# 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:_____

Dear Applicant/Family Member:

Garvey Manor is required by CMS (Centers for Medicare and Medicaid Services) to complete a screening (PA-PASRR Level One) on all applicants prior to admitting, to determine if a mental illness, an intellectual disability or related condition exists.

Garvey Manor is not able to admit any applicant with a MI, ID or ORC unless a PA-PASRR-EV (level II) form has been completed and an official letter is received indicating that the applicant is appropriate for Nursing Facility Services.

**It is imperative that the screening process begins as soon as possible so that an admission is not delayed. The applicant/family member is required to disclose any diagnoses of mental illness, intellectual disability or other related conditions to Garvey Manor prior to admission. Failure to do so can result in forfeiture of Medicaid reimbursement to the Nursing Facility during the period of non-compliance in accordance with Federal Regulations.**

## SERIOUS MENTAL ILLNESS (please note this is not an all-inclusive list)

**CIRCLE ALL THAT APPLY:**

Schizophrenia
Schizoaffective Disorder
Delusional Disorder
Psychotic Disorder
Personality Disorder
Panic or other Severe Anxiety Disorder
General Anxiety
Somatic Symptom Disorder
Bipolar Disorder
Depressive Disorder (note if general or major)

Other_____

**HAS APPLICANT HAD:**

- **Treatment in an acute psychiatric hospital at least once in past 2 years:**

  No
  Yes - Name of hospital and date(s):_____
  Reason: _____

**Treatment in a partial psychiatric program (Day Treatment Program) at least once in the past 2 years:**

No
Yes - Name of program and date(s):_____
Reason: _____

**Any admission to a state hospital:**

No
Yes - Name of hospital and dates(s):_____
Reason: _____

**One stay in a Long-Term Structured Residence (LTSR) in the past 2 years:**

A LTSR is a highly structured therapeutic residential mental health treatment facility designed to serve persons 18 years of age or older who are eligible for hospitalization but who can receive adequate care in an LTSR. Admission can occur voluntarily.

No
Yes - Name of LTSR and date(s):_____
Reason: _____

**Electroconvulsive Therapy (ECT) for Serious Mental Illness within the past 2 years:**

No
Yes – Date(s):_____

- **Suicide attempt or ideation within the past 2 years:**
  No
  Yes – Date(s) and explain/note if documented by a psychiatrist or physician:

  _____

  _____

**Substance Related Disorder Documented by a Physician within the past 2 years:**

No
Yes – List the substance(s):_____

## INTELLECTUAL DISABILITY:

Does the applicant have current evidence of an Intellectual Disability or Intellectual Disability Diagnosis (mild, moderate, severe or Profound)?

No
Yes – List diagnosis(es) or evidence:

_____

_____

Did this condition occur **prior to age 18?** No Yes Cannot determine

## OTHER RELATED CONDITIONS (please note this is not an all-inclusive list)

**PLEASE CIRCLE ANY THAT APPLY:**

Arthritis
Juvenile Rheumatoid Arthritis
Cerebral Palsy
Autism
Epilepsy
Seizure Disorder
Tourette's Syndrome
Meningitis
Encephalitis
Hydrocephalus
Huntingdon's Chorea
Multiple Sclerosis
Parkinson's Disease
Muscular Dystrophy
Polio
Spina Bifida
Anoxic Brain Damage
Blindness **and** deafness
Paraplegia or quadriplegia
Head injuries (gunshot wound, or other spinal injuries)
Other conditions_____

**Was the condition(s) diagnosed prior to age of 22?** No Yes

**Name of applicant:** _____

**I have reviewed the following form and none apply to the applicant** _____
**Initial**

_____ _____
**Signature of person completing form** **Date**