TO BE COMPLETED BY STAFF
*Date complete application received by M.H.. staff*_____

*1037 S. Logan Boulevard * Hollidaysburg, Pennsylvania *16648 *Phone* (814) 695-5571 * *Fax* (814) 695-8516

APPLICATION FOR ADMISSION

Please provide all information as requested. Additional information may be required as the application is processed. Inform the Director if significant information changes 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: _____

Current Address: _____City: _____State: ____ Zip: _____

Contact Information: Home #:_____ Cell Phone #:_____ E-mail:_____

Marital status: ____Single ____Currently Married _____Widowed ____Separated ____Divorced

Spouse's Name: _____ Is Application being completed for Spouse also?_____

Residents must be at least 60 years of age. Is applicant at least 60 years old? ___NO ___YES (Age verification required)

Personal Information

Are you currently employed? _____ Place of employment :_____

Are you a U.S. Citizen: ____ Yes _____No If NO provide verification of immigration status

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) _____

Do you currently smoke? _____

FINANCIAL INFORMAITON

Note: Prior to admission, you will be asked to verify information regarding income and assets to assure payment source.

Total Regular Monthly Income: From Social Security, Pensions: $ _____per month

Other ESTIMATED Monthly Income: From Interest, Investments: $_____ approximate per month

Asset value in Savings, Checking, CD's, Bonds, Securities, other Investments: Approximate asset value: $_____

Approximate Real Estate value: $ _____ Type:_____

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

EMERGENCY / PERSONAL CONTACTS

PRIMARY CONTACT – Person(s) 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: _____

May we put this contact on our mailing list for information and fund raising purposes? _____*Yes* _____*No*

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

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

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

May we put this contact on our mailing list for information and fund raising purposes? _____*Yes* _____*No*

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

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

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

May we put this contact on our mailing list for information and fund raising purposes? _____*Yes* _____*No*

Person to whom bills from Garvey Manor should be sent, if other than Applicant:

Name:_____ Relationship:_____

Address:_____ Business Name: _____

City _____ State: _____ Zip: _____

Home Phone:_____ Business Phone:_____ Cell 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: _____

May we put this contact on our mailing list for information and fund raising purposes? _____*Yes* _____*No*

TERMS OF APPLICATION AGREEMENT

Whereas, the information and disclosures provided in this Application by the Applicant (also includes any information provided by Applicant's representative) are made for the purpose of asking Garvey Manor, Marian Heights (hereinafter the Residence) to consider the Applicant for admission to Marian Heights 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 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 of all 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 that Applicant has made in the Application.

Therefore, the Applicant now provides the requested information to the Residence for consideration in the admission review process. The Applicant acknowledges, attests and certifies, by signing this Application that becomes part of the Admission Agreement if the Applicant is subsequently admitted, that information and disclosures provided are true and correct to the best of his/her knowledge and belief. Should admission to another level of care be considered in the future, a new application including more extensive financial disclosure to comply with the Federal Deficit Reduction Act will be required.

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, but are used in the admission decision-making process and as may be needed for use after and if the Applicant is admitted. Any incomplete or 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.

This Application form must be completed 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:_____

Witness's Address: _____

Marian Heights at Garvey Manor

SUPPLEMENTAL INFORMATION REQUESTED TO FOR ADMISSION

We request the following information from current residents in order to be supportive in the event of an emergency. Residents are not required to provide this information, but are advised that if the requested information is not provided to Marian Heights, then health and personal information should be readily available in a visible place within the your residence so that first responders can access information in the event of a medical emergency or health crisis.

Resident Name: _____ Date of Birth:_____

HEALTH CARE CONTACT INFORMATION

Do you have a **Living Will** or other **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: _____

- At the time of admission, you will be asked to provide a copy of these documents, if they exist so that we can have a copy on file available in case of medical emergency or health care crisis.
- You are not required to have a Living Will or any other Medical Advance Care Directive as a condition of admission.

Your Primary Care Physician: _____ Physician's Phone:_____

Physician's office location: _____

Other Specialist used for a primary medical condition:

Physician:_____ Specialty:_____

Phone:_____ Office location: _____

Preference of Hospital if emergency arises: _____ Ambulance Membership:_____

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

Signed:_____(Resident) Date:_____

Revised: 05/19/20

Marian Heights at Garvey Manor

Name: _____

ROUTINE FUNCTIONAL ABILITES

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 Wheelchair or Electric chair/scooter :_____ Describe:_____

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:_____

Alcohol use (describe): _____

GENERAL HEALTH INFORMATION

Medical equipment now used_____

Home Health or Rehabilitative Service currently being used: _____
**** Information needed so that service you contract with can be instructed on building access, rules, etc.**

List ALLERGIES (medication, food & others): _____

Past Major surgeries (describe):_____

Recent hospitalization/reason: _____

MEDICAL HISTORY :

List current **Medical Diagnosis and current Problems**: _____

_____

_____

_____

Mental Health treatment or hospitalization: (describe): _____

_____

Current Medications: _____

_____

_____

_____

Signed:_____ Date:_____

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