



Name: \_\_\_\_\_  
Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Marital Status: S M W D  
Social Security #: \_\_\_\_\_  
Medicare #: \_\_\_\_\_

Primary Physician Name/Phone: \_\_\_\_\_  
\_\_\_\_\_

**Family Members/Responsible Parties/Power of Attorney(s):**

(1) Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_  
Email Address: \_\_\_\_\_

(2) Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_  
Email Address: \_\_\_\_\_

(3) Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_  
Email Address: \_\_\_\_\_

**Applicant Medical Conditions:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medications:** (attach list if possible)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Applicant is looking for admission to:**

\_\_\_ Personal Care \_\_\_ Skilled Care \_\_\_ Dementia Unit  
\_\_\_ Skilled Short Stay Rehab \_\_\_ Not Sure

**Need for Admission:** \_\_\_ Immediate \_\_\_ within 6 months  
\_\_\_ 6-12 Months \_\_\_ Need Home Care or Home Health till then?

***Please attach a copy of identification, all current health insurance cards, front and back and COVID vaccination card.***

<b>Gross Monthly Income</b>	A=Applicant	S=Spouse
	<u>Applicant</u>	<u>Spouse</u>
Social Security	\$ _____	\$ _____
Pension	\$ _____	\$ _____
Federal CS Pension	\$ _____	\$ _____
Railroad Retirement	\$ _____	\$ _____
VA	\$ _____	\$ _____
MILITARY/DOD	\$ _____	\$ _____
Interest	\$ _____	\$ _____
Annuity	\$ _____	\$ _____
Other _____	\$ _____	\$ _____
Other _____	\$ _____	\$ _____
<b>TOTAL</b>	<b>\$ _____</b>	<b>\$ _____</b>

Are there any deductions from Gross income?  YES  NO  
 If Yes, amount of deduction \$ \_\_\_\_\_  
 Reason for deduction: \_\_\_\_\_

**Current Value of Assets** A=Applicant S=Spouse JT=Joint  
 TYPE=CK-Checking; SV-Savings; CD-Certificate of Deposit; M-Mutual  
 Funds; IRA-Individual Retirement Account; A-Annuity; LI-Life  
 Insurance; O-Other

<u>Financial Institution Name</u>	<u>A/S/JT</u>	<u>TYPE</u>	<u>Current Value</u>
_____			\$ _____
_____			\$ _____
_____			\$ _____
_____			\$ _____
_____			\$ _____
_____			\$ _____
_____			\$ _____
_____			\$ _____

**Current Value of Liabilities**

Yearly Real Estate Taxes \$ \_\_\_\_\_  
 Yearly School Taxes \$ \_\_\_\_\_  
 Yearly Home Owners Insurance \$ \_\_\_\_\_  
 Credit Card(s) \$ \_\_\_\_\_  
 Mortgage \$ \_\_\_\_\_  
 Vehicle Loan \$ \_\_\_\_\_  
 Other Debt \$ \_\_\_\_\_  
 Other Debt \$ \_\_\_\_\_  
 Other Debt \$ \_\_\_\_\_

**Do you currently own your home?**  YES  NO IF YES:  
 Address \_\_\_\_\_

Names of all individuals on deed \_\_\_\_\_  
 Current value of home \$ \_\_\_\_\_  
 How was this value determined? \_\_\_\_\_

Is there a current mortgage on home?  YES  NO  
 If yes: Current Balance \$ \_\_\_\_\_  
 Mortgage Company Name \_\_\_\_\_  
 Is anyone residing at home other than applicant?  YES  NO  
 If yes, name(s): \_\_\_\_\_

**Do you have any ownership interest in additional real estate or dwelling?**  YES  NO IF YES:

Description of real estate/dwelling \_\_\_\_\_  
 Address(s) \_\_\_\_\_  
 Names of all individuals on deed \_\_\_\_\_  
 Current Value \$ \_\_\_\_\_

How was this value determined?

Is there a current mortgage(s)?  YES  NO  
If yes: Current Balance(s) \$ \_\_\_\_\_  
Mortgage Company Name(s) \_\_\_\_\_

Is anyone residing at this additional real estate/dwelling?  
 YES  NO If yes, name(s): \_\_\_\_\_

**Has any property, home, or other real estate/dwelling you owned in the past 60 months been (a) sold, (b) transferred, (c) donated, or (d) given as a gift by you or a person on your behalf?**  
 YES  NO  Enter a / b / c / d if YES.

IF YES: Description of property, home, or other real estate/dwelling \_\_\_\_\_

Amount of sale, transfer, donation, or gift \_\_\_\_\_  
Individual(s) whom received transfer, donation, or gift \_\_\_\_\_  
Date(s) of sale, transfer, donation, or gift \_\_\_\_\_

**Within the past 60 months, have you or your spouse (a) sold, (b) transferred, (c) donated, (d) given as a gift, or (e) closed, in total or part of, to any individual or organization any assets such as: Cash, Bank Accounts, Certificates of Deposit, Bonds, Stocks, Real Estate, a Home, Land, Personal Property, Life Insurance Policy, Annuity, Bank Account, IRA, or any right to income you may have had?**  
 YES  NO  Enter a / b / c / d / e if YES.

Description of asset(s) sold, transferred, donated, gifted or closed  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Explain circumstances (attach extra paper if needed)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Amount of sale, transfer, donation, or gift \$ \_\_\_\_\_  
Individual(s) whom received transfer, donation, or gift \_\_\_\_\_

Date(s) of sale, transfer, donation, or gift \_\_\_\_\_

**Have you, or your Power of Attorney received financial planning services?**  YES  NO IF YES:

Name(s) of financial planning service employed by you, or your Power of Attorney \_\_\_\_\_

**Do you, or your Power of Attorney, have an attorney assisting you?**  YES  NO IF YES:  
Name of Attorney \_\_\_\_\_  
Phone # \_\_\_\_\_

**Do you have a Long Term Care Insurance Policy?**  
 YES  NO IF YES:

Name of company: \_\_\_\_\_  
Policy number: \_\_\_\_\_  
Daily Benefit: \$ \_\_\_\_\_

**Other Information**

Primary Insurance: \_\_\_\_\_  
Secondary Insurance: \_\_\_\_\_  
Prescription Insurance: \_\_\_\_\_  
Funeral Home: \_\_\_\_\_

## CERTIFICATION

I, THE UNDERSIGNED Applicant (or Power of Attorney/Responsible Party), hereby certify that the foregoing information provided by me is true, correct, and complete to the best of my knowledge, information, and belief. I understand that the information provided may be used by Homeland Center or by the Pennsylvania Department of Human Services in determining Applicant's eligibility for medical assistance. I further understand that: (a) false statements in the foregoing application may be subject to penalties provided by law; and (b) all information is confidential and this application does not obligate Homeland Center or me in any way. I have read this application in full (or someone has read it to me), and I understand all questions asked in the application.

**Applicant's Signature**

\_\_\_\_\_

**Date**    \_\_\_\_/\_\_\_\_/\_\_\_\_

**If a person other than the applicant is completing this form, please provide the following:**

**Name:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

**Phone:** (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

**Email:** \_\_\_\_\_

**Responsible Party Signature**

\_\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Additional information**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Attach additional sheets as needed to complete all information. You may be contacted to provide additional information after review of this applicant profile.

Please complete and email, mail, fax or deliver to:

Homeland Center  
1901 North Fifth Street  
Harrisburg, PA 17102-1598  
717-221-7900

**Dementia/Rehab/Skilled Care:** Susan Horvath  
[shorvath@homelandcenter.org](mailto:shorvath@homelandcenter.org)  
717-221-7706 (fax)

**Personal Care:** Jennifer Murray  
[jmurray@homelandcenter.org](mailto:jmurray@homelandcenter.org)  
717-232-0929 (fax)