THE McGUIRE GROUP

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

**ADMISSION QUESTIONNAIRE** DATE: _____

## I. APPLICANT DEMOGRAPHICS:

A Name of Applicant _____

B Home Address _____

City _____ County _____ State _____ Zip _____

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 _____. If married, name and location of spouse _____

H Applicant or Spouse Currently Employed: ❒ Yes ❒ No

I Location of Applicant _____

J Previous Nursing Home stays ❒ Yes ❒ No Facility name and dates 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:

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 Advance Directives: Health Care Proxy ❒ Yes ❒ No Name _____ Number _____
Living Will ❒ Yes ❒ No | MOLST ❒ Yes ❒ No | Do Not Resuscitate Order ❒ Yes ❒ No | Other _____

B Financial / Designated Representative (manages finances for applicant)

Name _____ Relation _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell _____ Work _____
Email address _____

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

C Emergency Contact

Name _____ Relation _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell _____ Work _____
Email address _____

## III. INSURANCE COVERAGE:

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

B Medicare _____ Effective Date: Part A _____ Part B _____

C Medicaid CIN# _____ County _____ 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, Medicare, Pharmacy & Social Security Cards

| Company / Insurer | ID # | Monthly Premium |
|---|---|---|
| | | |
| | | |

F Medicare Part D Plan & ID _____

G Prescription Drug Plan _____

## IV. STATEMENT OF INCOME:

| | Applicant Monthly | Spouse Monthly |
|---|---|---|
| A Social Security | $_____ | $_____ |
| SSI | $_____ | $_____ |
| Retirement / Pension | $_____ | $_____ |
| Veteran's Pension | $_____ | $_____ |
| Railroad Income | $_____ | $_____ |
| Rental Income | $_____ | $_____ |
| Salary | $_____ | $_____ |
| Other Income (Specify) | $_____ | $_____ |

_____

Consent to change of address for Monthly Income ❒Yes ❒ No

## V. ASSETS/RESOURCES:

A Real Estate ❒Yes ❒ No Type of Ownership: ❒ Sole ❒ Joint with _____

Life Estate ❒Yes ❒ No Year Established _____

Location of real estate _____ Value $ _____

_____

Location _____ Value $ _____

_____

B Life Insurance ❒Yes ❒ No If yes, Face Value $_____ Cash Value $ _____

Face Value $ _____ Cash Value $ _____

C Prepaid Funeral ❒Yes ❒ No Location _____ Phone _____

D Trust ❒Yes ❒ No If yes, Name _____ Date Established _____

E Additional Assets / Resources - Applicant or Joint with Applicant -

(Checking, Savings, CDs, 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 past 60 months to a life estate or to someone other than yourself?

❒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 issues 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 _____

_____

## VIII. COUNSEL:

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

If yes, please list name of firm: _____

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 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 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.

continued

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 other than those listed in section VII?

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.**

I have reviewed the information contained herein, and represent that it is factually true, accurate and complete. I understand that The McGuire Group utilizes this information in the admissions decision process. 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 this

_____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: _____