TO:

DATE:

**REQUEST FORM OPENING NURSING HOME CARE**

**Facility:** Kane/McKeesport

**Client Name:** Jensen Mette

**Case Number:**

Date Of Admission: 7/13/16

Admitted from: Home

Date Of Medicare Coverage: 7/13/16 thru 7/30/16

**Date of Security Blue Coverage:** N/A

**Date Of UPMC for Life Coverage** NA

**Date of Gateway HMO Coverage:** NA

**Date of Private Payments:** NA

**Expected Medical Assistance Date:** 7/31/16

**Expected Patient Pay Date:**

**Comments:** Denni Bona Business Office

DEPARTMENT OF PUBLIC WELFARE
OFFICE OF MEDICAL ASSISTANCE PROGRAMS

# LONG TERM CARE ADMISSION AND DISCHARGE TRANSMITTAL

## I. RESIDENT DATA

| 1. Name of Resident | 2. Access Number | 3. Social Security No | 4. Birthdate | 5. Sex |
|---|---|---|---|---|
| JENSEN, METTE | | 214769425 | 1/30/1966 | F |

6. County: ALLEGHENY

7. Type of service for which payment is presently authorized by the Department
a. [✓] Nursing facility services b. [ ] ICF/ORC c. [ ] Inpatient psychiatric d [ ] ICF/MR e [ ] Other ____

8. Admission date to facility (mm,dd,yy): 7/13/16

9. Short term stay
[ ] Yes - Length of stay ____

## II. PROVIDER DATA

| 10. Facility Name | 11. Service Provider ID-Service Location | 12. Attending Physician | 13. Physician Number |
|---|---|---|---|
| KANE REGIONAL MCKEESPORT | 1007463050048 | MUKHTAR | MD057971-L |

## III. DISCHARGE PLANNING DATA (to be completed by "Discharge Coordinator" or other appropriate person)

14. Date of Current Discharge Plan (mm,dd,yy):

15. Does the Current Discharge Plan include items a-f? (If "no" to any of the items, explain under comments.)

| | | | |
|---|---|---|---|
| a. [✓] Yes [ ] No | Information relative to current diagnoses | d. [✓] Yes [ ] No | Physician's advice concerning resident's immediate care needs |
| b. [✓] Yes [ ] No | Description of prior treatments | e. [✓] Yes [ ] No | Pertinent social information |
| c. [✓] Yes [ ] No | Description of rehabilitation potential | f. [✓] Yes [ ] No | Information on alternative available community resources to which the resident may be referred |

Comments:

## IV. CHANGE OF CARE RECOMMENDATION

16. The resident's condition warrants a change to: (Check one)
a. [ ] Nursing facility services b. [ ] ICF/ORC c. [ ] Inpatient psychiatric d. [ ] ICF/MR e. [ ] Other ____

Summarize condition that warrants the care recommended:

## V. TRANSFER/DISCHARGE SECTION

17. Discharge codes:
Discharge - The resident has no intent to return
Transfer - The resident intends to return

[ ] (01) Routine Discharge
[ ] (02) Discharge against medical advice
[ ] (03) Expired, no autopsy
[ ] (04) Expired, Autopsy
[ ] (05) Transfer / Disch. to hospital
[ ] (06) Transfer / Disch. to nursing facility
[ ] (07) Transfer / Disch. to rehab. facility
[ ] (08) Transfer / Disch. to psych. facility
[ ] (09) Disch. to boarding home
[ ] (11) Discharge to hosp. home care
[ ] (12) Other (specify) ____

Explanation of Codes:

**THIS SECTION FOR DISCHARGE ONLY**

18. [ ] 30-day notice of discharge was sent to this resident on 19. ____ (mm,dd,yy)
(a copy of this 30-day notice should be kept in the resident's clinical record)

## VI. TO BE COMPLETED BY FACILITY ADMINISTRATOR OR DESIGNEE

**The above information and attachments provide an accurate description of the resident's condition and needs at the time of this review. I recognize that the information referred to in the "Discharge Planning Data" section must be kept current with the resident's condition and must be provided to those responsible for the resident's post-discharge care.**

20. ____
Signature of administrator or designee

21. 7/13/16
Date (mm,dd,yy)

**RESIDENT'S CLINICAL RECORD**

MA 103 - 3/04

pennsylvania
DEPARTMENT OF HUMAN SERVICES

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

You may also apply online at www.compass.state.pa.us

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 application 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*

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 a face to face 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 past 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.

## PROVIDER USE

| | |
|---|---|
| NAME Mette Jensen | NUMBER |
| ADDRESS 100 Ninth Ave. McKeesport 15132 | NUMBER |
| DATE OF ADMISSION 7/13/2016 | DATE OF OPTIONS ASSESSMENT / REQUESTED EFFECTIVE DATE |
| CONTACT NAME/TELEPHONE NUMBER/ADDRESS Kim Karl. Senior Care Resources 412 751 6101 | |

## CAO USE

| | | | | |
|---|---|---|---|---|
| CO. | DIST | RECORD NUMBER | FILE CLEARED BY | APPL. REG. NO. |
| WORKER I.D. | | | CASELOAD | |
| ☐ AUTHORIZED REASON | | | | CATEGORY |
| ☐ NOT AUTHORIZED REASON | | | | DATE |

## PLEASE COMPLETE THE FOLLOWING INFORMATION FOR THE PERSON REQUESTING MEDICAL ASSISTANCE BENEFITS

| LAST NAME | FIRST NAME | MIDDLE INITIAL | (JR., SR., I, ETC.) |
|---|---|---|---|
| Jensen | Mette | S | |

| CURRENT ADDRESS (IF IN A FACILITY, USE FACILITY ADDRESS) | CITY | STATE | ZIP CODE + 4 | ADMISSION DATE |
|---|---|---|---|---|
| 2415 Riverview Avenue | McKeesport | PA | 15132 | |

| DATE MOVED TO THIS ADDRESS | TOWNSHIP | SCHOOL DISTRICT | AREA CODE AND TELEPHONE NUMBER |
|---|---|---|---|
| June 20, 2016 | | | (412) 251-6310 |

| PREVIOUS ADDRESS (IF IN A FACILITY, GIVE YOUR HOME ADDRESS. IF YOU ARE MARRIED, GIVE YOUR SPOUSE'S ADDRESS.) | AREA CODE AND TELEPHONE NUMBER |
|---|---|
| 14 Elder Place, Indian Head MD, 20640 | (301) 534 - 7709 |

Do you want an interpreter? ☐ Yes ☑ No

If yes, what language? _____

Do you need your notices in Spanish? ¿Necessita sus avisos en Español? ☐ Yes ☑ No

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? Maryland

What county? Charles County

How long? July - December 2014, April 2016 - July 2016

Record Number 530049059

Have you ever applied for or received benefits using a different Social Security Number? ☐ Yes ☑ No

If yes, what is the number? _____

Have you previously lived in a nursing facility? ☑ Yes ☐ No

If yes, provide name: Fort Washington Health and Rehabilitation Center

Address: 12021 Livingston Rd, Fort Washington, MD 20744

Dates: May 28, 2016 - June 17, 2016

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

*Attach an additional sheet of paper if you have more dependents.

| RELATIONSHIP | LAST NAME | FIRST NAME | MI | JR/SR | ALIAS/MAIDEN NAME | BIRTH DATE | SEX | *RACE | SSN |
|---|---|---|---|---|---|---|---|---|---|
| SELF | Jensen | Mette | S | | | 01/30/1966 | F | 5 | 214-76-9425 |
| SPOUSE | | | | | | | | | |
| DEPENDENT | | | | | | | | | |

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

## 2 Please answer and sign:

Are you a U.S. Citizen? ☐ Yes ☐ No If No, check one: ☑ Permanent Resident ☐ Temporary Resident ☐ Refugee ☐ Illegal Alien

Alien #: A30747902 Country of Origin: Denmark Date of Entry: 08/02/1973

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

_____ 7/26/2016
Signature Date

Name and address of sponsor if you have one: _____

_____

## 3 Marital Status

Please check one: ☐ Married ☐ Single ☐ Widowed ☑ Divorced ☐ Separated

If you checked widowed, what was the date of your spouse's death? _____ Name: _____

If you checked separated, what was the date of separation? _____ Please complete item #1 above for spouse.

## 4 Military Status

Veteran's Name _____

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. _____

## 5 Voter Registration (Optional)

If you are not registered to vote where you live now, would you like to apply 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 that 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 UPON YOUR RESPONSE ABOVE**

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

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

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

Medicare

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

## 8 MEDICAL INSURANCE INFORMATION (Including Long Term Care Insurance)

| INSURANCE COMPANY/MEDICARE | INSURANCE COMPANY ADDRESS | AGREEMENT/ POLICY NUMBER | GROUP NAME NUMBER | EFFECTIVE DATE OF COVERAGE | PREMIUM AMOUNT | PAID HOW OFTEN | POLICY HOLDER NAME AND ADDRESS |
|---|---|---|---|---|---|---|---|
| Medicare | 7500 Security Blvd Baltimore MD 21244 | 214769425A | | 10/2008 | 104.90 (up to Jan. 2016) | Monthly | Mette Jensen 2415 Riverview Avenue McKeesport, PA 15132 |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

**Add an additional sheet of paper if more space is needed. Please label what question number you are answering on any additional pages.**

## 9 Complete the following resource information for you and your spouse (if you are married):

### A. Real Estate None ☑

| LOCATION | OWNER | VALUE $ | INCOME PRODUCING ☐ YES ☐ NO | RESIDENT ☐ YES ☐ NO |
|---|---|---|---|---|
| WHO LIVES IN THE PROPERTY? | | IS THE PROPERTY LISTED FOR SALE? ☐ YES ☐ NO | IF YES - DATE LISTED | |
| IF FOR SALE GIVE ▶ REALTOR'S NAME AND TELEPHONE NUMBER * REMEMBER TO REPORT THE PROPERTY SALE TO US. | | | | |
| ARE YOU PLANNING TO RETURN TO THE PROPERTY? ☑ YES ☐ NO | | DO YOU OWN ANY OTHER REAL ESTATE? ◯ YES ◯ NO | | |

### 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 MOBILE HOME LISTED FOR SALE? ☐ YES ☐ NO IF YES GIVE ▶ REALTOR'S NAME AND TELEPHONE NUMBER | | | | |

### C. Burial Arrangements None ■

| 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 GIVE LOCATION ▶ | NUMBER OF SPACES | |

### D. Life Insurance None ☑

| COMPANY NAME | POLICY NUMBER | FACE VALUE | CURRENT CASH VALUE | WHO OWNS THE POLICY? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

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

| NAME OF OWNER(S) | YEAR | MAKE | MODEL | LICENSED? | PLATE NUMBER | ACCOUNT |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

**F. Bank Accounts (Checking, Savings, IRA, etc.)** List all accounts that include applicant's and/or spouse's name and money. None ☐

| BANK NAME/BRANCH | ACCOUNT TYPE | ACCOUNT NUMBER | CURRENT BALANCE | NAME(S) ON ACCOUNT/OWNER |
|---|---|---|---|---|
| **PNC** | **Checking** | **5330810471** | **$ 64.43** | **Mette & Chrissa** |
| **Andrews FCU** | **Savings** | **0220144216** | **$ 1.16** | **Mette & Chrissa** |
| **SSA direct express card** | **Direct Deposit** | **5332480288465745** | **$ 1.28** | **Mette** |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**G. Stocks, Bonds (including U.S. Savings Bonds), Trusts, Mutual Funds, cash on hand, etc.** None ■

| NAME ON INVESTMENT | TYPE ACCOUNT | ACCOUNT NUMBER | CURRENT ACCOUNT VALUE | NAME(S) ON ACCOUNT/OWNER |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**10** **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 policies, annuities, bank accounts, certificates of deposit, stocks, IRA, 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 RESOURCE(S) | MARKET VALUE AT TIME OF TRANSFER ▶ | $ | DATE OF TRANSFER OR CLOSING |
|---|---|---|---|
| | | | |

**11** **If you closed or depleted any accounts because you paid for nursing services, list these accounts.**

| TYPE OF RESOURCE | LOCATION | ACCOUNT NUMBER | OWNER(S) | DATE OF CLOSING |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

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

If yes, describe: _____ AMOUNT $ _____

_____ DATE EXPECTED _____

**13** **Income information for the applicant:**

| INCOME SOURCES | IDENTIFY INVESTMENT TYPE/NAME | GROSS INCOME AMOUNT | HOW OFTEN PAID |
|---|---|---|---|
| ☑ SOCIAL SECURITY | Disability benefits | $1,029/month | Monthly |
| ☐ VETERANS BENEFIT AID AND ATTENDANCE | | | |
| ☐ PENSIONS | | | |
| ☐ WORKER'S COMPENSATION | | | |
| ☐ RAILROAD RETIREMENT | | | |
| ☐ BLACK LUNG | | | |
| ☐ ANNUITY (COMPANY) | | | |
| ☐ PAYMENTS FROM A TRUST | | | |
| ☐ INTEREST/DIVIDEND (SOURCE) | | | |
| ☐ OTHER INCOME | | | |

| TO WHOM ARE THE CHECKS SENT? (GUARDIAN, REPRESENTATIVE PAYEE) | ADDRESS |
|---|---|
| ▶ Mette Jensen | 2415 Riverview Avenue<br>McKeesport, PA 15132 |

**Complete this section if you have a spouse or dependent. Skip this section if you are not married or do not have a dependent.**

## 14 Income information for the spouse and/or dependent:

| INCOME SOURCES | IDENTIFY INVESTMENT TYPE/NAME | GROSS INCOME AMOUNT | HOW OFTEN PAID |
|---|---|---|---|
| ☐ SOCIAL SECURITY | | | |
| ☐ VETERANS BENEFIT AID AND ATTENDANCE | | | |
| ☐ PENSIONS | | | |
| ☐ WORKER'S COMPENSATION | | | |
| ☐ RAILROAD RETIREMENT | | | |
| ☐ BLACK LUNG | | | |
| ☐ ANNUITY (COMPANY) | | | |
| ☐ PAYMENTS FROM A TRUST | | | |
| ☐ INTEREST/DIVIDEND (SOURCE) | | | |
| ☐ OTHER INCOME | | | |

## 15 Shelter expense:

MONTHLY RENT/MORTGAGE ..... $ $247.06/month

SALES OR LEASE PURCHASE AGREEMENT ..... $

PERSONAL CARE OR DOMICILIARY CARE RENTAL CHARGE ..... $

MAINTENANCE CHARGES FOR CONDO OR CO-OP RESIDENCE..... $ 332.21/month Home Owner's Association (HOA)

LOT RENT FOR MOBILE HOME ..... $

PROPERTY TAXES - ANNUAL AMOUNT ..... $ Included in mortgage

HOMEOWNERS INSURANCE - ANNUAL AMOUNT..... $ Included in mortgage

BASIC TELEPHONE ..... $ $25/year

GAS ..... $

ELECTRIC ..... $ $131/month

HEATING FUEL..... $

WATER..... $ Included in HOA expenses

SEWER..... $ Included in HOA expenses

GARBAGE ..... $ Included in HOA expenses

Cable/internet : $167/month

Do you pay for heating and/or air conditioning separate from your rent? ☑ Yes ☐ No (included in electric expenses)

**RIGHT TO NONDISCRIMINATION**
We may not discriminate on the basis of age, sex, race, color, ancestry, disability, religious creed, national origin, sexual preference, life-style, union membership, political belief, or because you applied for and/or received assistance before. If you feel you have been discriminated against by the Department or anyone providing services for the Department, you may file a verbal or written complaint with the Department or the county assistance office. The Department or county assistance office will then forward the complaint to the appropriate Federal or State agency.

**RIGHT TO APPEAL**
You have the right to ask for a Departmental hearing to appeal a decision of or failure to act by the Department which affects your benefits or that you feel is unfair or incorrect. You may file the appeal at the county assistance office. At the appeal hearing, you may represent yourself or someone else, such as a lawyer, friend, or a relative may represent you.

**RIGHT TO AN AGENCY CONFERENCE**
If you appeal, you may have an agency conference before the hearing.

**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 explain the reason on the notice. You have 30 days from the date of the notice to ask for a hearing if you disagree with the action taken and/or the reasons given.

**RIGHT TO CONFIDENTIALITY**
We keep information you give confidential and use it only to administer the programs you apply for and may be eligible for. Any person knowingly violating any of the rules and regulations of this Department made in accordance with this article shall be guilty of a misdemeanor, and upon conviction thereof, shall be sentenced to pay a fine, not exceeding one hundred dollars ($100), or to undergo imprisonment, not exceeding six months, or both (62 P.S. Section 483).

**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 MA Estate Recovery Program at 800-528-3708.

**CHANGES**
If you are not sure if you must report a particular change, you should report the change. You can report to a member of the county assistance office staff in person, by telephone, or by mail.

**USE OF THE PA ACCESS CARD**
You may use the PA ACCESS card for services only during the period you are eligible. You must use the card only for the person who is eligible and you may get only services that are needed and reasonable.

**RESPONSIBILITY TO PROVIDE SSNs**
You must provide a Social Security Number (SSN). If you do not have an SSN, you must apply for one. Refusal or failure to provide an SSN may result in disqualification. If you have a community spouse, he or she must also supply an SSN. We use the SSN to verify identity, administer our programs, prevent duplication in state and federal programs, for computer matches with other programs, and to get information about income and resources to determine eligibility for and/or the amount of your benefits (42 U.S.C. Section 1320b-7).

**PENALTIES**
If you do not report changes as required, your benefits may be reduced or stopped. If you purposely fail to give correct information or report changes, you may be fined and/or put in jail. Improper use of the PA Access Card for services may result in a fine, imprisonment or both.

**RESPONSIBILITY TO PROVIDE INFORMATION**
You must give true, correct and complete information to the best of your ability. You must cooperate in documenting or verifying the information. If you cannot provide proof, you should ask the county assistance office to help. You must cooperate fully with quality control and with persons from the Department or the Inspector General's Office who are conducting investigations.

***I Understand:***
My benefits may be reduced or I can be penalized for giving incomplete or false information or for not reporting changes that would affect my benefits.

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 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 recovered will not exceed the amount paid by Medical Assistance.

The state has the right to review all records of medical service paid for by Medical Assistance.

Payment for medical services will be made directly to the provider, not to me. This includes payments from Medicare.

I received a copy of my rights and responsibilities, have read them or someone has read them to me, and I understand them.

I agree to provide or cooperate in getting any information needed to prove my statements.

I must report any changes in my circumstances within 10 days of the change.

I am responsible for any fraudulent statements made on this application even if the application is submitted by someone acting on my behalf.

The state operates a fraud control program under which local, state, and federal officials may verify the information I have given.

The state may obtain information about my circumstances from other persons or organizations, including computer matches and Immigration and Naturalization.

My Social Security Number will be used to obtain information to verify my circumstances and eligibility.

# 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 |
|---|---|---|---|
| | 7/26/2016 | Maryland License R-320-115-758-513 | Daughter |

| ADDRESS OF REPRESENTATIVE | CITY | STATE | ZIP CODE + 4 | TELEPHONE NUMBER |
|---|---|---|---|---|
| 14 Elder Place | Indian Head | MD | 20640 | (301) 543-0434 |

| 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 |
|---|---|
| | |

| CAO OR OPTIONS | DATE |
|---|---|
| | |

- ☐ Face to Face Interview With _____
- ☐ Telephone Interview With _____
- ☐ Interview Waived

## Who is your 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 |
|---|---|---|---|---|
| Rutkai, Chrissa S | | | Daughter | |
| **ADDRESS** | **CITY** | **STATE** | **ZIP CODE + 4** | **TELEPHONE NUMBER** |
| 14 Elder Place | Indian Head | MD | 20640 | ( 301 ) 543-0434 |

## I WISH TO WITHDRAW MY APPLICATION

| SIGNATURE | DATE |
|---|---|
| | / / |

| CAO NAME AND ADDRESS |
|---|
| |

| CASE IDENTIFICATION | | | | |
|---|---|---|---|---|
| CO | RECORD NUMBER | CAT | CSLD | DIST |
| RECORD NAME | | | | DATE |

# AUTHORIZATION FOR RELEASE OF INFORMATION

| NAME | SOCIAL SECURITY NUMBER |
|---|---|
| Mette Jenson | 214769425 |
| ADDRESS | ZIP CODE |
| 100 Ninth Ave McKeesport PA | 15132 |

**I hereby authorize and request the disclosure to the county assistance office any information concerning the age, residence, citizenship, employment, applications for employment, education and training activities, income, resources and any additional information involving eligibility for public assistance for myself and/or those individuals on whose behalf public assistance benefits are paid to me. It is understood that the information obtained will be used only for purposes directly related to the eligibility of individuals in the public assistance case.**

| SIGNATURE | DATE |
|---|---|
| SIGNATURE OF REPRESENTATIVE APPLYING ON BEHALF OF CLIENT(S) | Daughter — LEGAL RELATIONSHIP OF REPRESENTATIVE TO CLIENT(S) |
| | 7 30 16 — DATE |

**ORIGINAL CASE RECORD FILE**

RECORD COPY FORM RETENTION PERIOD: ACTIVE CASE - RETAIN UNTIL NEW FORM IS SIGNED.
CLOSED CASE - RETAIN 4 YEARS FROM MONTH OF CASE CLOSURE

pennsylvania
DEPARTMENT OF HUMAN SERVICES

*Senior Care Resources, LLC*
4500 Walnut Street
McKeesport, PA 15132
Tel (412) 751-6101
Fax (412) 751-6109

**NOTICE OF REPRESENTATION**

Applicant Name: Mette Jansen
SS# 214769425

To Whom It May Concern:

I, Chrissa Rutkai, responsible party on record, for the above captioned Applicant, hereby authorize and empower Senior Care Resources, LLC, its employees and agents, to assist in establishing eligibility as well as filing appeals and representing the Applicant in said appeal, in order to obtain benefits and denied benefits for services provided under the Medical Assistance Program for payment for nursing home care provided to the Applicant. I authorize Senior Care Resources to secure from any third party any and all documents or other information needed for the application and/or appeal.

Specifically included under this Authorization is authorization to disclose to Senior Care Resources LLC any and all data, information and documents that is obtained from other governmental entities by the Pennsylvania Department of Human Services, including specifically that which is obtained by, and described on, the Department's form PA 162VR.

date 7-30-16