



MAGNOLIA MANOR
6 REES DRIVE
WILLOW STREET, PA 17584
717-464-1237 (P)
717-464-9830 (F)
magnoliamanor6@gmail.com

APPLICATION FOR RESIDENCY

Thank you for your interest in residency at Magnolia Manor.

This application forms request personal, financial and information about any current needs you may have. The information provided will be treated as confidential and will not be disclosed to a party unrelated to Magnolia Manor without your authorization except to the extent necessary to evaluate your application for residency. Please complete and sign the entire application, including the financial information and medical self-assessment, and submit completed form to the administrator for review.

In addition to this application , please submit the following as part of your application packet:

- Completed copy of Documentation of Medical Evaluation (DME). This form should be completed by your primary care physician and can be fax directly to Magnolia Manor at 717-464-9830
- Photocopy of the front and back of your Medicare card and supplemental insurance cards (medical and prescription)
- Photocopy of your identification card or passport
- Copy of your most recent social security award letter
- Copy of your most recent 3 month bank statement
- Copy of power of attorney - if applicable

OFFICE USE ONLY

Date application received: _____

Date of review: _____

❖ Accepted ___ Not Accepted ___ Reason: _____

Accepted by: _____

Date admission decision communicated: _____

Waiting List: _____

Notes: _____

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SECTION I: DEMOGRAPHICS/GENERAL INFORMATION

Applicant's Last Name	First Name	Middle Initial	Date of Application	
Address	City		State	Zip Code
Telephone Number	E-mail Address			
Social Security Number	Date of Birth	Age	Place of Birth	Sex
				Male Female
Height:	weight:	Hair Color:	Glasses:	Dentures:
Primary Language:		Religion:		
Are you or your spouse a veteran	No	Yes, If so was it during war time? _____		
Marital Status:	Single	Married	Divorced	Widowed Partnered
Full Name of Husband or Wife:				
Address of Spouse (if living):				
If Deceased Date of Death:		Where Buried:		

Health Insurance:	Policy Number:
Address:	
Medicare Number:	Part A: Part B: Part D:
Ambulance Club Name:	Ambulance club #:
Power of Attorney:	Phone Number:
Advanced Directives: Yes No	Living Will: Yes No
Hospital of Choice:	Phone Number:
Funeral Home:	Phone Number:

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SECTION II: FAMILY INFORMATION & PERSONAL HISTORY

List Your Children:		
Name	Address	Phone

Where have you lived most of your life? _____

Who do you live with now? Wife/Husband _____ Son/ Daughter _____ Alone ____ Other

Your profession, trade or occupation?

Highest grade level attained in school?

List your hobbies and interests:

Do you use tobacco: **Alcohol:** **Narcotics** **Other:**

Please note: smoking/vaping is not permitted at Magnolia Manor building or grounds

Have you applied to any other facilities? No Yes **If Yes where:**

Have you ever lived in another facility? ____No ____ Yes, if so, Where

Emergency Contact Information:

Name:	Relationship	Address	Phone Number

Miscellaneous Data

Life Insurance: No __ Yes __ , **If yes, Company Name:** _____ **Value \$** _____

Automobiles (make and model) _____ **Estimate Value \$** _____

Other: _____

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SECTION III: FINANCIAL INFORMATION

I am aware and understand that completion of the financial section of the application is a prerequisite to admission. I am also aware and understand that failure to completely and accurately disclose my financial information may constitute grounds for denial of admission or termination of residency contract agreement with Magnolia Manor.

<u>REGULAR MONTHLY INCOME</u>	<u>Description (if needed)</u>
Social Security (<i>Net</i>) \$ _____ Per Month	_____
Pension \$ _____ Per Month	_____
Pension from Spouse \$ _____ Per Month <i>(If collecting survivor benefit)</i>	_____
Annuity Income \$ _____ Per Month	# of years _____
Other Income \$ _____ Per Month <i>(Not from capital assets such as IRA, etc.)</i>	_____
TOTAL INCOME: \$ _____ Per Month	
<u>CAPITAL ASSETS (Value)</u>	<u>Description (if needed)</u>
Primary Residence \$ _____	_____
Real Estate \$ _____	_____
Cash/Savings/CDs \$ _____	_____
Stocks/Equity Funds \$ _____	_____
Bonds/Bond Funds \$ _____	_____
IRA/401K \$ _____	_____
Roth IRA \$ _____	_____
Other \$ _____	_____
TOTAL ASSETS: \$ _____	
<u>LIABILITIES</u>	<u>Description (if needed)</u>
Mortgage \$ _____	_____
Notes Payable/Endorsed \$ _____	_____
Personal Debts \$ _____ <i>(Including credit cards)</i>	_____
TOTAL LIABILITIES: \$ _____	

Applicant's Signature: _____ Date: _____

POA or Designated Person: _____ Date: _____
(If applicant is unable to sign)

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SECTION IV: MEDICAL INFORMATION & SELF-ASSESSMENT

Primary Physician:	Phone:
Practice Name:	
Address:	Zip Code:
Date of last visit and reason:	

Specialty Physician:	Phone:
Practice Address:	Zip Code:
Date of last Visit and reason:	

Specialty Physician:	Phone:
Practice Address:	Zip Code:
Date of last Visit and reason:	

List your last hospitalization:	
Hospital _____	Date:
Reason	

Please check any of the following you have or did have:				
Heart Disease	High Blood Pressure	Incontinence	Cancer	Cataracts
Memory Loss	Low Blood Pressure	Stroke	Arthritis	Confusion
Limb Impairments	Parkinson's Disease	Paralysis	Stroke	Diabetes

Please check any of the following you need assistance with:					
Ambulation	Eating	Special diet	Transportation	Shopping	Interpreter Services
Dressing	Bathing	Finances	Housekeeping	Laundry	Other
Toileting	Grooming	Telephone	Medications	Other	

Any other notes:

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**SECTION III: AUTHORIZATION FOR USE &
DISCLOSURE OF PROTECTED HEALTH INFORMATION**

Applicant's Name: _____ **DOB:** _____

I hereby authorize the use and disclosure of protected health information about the above Applicant as follows:

A. Name of person, class of persons, or organization authorized to make the requested disclosure:

Name of Primary Care Physician: _____

B. Name of person, class of persons, or organization authorized to receive and use my protected health informatio

• **Description of Applicant's protected health information to be disclosed:**

Medical records, medical histories, mental health records, laboratory results, progress notes, physicians' orders, and lists of medications.

• **Applicant's protected health information is being disclosed for the following purpose(s):**

To determine Applicant's eligibility for admission to Magnolia Manor, identify Applicant's personal needs, and develop a plan of care for Applicant if needed.

I understand that I have the following rights with respect to this Authorization:

- The recipient of the protected health information may not further disclose the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law.
- I am not be required to sign this Authorization as a condition of admission.
- Provider will provide me with a copy of this Authorization.
- I may revoke this Authorization at any time by mailing or personally delivering a signed, written notice of revocation to the attention of the Administrator at Magnolia Manor 6 Rees Drive, Willow Street, PA 17584. Such revocation will be effective upon receipt, except to the extent that the recipient has taken action in reliance on this Authorization. I understand that such revocation will be considered a withdrawal of my Application for Residency.

Applicant Signature: _____ **Date:** _____

POA or Designated Person: _____ **Date:** _____

(If applicant is unable to sign)