Garvey Manor Nursing Home &
Our Lady of the Alleghenies Residence

1037 South Logan Boulevard * Hollidaysburg, PA 16648
(814) 695-5571 * www.garveymanor.org

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: _____ **Date of Birth:** _____

REASON FOR MAKING APPLICATION FOR ADMISSION: _____

_____

CONTACT INFORMATION

PRIMARY CONTACT: **Name:** _____ Spouse's first name: _____

Relationship: _____ **Applicant's Power of Attorney**: Health Care ___Yes ___No Financial ___Yes ___No

Address: _____ **Email:** _____

Phone Contact – Home: _____ Cell: _____ Work: _____ Business Name: _____

PERSON RESPONSIBLE FOR FINANCIAL AFFAIRS: Name: _____ Spouse's first name: _____

Relationship to Applicant: _____ **Applicant's Financial Power of Attorney**: ___Yes ___No

Address: _____ **Email:** _____

Phone contact – Home: _____ Cell: _____ Work: _____ Business Name: _____

OTHER PERSONAL CONTACTS:

Name: _____ Spouse's first name: _____ Relationship: _____

Address: _____ **Email:** _____

Phone contact – Home: _____ Cell: _____ Work: _____ Business Name: _____

Name: _____ Spouse's first name: _____ Relationship: _____

Address: _____ **Email:** _____

Phone contact – Home: _____ Cell: _____ Work: _____ Business Name: _____

PERSONAL INFORMATION

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

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

Names of deceased siblings: _____

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

Religious Affiliation: _____ Place of Worship: _____ Ethnic Heritage: _____

Highest Education: _____ Line of Work/Primary Employer: _____ Date Retired: _____

Date Married: _____ Spouse's Name: _____ Date Spouse's Death: _____ Separated: __ Divorced: __ Never Married: __

Names of children: _____

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

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

Does Applicant have current Driver's 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: _____

CURRENT FINANCIAL RESOURCES – Complete thoroughly – Please mark with N/A if non-applicable
FINANCIAL RESOURCE VERIFICATION MAY BE REQUESTED PRIOR TO ADMISSION

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 **Medicare #: _____ Social Security #: _____**

Medicare Supplement Plan: _____ ID #: _____

Other Health Insurance (specify): HMO / PPO _____ ID #: _____

Medicare D (Pharmacy) Plan: _____ ID #: _____

Long-Term Care Insurance: Company: _____ 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 funds' by the Department of Human Services (DHS) 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 ineligibility'. 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: _____

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

_____

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 Applicant's 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.