Garvey Manor &
Our Lady of the Alleghenies Residence
Carmelite Sisters for the Aged and Infirm • Diocese of Altoona Johnstown

1037 South Logan Boulevard • Hollidaysburg, Pennsylvania 16648 • Phone: 814-695-5571
Fax: 814-695-8516

Dear Applicant or Responsible Party,

Enclosed is the application and list of required documents necessary to consider the applicant for admission to Garvey Manor. Also, included in this packet are the admission policies and procedures of Garvey Manor, room rates, and charge sheet.

All enclosed forms, including the application must be completed in full by the applicant or their legal representative and/or responsible party. With the application, please provide a copy of the Power of Attorney for financial and healthcare decisions, a copy of an Advance Directive or Living Will, and a copy of all health insurance cards. If you do not have a Power of Attorney document or Living Will, you might consider obtaining those documents for future needs. You are not required to have these documents for admission to Garvey Manor, but it is highly recommended.

We also require current medical information. The medical information should be in the form of a medical transcript if the applicant is currently a patient in a hospital or a rehab center or current office records from the primary care physician if the applicant is residing in the community.

All enclosed forms, completed in full, as well as the applicant's medical records must be received before the applicant can be considered for admission. An incomplete application or not providing Garvey Manor with required documents will delay the admission process.

We do retain an active waiting list; however, each individual's needs and priorities are taken into account at the time a vacancy occurs. If you would like to have a personal interview or a tour of the facility, an appointment can be arranged upon your request. Applications are active for one year from date of completion.

If I can assist you further, please feel free to contact me.

Sincerely,

Natalie A. Neff, LPN
Admission Coordinator

Enclosures

Garvey Manor Nursing Home
Our Lady of the Alleghenies Residence

1037 South Logan Boulevard * Hollidaysburg, Pa. 16648 * (814) 695-5571

APPLICATION AGREEMENT

Note: This Application Agreement form must be completed in its entirety and to the best of your ability, before the applicant can be considered for admission to Garvey Manor.

This Application Agreement is made between **Garvey Manor** ("Home") and Applicant seeking admission to become

"Resident" _____ (Applicant)

and (if applicable) _____ Applicant's Representative.

Applicant's Maiden Name: _____ Phone: _____

Current address: _____ City: _____ State: _____ Zip: _____

Address in past year (If different than above): _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ US Citizen: _____ if No, Citizen of: _____

If not born in US, but you are a US Citizen when did you become a US Citizen? _____

MARITAL STATUS: ☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

LEGAL PROFILE: Past Felony Conviction: ☐ Yes ☐ No Served Prison Time: ☐ Yes ☐ No Legal Action Pending: ☐ Yes ☐ No

PRIMARY CARE PHYSICIAN

Physician: _____ City: _____

Is applicant currently receiving services from Home Health, Waiver, or Hospice provider: ☐ Yes ☐ No If yes, name of provider: _____

PERSON COMPLETING APPLICATION (CONTACT PERSON**)** - if other than the Applicant

Name (include spouse's first name): _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Relationship to Applicant: _____

Health Care Power of Attorney: ☐ Yes ☐ No Financial Power of Attorney: ☐ Yes ☐ No

APPLICANT'S HEALTH CARE POWER OF ATTORNEY (IF DIFFERENT THAN ABOVE**)**

Name (include spouse's first name): _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Relationship to Applicant: _____

Financial Power of Attorney: ☐ Yes ☐ No

APPLICANT'S LEGAL REPRESENTATIVE FOR FINANCIAL AFFAIRS (IF DIFFERENT THAN ABOVE)

Name (include spouse first name): _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Relationship to Applicant: _____

Health Care Power of Attorney: ☐ Yes ☐ No Financial Power of Attorney: ☐ Yes ☐ No

OTHER PERSONAL CONTACTS - FAMILY MEMBERS (not already listed on application)

Name (include spouse first name): _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Relationship to Applicant: _____

Name (include spouse first name): _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Relationship to Applicant: _____

Name (include spouse first name): _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Relationship to Applicant: _____

MEDICAL INSURANCE

Social Security #: _____ Medicare #: _____

Access #: _____ Community Health Choices: _____

Medicare Supplement: _____

Other health insurance / HMO (specify): _____

CURRENT FINANCIAL RESOURCES – Complete thoroughly – Please mark with (N/A) if non-applicable

FINANCIAL RESOURCE VERIFICATION MAY BE REQUESTED PRIOR TO ADMISSION

Social Security: Amount _____/month Railroad Retirement: _____/month

Pension Income (specify) Company: _____ Amount: _____/month

Other Monthly Income (specify): _____ Amount: _____

Other Monthly Income (specify): _____ Amount: _____

Assets:

Checking Account Value: _____ Savings Account Value: _____

Stocks Value: _____ CD's Value: _____ Bonds Value: _____

Real Estate - Type: _____ Approximate Value: _____ Listed for Sale: ☐Yes ☐ No

Other: _____

Outstanding Liabilities: (Mortgages, Car Loans, Personal Loans, Credit Card Debt, Etc.) _____

LONG TERM CARE INSURANCE

Company: _____ Per Diem Rate (if known): _____

Length of Policy Term: _____

LIFE INSURANCE

Company: _____ Policy #: _____ Face Amount: _____

Company: _____ Policy #: _____ Face Amount: _____

Who owns the life insurance policy (example: self or funeral home): _____

BURIAL ARRANGEMENTS

Funeral Home: _____ City: _____Phone: _____

Cemetery: _____ Lot Owner: _____

Are arrangements already on file with the funeral home? ☐ Yes ☐ No If yes, are arrangements prepaid? ☐ Yes ☐ No

Is there a prepaid funeral policy? ☐ Yes ☐ No If yes, amount: _____

ADVANCE DIRECTIVES/LIVING WILL: ☐ Yes ☐ No Name(s) of Surrogate(s): _____

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:

- The Medicaid application process requires the 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 'inappropriate use of funds' by the Department of Human Services and thus result in an applicant being ineligible for Medicaid benefits.
- When a Medicaid application is filed for a person residing in a nursing home and an inappropriate asset transfer, gifting, undervalue sale activity is discovered, there will be a denial of benefits, resulting in a 'penalty period of ineligibility'. The penalty period commences when the individual, residing in a nursing home, would otherwise be eligible for Medicaid benefits, except for the inappropriate asset transfer/gifting/sale.
- 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 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 to the nursing home. We require disclosure of gifting, asset transfer, undervalue sale, or the like prior to admission. When a person is admitted to Garvey Manor or Our Lady of the Alleghenies Residence, the applicant/responsible party signs a contract with Garvey Manor guaranteeing no activities that will affect Medicaid eligibility have already taken place or will take place in the future. The disclosure form below validates the contract. If you have questions about the DRA, asset shielding, or Medicaid eligibility please contact the Admission Office.

THIS SECTION MUST BE COMPLETED:
Fully disclose asset transfers, gifting (over $500 per month total), undervalue asset sales that occurred in the last five years. (Include value and date of the transaction – verification may be requested prior to admission.)

Gifting Cash: _____ **Sale or Transfer of Real Estate:** _____

Transfer of Bank Accounts /CD's/IRA/Stocks/Bonds/Trust Fund: _____

Annuity / Ownership of Insurance Policy: _____

Other: _____

***If there has been no asset transfer/gifting/undervalue asset sale within the last five years initial here [_____]**

GARVEY MANOR NURSING HOME
APPLICANT'S PERSONAL CARE ABILITIES & GENERAL HEALTH INFORMATION SHEET

Applicant's Name: _____ DOB: _____

Eye color: _____ Hair color: _____ Race: _____ Ethnic Heritage: _____ Sex: _____

Height: _____ Weight: _____

Religion: _____ Church or Place of Worship: _____

Primary Language: _____ if other than English, does Applicant understand/speak English? _____

Tobacco use: _____ Alcohol use: _____

FAMILY HISTORY

Father's Name: _____ Mother's Name: _____ Place of Birth: _____

Total number of siblings: ____ Names of living siblings: _____

Names of deceased siblings: _____

Spouse's Name: _____ Date of Marriage: _____

Date of Spouse's Death (if applicable): _____ Other Last Name used: _____

Date of Divorce (if applicable): _____ Any previous marriages: _____

Total number of children: _____ Names of living children: _____

_____

Names of deceased children: _____

EDUCATION / WORK HISTORY

Highest level of education completed: _____

Profession and last employer: _____ Date retired: _____

Was **applicant** in the Military Service: _____ Date and branch of service: _____

Was applicant's **spouse** in the Military Service: _____ Date and branch of service: _____

PERSONAL CARE ABILITIES

Walking: ☐ Independent ☐ Needs assistance ☐ Not able to walk ☐ Not able to stand

Assistive Device: ☐ Cane ☐ Walker

Wheelchair use: ☐ All times ☐ Distance only ☐ Propels self ☐ Has own wheelchair ☐ Motorized chair/scooter

History of falls: ☐ Yes, Date of last fall: _____ ☐ No

Toilet function: ☐ Independent ☐ Needs help to use toilet or with personal hygiene

Bladder Control – ☐ No problems ☐ Occasionally lacks control ☐ Frequently lacks control ☐ Catheter

☐ Wears protective garment ☐ Self manages protective garment ☐ Needs assistance with garments

Bowel Function – ☐ No problems ☐ Occasionally lacks control ☐ Frequently lacks control

☐ Frequent constipation ☐ Frequent diarrhea ☐ Colostomy

Skin: ☐ Intact ☐ Areas of concern _____

Eating: ☐ Independent ☐ Needs assistance ☐ Adaptive utensils ☐ Tube Feeding

Diet restrictions: _____ Usual diet:_____

☐ Natural Teeth ☐ Dentures: ☐ Upper ☐ Lower Partial: ☐ Upper ☐ Lower ☐ No Teeth

Bathing: ☐ Bathes self ☐ Requires assistance (describe):_____

Is there a fear of water: ☐ Yes ☐ No Prefers: ☐ Tub Bath ☐ Shower Time of day: ☐ Morning ☐ Night

What do you do to make bath routine better? _____

_____

Grooming/Dressing: ☐ Independent ☐ Requires minimal assistance ☐ Requires considerable assistance

Sleep Pattern: Bed time _____ When does he/she wake _____

Sleep disruption: ☐ Yes ☐ No What helps to return to sleep? _____

Cognition: Alert: ☐ Yes ☐ No Oriented to: ☐ Self ☐ Others ☐ Time ☐ Place

☐ Able to make own decisions ☐ Needs help with decisions ☐ Dependent – cannot make decisions

Memory Impairment: ☐ Short-term ☐ Long-term Describe cognitive problems: _____

_____

Speech: ☐ Clear ☐ Difficulty speaking ☐ Difficult to be understood

Hearing: ☐ No impairment ☐ Hard of hearing Wears hearing aid: ☐ Right ear ☐ Left ear ☐ Deaf

Sight: ☐ No impairment **Glasses**: ☐ All times ☐ Reading only ☐ Sight impaired with glasses ☐ Contact lenses

Specific visual limitations/eye conditions: _____

Mood/Behavior: ☐ Cooperative with care ☐ Physically resistive to care ☐ Verbally resistive to care

☐ Aggressive behavior towards others during non-care times ☐ Wandering

Describe behaviors: _____

☐ Fearful If yes, of what _____ What is reassuring to applicant _____

_____

Mental Health Diagnosis: _____

Describe treatment/hospitalization for mental health issues:_____

_____

Does applicant have pain: ☐ Yes ☐ No Source of pain (Arthritis, back, headaches, etc.) _____

How does he/she express pain? (Verbal complaints, restlessness, change in mood, etc.) _____

_____

What helps to alleviate the pain? _____

_____

Usual daily routine and other information that may help us provide person centered care and services:

_____

_____

General interests / Preferred leisure activities / Involvement in organizations/clubs:

_____

_____

HAS THE APPLICANT EXPERIENCED ANY PRIOR ADVERSE LIFE EXPERIENCE(S) THAT MIGHT IMPACT HIM/HER AND BE IMPORTANT FOR US TO KNOW IN ORDER TO PROVIDE PERSON CENTERED, QUALITY CARE? ☐ **Yes** ☐ **No** ☐ **Unknown**

If yes, please explain, as you feel comfortable: _____

_____

_____

If yes, are there any specific triggers that may cause re-traumatization/stress: _____

_____

_____

If yes, please note any successful interventions to decrease any adverse reaction(s)/symptom(s): _____

_____

_____

Revised 12/2019

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**

TERMS OF AGREEMENT

WHEREAS, the information and disclosures provided in this Application Agreement by the Applicant who seeks to become a Resident and/or his/her Representative are made to assist the Home in considering the Applicant for admission into the Home.

WHEREAS, the Home relies on this Application Agreement, among other factors, for determining whether to admit the Applicant into the Home in accordance with the terms and conditions of the Nursing Home Admission Agreement (hereinafter "Admission Agreement").

WHEREAS, the Home shall keep all information and disclosures in this Application Agreement confidential and include the Application Agreement as part of the Admission Agreement.

WHEREAS, the Applicant and/or Representative agrees to execute any releases required for the purpose of verifying any and all representations regarding Applicant's financial resources and assets that Applicant and/or Representative has made in the Application Agreement.

THEREFORE, the Applicant and/or Representative provide the requested information to the Home for consideration in the Admission Application review process. The Applicant and/or Representative acknowledge and attest that the information and disclosures provided are true and correct to the best of his/her/their knowledge and belief. If the Applicant or the Representative completing the Application Agreement is not aware of the financial resources and/or the Deficit Reduction Disclosures, then the Applicant or Representative must so state and then must contact the financially responsible person who can accurately complete those sections.

Applicant and/or Representative acknowledge that he/she/they understands that the information and disclosures provided in this Application Agreement do not obligate the Home to accept the Applicant for admission and are used only in the admission decision-making process.

DECLARATION AND SIGNATURE

I have read and I understand the above information regarding the Terms of Agreement, the Deficit Reduction Act of 2005, the Summary of Admission Services and Admission Policies, including the Policy Statement regarding Resident Resuscitation.

By signing below, the Applicant and/or Representative certifies that the information and disclosures provided in this Application Agreement are true, correct and complete to the best of his/her/their knowledge and belief. Any false information, misrepresentation of information or lack of disclosure in this Application Agreement may result in the rejection of the Applicant's application and/or the termination of the Admission Agreement and/or legal proceedings, at any time Garvey Manor Nursing Home learns of the false information, misrepresentation, or lack of disclosure.

Copies of the following documents **must** be provided upon request to have this Application Agreement considered complete:

1. Picture identification of the Applicant
2. Social Security, Medicare, supplemental insurance, PACE, Medicare D, Access, and/or other insurance cards
3. Financial Power-of-Attorney, if one has been executed
4. Durable Power-of-Attorney for Healthcare and/or Living Will, if one has been executed

The parties, intending to be legally bound hereby, have signed this Application Agreement

this _____ day of _____, 20_____.

_____ _____

Signature of Applicant | Signature of Representative of Applicant Completing Application

_____ _____

Signature of Legal Representative (POA or Guardian) (If different than above) | Date Signed

RECEIVED FOR GARVEY MANOR

By: _____

Title: _____

Date Received: _____

***This application will be kept on file for one year**

Revised: 12/2018