Our Lady of the Alleghenies Residence

Independent Living Apartments at Garvey Manor

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.
****If application is being completed for a couple, use an additional application to provide spouse's personal information**

Applicant's Name: _____ Maiden Name: _____

Marital status: ____Single ____Currently Married _____Widowed ____Separated ____Divorced

Spouse's Name: _____ Date of Marriage:_____ If Deceased, Date Spouse Died: _____

Current Address: _____City: _____State: ____ Zip: _____

Demographic Information

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

U.S. Citizen: ___Yes If NO, Country you are a Citizen of: _____ PA Resident: __Yes __No How long in PA:_____

Religious Affiliation: _____ Place of Worship: _____

Previous Primary Employer/ Line of Work: _____ Year Retired:_____

Military Service: Branch:_____ Rank: _____ Dates of Service: _____ Eligible for VA Benefits: ___Yes ___No

Spouse's Military Service: Branch: _____ Dates of Service: _____ Eligible for VA Benefits: ___Yes ___No

Personal Information

Have you ever been convicted of a felony?_____

Do you have any legal actions pending against you? _____

Do you plan to have a vehicle you drive on site if you are admitted:_____

Do you currently have a pet that you want to move in with you? (type) _____

Medical Insurance Information * Such as Medicare alternative, Medicare supplement, Medicare HMO,

Medicare #: _____ Social Security #: _____

*Other Health Insurance -Type:_____ Company:_____ ID #: _____

*Other Health Insurance -Type:_____ Company: _____ ID #: _____

Supplemental Insurance -Type:_____ Company:_____ ID #: _____

. Such as Long Term Care Insurance, etc

EMERGENCY CONTACT / PERSONAL CONTACTS

PRIMARY CONTACT – Persons to contact in case of emergency – list in order of priority

* Please designate if you have given Power of Attorney to any of the following persons

(#1) Name: (Include spouse first name) _____ Relationship: _____

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

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

(#2) Name**:** (Include spouse first name) _____ Relationship: _____

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

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

(#3) Name: (Include spouse first name) _____ Relationship: _____

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

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

Person Responsible for Managing Financial Affairs (If different than self)

Name: _____ Relationship: _____

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

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

FINANCIAL INFORMAITON

Note: Prior to admission, you may be asked to verify income/assets

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

Other Monthly Income: From: _____ Amount: $_____

Approximate Asset value: $_____

Approximate Home/Real Estate value: $ _____ Type:_____

HEALTH CARE CONTACT INFORMATION

Describe type if you have a **Living Will** or other form of a **Medical Advance Care Directive** _____

Do you have a document, naming a person your **Health Care Proxy** (Durable Power of Attorney for Health Care) to make health care decisions for you in case you are not able to make decision for yourself ___Yes ___No

If YES, Name of **Health Care Proxy**: _____Date Document Signed: _____

- Prior to or at the time of admission, you will be asked to provide a copy of these documents, if they exist.
- You are not required to have a Living Will or any other Medical Advance Care Directive as a condition of admission.

Primary Care Physician: _____ Address or Medical Group:_____

Preference of **Hospita**l if emergency arises: _____ Ambulance Membership: _____

GENERAL HEALTH INFORMATION

FUNCTIONING ABILITIES

Ability to WALK: Independent:____ Uses cane:____ Uses walker:____ Can't walk:____ Able to use stairs:_____

Uses wheelchair: all times: ____ for long distance only:____ Owns & uses Electric chair/scooter :_____

SPEECH: Clear:____ Difficulty speaking:____ Language spoken if other than English:_____

HEARING: Good:____ Impaired:____ Not able to hear:_____ Wears hearing aid: Right ear:____ Left ear:____

SIGHT: Good:_____ Vision good with glasses/contacts:_____ Impaired even with glasses:____ Blind:____

PERSONAL HYGIENE & BATHING: Needs NO assistance: ____ Needs Assistance: _____

EATING: Usual Diet:_____ Diet restrictions: _____ Eating Problems:_____

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

Do you currently have a condition that is considered contageous? _____

Medical equipment now used_____

Do you currently use Home Health or Rehabilitative Services? _____

List allergies (medication, food & others): _____

Major surgeries (describe):_____

Most recent hospitalization/reason: _____

MEDICAL HISTORY Check all that apply**:**

Heart trouble____ Pacemaker_____ Stroke____ Diabetes____ High blood pressure____ Cancer____ Arthritis____
Seizures____ Digestion problems____ Poor circulation____ Emphysema/Asthma:____ Back Problems_____
Chronic Pain_____ List OTHER:_____

List current **Medical Diagnosis**: _____

_____

Briefly describe any Memory problems, Anxiety, Depression, Post Tramatic Stress Disorder or other Mental Health conditions:

_____

Have you been treated or hospitalized for any Mental Health related condition? (describe): _____

_____

Describe any Physical limitations or other important health information: _____

_____

_____

List **Current Medications**: _____

_____

_____

Other important information: _____

THE DEFICIT REDUCTION ACT OF 2005 SUMMARY

The Deficit Reduction Act of 2005 (DRA) restricts Medical Assistance (Medicaid) eligibility based on the Medicaid Asset Transfer Laws. These include:

- **A Five Year Look Back Period for transfer of assets to individuals or to a trust:** The Medicaid application process requires an applicant to disclose a five-year financial history accounting for the use, gifting, sale, and transfer of assets. While these activities may be legal, they can be considered ónappropriate use of fundsôby the Department of Public Welfare (DPW) and thus result in an applicant being ineligible for Medicaid benefits.

- **The Penalty Period of Ineligibility:** When a Medicaid application is filed for a person residing in a nursing home and inappropriate asset transfer/gifting/undervalue asset sale is discovered, there will be a denial of benefits, resulting in a ópenalty period of ineligibilityô. The penalty period commences when the individual would otherwise be eligible for Medicaid benefits in the nursing home, except for the inappropriate asset transfer/gifting/sale.

- **The Valuable Home Rule:** Having equity in a home exceeding $500,000 automatically makes a person ineligible for Medicaid benefits. Title transfer or undervalue sale of a home results in ineligibility.

Garvey Manor/Our Lady of the Alleghenies Residence cannot provide care and services unless a payment source is assured. This includes the potential that a resident may require Medicaid benefits sometime in the future, if not at the time of admission. Because of the DRA, we require disclosure of gifting, asset transfer, undervalue sale, prior to admission. When admitted to our facility, the applicant/responsible person signs a contract guaranteeing no activities have already taken place or will take place in the future that will affect Medicaid eligibility. This disclosure section validates the Admission Contract. Refer questions about DRA, asset shielding, or Medicaid eligibility to the Admissions Office.

Fully disclose asset transfers, significant gifting (over $500 per month total), undervalue asset sales that occurred in the last five years. The value and date of the transaction must be included**.** Specific documentation may be requested.

Cash: _____

Bank Account/CD/IRA/Stock/Bond/Trust Fund: _____

Real Estate: _____

Insurance Policy/Annuity Ownership: _____

Other: _____

OR [_____] (Initial) **There have been no asset transfers/gifting/undervalue asset sales within the last five years.**

_____

TERMS OF APPLICATION 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, disclosing information only as needed administratively. 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 Applicantôs 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: _____

Witness:_____ Date:_____

Witnessôs Address:_____