Inglis House
Ability & Independence. Redefined.
inglis.org

2600 Belmont Avenue
Philadelphia, PA 19131
215.878.5600

Thank you for inquiring about living at Inglis House. Inglis is dedicated to enabling people with physical disabilities, and those who care for them, to achieve their goals and live life to the fullest. Whether you've visited Inglis House in person or virtually through our website, www.inglis.org, we welcome your interest!

The packet includes information we need to process your application. By providing all of the requested documentation about your medical history and disability, you will help us to process your application and enable our physicians and staff to meet your specific needs. Our admissions team is available to answer your questions and guide you to obtain the required information when possible.

Please mail or fax (215-878-4657) the application materials to:

Admissions Coordinator
Inglis House
2600 Belmont Avenue
Philadelphia, PA 19131

Again, thank you for your interest in Inglis House. We will review your application and contact you with an answer within 30 days. In the meantime, do not hesitate to call (215-581-0776) or email admissions@inglis.org with any questions or concerns.

Warmest regards,

Inglis House Admissions

To apply for admission, please submit:

Part 1:

- □ Admissions application (enclosed)
- □ Authorization to secure criminal record information completed and signed.
- □ Copy of prospective resident's:
  - Identification Card
  - Insurance cards
  - Social Security Card or Birth Certificate
- □ Copy of the following information:
  - Power of Attorney paperwork
  - Living Will
  - Burial Information

Part 2:

If the applicant is in a Nursing Home and a Medicaid recipient, please provide the following:

- □ **All items from Part 1 (above)**
- □ PA 162- Medicaid Approval Notice
- □ Cost of Living Adjustment (COLA) – the Social Security Annual Notice
- □ Copy of the applicant's most recent bank statement (FMLA if established at the NH or directly from the bank)
- □ Medical Records Including:
  - Face Sheet
  - History and Physical
  - Current Medications
  - Orders/Treatments
  - Physical/Occupational and/or Speech therapy evaluations/notes
  - Special equipment needs
  - PASSR
  - MDS
  - Most recent 60 days of nursing notes
  - Most recent 60 days of behavior and progress notes
  - Most recent 60 days of wound notes

Part 3:

If the applicant is either at home, in a hospital or in another nursing home and:

1- Is not the recipient of approved Medicaid or

2- Is Medicaid pending or

3- Is the recipient of community services Medicaid

Please provide the following:

- □ **All items from Part 1 (above)**
- □ Medical assistance application (PA-600). Copy of application attached below

- □ Philadelphia Corporation of Aging (or your local County Aging office) Level of Care assessment with signed MA 51
- □ Pre-Admission Screening and Resident Review (PASRR) Level 1
- □ Level 2 PASRR if indicated
- □ Social Security Award Letter
- □ Five years of bank statements (most recent years)
- □ Verifications of all single transactions (withdrawals and deposits) $500 and above
- □ If applicable, verification of the following:
    - Pension and annuity
    - Burial reserve
    - Life Insurance

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ADMISSION CRITERIA

Inglis House strives to offer adults with physical disabilities an active and participatory community of mutual respect, with continually improving services where we ensure the highest quality of life for residents by minimizing their acute medical problems, maximizing their level of independence and involving them in activities from which they derive personal fulfillment.

To be considered for admission to Inglis House, a prospective resident must:

- 18 years or older;
- Wheelchair user;
- Assessed to have a primary diagnosis of a neuromuscular or musculoskeletal condition that results in a significant loss of physical functioning;
- Able to benefit from Inglis House services and programs;
- Without unresolved behavior issues during the last six months or have an effective behavior plan of care in place for a minimum of six months; and
- A non-smoker or a reformed smoker who has been smoke free for at least 2 years.

Inglis House does not accept prospective residents who:

- Are ventilator dependent
- Smoke
- Have a primary diagnosis of an Intellectual Developmental Disability or mental illness;
- Have a psychiatric diagnosis where symptoms:
  - Are in an active state;
  - Are not manageable in an open environment;
  - Prevent responsible behavior;
  - May at times pose a danger to self or others.
- Have a cognitive status such that they cannot interact with others or benefit from services; ☐ Have tuberculosis (TB) that is currently contagious;
- Is actively smoking or has not been smoke free for the last six months.
- Have a history of felony conviction(s) which may impact the Inglis community.
- Have been screened by the Office of Special Programs and determined ineligible for nursing home services.

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PAYMENT FORMS ACCEPTED:

- Private Pay
- Traditional Medicare
- Medical Assistance
- Other insurances with approval from insurance company

SERVICES AVAILABLE AT INGLIS HOUSE INCLUDE:

- Long term care with around-the-clock nursing and physician's services
  - Pain management
  - Respiratory therapy
  - Wound care
  - Specialty physician's clinic on-site
- Rehab services including physical, occupational and speech therapy
  - Wheelchair clinic and physiatrist consultations
  - Assistive devices provided to fit your particular need
  - Restorative program
- Social, recreational and educational programming
  - Therapeutic recreational programs
  - Resident computer lab with full-time certified staff to assist with skills' assessment and training
  - Lifelong learning program including associates' and bachelor's degree programs through Community College of Philadelphia and Neumann University
  - Support groups and special interest discussion groups
  - Planned trips
  - Full-time chaplain and spiritual programming for all faith
  - Social services

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ADMISSION APPLICATION **DATE:** _____

Applicant's Name: _____ Home Phone_____

Address: _____

DOB: _____ Sex: _____ Religion: _____ Marital Status*: _____
If divorced, please attach a copy of divorce decree

Social Security Number: _____

How did you hear about Inglis House? _____

Copies of ID (State Driver License, Social Security Card, Birth Certificate, etc) &
Copies of Insurance Cards (Including Medicare Card & Access Cards) must be attached to application. Medicare

Number: _____ Part A Part B

Medicare D: Yes No Plan Name: _____ Effective: _____

Medicare HMO: _____ Policy # _____

Supplement Insurance: _____ Policy # _____

Other Insurance: _____ Policy # _____

Has applicant ever been in another nursing center? **Yes** _____ **No** _____

If yes, please list the nursing center and dates of stay: _____

Primary Contact Information:

Primary Contact Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail: _____

Other persons to contact in case of an emergency:

Name	*Relationship*	*Address*	*Phone Number*

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MEDICAL AND PERSONAL DATA

Primary Diagnosis _____ **Age of Onset**_____

Secondary Diagnosis _____

Primary Physician: _____ Phone Number: _____

Other Physician: _____ Phone Number: _____

Other Physician: _____ Phone Number: _____

Other Physician: _____ Phone Number: _____

Is the applicant aware of the placement decision?	Yes	No
Is there an Advance Directives or Living Will?	Yes	No
Has the applicant made pre-paid funeral arrangements?	Yes	No

Funeral Home preference: _____ Phone Number: _____

HOSPITALIZATIONS

Please list ALL hospitalizations within the last two years, including any psychiatric and drug/alcohol treatment centers

Facility Name	Address	Dates	Reason

Please indicate any special needs, requirements or equipment the applicant has or will need.

Is the applicant a smoker? Please circle and comment:

Never Have Smoked

YES- How many a day? _____

Quit – How long ago?_____

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FINANCIAL INFORMATION

To process your application, the following information is needed. The information supplied is strictly confidential and allows us to assist you in the financial planning of the Resident's care. The financial data should be that of the applicant. Your cooperation is appreciated in order to expedite admission.

The name(s) of the person(s) who will be responsible for facilitating payment:

Name Address Home/office phone Relationship

_____

_____

_____

Responsible Party Signature:

_____

Does the applicant have any of the following?

Trust Account: _____ Yes _____ No _____

Legal Guardian: _____ Yes _____ No _____

Power of Attorney: _____ Yes _____ No _____

If yes, DOCUMENTATION of Trust, Guardianship, or Power of Attorney is required.

MONTHLY INCOME:	**AMOUNT:**
Salary	_____
Social Security (**Please attached a SS Letter**)	_____
Pensions/Annuities	_____
IRA	_____
Interest/Dividend	_____
Income Veteran's	_____
Benefits Alimony	_____
Other	_____
TOTAL MONTHLY INCOME	_____

Please use this space for any comment on the above financial information:

_____

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ASSETS*:

	Bank Name/Location	Account #	Balance
Cash			
Checking			
Saving			
Other			
Securities			

*** Please provide copies of assets, including bank statements for the last 5 years. This information is required to determine eligibility under state payment plans. The state also requires verification of all transactions over $500.**

Real Estate (Description/Location) & Address

_____ $ _____

_____ $ _____

Jointly Owned? Yes No Name of Co-Owner _____

Is anyone currently living in this home? Yes No

If yes; Name/ Relationship: _____

_____

Is the applicant planning to return to the home? Yes No

Is the real estate currently for sale, or is there intent to sell within the next 12 months? Yes No

OTHER ASSETS:

1. Cash Value of Life $ _____
Insurance 2 Vested Pension $ _____
Benefits $ _____
3. Business Interests $ _____
4. Automobiles $ _____
5. Funeral Account (If not irrevocable trust)
6. Other $ _____

TOTAL ASSETS (A): $ _____

Please use this space for any comment on the above assets:

_____

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LIABILITIES

Home Mortgage	$ _____
Credit Cards/Charge Accounts	$ _____
Loans	$ _____
Other Personal Debts	$ _____
Medical Expenses	$ _____
Tax Owned/Liens	$ _____
TOTAL LIABILITIES (B):	$ _____

NET WORTH (*Subtract Line B from Line A*) $ _____

Please provide the appropriate statements/documentation to support the above financial data.

Does the applicant currently receive Medicaid benefits in the community?

Yes No If yes, Medicaid # _____ Effective Date: _____

Has an application for Medicaid Long Term Care Benefits been initiated?

Yes No If yes, Case Worker's Name _____ Telephone#_____

Has an application for Medicaid for Long Term Care Benefits been denied?

Approved _____ Date_____ Medicaid # _____

_____ Denied _____ Date _____ Reason

_____

I hereby certify that to the best of my knowledge and belief, the above stated information is true, correct and complete. I understand that the Facility will rely upon the accuracy and completeness of the information in making an admission decision, and if any information has been falsely represented, this will be sufficient cause for voiding my application for admission. In addition, I understand that the Facility will rely upon the accuracy and completeness of the financial information to determine the applicant's responsibility for private payments or eligibility for benefits under government or commercial insurance programs. I understand that I must notify the Facility in writing of any substantial change in financial condition. All of the information will be kept confidential.

Signature of Applicant and/or Responsible Party:

Signature: _____ Date: _____

Signature of Facility Representative (if presently residing in a Assisted Living or Nursing Facility):

Signature: _____ Date: _____

NOTE: The Physician's Medical Report on the next four pages is to be filled out by your physician. This report must be returned with the application.

PHYSICIAN'S MEDICAL REPORT

NAME				DATE OF BIRTH	
HEIGHT	WEIGHT	BP	HR	RESP	TEMP

HOSPITALIZATIONS IN THE PAST 6 MONTHS [ ] Yes [ ] No If Yes, please list dates, hospital and reason for hospitalization

ALLERGIES [ ] Yes [ ] No If Yes, please list all known allergies

DIETARY RESTRICTIONS [ ] Yes [ ] No If Yes, please list all restrictions

IMMUNIZATIONS [ ] Yes [ ] No If Yes, please list all & most recent dates

MEDICATIONS [ ] Yes [ ] No If Yes, please list all medications

MEDICATION	DOSE / FREQUENCY	PSYCHOTROPIC MEDICATION	DOSE / FREQUENCY

PHYSICIAN'S MEDICAL REPORT

PHYSICAL EXAMINATION PLEASE PROVIDE ADDITIONAL INFORMATION FOR ALL ABNORMAL ITEMS

EYES	[ ] NORMAL	[ ] ABNORMAL	
EARS	[ ] NORMAL	[ ] ABNORMAL	
NOSE	[ ] NORMAL	[ ] ABNORMAL	
THROAT	[ ] NORMAL	[ ] ABNORMAL	
MOUTH	[ ] NORMAL	[ ] ABNORMAL	
NECK	[ ] NORMAL	[ ] ABNORMAL	
SKIN	[ ] NORMAL	[ ] ABNORMAL	
LUNGS	[ ] NORMAL	[ ] ABNORMAL	
HEART	[ ] NORMAL	[ ] ABNORMAL	
ARTERIES	[ ] NORMAL	[ ] ABNORMAL	
VEINS	[ ] NORMAL	[ ] ABNORMAL	
ABDOMEN	[ ] NORMAL	[ ] ABNORMAL	
HERNIA	[ ] NORMAL	[ ] ABNORMAL	
GYNECOLOGICAL	[ ] NORMAL	[ ] ABNORMAL	
GENITALIA (MALE)	[ ] NORMAL	[ ] ABNORMAL	
ANAL / RECTAL	[ ] NORMAL	[ ] ABNORMAL	
NERVOUS SYSTEM	[ ] NORMAL	[ ] ABNORMAL	
OTHER (PLEASE SPECIFY)	[ ] NORMAL	[ ] ABNORMAL	

COMMUNICABLE DISEASES [ ] Yes [ ] No If Yes, please specify disease/diagnosis and list the precautions needed to ensure the safety of other residents and staff. Please note immunizations also.

FALL RISK [ ] Yes [ ] No If Yes, please list fall precautions presently in place

PHYSICIAN'S MEDICAL REPORT – FUNCTIONAL LEVEL

NAME	**DATE OF BIRTH**

BED MOBILITY How an applicant moves to and from a lying position, turns side to side, and positions body while in bed.	[ ] Independent [ ] Limited Assistance [ ] Extensive Assistance [ ] Total Dependence
TRANSFERS How applicant moves to and from bed, chair, wheelchair, standing.	[ ] Independent [ ] Limited Assistance [ ] Extensive Assistance [ ] Total Dependence
EATING How an applicant eats/drinks regardless of skill (includes G-tube).	[ ] Independent [ ] Limited Assistance [ ] Extensive Assistance [ ] Total Dependence
TOILET USE How applicant uses the toilet room/ commode/bedpan/urinal.	[ ] Independent [ ] Limited Assistance [ ] Extensive Assistance [ ] Total Dependence
BLADDER FUNCTION	[ ] Continent [ ] Incontinent >>> [ ] Occasional [ ] Daily Foley Catheter [ ] Yes [ ] No Supra Pubic Catheter [ ] Yes [ ] No Ostomy [ ] Yes [ ] No
BOWEL FUNCTION	[ ] Continent [ ] Incontinent >>> [ ] Occasional [ ] Daily Constipation [ ] Yes [ ] No History of Impaction [ ] Yes [ ] No Uses Suppository [ ] Yes [ ] No Ostomy [ ] Yes [ ] No Type: _____ Colostomy [ ] Yes [ ] No
MOBILITY	[ ] Ambulatory [ ] Wheelchair – Powered [ ] Cane/Walker [ ] Wheelchair – Manual
SPEECH	[ ] Unimpaired [ ] Mild Difficulty [ ] Aphasic
MEMORY	[ ] Intact [ ] Impaired Short Term [ ] Impaired Long Term

MENTAL STATUS	[ ] Clear [ ] Occasionally Confused [ ] Confused
MENTAL HEALTH HISTORY Please provide additional information	**HISTORY OF SUICIDAL ATTEMPTS** [ ] Yes [ ] No If Yes, please provide additional information

PHYSICIAN'S MEDICAL REPORT – DIAGNOSIS INFORMATION

NAME	DATE OF BIRTH

PLEASE CHECK [✓] ALL DIAGNOSES THAT APPLY — **Please List Additional Diagnoses Below**

- [ ] Comatose
- [ ] Cerebral Palsy
- [ ] Multiple Sclerosis
- [ ] Paraplegia
- [ ] Quadriplegia
- [ ] TBI

SPINA BIFIDA

- [ ] Spina bifida with hydrocephalus-cervical region (741.01)
- [ ] Spina bifida with hydrocephalus-dorsal region (741.02)
- [ ] Spina bifida with hydrocephalus-lumbar region (741.03)
- [ ] Spina bifida with hydrocephalus – NOS (741.00)
- [ ] Spina bifida (w/o mention of hydrocephalus) (741.90)
- [ ] Spina bifida-cervical region w/o mention of hydrocephalus (741.91)
- [ ] Spina bifida-dorsal region w/o mention of hydrocephalus (741.92)
- [ ] Spina bifida-lumbar region w/o mention of hydrocephalus (741.93)
- [ ] Spina bifida occulta (756.17)

SPINAL CORD INJURY

- [ ] Spinal cord injury NOS (952.9)
- [ ] Spinal cord injury at birth (767.4)

MUSCULAR DYSTROPHY

- [ ] Hereditary progressive muscular dystrophy (359.1)
- [ ] Congenital hereditary muscular dystrophy (359.0)

ENCEPHALOPATHY

- [ ] Encephalopathy NOS (348.3)
- [ ] Metabolic encephalopathy (348.31)
- [ ] Toxic encephalopathy (349.82)

OTHER DIAGNOSES

- [ ] Late effect cerebral aneurysm, including hemiplegia (438.20)
- [ ] Anoxic brain damage (348.1)
- [ ] Friedeich's ataxia (334.0)
- [ ] Myositis ossificans progressive (728.11)
- [ ] Charcot-Marie-Tooth disease (356.1)
- [ ] Amyotrophic sclerosis (335.20)
- [ ] Primary lateral sclerosis (335.24)
- [ ] Spinal curvature - NOS in other disease (737.40)
- [ ] Cerebellar ataxia (334.3)
- [ ] Dystonia musculorum progressive (333.6)
- [ ] Cerebral degeneration (331.7)
- [ ] Huntington's chorea (333.4)

- [ ] **None of the Above Diagnoses Apply**

NAME OF PHYSICIAN (PLEASE PRINT)

ADDRESS

PHONE NUMBER(S)

PHYSICIAN'S SIGNATURE:	DATE:

Applicant/Contractor Authorization Form
to Secure Criminal History Record Information

Please **clearly** and **fully** complete the *entire* form. Incomplete and/or illegible forms will slow your hiring process.

PERSONAL INFORMATION:

Date:_____

First Name:_____ **Middle Initial:**_____ **Last Name:**_____

Other name(s) I use or by which I have been known include: *(if n/a please make note)*

_____Maiden or Alias?_____

_____Maiden or Alias?_____

Social Security Number: _____ **Date of Birth:** _____

I have been advised that Inglis obtains Criminal History Record Information and/or an investigative consumer report (which might include information with respect to your character, general reputation, personal characteristics and/or mode of living) in connection with all employment applications pursuant to Pennsylvania state law. Because I wish to be considered for employment, I authorize Inglis to secure all information concerning all criminal acts of which I have been convicted and which have not been annulled, expunged or sealed by a court, but excluding summary offenses, such as violations of motor vehicle laws.

The following are the dates and addresses of all places where I have resided during the past seven (7) years: **Please start with current address and work backwards.*

Dates of Residence:	Street Address	City & State	Zip Code

CRIMINAL HISTORY:

Since reaching the age of eighteen (18), have you ever been convicted of a crime, including felonies and misdemeanors but excluding summary offenses such as speeding tickets, which has not been annulled, expunged or sealed by a court?

◯ Yes ◯ No

If "Yes", please describe in full detail including date(s), location(s), the nature of the offense(s) and the legal finding.

_____

_____

_____

_____

_____

I hereby certify that all information provided in this Authorization is true, correct and complete. I understand that any misrepresentation of any fact or omission will be cause for my disqualification from further consideration and/or, if such misrepresentation or omission is discovered after an offer of employment has been extended/accepted, will result in the revocation of such offer/termination of my employment with Inglis.

I hereby release from liability all representatives of Inglis for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications.

Signature: _____ Date:_____

***Note to Applicant**: Your completion of this Authorization Form **does not** constitute an Offer of Employment by Inglis.*

I attest/affirm that I'm not disqualified from employment under the Older Adult Protective Services Act (details on page 5).

Signature:_____ Date:_____

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PROFESSIONAL REFERENCE REQUEST FORM:

Please note we cannot reach references via e-mail. A phone number is required.

APPLICANT INFORMATION:

Applicant Name:_____

E-Mail Address:_____ Phone:_____

Position Applied For:_____

Recruiter Name: _____

FIRST REFERENCE:

You need to provide only 1 reference. Personal or professional, but no family member may be a reference. Please provide email, if possible

Name of Contact:_____ Position/Title:_____

Company:_____ Phone:_____

Street Address:_____

City & State: _____ Zip Code:_____

SECOND REFERENCE:

First Reference Email Address: _____

Name of Contact:_____ Position/Title:_____

Company:_____ Phone:_____

Street Address:_____

City & State: _____ Zip Code:_____

THIRD REFERENCE:

Name of Contact:_____ Position/Title:_____

Company:_____ Phone:_____

Street Address:_____

City & State: _____ Zip Code:_____

***Pro Tip:** *It is always a good idea to let your references know when you've listed them and to expect a phone call on your behalf. This helps keep the process running smooth & ensures we get you hired as soon as possible.*

DISCLOSURE & AUTHORIZATION:

I acknowledge receipt of the separate stand-alone Disclosure and certify that I have read and understand it and this authorization. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" at any time after receipt of this authorization and as necessary for me to obtain employment. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by Accutrace, Inc. or another outside organization acting on behalf of Inglis, and/or the entity for whom I may be performing services, itself.

I acknowledge receipt of the Disclosure Form regarding Background Checks. I acknowledge receipt of the document A Summary of Your Rights under the Fair Credit Reporting Act. I agree that a facsimile ("fax") or photographic copy of this Authorization shall be as valid as the original. I consent to have any legally required notices sent electronically.

(_☑_ I do) (_☐_ I do not) authorize you to contact, through Accutrace, Inc., *my current* employer for Employment and Reference Verifications. *(Checking **"I do"** will authorize inquiries to the Human Resources Department and to any listed supervisors.)*

Please print clearly.

Applicant Name: _____
(First, Middle Initial, Last)

Maiden Name(s) Used: _____ Alias(s) Used: _____

E-mail Address:_____ Phone: _____

Signature:_____ Date: _____

Date of Birth: _____ Social Security Number: _____

Driver's License/State ID Number: _____ State: _____

Professional License/Certificate Number: _____ State Issued: _____
(type n/a if no license/cert needed)

Profession: _____ School Name: _____

Degree or Diploma Type: _____ Date Received: _____

Current Address: _____
(Street address, City & State, Zip)

Number of Years at Current Address: _____

All background investigations completed by:
ACCUTRACE

OLDER ADULTS PROTECTIVE SERVICES ACT

Prohibitive Offenses Contained in Act 169 of 1996 as Amended by Act 13

Following Offenses as Contained in PA Crimes Code (18 Pa. C.S.)

Offense Code	Prohibitive Offense Description	Type/Grading of Conviction
CC2500	Criminal Homicide	Any
CC2502A	Murder I	Any
CC2502B	Murder II	Any
CC2502C	Murder III	Any
CC2503	Voluntary Manslaughter	Any
CC2504	Involuntary Manslaughter	Any
CC2505	Causing or Aiding Suicide	Any
CC2506	Drug Delivery Resulting in Death	Any
CC2702	Aggravated Assault	Any
CC2901	Kidnapping	Any
CC2902	Unlawful Restraint	Any
CC3121	Rape	Any
CC3122.1	Statutory Sexual Assault	Any
CC3123	Involuntary Deviate Sexual Intercourse	Any
CC3124.1	Sexual Assault	Any
CC3125	Aggravated Indecent Assault	Any
CC3126	Indecent Assault	Any
CC3127	Indecent Exposure	Any
CC3301	Arson and Related Offenses	Any
CC3502	Burglary	Any
CC3701	Robbery	Any
CC3901	Theft	Any ONE (1) FELONY or TWO (2) MISDEMEANORS within the 3900 Series (CC3901-CC3934)
CC3921	Theft By Unlawful Taking	
CC3922	Theft By Deception	
CC3923	Theft By Extortion	
CC3924	Theft By Property Lost	
CC3925	Receiving Stolen Property	
CC3926	Theft of Services	
CC3927	Theft By Failure to Deposit	
CC3928	Unauthorized Use of a Motor Vehicle	
CC3929	Retail Theft	
CC3929.1	Library Theft	
CC3929.2	Unlawful Possession of Retail or Library Theft Instruments	
CC3929.3	Organized Retail Theft	
CC3930	Theft of Trade Secrets	
CC3931	Theft of Unpublished Dramas or Musicals	
CC3932	Theft of Leased Properties	
CC3933	Unlawful Use of a Computer	
CC3934	Theft From a Motor Vehicle	
CC4101	Forgery	Any
CC4114	Securing Execution of Documents by Deception	Any
CC4302	Incest	Any
CC4303	Concealing Death of a Child	Any
CC4304	Endangering Welfare of a Child	Any
CC4305	Dealing in Infant Children	Any
CC4952	Intimidation of Witnesses or Victims	Any
CC4953	Retaliation Against Witness or Victim	Any
CC5902B	Promoting Prostitution	Felony
CC5903C	Obscene or Other Sexual Materials to Minors	Any
CC5903D	Obscene or Other Sexual Materials	Any
CC6301	Corruption of Minors	Any
CC6312	Sexual Abuse of Children	Any

*Offenses as Contained in PA Controlled Substance, Drug, Device & Cosmetic Act (P.L. 233, No. 64)-**PARTIAL LISTING***

Offense Code	Prohibitive Offense Description	Type/Grading of Conviction
CS13A12	Acquisition of Controlled Substance by Fraud	Felony
CS13A14	Delivery by Practitioner	Felony
CS13A30	Possession with Intent to Deliver	Felony
CS13A35 (i), (ii), (iii)	Illegal Sale of Non-Controlled Substance	Felony
CS13A36	Designer Drugs	Felony
CS13Axx*	ANY OTHER FELONY DRUG CONVICTION APPEARING ON PA RAP SHEET	

Para información en español, visite www.consumerfinance.gov/learnmore o escribe a la Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.

- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
  - a person has taken adverse action against you because of information in your credit report;
  - you are the victim of identity theft and place a fraud alert in your file;
  - your file contains inaccurate information as a result of fraud;
  - you are on public assistance;
  - you are unemployed but expect to apply for employment within 60 days.

  In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.consumerfinance.gov/learnmore for additional information.

- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.

- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.

- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete, or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.

- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.

- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need -- usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.

- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.

- **You many limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt out with the nationwide credit bureaus at 1-888-5-OPTOUT (1-888-567-8688).

- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.

- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.consumerfinance.gov/learnmore.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For information about your federal rights, contact:

TYPE OF BUSINESS:	CONTACT:
1.a. Banks, savings associations, and credit unions with total assets of over $10 billion and their affiliates	a. Consumer Financial Protection Bureau 1700 G Street, N.W. Washington, DC 20552
b. Such affiliates that are not banks, savings associations, or credit unions also should list,	b. Federal Trade Commission: Consumer Response Center – FCRA

in addition to the CFPB:	Washington, DC 20580 (877) 382-4357
2. To the extent not included in item 1 above: a. National banks, federal savings associations, and federal branches and federal agencies of foreign banks b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and Insured State Branches of Foreign Banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act c. Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations d. Federal Credit Unions	 a. Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney Street, Suite 3450 Houston, TX 77010-9050 b. Federal Reserve Consumer Help Center P.O. Box. 1200 Minneapolis, MN 55480 c. FDIC Consumer Response Center 1100 Walnut Street, Box #11 Kansas City, MO 64106 d. National Credit Union Administration Office of Consumer Protection (OCP) Division of Consumer Compliance and Outreach (DCCO) 1775 Duke Street Alexandria, VA 22314
3. Air carriers	Asst. General Counsel for Aviation Enforcement & Proceedings Aviation Consumer Protection Division Department of Transportation 1200 New Jersey Avenue, S.E. Washington, DC 20590
4. Creditors Subject to the Surface Transportation Board	Office of Proceedings, Surface Transportation Board Department of Transportation 395 E Street, S.W. Washington, DC 20423
5. Creditors Subject to the Packers and Stockyards Act, 1921	Nearest Packers and Stockyards Administration area supervisor
6. Small Business Investment Companies	Associate Deputy Administrator for Capital Access United States Small Business Administration 409 Third Street, S.W., 8th Floor Washington, DC 20416
7. Brokers and Dealers	Securities and Exchange Commission 100 F Street, N.E.

	Washington, DC 20549
8. Federal Land Banks, Federal Land Bank Associations, Federal Intermediate Credit Banks, and Production Credit Associations	Farm Credit Administration 1501 Farm Credit Drive McLean, VA 22102-5090
9. Retailers, Finance Companies, and All Other Creditors Not Listed Above	FTC Regional Office for region in which the creditor operates or Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 (877) 382-4357

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Medical Assistance (Medicaid) Financial Eligibility Application for Long Term Care, Supports and Services

Check any that you are applying for:

- ☐ Care in a facility
- ☐ Home and Community Waiver Services – Type/Name of Waiver/Service: _____
- ☐ Other: _____

- Please read the entire form.
- Print the requested information in the unshaded sections.
- If you need help, another person can help you or you can get help from your county assistance office.
- Please review any information printed on this form. If any already printed information is incorrect or has changed, strike out the printed information and provide updated information. Please review all questions that do not have a printed response and provide a response unless the instructions tell you that you can choose not to answer.

You or any representative you choose may complete this application. Your representative can be your spouse, a friend, a relative, a person who has your power of attorney, or your medical provider. It should be someone who knows and can provide information about your income and resources. If you are married, information in some sections must be completed for both you and your spouse.

After the form is completed, bring it, have someone else bring it, or mail it to the county assistance office unless you are instructed otherwise. The county assistance office will tell you if an interview is needed. You will need proof of identity and verification for other information on the form unless we already have the information in our records. If you need help to obtain any information ask the county assistance office for help. You should attach verification to this form.

Persons who have given away assets (income or resources) within the past 60 months, or set up or transferred assets to a trust within the last 60 months prior to applying for Medical Assistance for long term care, supports and services may be ineligible for benefits. Because of this requirement, you may need to provide verification of assets owned during the past 60 months even though you may no longer own them. We will use your Social Security number to get information about your assets for the 60 months prior to your application.

If the information is complete and you have provided the necessary verification (with this form, if possible) the county assistance office will notify you within 30 days of receiving your application if you are eligible, ineligible, or if additional information is needed.

This is an application for Medical Assistance benefits. If you need help translating it, please contact your county assistance office, CAO. Translation services will be provided free of charge.

Esta es una solicitud de beneficios de Asistencia Médica. Si necesita ayuda con la traducción comuníquese con la Oficina de Asistencia del Condado (CAO) que le corresponde. Los servicios de traducción son gratuitos.

នេះជាពាក្យដាក់សុំអត្ថប្រយោជន៍សំរាប្រគ្រពេទ្យ។
បើលោកអ្នកត្រូវការជំនួយបកប្រែ
សូមទាក់ទងទៅការិយាល័យរដ្ឋបាលប្រៃដែលនៅតាមតំបន់របស់លោកអ្នក។
ការបកប្រែនឹងផ្តល់អោយដោយឥតគិតថ្លៃ។

这是关于医疗协助福利的申请。
如果你需要翻译协助，请联络你所在
地方的郡县援助办事处。可以免费提供翻译服务。

هذا طلب للحصول على منافع المساعدة الطبية. إذا كنت بحاجة إلى مساعدة في ترجمته، يرجى الاتصال بمكتب معونة مقاطعتك CAO.
ستقدم خدمات الترجمة مجانًا.

Настоящий документ является заявлением на получение обслуживания по программе Medical Assistance.
Если вам нужна помощь в переводе данного заявления, обращайтесь в Окружное бюро помощи (County Assistance Office).
Услуги по переводу предоставляются бесплатно.

Đây là mẫu đơn xin hưởng phúc lợi Bảo Trợ Y Tế.
Nếu quí vị cần phiên dịch đơn này, xin liên lạc
Văn Phòng Trợ Cấp Quận Hạt nơi quí vị cư ngụ.
Dịch vụ phiên dịch sẽ được cung cấp miễn phí.

COMPASS
CLICK. APPLY. BENEFIT.

You can also apply online at: **www.compass.state.pa.us**.

PA 600 L (AS) 1/20

DO NOT COMPLETE – PROVIDER USE ONLY		
PROVIDER NAME	NUMBER	
ADDRESS	CONTACT NAME/TELEPHONE NUMBER	
DATE OF ADMISSION	DATE OF LEVEL OF CARE DETERMINATION	REQUESTED EFFECTIVE DATE

DO NOT COMPLETE - COUNTY ASSISTANCE OFFICE USE ONLY						
CO.	DIST	RECORD NUMBER	FILE CLEARED BY	APPL. REG. NO.	WORKER I.D.	CASELOAD
☐ AUTHORIZED REASON					CATEGORY	
☐ NOT AUTHORIZED REASON					DATE	

Getting Started

What language do you prefer? ¿Qué idioma prefiere usted? ☐ English/Inglés ☐ Spanish/Español ☐ Other/Otro (specify/especifique) _____

Do you need an interpreter? ¿Necesita un intérprete? ☐ Yes/Sí ☐ No If yes, what language? En caso afirmativo, ¿de qué idioma? _____

Complete all information in this section for you, the applicant. Tell us about yourself. Please review any information printed below. If this information is incorrect, please strike it out and write in the correct information.

NAME (INCLUDE FIRST, MIDDLE INITIAL, LAST, SUFFIX-JR./SR./ETC.):	SOCIAL SECURITY NUMBER:	BIRTH DATE (MM/DD/YYYY):	SEX: ☐ MALE ☐ FEMALE

MARITAL STATUS: ☐ SINGLE ☐ SEPARATED ☐ MARRIED ☐ DIVORCED ☐ WIDOWED IF SEPARATED, PLEASE COMPLETE RELATIONSHIP SECTION FOR SEPARATED SPOUSE.	IF YOU CHECKED SEPARATED, WHAT WAS THE DATE OF SEPARATION?
IF YOU CHECKED WIDOWED, WHAT WAS THE DATE OF YOUR SPOUSE'S DEATH?	SPOUSE'S NAME?

RACE (OPTIONAL) (CHECK ALL THAT APPLY):

☐ BLACK OR AFRICAN AMERICAN ☐ ASIAN ☐ NATIVE HAWAIIAN OR PACIFIC ISLANDER ☐ AMERICAN INDIAN OR ALASKA NATIVE

☐ WHITE ☐ OTHER _____

CURRENT ADDRESS (IF IN A FACILITY, USE FACILITY ADDRESS):	PHONE NUMBER:	DATE MOVED TO THIS ADDRESS:
Inglis House - SNF, 2600 Belmont Ave., Philadelphia, PA 19131	215-581-5794	

TOWNSHIP:	SCHOOL DISTRICT:	PREVIOUS ADDRESS (IF IN A FACILITY, GIVE YOUR HOME ADDRESS. IF YOU ARE MARRIED, GIVE YOUR SPOUSE'S ADDRESS):
Philadelphia	Philadelphia	

HAVE YOU EVER APPLIED FOR OR RECEIVED CASH OR MEDICAL BENEFITS OR PARTICIPATED IN THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP), FORMERLY KNOWN AS FOOD STAMPS IN ANOTHER COUNTY IN PENNSYLVANIA OR IN ANOTHER STATE? ☐ YES ☐ NO	IF YES, WHAT STATE?	HOW LONG?
	WHAT COUNTY?	RECORD NUMBER:

HAVE YOU PREVIOUSLY LIVED IN A NURSING FACILITY? ☐ YES ☐ NO	IF YES, PROVIDE NAME:	ADDRESS:	DATES:

ARE YOU A U.S. CITIZEN OR NATIONAL? ☐ YES ☐ NO ▶ **If you are not a U.S. citizen or national,** answer the following questions:

DO YOU HAVE ELIGIBLE IMMIGRATION STATUS? ☐ YES ☐ NO	IF YES, FILL IN YOUR DOCUMENT TYPE AND ID NUMBER:	DOCUMENT TYPE:	DOCUMENT ID NUMBER:	ALIEN NUMBER:
WERE YOU LIVING IN THE U.S. BEFORE 1996? ☐ YES ☐ NO		COUNTRY OF ORIGIN:		
IF YOU HAVE A SPONSOR, NAME AND ADDRESS OF YOUR SPONSOR:				

Sign to declare your citizenship or alien status as marked above:

_____ SIGNATURE

_____ DATE

Complete all information in this section for your spouse if you are married or separated and any dependent children or siblings.

Please review any information printed below. If this information is incorrect, please strike it out and write in the correct information.

RELATIONSHIP:	NAME (INCLUDE FIRST, MIDDLE INITIAL, LAST, SUFFIX-JR./SR./ETC.):		ALIAS/MAIDEN NAME:
BIRTH DATE (MM/DD/YYYY):	SEX:	*RACE:	SSN

RELATIONSHIP:	NAME (INCLUDE FIRST, MIDDLE INITIAL, LAST, SUFFIX-JR./SR./ETC.):		ALIAS/MAIDEN NAME:
BIRTH DATE (MM/DD/YYYY):	SEX:	*RACE:	SSN

RELATIONSHIP:	NAME (INCLUDE FIRST, MIDDLE INITIAL, LAST, SUFFIX-JR./SR./ETC.):		ALIAS/MAIDEN NAME:
BIRTH DATE (MM/DD/YYYY):	SEX:	*RACE:	SSN

RELATIONSHIP:	NAME (INCLUDE FIRST, MIDDLE INITIAL, LAST, SUFFIX-JR./SR./ETC.):		ALIAS/MAIDEN NAME:
BIRTH DATE (MM/DD/YYYY):	SEX:	*RACE:	SSN

* For Race: Your benefits will not be affected if you do not wish to answer. Please use one of the following codes:
1. Black or African American 2. Asian 3. Native Hawaiian or Pacific Islander 4. American Indian or Alaska Native 5. White 6. Other: ______

Military Status

Please review any information printed below. If this information is incorrect, please strike it out and write in the correct information.

PLEASE CHECK ONE:

☐ VETERAN ☐ ACTIVE MILITARY ☐ NATIONAL GUARD ☐ RESERVES ☐ WIDOW/SPOUSE OR DEPENDENT CHILD OF A VETERAN

BRANCH OF SERVICE:	DATE ENTERED:	DATE LEFT:	CLAIM NO.:

Voter Registration (Optional)

If you are not registered to vote where you live now, would you like to register to vote here today? ☐ YES ☐ NO

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

To register, you must: 1) Be at least 18 on the day of the next election; 2) Be a citizen of the United States for at least one month PRIOR TO THE NEXT ELECTION; 3) Reside in Pennsylvania and the voting district at least 30 days prior to the next election.

Applying to register or declining to register to vote will not affect the amount of assistance you will be provided by this agency.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. Please contact the county assistance office if you would like help. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Secretary of the Commonwealth, PA Department of State, Harrisburg, PA 17120. (Toll-free telephone number 1-877-VOTESPA).

COUNTY ASSISTANCE OFFICE STAFF WILL COMPLETE THIS BOX BASED ON YOUR RESPONSE ABOVE

☐ Given to Client __/__/__ ☐ Sent to voter registration __/__/__ ☐ Mailed to Client __/__/__

☐ Declined, not interested __/__/__ ☐ Not a U.S. citizen __/__/__ ☐ Declined, already registered __/__/__

If you are receiving or have received long term care, supports and services, how are/were your expenses being paid?

Do you have unpaid medical bills? ☐ Yes ☐ No
If you are requesting Medical Assistance for these bills, attach copies.

Medical Insurance Information (including long term care insurance)
Please review any information printed below. If this information is incorrect, please strike it out and write in the correct information.

Who is covered?	Insurance Company	Policy Number	Premium	How Often?

Resource Information for Applicant and Spouse:
Please review any information printed below. If this information is incorrect, please strike it out and write in the correct information. Add an additional sheet of paper if more space is needed. Please label what question you are answering on any additional pages.

A. Real Estate **None** ☐

LOCATION:	OWNER:	VALUE: $	INCOME PRODUCING: ☐ YES ☐ NO	RESIDENT: ☐ YES ☐ NO
WHO LIVES IN THE PROPERTY?	ARE YOU PLANNING TO RETURN TO THE PROPERTY? ☐ YES ☐ NO		DO YOU OWN ANY OTHER REAL ESTATE? ☐ YES ☐ NO	
IS THE PROPERTY LISTED FOR SALE? ☐ YES ☐ NO	IF FOR SALE, REALTOR'S NAME AND TELEPHONE NUMBER: (REMEMBER TO REPORT THE PROPERTY SALE TO US)			IF YES, DATE LISTED:

LOCATION:	OWNER:	VALUE: $	INCOME PRODUCING: ☐ YES ☐ NO	RESIDENT: ☐ YES ☐ NO
WHO LIVES IN THE PROPERTY?	ARE YOU PLANNING TO RETURN TO THE PROPERTY? ☐ YES ☐ NO		DO YOU OWN ANY OTHER REAL ESTATE? ☐ YES ☐ NO	
IS THE PROPERTY LISTED FOR SALE? ☐ YES ☐ NO	IF FOR SALE, REALTOR'S NAME AND TELEPHONE NUMBER: (REMEMBER TO REPORT THE PROPERTY SALE TO US)			IF YES, DATE LISTED:

B. Mobile Home **None** ☐

LOCATION:	OWNER:	VALUE: $	INCOME PRODUCING: ☐ YES ☐ NO	RESIDENT: ☐ YES ☐ NO
YEAR AND MODEL:		WHO LIVES IN THE MOBILE HOME?		
IS THE PROPERTY LISTED FOR SALE? ☐ YES ☐ NO	IF FOR SALE, REALTOR'S NAME AND TELEPHONE NUMBER: (REMEMBER TO REPORT THE PROPERTY SALE TO US)			IF YES, DATE LISTED:

C. Burial Arrangements **None** ☐

OWNER:	BANK/INSURANCE COMPANY NAME AND ADDRESS:	ACCOUNT NUMBERS:
FUNERAL HOME:	VALUE OF ACCOUNT: $	DATE ESTABLISHED:
CAN MONEY BE WITHDRAWN BEFORE DEATH OF INDIVIDUAL? ☐ YES ☐ NO	CAN INTEREST BE WITHDRAWN? ☐ YES ☐ NO	
DO YOU OWN ANY BURIAL SPACES? ☐ YES ☐ NO	IF YES, LOCATION:	NUMBER OF SPACES:

OWNER:	BANK/INSURANCE COMPANY NAME AND ADDRESS:	ACCOUNT NUMBERS:
FUNERAL HOME:	VALUE OF ACCOUNT: $	DATE ESTABLISHED:
CAN MONEY BE WITHDRAWN BEFORE DEATH OF INDIVIDUAL? ☐ YES ☐ NO	CAN INTEREST BE WITHDRAWN? ☐ YES ☐ NO	
DO YOU OWN ANY BURIAL SPACES? ☐ YES ☐ NO	IF YES, LOCATION:	NUMBER OF SPACES:

D. Life Insurance **None** ☐

Please review any information printed below. If this information is incorrect, please strike it out and write in the correct information.

Policy Owner	Company Name	Policy Number	Face Value	Current Cash Value	Beneficiary

E. Automobiles, Recreational Vehicles, Trucks, Motorcycles **None** ☐

Please review any information printed below. If this information is incorrect, please strike it out and write in the correct information.

Name of Owner(s)	Year, Make, Model	Licensed?	Plate Number	Amount Owed	% Owned	Comments
		☐ YES ☐ NO				
		☐ YES ☐ NO				
		☐ YES ☐ NO				
		☐ YES ☐ NO				
		☐ YES ☐ NO				
		☐ YES ☐ NO				

F. Other Resources **None** ☐

Please review any information printed below. If this information is incorrect, please strike it out and write in the correct information.

Resources include bank accounts (including checking, savings, vacation accounts); Certificates of Deposits (CD); retirement accounts (including IRA, KEOGH); stocks; bonds (including U.S. Savings Bonds); annuities; trust funds; mutual funds and cash-on-hand.

Name of Owner(s)	Resource	Current Value	Bank Name/Account Number	Percentage Owned	Comments
		$			
		$			
		$			
		$			
		$			
		$			
		$			
		$			
		$			

Within the past 60 months have you or your spouse closed, given away, sold or transferred any assets such as: a home, land, personal property, life insurance polices, annuities, bank accounts, certificates of deposit, stocks, IRA, bonds, trust bonds, or a right to income? ☐ **Yes** ☐ **No**

Within the past 60 months, have you or your spouse transferred any assets into a trust? ☐ **Yes** ☐ **No**

If yes to either question, explain circumstances (attach extra paper if needed): _____

TYPE OF RESOURCES:	MARKET VALUE AT TIME OF TRANSFER:	DATE OF TRANSFER OR CLOSING:
	$	

If you closed or depleted any accounts because you paid for nursing services, list these accounts:

Account Owner(s)	Type of Resource	Location	Account Number	Date of Closing

Have you or your spouse received or do either of you expect to receive any income/asset/settlement/ lump sum/inheritance? ☐ Yes ☐ No

If yes, explain circumstances (attach extra paper if needed): _____

AMOUNT:	DATE EXPECTED:
$	

Income Information for the Applicant, Spouse, and/or Dependent(s)

Please review any information printed below. If this information is incorrect, please strike it out and write in the correct information. Add an additional sheet of paper if more space is needed. Please label what question you are answering on any additional pages.

List all household income including but not limited to: earned income (wages, self-employment, rental income, room and board, commissions, etc.) and unearned income (pensions, Veterans benefits, Social Security benefits, Unemployment Compensation, Workers' Compensation, Railroad Retirement, Black Lung payments, sick benefits, payments from trusts or annuities, support or alimony, dividends or interest, lottery/ gambling winnings, etc.)

Whose income is this?	Income Type	Income Source	Frequency (weekly, biweekly, monthly, yearly)	Average Hours Worked Each Week	Gross Amount (amount of income before taxes and deductions)	Comments

TO WHOM ARE THE CHECKS SENT? (GUARDIAN, REPRESENTATIVE PAYEE):	ADDRESS:

Shelter Expenses

$	Monthly rent/mortgage
$	Sales or lease purchase agreement
$	Personal care or domiciliary care rental charge
$	Maintenance charges for condo or co-op residence
$	Lot rent for mobile home
$	Property taxes - annual amount
$	Homeowners insurance - annual amount

$	Basic telephone
$	Gas
$	Electric
$	Heating fuel
$	Water
$	Sewer
$	Garbage

Do you pay for heating and/or air conditioning separate from your rent? ☐ Yes ☐ No

Your Rights and Responsibilities Read about your rights and responsibilities:

RIGHT TO NONDISCRIMINATION

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

RIGHT TO CONFIDENTIALITY

We will keep your information private. It will only be used to decide which programs you may be eligible for. The county assistance office (CAO), when requested, must provide federal, state and local law enforcement officials with the address, Social Security number (SSN) and photograph (if available) of an individual who is fleeing to avoid prosecution, custody or confinement for a felony or violating probation or parole. Any person knowingly violating any of the rules and regulations of this department shall be guilty of a misdemeanor and, upon conviction shall be sentenced to pay a fine, not exceeding one hundred ($100) dollars, or to undergo imprisonment, not exceeding six months, or both (62 P.S. section 483).

RIGHT TO A WRITTEN NOTICE

We will give you a written notice explaining your benefits. If we deny, change, suspend or stop benefits, we will give you a written explanation of why. You have 30 days from the mailing date of the notice to ask for a hearing.

RIGHT TO APPEAL

You have the right to ask for a Department of Human Services (DHS) hearing to appeal a decision if you believe it is unfair or incorrect, or if DHS fails to act on your application for benefits. You may file the appeal at the CAO. If you appeal, you may also request an agency conference before the hearing. At the hearing you may represent yourself, or someone else, such as a lawyer, friend or relative may represent you.

RIGHT TO CLAIM GOOD CAUSE

If you apply for cash or Medical Assistance benefits, the law requires you to cooperate with establishing paternity and seeking support. You may be excused from these requirements if you prove it may be dangerous for you and/or your children. This is known as good cause. Unless a good cause exemption is established, you will be required to meet employment and training requirements. You will also be required to meet semi-annual reporting requirements unless good cause is granted.

ESTATE RECOVERY

If you are age 55 or older and receive Medical Assistance to pay for nursing facility services, home and community-based waiver services and any related hospital and prescription drug service, you will be required to repay the cost of these services from your probate estate. You may call the Medical Assistance Estate Recovery Program at 1-800-528-3708.

RIGHT TO CERTIFICATE OF CREDITABLE COVERAGE

Federal law limits when health coverage may be denied or limited for a pre-existing condition. If you enroll in a group health plan that excludes treatment for a condition you already had, you can be credited for the time you received Medical Assistance coverage. This may help you obtain coverage. Contact your caseworker to request this certificate.

RESPONSIBILITY TO PROVIDE INFORMATION

You must give true, correct and complete information. You must help in proving the information you give. Benefits may be denied if you fail to provide certain proof. If you cannot provide proof, you should ask the CAO to help you obtain it. If you are contacted by DHS or the Office of State Inspector General, you must fully cooperate with those persons or investigators. If you are age 55 or older and receive Medical Assistance to pay for nursing facility services, home and community-based waiver services and any related hospital and prescription drug service, you may be required to repay the cost of these services from your probate estate. If you are applying for cash assistance, we may require you to sign an agreement to repay benefits that you, your spouse and your children have received.

RESPONSIBILITY TO PROVIDE SOCIAL SECURITY NUMBERS

For Medical Assistance benefits, you must provide an SSN for each person for whom you are applying. If you do not have an SSN, you must apply for one. Not providing an SSN may result in not being able to receive benefits. Your SSN will be used for identity, for computer matches which verify income and resources, and to prevent duplication of state and federal benefits. A non-citizen who is applying for emergency Medical Assistance only is not required to provide an SSN. (42 U.S. C 1320b-7)

RESPONSIBILITY TO USE THE PA ACCESS CARD LAWFULLY

Once you are eligible for benefits, you will be issued a PA ACCESS card. This card may only be used for the person who is eligible and only during the eligibility period. You may only use the card for services that are needed and reasonable.

RESPONSIBILITY TO REPORT CHANGES

If you qualify for benefits, you will be required to report changes in your circumstances to your caseworker or to the Customer Service Center. Types of changes reported would include people leaving or moving into the house, a new address, a new job for someone, if someone loses a job, birth of a child, new sources of income or changes to income, and lottery and gambling winnings. Your caseworker and notices you receive will cover the specifics in detail based on the programs and benefits you are eligible for. Failure to report required changes within the program guidelines could result in a loss of benefits, sanctions, or civil or criminal charges. You may report changes to the CAO in person, by phone, fax, mail or through a MyCOMPASS account. You may also report changes to the Customer Service Center at 1-877-395-8930, or for Philadelphia, 1-215-560-7226 any time.

Understanding Your Rights and Responsibilities

When I sign this form:

- I understand that Pennsylvania receives information from the Income Eligibility Verification System (IEVS), financial institutions, consumer reporting and state and federal agencies to verify the information I give them. Information available through IEVS and other entities will be requested, used and may be verified through collateral contact when conflicting details are found by the State agency, and such information may affect my household's eligibility and level of benefits.
- I understand that by signing this application, I am authorizing any financial institution to disclose, through electronic or any other means, any and all financial information held by that institution, to the Department of Human Services or its designated agent or contractor for the purpose of identifying and verifying resources (also called "assets") when needed to determine and redetermine eligibility for Medical Assistance. I understand that financial information includes deposits, withdrawals, account closures and other relevant information requested or received from the financial institution, including other transactions undertaken by the financial institution with respect to the account or asset. I understand that this authorization is effective until Medical Assistance eligibility is denied or ends, or if I decide to revoke it by written notification to the Department, whichever happens first. I understand that if I revoke this authorization, that may make me or my household ineligible for Medical Assistance.
- I understand that if I misrepresent, hide or withhold facts that may affect my eligibility for benefits, I may be required to repay my benefits and I may be prosecuted and disqualified from receiving certain future benefits.
- I understand that I can designate a representative or Power of Attorney by completing the Representative or Power of Attorney section.
- I understand and agree that I am responsible for any fraudulent statements made on this application, even if the application is being submitted by someone acting on my behalf.
- I understand any person enriched as a result of a transfer of assets or income, which would have affected my eligibility, will be liable for repayment of those benefits issued incorrectly.
- I received a copy of my rights and responsibilities, have read them or someone has read them to me, and I understand them.
- I understand that the information entered in this application will be kept confidential and only to administer benefits. I authorize the release of personal, financial and medical information for the purpose of determining eligibility.
- I understand that any changes I am required to report must be reported within 10 days of the change.
- I understand that I am required to report lottery and gambling winnings.
- I understand that I will receive a written notice explaining the benefits. If benefits are denied, changed, suspended or stopped, the written notice will explain why.
- I understand that I will have 30 days from the date of the notice to request a hearing if I do not agree with the decision made on this application.
- I understand that my situation is subject to verification from employers, financial sources and other third parties.
- I understand that applicants must provide their Social Security number or apply for one if they do not have one. This number may be used to check the information on this application.
- I understand that I must use the PA ACCESS Card only during the period I am eligible. I must use the PA ACCESS Card only for the person who is eligible and may get only the benefits that are needed and reasonable.
- I understand that I do not have to provide a Social Security number for anyone who is not applying for assistance. If I do provide their Social Security number, it may be used to check the information on this application.
- I certify that all information that has been entered is true under penalty of perjury.
- I understand that I have the right to a certificate of creditable coverage to verify my medical coverage. Federal law limits when health care coverage may be denied or limited for a pre-existing condition. If I enroll in a group health plan that has a pre-existing condition clause, I can get credit for the time I received Medical Assistance.
- I understand that if I am determined eligible for Medical Assistance, I will be placed in the most comprehensive health care benefit package that is available to me. I understand that I may be required to enroll in a health plan. I understand that enrolling in a health plan may be free or low cost to me, because the Department pays a monthly fee to the health plan for me. I understand that the monthly fee is a capitation fee. I understand that if I receive Medical Assistance that I am not eligible for, due to error, fraud, or any other reason, then I may be required to repay the Department all monthly fees paid on my behalf.
- I understand the state has the right to review all records of medical service paid by Medical Assistance. Payment for service will be made directly to the provider, not me. This includes payments from Medicare.
- I am giving the state the right to seek, with or without legal action, payment from private or public health insurance or liable third party. The amount recorded will not exceed the amount paid by Medical Assistance.
- I understand that I have the right to ask the county assistance office (CAO) for assistance in getting proof of expenses and that the CAO can contact other people for confirmation if I am having trouble getting proof of anything.
- I understand that if some or all of the individuals applying do not qualify for Medical Assistance through the Department, that they may be eligible for federal benefits and/or explore private health care options through the Health Insurance Marketplace. If this is the case, I authorize the Department to give my name and information on this application to the Marketplace.
- **Renewal of coverage in future years:** To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Health Insurance Marketplace to use my income data, including information from tax returns. The Marketplace will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next: (Check one):

- ☐ Five years (the maximum number of years allowed)
- ☐ Four years
- ☐ Three years
- ☐ Two years
- ☐ One year
- ☐ Do not use my information from tax returns to renew my coverage.

X _____ _____

Signature of Applicant or Authorized Representative — Date

IMPORTANT: If your household is eligible for SNAP/LIHEAP, you may receive a Fast Track consent form in the mail that could allow you and your household members to be automatically enrolled in Medical Assistance.

Name of Authorized Representative	Address of Authorized Representative	Phone Number

COUNTY ASSISTANCE OFFICE ONLY

I have explained to the applicant her or his rights and responsibilities.

_____ _____

CAO Signature — Date

BE SURE TO SIGN AND DATE THIS APPLICATION AND INCLUDE REQUIRED DOCUMENTS

Affidavit

I certify, subject to penalties provided by law, that the information I gave is true and correct and complete to the best of my knowledge. I have read this application in full or someone has read it to me and I understand the questions asked. I have received a copy of and read my rights and responsibilities, or someone has read them to me, and I understand them.

APPLICANT OR AUTHORIZED REPRESENTATIVE SIGNATURE | DATE | I.D. VERIFIED | RELATIONSHIP TO APPLICANT

ADDRESS OF REPRESENTATIVE | CITY, STATE, ZIP CODE +4 | TELEPHONE NUMBER

WITNESS (IF SIGNED WITH AN X ABOVE) | DATE

ADDRESS OF WITNESS | CITY, STATE, ZIP CODE +4 | TELEPHONE NUMBER

PROVIDER SIGNATURE (IF SUBMITTED BY PROVIDER) | DATE

☐ Face-to-face interview with: _____

☐ Telephone interview with: _____

CAO OR OPTIONS | DATE

☐ Interview waived

Representative or Power of Attorney

Please complete if you have a representative or Power of Attorney. Copies of notices will be sent to the person named.

LAST NAME, FIRST NAME, MIDDLE INITIAL:		RELATIONSHIP TO APPLICANT:		☐ REPRESENTATIVE ☐ POWER OF ATTORNEY
ADDRESS:	CITY:	STATE:	ZIP CODE:	TELEPHONE NUMBER:

I wish to withdraw my application:

SIGNATURE | DATE

Your Rights and Responsibilities Read about your rights and responsibilities:

RIGHT TO NONDISCRIMINATION

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

RIGHT TO CONFIDENTIALITY

We will keep your information private. It will only be used to decide which programs you may be eligible for. The county assistance office (CAO), when requested, must provide federal, state and local law enforcement officials with the address, Social Security number (SSN) and photograph (if available) of an individual who is fleeing to avoid prosecution, custody or confinement for a felony or violating probation or parole. Any person knowingly violating any of the rules and regulations of this department shall be guilty of a misdemeanor and, upon conviction shall be sentenced to pay a fine, not exceeding one hundred ($100) dollars, or to undergo imprisonment, not exceeding six months, or both (62 P.S. section 483).

RIGHT TO A WRITTEN NOTICE

We will give you a written notice explaining your benefits. If we deny, change, suspend or stop benefits, we will give you a written explanation of why. You have 30 days from the mailing date of the notice to ask for a hearing.

RIGHT TO APPEAL

You have the right to ask for a Department of Human Services (DHS) hearing to appeal a decision if you believe it is unfair or incorrect, or if DHS fails to act on your application for benefits. You may file the appeal at the CAO. If you appeal, you may also request an agency conference before the hearing. At the hearing you may represent yourself, or someone else, such as a lawyer, friend or relative may represent you.

RIGHT TO CLAIM GOOD CAUSE

If you apply for cash or Medical Assistance benefits, the law requires you to cooperate with establishing paternity and seeking support. You may be excused from these requirements if you prove it may be dangerous for you and/or your children. This is known as good cause. Unless a good cause exemption is established, you will be required to meet employment and training requirements. You will also be required to meet semi-annual reporting requirements unless good cause is granted.

ESTATE RECOVERY

If you are age 55 or older and receive Medical Assistance to pay for nursing facility services, home and community-based waiver services and any related hospital and prescription drug service, you will be required to repay the cost of these services from your probate estate. You may call the Medical Assistance Estate Recovery Program at 1-800-528-3708.

RIGHT TO CERTIFICATE OF CREDITABLE COVERAGE

Federal law limits when health coverage may be denied or limited for a pre-existing condition. If you enroll in a group health plan that excludes treatment for a condition you already had, you can be credited for the time you received Medical Assistance coverage. This may help you obtain coverage. Contact your caseworker to request this certificate.

RESPONSIBILITY TO PROVIDE INFORMATION

You must give true, correct and complete information. You must help in proving the information you give. Benefits may be denied if you fail to provide certain proof. If you cannot provide proof, you should ask the CAO to help you obtain it. If you are contacted by DHS or the Office of State Inspector General, you must fully cooperate with those persons or investigators. If you are age 55 or older and receive Medical Assistance to pay for nursing facility services, home and community-based waiver services and any related hospital and prescription drug service, you may be required to repay the cost of these services from your probate estate. If you are applying for cash assistance, we may require you to sign an agreement to repay benefits that you, your spouse and your children have received.

RESPONSIBILITY TO PROVIDE SOCIAL SECURITY NUMBERS

For Medical Assistance benefits, you must provide an SSN for each person for whom you are applying. If you do not have an SSN, you must apply for one. Not providing an SSN may result in not being able to receive benefits. Your SSN will be used for identity, for computer matches which verify income and resources, and to prevent duplication of state and federal benefits. A non-citizen who is applying for emergency Medical Assistance only is not required to provide an SSN. (42 U.S. C 1320b-7)

RESPONSIBILITY TO USE THE PA ACCESS CARD LAWFULLY

Once you are eligible for benefits, you will be issued a PA ACCESS card. This card may only be used for the person who is eligible and only during the eligibility period. You may only use the card for services that are needed and reasonable.

RESPONSIBILITY TO REPORT CHANGES

If you qualify for benefits, you will be required to report changes in your circumstances to your caseworker or to the Customer Service Center. Types of changes reported would include people leaving or moving into the house, a new address, a new job for someone, if someone loses a job, birth of a child, new sources of income or changes to income, and lottery and gambling winnings. Your caseworker and notices you receive will cover the specifics in detail based on the programs and benefits you are eligible for. Failure to report required changes within the program guidelines could result in a loss of benefits, sanctions, or civil or criminal charges. You may report changes to the CAO in person, by phone, fax, mail or through a MyCOMPASS account. You may also report changes to the Customer Service Center at 1-877-395-8930, or for Philadelphia, 1-215-560-7226 any time.

Understanding Your Rights and Responsibilities

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- I understand that by signing this application, I am authorizing any financial institution to disclose, through electronic or any other means, any and all financial information held by that institution, to the Department of Human Services or its designated agent or contractor for the purpose of identifying and verifying resources (also called "assets") when needed to determine and redetermine eligibility for Medical Assistance. I understand that financial information includes deposits, withdrawals, account closures and other relevant information requested or received from the financial institution, including other transactions undertaken by the financial institution with respect to the account or asset. I understand that this authorization is effective until Medical Assistance eligibility is denied or ends, or if I decide to revoke it by written notification to the Department, whichever happens first. I understand that if I revoke this authorization, that may make me or my household ineligible for Medical Assistance.
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Yes, renew my eligibility automatically for the next: (Check one):

- ☐ Five years (the maximum number of years allowed)
- ☐ Four years
- ☐ Three years
- ☐ Two years
- ☐ One year
- ☐ Do not use my information from tax returns to renew my coverage.

INSTRUCTIONS FOR COMPLETING MA-51 MEDICAL EVALUATION

NOTE: THE MA-51 IS VALID AS LONG AS IT REFLECTS THE CURRENT CONDITIONS FOR THE APPLICANT

At the top of the page, mark if this is a new or updated MA-51.

Questions 1-7 are self-explanatory.

8. **Physician License Number.** Enter the physician license number, not the Medical Assistance number.

9. **Evaluation At.** Enter 1-5 to describe where evaluation took place. If 5 is used, specify where evaluation was completed.

10. **Signature.** Applicant should sign if able. If unable, legal guardian or responsible party may sign.

11. **Essential Vital Signs.** Self-explanatory.

12. **Medical Summary.** Include any medical information you feel is important for determination of level of care. **Please list patient's known allergies in this section.**

13. **Vacating of building.** How much assistance does the patient require to vacate the building?

14. **Medication Administration.** Is the patient capable of being trained to self-administer medications?

15. **Diagnostic Codes and Diagnoses.** ICD diagnostic codes should be put in the blocks, then written by name in the space next to the block. List diagnoses starting with primary, then secondary, and finally tertiary. There is room for any other pertinent diagnoses.

16. **Professional and Technical Care Needs.** Indicate care needed. Examples of "other" include mental health and case management.

17. **Physician Orders.** Orders should meet needs indicated in box 16. Medications should have diagnoses to support their use.

18. **Prognosis.** Indicate patient's prognosis based on current medical condition.

19. **Rehabilitation Potential.** Indicate based on current condition. Should be consistent with box 18.

20A. **Physician's Recommendation.** Physician must recommend patient's level of care. If the box for "other" is checked, write in level of care. In order to provide assistance to a physician in the level of care recommendation, the following definitional guidelines should be considered:

Nursing Facility Clinically Eligible (NFCE)	Personal Care Home	ICF/ID Care	ICF/ORC Care	Inpatient Psychiatric Care
Requires health-related care and services because the physical condition necessitates care and services that can be provided in the community with Home and Community Based Services or in a Nursing Facility.	Provides Personal Care services such as meals, housekeeping, & ADL assistance as needed to residents who live on their own in a residential facility.	Provides health-related care to ID individuals. More care than custodial care but less than in a NF.	Provides health-related care to ORC individuals. More care than custodial care but less than in a NF.	Provides inpatient psychiatric services for the diagnoses and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

20B. **Complete only if Consumer is NFCE and will be served in a Nursing Facility.** Check whether the patient will be eventually be discharged from facility based on current prognosis. If yes, check expected length of stay.

20C. The physician must sign and date the MA-51. A licensed physician must sign the MA-51. It may not be signed by a "physician in training" (a Medical Doctor in Training [MT] or an Osteopathic Doctor in Training [OT].

Questions 21 and 22 completed by the OPTIONS Unit in the Area Agency on Aging.

MEDICAL EVALUATION ☐ NEW ☐ UPDATED

1. MA RECIPIENT NUMBER	2. NAME OF APPLICANT (Last, first, middle initial)	3. SOCIAL SECURITY NO.	4. BIRTHDATE

5. AGE	6. SEX	7. ATTENDING PHYSICIAN	8. PHYSICIAN LICENSE NUMBER

9. EVALUATION AT (Description and code)

01 Hospital
02 NF
03 Personal Care/Dom Care
04 Own House/Apartment
05 Other (Specify) _____

10. For the purpose of determining my need for TITLE XIX INPATIENT CARE, Home and Community Based Services, and if applicable, my need for a shelter deduction, I authorize the release of any medical information by the physician to the county assistance office, Pennsylvania Department of Human Services or its agents.

SIGNATURE - APPLICANT OR PERSON ACTING FOR APPLICANT _____ DATE _____

11. HEIGHT	WEIGHT	BLOOD PRESSURE	TEMPERATURE	PULSE RATE	CARDIAC RHYTHM

12. MEDICAL SUMMARY

13. IN EVENT OF AN EMERGENCY THE PATIENT CAN VACATE THE BUILDING

☐ 1. Independently ☐ 2. With Minimal Assistance ☐ 3. With Total Assistance

14. PATIENT IS CAPABLE OF ADMINISTERING HIS/HER OWN MEDICATIONS

☐ 1. Self ☐ 2. Under Supervision ☐ 3. No

15. ICD DIAGNOSTIC CODES

PRIMARY (Principal)
SECONDARY
TERTIARY

16. PROFESSIONAL AND TECHNICAL CARE NEEDED - CHECK ✓ EACH CATEGORY THAT IS APPLICABLE

☐ Physical Therapy ☐ Speech Therapy ☐ Occupational Therapy ☐ Inhalation Therapy ☐ Special Dressings ☐ Irrigations
☐ Special Skin Care ☐ Parenteral Fluids ☐ Suctioning ☐ Other (Specify) _____

17. PHYSICIAN ORDERS

Medications _____
Treatment _____
Rehabilitative and Restorative Services _____
Therapies _____
Diet _____
Activities _____
Social Services _____
Special Procedures for Health and Safety or to Meet Objectives _____

18. PROGNOSIS - CHECK ✓ ONLY ONE

☐ 1. Stable ☐ 2. Improving ☐ 3. Deteriorating

19. REHABILITATION POTENTIAL - CHECK ✓ ONLY ONE

☐ 1. Good ☐ 2. Limited ☐ 3. Poor

20A **PHYSICIAN'S RECOMMENDATION**

To the best of my knowledge, the patient's medical condition and related needs are essentially as indicated above. I recommend that the services and care to meet these needs can be provided at the level of care indicated - check ✓ only one

☐ Nursing Facility Clinically Eligible Services to be provided at home or in a nursing facility
☐ Personal Care Home Services provided in a Personal Care Home
☐ ICF/ID Care Services to be provided at home or in an Intermediate care facility for the intellectually disabled
☐ ICF/ORC Care Services to be provided at home or in an Intermediate care facility for consumers with ORCs
☐ Inpatient Psychiatric Care
☐ Other (Please Specify) _____

20B. **COMPLETE ONLY IF CONSUMER IS NURSING FACILITY CLINICALLY ELIGIBLE AND WILL BE SERVED IN A NURSING FACILITY.**

ON THE BASIS OF PRESENT MEDICAL FINDINGS THE PATIENT MAY EVENTUALLY RETURN HOME OR BE DISCHARGED. ☐ YES ☐ NO If Yes, Check ✓ Only One ☐ 1. Within 180 days ☐ 2. Over 180 days

20C. **PHYSICIAN'S SIGNATURE**

PHYSICIAN (PRINTED NAME) _____ TELEPHONE _____ PHYSICIAN SIGNATURE _____ DATE _____

FOR DEPARTMENT USE Medical and other professional personnel of the Medicaid agency or its designee MUST evaluate each applicant's or recipient's need for admission by reviewing and assessing the evaluations required by regulations.

21A. **MEDICALLY ELIGIBLE** ☐ Yes ☐ No ☐ Medically Appropriate for Waiver Services

21B. **Length of Stay** ☐ Within 180 days ☐ Over 180 days

22 **Comments. Attach a separate sheet if additional comments are necessary.**

REVIEWER'S SIGNATURE AND TITLE _____ DATE _____

ORIGINAL TO CAO - RETAIN PHOTOCOPY FOR YOUR FILE