HOMELAND CENTER
PERSONAL + SKILLED + MEMORY + REHAB

Applicant Profile

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 email a copy of Photo ID, Medicare Card, Other Insurance Cards – including RX Card (front and back of all of these), COVID vaccine card, Medical & Financial POAs, Living Will/Advanced Directive to Susan Horvath at shorvath@homelandcenter.org for Skilled or Jennifer Murray at jmurray@homelandcenter.org for Personal Care.

Gross Monthly Income A=Applicant S=Spouse

	Applicant	Spouse
Social Security	$_____	$_____
Pension	$_____	$_____
Federal CS Pension	$_____	$_____
Railroad Retirement	$_____	$_____
VA	$_____	$_____
MILITARY/DOD	$_____	$_____
Interest	$_____	$_____
Annuity	$_____	$_____
Other _____	$_____	$_____
Other _____	$_____	$_____
TOTAL	$_____	$_____

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

Financial Institution Name	A/S/JT	TYPE	Current Value
_____			$_____
_____			$_____
_____			$_____
_____			$_____
_____			$_____
_____			$_____
_____			$_____
_____			$_____

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: _____

Do you have an irrevocable burial fund? ___ yes ___no

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
717-221-7706 (fax)

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

Additional Questions:

What is your preferred name? _____

What is your religion? _____

Name of religious institution: _____

Hospital Preference: _____

Please list any specialists you currently use. Note their name, type of practitioner, phone number, and address: