3026 MT HOPE HOME ROAD
MANHEIM, PA 17545
(717)665-6365
FAX (717)665-6366

APPLICATION FOR ADMISSION

ADMISSION POLICY:
All residents have the right to equal access to quality care without discrimination regardless of diagnosis, severity of condition, or pay source. The residents have a right to care without discrimination based on any of the following: All persons regardless of basis of race, color, famial status, religious creed, ancestry, age, sex gender, sexual orientation, gender identity, or expression, national origin, ability to pay, handicap or disability, use of guide or support animals because of blindness, deafness, or physical handicap of the resident or because the resident is a handler or trainer of support or guide animals. In addition, marital status, Veteran status, political beliefs, or prior civil rights activity. All are eligible for admission and care into Mt Hope.

NURSING CARE_______ COTTAGE_______

PERSONAL AND FAMILY INFORMATION

Name ____ ____
(First) (Middle) (Last)

Address____

____Telephone_____________

Date of Birth___________ Place of Birth____
Marital Status___ __________ Spouse's ____

Resident Representative ______________________ Email __________________________
Address____

P.O.A (circle on) Yes No

Address____

____Telephone___________________

My bill should be sent to ____

Address____

____Telephone____________________

Lifetime Occupation/Profession/Trade____

Retirement Date__________________________

Church____

Address____Telephone____________________

Pastor____Telephone_____________________________

Physician's Name____________________Telephone_________________

Address____

Funeral Director___________________Telephone________________

Address____

Are you donating your body to Medical Science? If yes which Funeral Home will you be working with?

_____No____

Executor of Will_______________________Telephone________________

Address____

The Federal Government now requires that every person declaring United States citizenship that receives Medical Assistance and/or is admitted into a Long-Term Care Facility must provide proof of United States Citizenship and identity.

Please provide a copy of your birth certificate, alien registration card, or Naturalization Certificate as proof of citizenship and/or legal status.

Please answer and Sign

Are you a United States Citizen ____ YES _____NO

If NO check One: _____ Permanent Resident _____ Temporary Resident
_____ Refugee _____ Illegal Alien

Alien #_________________________ Date of Entry: ____

Country of Origin: ____
Sign to declare your citizenship or alien status as marked above:

____

Signature

Name and Address of Sponsor if you have one.

FINANCIAL INFORMATION
(Must be completed before application can be considered for admission)

Have you assigned and/or transferred any assets for less than fair market value within the past five years?

Circle one Yes No

If yes, explain ____

Have you gifted any funds over 500 dollars in the past five years?

Circle one Yes No

If yes, explain ____

Be as complete and accurate as possible. Note any assets held jointly with spouse or anyone else.

Assets

Cash	$____________
Savings	$__________________
Checking	$__________________
Certificate of Deposit	$__________________
Savings Bonds	$__________________
Mutual Funds	$__________________
Stocks and Bonds	$__________________
IRA/403(b)/401(k)	$__________________
Real Estate Value	$__________________
Trust Fund	$__________________
Annuities	$__________________
Vehicles	$__________________
Value of Business	$__________________
Loans to Others	$__________________
Other Assets*	$__________________

Monthly Income

Social Security	$_____________________
Pension	$______________________
Annuities	$______________________
Interest/Dividends	$______________________
IRA	$______________________
Rental Income	$______________________
Other *	$______________________
Total Income	$______________________

Expenses

Rent/Mortgage	$______________________
Notes Payable	$______________________
Credit Card Debit	$______________________
Outstanding Medical Bills	$______________________

Total Assets $__________________ Other Debt* $_____________________

Total Debt $_____________________

(Please attach documentation to verify figures)
*List Information regarding other items on the back of this form.

Do you have a pre-paid Funeral Reserve? (Circle One) Yes No
Do you have a burial plot? (Circle One) Yes No

Value of Funeral Reserve $_____________ Location ________________

If someone other than the applicant has filled out this application, please include

Name_____ _____________________________Telephone__________________

Address____

Relationship____

HEALTH INSURANCE INFORMATION

Name____

Social Security Number___________________________________

Medicare No. _____Medicare Part A (hospital)_____ Part B (medical)______

Prescription plan name and Policy #____

Address____

Telephone___________________________

Medicare Supplement (name of plan) ____

Address____

Telephone__________________________ID#____Group #____

Supply a copy of the summary page of benefits for Long Term Insurance policies.

Long Term Care Insurance Provider____

Have you made application to Medicaid? (Circle one) Yes No

Date submitted__________________________Medicaid No. _____________________________________

County application submitted_________________________________

Type of service approved for: (Circle one)

Assisted Living Long Term Care MR MH

Other Health insurance plans you are currently covered under.

Name____Telephone________________________

Address____

ID#_____________________________________Group #______________________________________

Hospital Preference ______LGH ____Ephrata Comm. _____ Good Samaritan_______

____ UPMC Pinnacle Lititz _____ Hershey Medical Center _____Other __________________

Be sure to supply copies of all insurance and prescription cards at time of admission. Inform us any time there is any change in health insurance information,

EMERGENCY INFORMATION

Indicate the person(s) to be notified and in the order they are to be contacted.

Name	Address	Phone	Relationship

HOSPITALIZATION RECORD

Were you in the hospital in the last year? (Circle one) Yes No

Complete the following for any hospitalization within the last year of the two most recent hospitalizations.

Hospital	Inpatient/Outpatient	Dates	Reason

Details of any other significant hospitalizations or surgeries______________________________________

MENTAL HEALTH HISTORY
Have you ever received treatment for mental illness? (Circle one) Yes No
Give details on any previous psychiatric treatment

Provider	Inpatient/Outpatient	Year	Treatment

PREVIOUS ADMISSION TO NURSING OR ASSISTED LIVING FACILITY
Previous admission to nursing or assisted living facility? (Circle one) Yes No

Name of facility	Dates of stay	Reason for admission

THERAPIES/HOME HEALTH
Have you received outpatient care in the last year? (Circle one) Yes No
(This includes physical therapy, occupational therapy, speech therapy, home health services, etc.)

Provider	Date	Reason for treatment

Bed Hold/ Readmission Policy/Dual Eligibility
Medicaid Residents
If a resident is a Medical Assistance recipient, and leaves Mt. Hope Nazarene Retirement Community for a period of hospitalization or therapeutic leave Mt. Hope will reserve the bed for the maximum number of days under the Pennsylvania Department of Public Welfare program. Currently state law requires a maximum of 15 days. If the leave is more than the 15 days, the Resident is entitled to the first available bed, or in the alternative, the Resident can reserve his or her bed by electing to pay the Medicaid per diem rate.

Medical Assistance Residents on Part A Medicare are not billed for the first 20 days, on the 21st day the Co-Insurance or Third-party insurance is billed if applicable. Residents having no Co-Insurance and not approved for Medicaid are responsible for payment. If any Resident and/or resident representative are rejected for MA or MC services, the party is responsible for all monies due for that period.

*Residents/Resident Representative are not required to sign an arbitration agreement as a condition of admission or to receive care. For the Nursing Home no deposit is required for application or admission.

Pending Medical Assistance Residents

Pending Medical Assistance Residents are required to pay their income while waiting for approval. Residents and/or resident representatives are responsible to submit income in the same time frame as private pay policies If any Resident and/or resident representative are rejected by MA or MC services, the party is responsible for all monies due for that period.

Medicare Residents:

In the event that a Resident is eligible for Medicare Part A benefits is transferred to or readmitted to a hospital, Medicare Part A eligibility will be discontinued on the day the resident is admitted into the hospital. The resident's bed will be reserved at the Daily Rate, unless the Resident or Responsible Party elects via a phone conversation and in signature to reserve the bed and do a Bed Hold. If a resident elects not to hold the bed, then the Resident will be discharged from the facility. The effective date will be the date the Resident or Responsible Party gives notice. If the Resident would like to change their mind and be readmitted , the readmission will be subject to bed availability.

Private Pay Residents

If private pay resident leaves the Facility for a period of hospital stay and or therapeutic leave , or any other reason other than the residents death, and if Resident is not eligible for, or receiving Medical Assistance benefits, Residents Bed will be reserved through payment of the Basic Daily rate. Facility will continue to hold the bed until notified via phone conversation and documentation by Resident or Resident Responsible Party. If Resident or Resident Responsible party elect to not hold the bed, resident will be discharged from the facility the date notified. Readmission of the Resident to the facility shall be subject to bed availability.

Permitting Residents to Return Facility

A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room.

Disposition Upon Residents Death

In the event of a resident's death, Mt Hope is authorized to transfer the Resident's personal property to a duly authorized resident representative. Personal property is to be removed within the first 24 hours of discharge, death or transfer. Property that is not picked up will be moved to storage until family can pick up the personal property.

If property is left over 5 days after discharge, death, or transfer, Mt. Hope will dispose or donate said property and not be responsible for any damages incurred to property as a result of extended storage.

Monthly Statements

Mt Hope Nazarene will mail Resident or Resident Representative on or about the first (1st) calendar day of the month a billing statement reflecting charges for nursing services for the month. Statements are due and payable upon receipt of the Monthly statement.

Rate Schedule

Mt Hope Nazarene reserves the right to change from time-to-time the Rate Schedule reflecting the amount of any of its charges or how and when charges are computed, billed or become due. Mt Hope Nazarene will provide thirty (60) days advance written notice of any such changes in the Rate Schedule.

Medicaid Benefits
For residents approved for Medical Assistance benefits, Mt Hope Nazarene will accept payment from the Commonwealth of Pennsylvania and, if applicable, the Resident's Patient Pay Amount as determined by Department of Public Welfare as payment in full only for those services covered by the Medicaid program. Residents remain obligated to pay such Patient Pay Amount, less any qualified medical expense deductions, on a monthly basis.

Pharmacy
The Resident agrees He/ She shall be responsible to pay prescription co-pays or other charges related to the provision of medications and other services provided by Brockie Pharmtech which are not covered by insurance or Pennsylvania Medicaid Programs.

Room Assignments and Changes
We cannot guarantee that the room that a resident was first assigned upon admission will be the room that the resident will remain in throughout the skilled stay. We will make every reasonable effort to assign rooms based on resident preference, safety and needs of the residents when considering room transfers and requests and honoring residents rights.

Termination, Transfer, Discharge
A resident may terminate their stay at Mt Hope upon thirty days written notice to Mt Hope. If resident leaves Mt Hope other than medical emergency or death a written notice must be given in advance of the transfer. Mt Hope may transfer, discharge or terminate a resident stay if

(a) Mt Hope finds the transfer or discharge necessary to meet the resident's welfare and the residents needs Cannot be met at Mt Hope
(b) Residents' health has improved sufficiently so that the resident no longer needs the services provided by Mt Hope.
(c) The safety, health and wellbeing of other residents at Mt Hope are endangered
(d) Resident has failed, after notice to pay for or to have paid or treated as paid under Medicare or Medicaid program charges for resident care and stay at Mt Hope
(e) Mt Hope ceases to operate

Name of Legal Power of Attorney/Resident Represnetative

____

***Upon admission you must supply a copy of Power of Attorney to keep on file at Mt Hope Nazarene Retirement Community.**
Please note: Medical and Financial information may only be given to the Power of Attorney unless otherwise specified by the resident or legal representative.

Have you completed a living will or an advance directive? (Circle one) Yes No

***Upon admission you must supply a copy of living will.**

I certify that the information contained in this application to be complete and accurate and authorize Mt. Hope Nazarene Retirement Community to research information for verification purposes.

To the best of my knowledge, the information I have submitted is true and correct. I understand that any misrepresentation, including financial information, may be considered grounds for refusal of admission at Mt. Hope Nazarene Retirement Community.

Applicants Signature____ **Date**____________

Power of Attorney/Resident Representative _________________________ **Date**_____________
(If applicant is unable to sign)