Garvey Manor Nursing Home & Our Lady of the Alleghenies Residence

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

PERSONAL CARE HOME APPLICATION

Date complete application received by O.L.A.R. staff
_________________by_________

Please provide all information requested. Additional information may be required when the application is processed. Inform the Admission Coordinator if information changes significantly after the application has been submitted.

PRINT PLEASE

Applicant: ____ **Maiden Name**: _____________________ **Phone**:_____________

Address: ___________________________________**City**:__________________________**State**: _____ **Zip**: ___________

REASON FOR MAKING APPLICATION FOR ADMISSION : ____

____

CONTACT INFORMATION

PRIMARY CONTACT: Name: ______________________________________ Spouseøs first name:_____________________

Relationship: _______________ **Applicant's Power of Attorney**: Personal ___Yes___No - Financial ___Yes___No

Address: ____ City: ___________________ State: ______ Zip: ________

Phone Contact - Home: ______________________ Cell: ________________________ Work: _______________________

PERSON RESPONSIBLE FOR FINANCIAL AFFAIRS: Name: ____________________________ Spouse first name:_________

Relationship to Applicant: ___________________________ **Applicant's Financial Power of Attorney**: ___Yes___No

Address: ____ City: ___________________ State: ______ Zip: ________

Phone contact - Home: _____________ Cell: ____________ Work: _____________ Business Name:_________________

OTHER PERSONAL CONTACTS:

Name: ____ Spouse first name:__________ Relationship: __________________

Address: ____ City: _____________________ State: ______ Zip: _________

Phone contact - Home: ______________ Cell: _____________ Work: _____________ Business Name:_________________

Name: ____ Spouse first name:__________ Relationship: __________________

Address: ____ City: ____________________ State: ______ Zip: __________

Phone contact - Home: ______________ Cell: ____________ Work: _____________ Business Name:_________________

PERSONAL INFORMATION

Birth date: __________ Place of Birth: _______________________ Fatherøs Name___________ Motherøs Name:________________

U.S. Citizen: _____Yes If No, Citizen of: __________________ PA Resident: ____Yes ____No Primary Language: ____________

Religious Affiliation: ________________________ Place of Worship: _____________________

Highest Education: _________________ Line of Work/Primary Employer: __________________________ Date Retired:_________

Date Married: _________ Spouseøs Name: _____________ Date Spouseøs Death: ________ Separated:__ Divorced:__ Never Married:___

Names of children: ____

Military Service: Branch:________________ Rank: ______________ Service Dates: _________________ Eligible VA Benefits: ___Yes ___No

Spouseøs Military Service: Branch: _________________ Service Dates: _________________ Eligible VA Benefits: ___Yes ___No

Does Applicant have current Driverøs License_____ or Other Government Issued Photo ID: Type ___________________________

Applicant currently drives: ____Yes ____No Applicant plans to bring vehicle if admitted: ____Yes _____No

DESCRIBE - Tobacco use: ____________________ Alcohol use:_________________ Drug dependence:______________________

PROFILE: Any legal action pending: ____ Past felony conviction: ____ Served prison time:____ History drug/alcohol abuse :_____

FINANCIAL RESOURCES INFORMATION

Monthly Social Security: $___________________ Pension (Company) ______________________ Monthly Pension: $____________

Other Income: From: _______________________________________ Monthly Amount: $________________________

Estimate: Savings $______________ Checking $___________ Stocks/Bonds:$_________ IRA/Retirement Plan $_______________

Home/Real Estate - Describe: _______________________________________ Estimate Value: $ __________________

Other Assets: Type: ________________ Value: $______________ Type: _________________ Value: $____________

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

MEDICAL INSURANCE

Primary Medical Insurance: __________________________________ ID#:_______________

Medicare #: ___________________ **Social Security #:**___________________ **Medicare D -** Plan & ID#:__________________

Medicare Supplement Plan: ____ ID #: _______________

Other Supplemental Insurance (Long Tem Care Insurance, etc): ________________________________ID #: ________________

HEALTH CARE DECISION INFORMATION

Living Will: ___No ___Yes date signed: __________ **Durable Health Care Power of Attorney** _____No ___Yes date signed:_________

Name Health Care Agent: ______________________________ Relationship:________________ Phone: _________________

Primary Care Physician: ________________________________ **Other Specialist /Service**: _________________________________

Dentist: _________________________ Eye Doctor: __________________________ Podiatrist: ____________________________

Ambulance Membership: _______________________________

Funeral Director: ____________________________ City:__________________ Prepaid Funeral Arrangements: __Yes ___No

PERSONAL CARE ABILITIES & GENERAL HEALTH INFORMATION

Walking: Independent:_____ Cane:____ Walker:_____ Needs assistance:_____ Not able to walk:______ Not able to stand: ______

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

Speech: Clear:______ Difficulty speaking______ Difficult to be understood:_______ Alternate Language: ____________________

Hearing: No impairment:_______ Hard of hearing:_________ Deaf:______ Wears hearing aid: Right ear:____ Left ear:____

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

Specific visual limitations/eye conditions: ____

Toilet function: Independent:______ Needs help to use toilet or with personal hygiene:_______day time_______night time

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: ___________________

Eating - Independent: _____ Needs assistance: ____ Adaptive utensils: _________ Dentures: ____Upper ____Lower ____Natural

Diet restrictions: ____ Usual diet:_____________________________________

Bathing - Bathes self:______ Requires assistance:_______________________ Prefers Tub Bath:_______ Prefers Shower:________

Grooming/Dressing - Self care:_______ Requires minimal assistance:_________ Requires considerable assistance:____________

Mental Capacity - Alert all times:_______ Able to make own decisions:______ Needs help with decisions:____________________

Memory: Good:_____ Forgets - Ocassionally:____ Often:_______ Memory very poor:________________________________

Describe cognitive problems, inappropriate behavior, wandering : ____

____

Describe treatment/hospitalization for mental health issues:____

MEDICAL EQUIPMENT: ____

Home Health/Rehabilitative Services currently/recently used: ____

CURRENT MEDICAL CONDITIONS:____

____

Check all that apply: Pacemaker____ Seizures____ Chest Pain____ Breathing problems_____ Prosthesis(describe)______________

Allergies: medication, food & others: ____

Major Surgeries:____

Most recent hospitalization/reason: ____

Physical limitations & other health information: ____

____

CURRENT MEDICATIONS:____

____

Any other relevant 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 ÷inappropriate use of fundsø by 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 ÷penalty period of ineligibilityø 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 (also includes any information provided by Representative) are made for the purpose of asking Garvey Manor, Our Lady of the Alleghenies Residence (hereinafter the Facility) to consider the Applicant for admission to the Facility. Whereas, the Facility 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 Facility shall keep all information and disclosures in this Application confidential and include it as part of the Admission Agreement. Whereas, the Applicant authorizes the Facility to obtain financial information and agrees to execute any releases required for the purpose of verifying any representation regarding the Applicantøs 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 Facility 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 she/he understands that the information and disclosures provided in this Application do not obligate the Facility to accept the Applicant for admission and are used only in the admission review process. Any false information, misrepresentation or lack of disclosure 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 Facility learns of such. The Application form must be complete to the best of your ability, 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: ____ Relation:_____________ Date:______________

Signed/co-signed by Representative if any part has been completed by other than Applicant, or if Applicant is not able to sign.

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 (MI), an intellectual disability (ID) or other related condition (ORC) 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 ó Date(s):_____________________________

Suicide attempt or ideation <u>within the past 2 years:</u>
No
Yes ó Date(s) and explain/note if documented by a psychiatrist or physician:
____

____

SUBSTANCE RELATED DISORDER **<u>Documented by a Physician within the past 2 years</u>:**
No
Yes ó List the substance(s):____

<u>INTELLECTUAL DISABILITY</u>:

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

No
Yes ó List diagnosis (es) or evidence:
____

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

<u>OTHER RELATED CONDITIONS</u> <u>(please note this is not an all-inclusive list)</u>

<u>PLEASE CIRCLE ANY THAT APPLY</u>:
Arthritis
Juvenile Rheumatoid Arthritis
Cerebral Palsy
Autism
Epilepsy
Seizure Disorder
Touretteøs Syndrome
Meningitis
Encephalitis
Hydrocephalus
Huntingdonøs Chorea
Multiple Sclerosis
Parkinsonøs 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 <u>prior to age of 22</u>? No Yes

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

______________________________________ ____________
Signature of person completing form **Date**

Adult Residential Licensing - Documentation of Medical Evaluation (DME)
INSTRUCTIONS FOR USE

Applicable Regulations

§ 2600.141(a)(1) - A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

§ 2600.141(a)(2) - The medical evaluation shall include the following:
(1) A general physical examination by a physician, physician's assistant or nurse practitioner.
(2) Medical diagnosis including physical or mental disabilities of the resident, if any.
(3) Medical information pertinent to diagnosis and treatment in case of an emergency.
(4) Special health or dietary needs of the resident.
(5) Allergies.
(6) Immunization history.
(7) Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
(8) Body positioning and movement stimulation for residents, if appropriate.
(9) Health status.
(10) Mobility assessment, updated annually or at the Department's request.

§ 2600.141(b)(1) - A resident shall have a medical evaluation at least annually.

§ 2600.141(b)(2) - A resident shall have a new medical evaluation if the medical condition of the resident changes prior to the annual medical evaluation.

It's important to remember that the primary focus of these requirements is the need for residents to be evaluated by a physician, physician's assistant or certified registered nurse practitioner – **NOT that a form be completed**. The Department specifies a form simply to ensure that all of the required elements of the evaluation are performed during the evaluation.

Homes are PERMITTED to:

- Complete all or a portion of the DME prior to the in-person evaluation, except for the "Medical Professional Information" section, and present the DME to the physician, physician's assistant or certified registered nurse practitioner for signature at the time of the examination.
- Complete all or a portion of the DME after an in-person evaluation that was performed within the timeframes specified by this regulation, except for the "Medical Professional Information" section, and present the completed form to the physician, physician's assistant or certified registered nurse practitioner for signature in person, by facsimile, or via electronic mail.
- Correct a DME upon discovering that the physician, physician's assistant or certified registered nurse practitioner has recorded inaccurate information or omitted information, IF a registered nurse (RN) or licensed practical nurse (LPN) contacts the person who performed the evaluation, AND receives permission from that person to correct the DME, AND documents the date, time, and person spoken to on the DME next to the correction.

Homes are PROHIBITED from:

- Completing the "Medical Professional Information" section, unless the home employs a physician, physician's assistant or certified registered nurse practitioner.
- Completing all or a portion of the DME without an in-person evaluation by a medical professional.
- Completing all or a portion of the DME after an in-person evaluation that was performed outside of the timeframes specified by this regulation.
- Changing the content of a DME without the consent of the person who performed the evaluation. After obtaining consent, the DME must be changed by a registered nurse (RN) or licensed practical nurse (LPN).

It is strongly recommended that homes carefully review DME forms completed by a physician, physician's assistant or certified registered nurse practitioner to verify that all of the required information was recorded. Although the evaluations must be completed by medical professionals, homes are responsible for ensuring that the evaluations were complete and that the DMEs were filled out in their entirety.

Adult Residential Licensing - Documentation of Medical Evaluation (DME)

Resident Information	Evaluation Information		
Name:	Type (Check one) ☐ INITIAL ☐ ANNUAL ☐ STATUS CHANGE	Date Resident Evaluated:	Date Form Completed:
Date of Birth:			

(1) - General Physical Examination	Height:	Weight:	Pulse Rate:
Blood Pressure:	Temperature:		

(2) - Medical Diagnoses, Physical / Mental	(3) - Medical Information Pertinent to Diagnoses and Treatment, if applicable
1.	
2.	
3.	

FOR ADDITIONAL DIAGNOSES, SEE "DIAGNOSES ADDENDUM" BELOW

(4) Special Health or Dietary Needs

☐ None
☐ This resident **CAN** safely use or avoid poisonous materials
☐ Secured Dementia Care (For SDCU admissions only)
☐ Other - SEE "NEEDS ADDENDUM" BELOW

(6) - Immunization History

Are immunizations current? ☐ Yes ☐ No ☐ Unknown

Td/Tdap Date:	Influenza Date:

Other Immunizations (List Date and Type):

(5) - Allergies

☐ None ☐ Unknown ☐ Listed Below:

(7) - Medications

☐ None

OR SEE "MEDICATION ADDENDUM" BELOW

Ability to Self-Administer Medications - Check all that apply:

☐ Can self-administer - no assistance from others
☐ Can self-administer - assistance to store medications in a secure place
☐ Can self-administer - assistance in remembering schedule
☐ Can self-administer - assistance in offering medications at prescribed times
☐ Can self-administer - assistance in opening container or locked storage area
☐ Can self-administer some medications but not others - See MED. ADDENDUM
OR
☐ Cannot self-administer medications

(8) Body Positioning / Movement	(9) - Health Status	Cognitive Functioning
☐ None ☐ Listed Below:	☐ Excellent ☐ Poor ☐ Good ☐ Actively Dying ☐ Fair	☐ Excellent ☐ Poor ☐ Good ☐ None ☐ Fair

(10) Mobility Needs Assessment	☐ Independent (Mobile) Resident has **no** mobility needs and can evacuate independently in an emergency	☐ Minimal (Mobile) Resident requires **limited** physical or oral assistance to evacuate in an emergency	☐ Moderate (Immobile) Resident requires **moderate** physical or oral assistance to evacuate in an emergency	☐ Total (Immobile) Resident requires **total** physical or oral assistance to evacuate in an emergency from one or more staff persons

Medical Professional Information

By signing below, I certify that:

- I am a physician, physician's assistant or certified registered nurse practitioner whose license to practice is in good standing.
- The information on this form, the addendum sheet, and any attached list of medications was generated based on my evaluation
- The above-named resident requires assistance or supervision with Activities of Daily Living, Instrumental Activities of Daily Living, or both, as defined by 55 Pa. Code Chapter 2600

Medical Professional Name:	Medical Professional License #:
Medical Professional Signature:	Date Signed:

Documentation of Medical Evaluation (DME) - Addendum Sheet

This sheet may be copied as needed if additional space is required

Resident Information	**Evaluation Information**	
Name:	Date Resident Examined:	Date Form Completed:

Diagnoses Addendum

(2) - Medical Diagnoses, Physical / Mental	**(3) - Medical Information Pertinent to Diagnoses and Treatment, if Applicable**
4.	
5.	
6.	
7.	
8.	
9.	
10.	

(4) Needs Addendum

☐ Special Diet - Check all that apply

☐ No Added Sodium
☐ Mechanical Soft Foods
☐ Pureed Foods
☐ Low cholesterol
☐ Heart Healthy
☐ No Concentrated Sweets

Other (describe):

☐ Special Health Needs - Include Description

(7) Medication Addendum

Medication Name	Strength (Example: 100 mg.)	Dose (Example: 2 Tablets)	Frequency (Example: 2x / Day)	Purpose (Example: COPD)	Self-Administration* (Check One)
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

*** Residents may be able to self-administer some medications, but not others. The resident's ability to self-administer each medication should be assessed. If the resident can self-administer a medication, check "Yes." If a resident cannot self-administer a medication, check "No." If nothing is checked, the Department will assume that the resident cannot self-administer the medication.**