _____ **Name of Eye Doctor**: _____
Preference of Hospital if need arises: _____ **Ambulance Membership**: _____
Choice of Funeral Director: _____

PERSONAL CARE & GENERAL HEALTH INFORMATION (To be completed by Applicant)

Ability to WALK: By self, no help: Can't walk: Can't stand: Uses cane: Uses walker:
Needs help of another person to walk: Only takes a few steps: Needs help to get up: Must be lifted:
Uses wheelchair all times: Wheelchair for distance only: Owns wheelchair: /Electric chair:

SPEECH: Clear: Difficult to speak & be understood: Not able to talk: Language other than English: _____

HEARING: Good: Impaired: Deaf: Wears hearing aid: Right ear: Left ear:

SIGHT: Good: Impaired even with glasses: Blind: Glaucoma: Macular Degeneration:

Glasses: All Times: Reading only: Contact lenses: Regularly uses eye drops:

TOILET FUNCTION: Needs help to & from toilet: daytime night time Needs help with personal hygiene

Bladder: No problems: Occasionally lacks control: Frequently lacks control: No control: At times incontinent in bed:

Wears protective garment: Manages own bladder control garments: Yes No Catheter

Bowel: No problems: Occasionally lacks control: Frequently lacks control: Constipation: Frequent diarrhea:

EATING: Independent: Needs assistance: Adaptive utensils needed: Usual Diet: _____

Diet restrictions: _____ Usual meal pattern: _____

BATHING: Able to bathe self: Requires assistance: Prefers Tub Bath: Prefers Shower:

GROOMING/DRESSING: Self care: Requires minimal help: Requires considerable help:

MENTAL CAPACITY: Alert all times: Able to decide most things by self: Needs help with daily decisions:

Memory: Good: Forgets recent events: at times: often: Memory very poor: Has wandered or gotten lost:

Confusion: at times: always: Describe problems & any inappropriate behaviors: _____

Tobacco use (describe): _____ **Alcohol** use (describe): _____

Currently uses **medical equipment**? _____

Uses **Home Health or Rehabilitative Services**? _____

Check all that apply: Heart trouble: Stroke Diabetes High blood pressure Cancer Arthritis

Seizures: Digestion problems: Poor circulation: Emphysema/Asthma: Requires use of oxygen:

List allergies (medication, food & others): _____

Have you been treated or hospitalized for mental illness (describe): _____

Major surgeries (describe): _____

Most recent hospitalization/reason: _____

List current medical diagnosis: _____

Describe general physical limitations & other important health information: _____

List **Current Medications**: _____

Why are you seeking admission to Our Lady of the Alleghenies Residence: _____

Other Information that may be important: _____

How were you referred to Garvey Manor/Our Lady of the Alleghenies Residence: _____

Terms of Agreement: Whereas, the information and disclosures provided in this Application by the Applicant (reference to Applicant also includes any information provided by his/her representative) are made for the purpose of asking Garvey Manor, Our Lady of the Alleghenies Residence (hereinafter the Residence) to consider the Applicant for admission to Our Lady of the Alleghenies Residence. Whereas, the Residence relies on this Application, among other factors, for determining whether to admit the Applicant in accordance with the terms and conditions of the Admission Agreement. Whereas, the Residence shall keep all information and disclosures in this Application confidential and include it as part of the Admission Agreement. Whereas, the Applicant authorizes the Residence to obtain financial information and agrees to execute any releases required for the purpose of verifying any representation regarding the Applicant's financial resources, asset and other information including medical information, that Applicant has made in the Application.

Therefore, the Applicant provides the requested information to the Residence for consideration in the admission review process. The Applicant acknowledges and attests and, by signing, certifies that the information and disclosures provided are true and correct to the best of his/her knowledge and belief. The Applicant acknowledges that (s)he understands that the information and disclosures provided in this Application do not obligate the Residence to accept the Applicant for admission and are used only in the admission decision-making process. Any false information, lack of disclosure or misrepresentation in this Application may result in rejection of the Application and/or termination of the Admission Agreement if the Applicant is admitted, and may result in legal proceedings at any time the Residence learns of false information, misrepresentation or lack of disclosure. Application form must be complete to the best of your ability, Application must be signed and any requested documents must be provided before the Applicant can be considered for admission.

Signature of Applicant: _____ Date: _____

Applicant's Representative: _____ Date: _____
(if all or part of the Application is completed by other than Applicant, or if representative is responsible for the Applicant)