



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

**ADMISSION QUESTIONNAIRE**

DATE: \_\_\_\_\_

**I. APPLICANT DEMOGRAPHICS:**

- A Name of Applicant \_\_\_\_\_
- B Home Address \_\_\_\_\_  
City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
- C Telephone # \_\_\_\_\_ 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 \_\_\_\_\_  
If married, name and location of spouse \_\_\_\_\_  
\_\_\_\_\_
- H Location of Applicant \_\_\_\_\_
- I Previous Nursing Home stays  Yes  No  
If yes, Facility name and dates of stay \_\_\_\_\_  
\_\_\_\_\_

**II. APPLICANT DEMOGRAPHICS:**

The McGuire Group 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 Financial / Designated Representative (manages finances for applicant)  
Name \_\_\_\_\_ Relation \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Bank POA:  Yes  No Durable POA:  Yes  No Conservator/Guardian:  Yes  No  
(If yes, please provide proof)
- B Other Contacts  
Name \_\_\_\_\_ Relation \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**III. INSURANCE COVERAGE:**

- A Veteran  Yes  No                      Spouse Veteran  Yes  No
- B Medicare # \_\_\_\_\_
- C Medicaid CIN# \_\_\_\_\_ Effective Date \_\_\_\_\_  
If Medicaid Pending, Interview Date \_\_\_\_\_
- D Long-Term Care Insurance  Yes  No Provider \_\_\_\_\_
- E Other Medical Insurance (BC/BC, IHA, HCP, Univera, EPIC, No Fault)  
Provide copies of all insurance cards  
Company / Insurer                                      ID #                                      Prescription Card  Yes  No  
\_\_\_\_\_  
\_\_\_\_\_
- F Medicare Part D Provider \_\_\_\_\_

**IV. STATEMENT OF INCOME:**

	Applicant	Spouse
A Social Security	\$ _____	\$ _____
SSI	\$ _____	\$ _____
Retirement / Pension	\$ _____	\$ _____
Veteran's Pension	\$ _____	\$ _____
Rental Income	\$ _____	\$ _____
Other Income (Specify)	\$ _____	\$ _____

Consent to change of address for Monthly Income  Yes  No

**V. ASSETS/RESOURCES:**

- A Real Estate  Yes  No  
If yes, Location \_\_\_\_\_ Value \$ \_\_\_\_\_  
\_\_\_\_\_  
Location \_\_\_\_\_ Value \$ \_\_\_\_\_  
\_\_\_\_\_
- B Life Insurance  Yes  No If yes, Face Value \$ \_\_\_\_\_ Cash Value \$ \_\_\_\_\_  
Face Value \$ \_\_\_\_\_ Cash Value \$ \_\_\_\_\_
- C Prepaid Funeral  Yes  No Location \_\_\_\_\_
- D Trust  Yes  No If yes, Name \_\_\_\_\_ Date Established \_\_\_\_\_
- E Additional Assets / Resources - Applicant or Joint with Applicant -  
(Checking, Savings, CD's, stocks, bonds, annuities, money market, etc.)  
Account Name                                      Type of Account                                      Balance  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\* Are any of the above annuitized?  Yes  No Total Balance \$ \_\_\_\_\_

**VI. LIABILITIES:**

- A Home Mortgage:  Yes  No If yes, amount owed \$ \_\_\_\_\_
- B Loans:  Yes  No If yes, amount owed \$ \_\_\_\_\_
- C Credit Cards:  Yes  No If yes, amount owed \$ \_\_\_\_\_
- D Other (home equity, etc):  Yes  No If yes, amount owed \$ \_\_\_\_\_

**VII. DIVESTING:**

- A Has applicant / financial representative transferred assets or property in the last 60 months?  
 Yes  No If yes, Value \$ \_\_\_\_\_ Date of Transfer \_\_\_\_\_
- B Has applicant given gifts of money in the last 60 months?  
 Yes  No If yes, Value \$ \_\_\_\_\_ Date of Gift \_\_\_\_\_
- 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 \_\_\_\_\_

I, \_\_\_\_\_ the resident and/or the Designated Representative, each separately and individually, warrant that the financial information submitted to the facility concerning the Resident’s finances is true, accurate and complete in all material respects, and that there are no material omissions.

\_\_\_\_\_ I/we acknowledge that The McGuire Group has relied and will continue to rely upon my/our truthful representation of all of the Resident’s known income, assets, resources and liabilities, as well as my/our full disclosure of any transfers of income, and that my/our misrepresentation or failure to provide full disclosure may result in an interruption in payment or in qualification for benefits for payment of expenses incurred by the resident.

\_\_\_\_\_ the resident and/or Designated Representative assure payment of all expenses incurred to the extent of the applicant’s resources.

**REPRESENTATIONS, WARRANTIES AND INDEMNIFICATION AGREEMENT**

1. Upon satisfactory review of the Questionnaire, including the representations and warranties made herein, The McGuire Group will consider the Resident for admission.
2. The Resident and Representative each acknowledge The McGuire Group’s reliance on the statements made by them in the Admission Questionnaire and the promises made herein and agree to indemnify and hold The McGuire Group harmless from any and all liability, loss, expense, and/or damage which The McGuire Group may incur by reason of any misrepresentation contained in either document or their noncompliance with either document.
3. The Resident and Representative represent and warrant to The McGuire Group that the Resident’s assets are fully and accurately disclosed on the Questionnaire and that there have been no transfers of the Resident’s ownership interest in any assets or resources within the past 60 months for which fair payment has not been received.

4. The Resident and Representative agree that neither of them has previously done anything nor will either of them at any time hereafter do anything that would cause the Resident to become ineligible or disqualified for Medicaid for any period of time whether by reason of having transferred the Resident's present or future acquired assets without receiving fair payment or value in exchange for such transfer or otherwise.

5. If the Resident is the owner of a residence, the Resident and Representative represent and warrant that if and when the Resident no longer intends to return to such residence, such residence will be promptly sold for fair value and the proceeds used to discharge Resident's obligations to The McGuire Group if and when other resources are exhausted. Prior to exhausting Resident'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 Resident's legal obligations, including the obligations to The McGuire Group.

6. The Resident and Representative agree that prior to exhausting the Resident's assets and resources, they will make timely application for Medicaid. The application shall be made in such manner and at such time that the Resident will be able to pay his/her obligations to The McGuire Group by means of the Resident's assets and resources and/or medical assistance provided by the State of New York or other government agency.

7. If the Resident is denied timely Medicaid coverage due to the willful or negligent failure of Resident and/or Representative to abide by this Agreement, they agree to indemnify and hold The McGuire Group harmless of and from any and all loss or damage occasioned by any misrepresentation or failure to qualify for Medicaid and they each agree to pay and reimburse The McGuire Group unconditionally all amounts that The McGuire Group would have received had a timely Medicaid pick-up date occurred.

8. The liability of the Resident and the Representative for all damages incurred by The McGuire Group as a result of the breach by either of them of any of the covenants and representations made herein will be joint and several. **Nothing herein, however, shall be construed to be a personal guaranty by the Representative of the obligations of the Resident to The McGuire Group for the room, board and/or care provided to Resident at The McGuire Group except to the extent that such obligation arises as a result of a breach of the covenants made herein.**

The above terms and conditions will become effective and be binding upon and enforceable against the Resident and the Representative upon The McGuire Group's admission of the Resident pursuant to this Questionnaire, the terms and provisions of which are hereby agreed to the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ by

THE MCGUIRE GROUP AND

(Please Print) \_\_\_\_\_ ("Resident") and

(Please Print) \_\_\_\_\_ ("Representative").

\_\_\_\_\_  
Applicant's/Resident's Signature

\_\_\_\_\_  
Street

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Representative's Signature

\_\_\_\_\_  
Street

\_\_\_\_\_  
City, State, Zip Code

Approved and Accepted: \_\_\_\_\_