McGUIRE GROUP PORTFOLIO

- ❒ Autumn View Health Care Facility
- ❒ Brookhaven Health Care Facility
- ❒ Garden Gate Health Care Facility
- ❒ Harris Hill Nursing Facility
- ❒ Northgate Health Care Facility
- ❒ Seneca Health Care Center

VESTRACARE PORTFOLIO

- ❒ Chautauqua Nursing & Rehab Center
- ❒ Roscoe Rehab & Nursing Center
- ❒ Sunset Nursing & Rehab Center
- ❒ Susquehanna Nursing & Rehab Center

TACONIC PORTFOLIO

- ❒ Taconic Rehab & Nursing Beacon
- ❒ Taconic Rehab & Nursing Hopewell
- ❒ Taconic Rehab & Nursing Ulster

(The facility identified above is referred to as the "Facility")

ADMISSION QUESTIONNAIRE

I. APPLICANT DEMOGRAPHICS:

DATE: _____

A Name of Applicant _____

B Home Address _____

City _____ County _____ State _____ Zip _____

Who else resides in the home? _____ Relationship to applicant _____

C Home Phone _____ Cell _____ Work _____

Email address _____ Religion _____

D Social Security # _____ Gender ❒ M ❒ F

E Date of Birth _____ Place of Birth _____

F U.S. Citizen ❒ Yes ❒ No If yes, is proof available? ❒ Yes ❒ No

G Marital Status: ☐ Single ☐ Divorced ☐ Widowed ☐ Married ☐ Legally Separated

H Applicant or Spouse Currently Employed: ❒ Yes ❒ No Spouse Social Security # _____

I Location of Applicant _____

J Previous Nursing Home or Assisted Living Stays in the past 12 Months

Name of Provider	Address	Date of Stay
_____	_____	_____
_____	_____	_____
_____	_____	_____

K Recent hospital stay(s): Hospital _____ Date(s) _____ Reason _____

L Primary Physician: Name _____ Practice _____ Phone _____

Consulting Physician: Name _____ Practice _____ Phone __

II. RESPONSIBLE PARTY/EMERGENCY CONTACTS

Our Facility requests that to the greatest extent feasible, the individual named as the Financial/Designated Representative for the applicant to be an existing attorney-in-fact for the applicant, or be granted a Durable Power of Attorney by the applicant as soon as possible to ensure continuity of payment of all expenses incurred to the extent of the applicant's resources.

A Designated Representative (controls or manages finances for applicant) (referred to below as the "Designated Representative or the "Representative")

Bank POA: ❒ Yes ❒ No Durable POA: ❒ Yes ❒ No Conservator/Guardian: ❒ Yes ❒ No
(If yes, please provide proof document)

Name _____ Relation _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____

Email address _____

continued

B Emergency Contact

Name _____ Relation _____

Address _____

City _____ State_____Zip _____

Home Phone_____Cell _____Work _____

Email address _____

III. ADVANCE DIRECTIVES

A Advance Directives: Health Care Proxy ❒ Yes ❒ No Name_____Number_____

Living Will ❒ Yes ❒ No | MOLST ❒ Yes ❒ No | Do Not Resuscitate Order ❒ Yes ❒ No | Other _____

IV. INSURANCE COVERAGE:

A Veteran ❒Yes ❒ No Spouse Veteran ❒Yes ❒ No

B Medicare # _____Effective Date: Part A_____Part B_____

C Medicaid # _____County _____Effective Date_____

If Medicaid Pending, Interview Date _____

D Long-Term Care Insurance ❒Yes ❒ No Insurance Company _____

E Other Medical Insurance (BC/BC, IHA, HCP, Univera, EPIC, No Fault)

Provide copies of all Insurance, Medicare, Pharmacy & Social Security Cards

Company / Insurer	ID #	Monthly Premium

F Medicare Part D Plan & ID_____

G Prescription Drug Plan_____

V. FINANCIAL INFORMATION:

A Monthly Income

Financial Information: Please attach current bank/financial statements for all information listed.

Please list applicant and spouse/significant other information

	Applicant Monthly	Spouse/Significant Other Monthly
Social Security	$_____	$_____
Pensions:		
Retirement Pension	$_____	$_____
Veteran's Pension	$_____	$_____
Railroad Pension	$_____	$_____
Other _____	$_____	$_____
Bank/Investment Income:		
Dividends	$_____	$_____
Interest	$_____	$_____
IRA/TDA/TSA	$_____	$_____
Safe Deposit Box (value)	$_____	$_____
Trust Funds	$_____	$_____
Public Assistance		
Public Assistance Grant	$_____	$_____
Income		
Salary	$_____	$_____
Name of Employer	_____	
Disability	$_____	$_____
Supplementary Security Income	$_____	$_____
Social Security Disability	$_____	$_____
Worker's Compensation	$_____	$_____

Rental Income	$_____	$_____
Gifts Received	$_____	$_____
Alimony	$_____	$_____
No Fault Insurance Benefits	$_____	$_____

Other Monthly Income Not Listed

$_____ $_____

B Monthly Expenses

	Applicant Monthly	Spouse/Significant Other Monthly
Health Insurance Premiums	$_____	$_____
Mortgage/Rent Payment	$_____	$_____
Outstanding Loans	$_____	$_____
Long-Term Care Insurance	$_____	$_____
Other Liabilities	$_____	$_____
Credit Card	$_____	$_____
Child Support	$_____	$_____
Tuition and Fees	$_____	$_____
Alimony	$_____	$_____
Garnishment	$_____	$_____

C Bank Accounts

Name of Investment/Broker Accts _____ Present Value _____

Address of Investment/Broker Accts _____

Checking Accounts:

Bank _____ Account # _____ Balance $_____

Bank _____ Account # _____ Balance $_____

Savings Accounts:

Bank _____ Account # _____ Balance $_____

Bank _____ Account # _____ Balance $_____

Other Bank Accounts (cash deposits):

Bank _____ Account # _____ Balance $_____

Bank _____ Account # _____ Balance $_____

Bank _____ Account # _____ Balance $_____

Bank _____ Account # _____ Balance $_____

Stock/Stock Funds/Bonds/Money Markets/Trust Accounts:

Name/Address _____ Value _____

Name/Address _____ Value _____

Name/Address _____ Value _____

Name/Address _____ Value _____

Annuities:

Name/Address _____ Value _____

Name/Address _____ Value _____

Life Insurance Policies:

Name/Address _____ Face Value _____

Real Estate:

Address _____ Assessed Value _____

How owned? ❒ Individually ❒ Joint Tenant (Name/Address of Other Tenant) _____

❒ Trust (Name/Address of Trustee) _____

❒ Rental Property ❒ Life Estate Year Established _____

Address _____ Assessed Value _____

How owned? ❒ Individually ❒ Joint Tenant (Name/Address of Other Tenant) _____

❒ Trust (Name/Address of Trustee) _____

❒ Rental Property ❒ Life Estate Year Established _____

Applicant has additional resources not listed above:

_____

Trusts:

Name/Address _____ Date Established ____/____/____

Prepaid Burial Account: ❒ Yes ❒ No

Name/Address of Trusts _____ Date Established ____/____/____

Beneficiaries _____ Amount _____

Other Assets _____

Third Party Responsibility: If any other person will be responsible for paying a part or the entire monthly rent, responsible party must sign admission agreement (Applies to Assisted Living).

VI. DIVESTING:

A Has applicant / financial representative transferred assets or property in the past 60 months to a life estate or to someone other than yourself?

❒ Yes ❒ No If yes, Value $_____ Date of Transfer_____ To whom: _____

B Has applicant given gifts of money in the last 60 months?

❒ Yes ❒ No If yes, Value $_____ Date of Gift_____ To whom: _____

C Has applicant issued any Promissory Notes?

❒ Yes ❒ No If yes, Value $ _____ Date of Issue_____

D Has applicant been part of a Personal Care Agreement?

❒ Yes ❒ No If yes, describe _____ Date of Agreement _____

E Additional Financial Information _____

VII. COUNSEL:

Are you currently working with an attorney or other firm for ❒ Estate Planning ❒ Medical Planning?

If yes, please list name of firm: _____

WARRANTIES AND REPRESENTATIONS

Applicant and the Designated Representative, each separately and individually, certify as follows:

1. The financial information submitted to the Facility concerning the Applicant's finances, including pursuant to this form, is true, accurate and complete in all material respects, and that there are no material omissions.

2. The Facility has relied and will continue to rely upon the accuracy of this Questionnaire (including without limitation that the Applicant's assets are fully and accurately disclosed on this Questionnaire and that there have been no transfers of the Applicant's ownership interest in any assets or resources within the past 60 months for which fair payment has not been received other than those listed in section VI) and the representations and warranties made herein in determining whether to admit the Applicant to the Facility.

3. The Applicant and Designated Representative (to the extent that the Designated Representative has access to the Applicant's resources) will assure payment from the Applicant's resources of all charges by the Facility.

4. Each has previously not done anything nor will either of them at any time hereafter do anything that would cause the Applicant to become ineligible or disqualified for Medicaid for any period of time whether by reason of having transferred the Applicant's present or future acquired assets without receiving fair payment or value in exchange for such transfer or otherwise.

continued

5. If the Applicant is the owner of a residence, upon the Applicant no longer intending to return to such residence, such residence will be promptly sold for fair value and the proceeds used to discharge Applicant's obligations to the Facility if and when other resources are exhausted. Prior to exhausting the Applicant's other assets, they will list the residence for sale (with an M-L broker) for its then fair market value and diligently pursue the closing of a sale of the residence. The proceeds of sale will be held and used solely for discharging the Applicant's legal obligations, including the obligations to the Facility.

6. Prior to exhausting the Applicant's assets and resources, they will make timely application on behalf of Applicant for Medicaid eligibility. The application shall be made in such manner and at such time that the Applicant will be able to pay the Applicant's obligations to the Facility by means of the Applicant's resources, Medicaid or other government agency.

INDEMNIFICATION

Each of the Applicant and the Designated Representative, jointly and severally, agree to indemnify and hold the Facility harmless from any and all liability, loss, expense, and/or damage which the Facility may incur by reason of any breach of their warranties and representations in this Questionnaire. Such damages shall include but are not limited to all amounts that the Facility would have received had a timely Medicaid pick-up date occurred if the pickup date was caused by a breach of such warranties and representations.

Nothing herein, however, shall be construed to be a personal guaranty by the Designated Representative of the obligations of the Applicant to the Facility for the room, board and/or care provided to Applicant at the Facility except to the extent that such obligation arises as a result of a breach of the warranties and representations made herein.

IT IS HEREBY AGREED by the signatories below that the above terms and conditions will become effective and be binding upon and enforceable against the Applicant and the Designated Representative upon the Facility's admission of the Applicant.

RESIDENT SIGNATURE: _____ Print Name: _____

Address: _____

DESIGNATED REPRESENTATIVE SIGNATURE: _____

Print Name: _____ Address: _____

THE FACILITY

By: _____ Authorized Signatory