VESTRACARE PORTFOLIO

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

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

TACONIC PORTFOLIO

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

ABSOLUT CARE PORTFOLIO

❒ Absolut Care of Allegany
❒ Absolut Care of Aurora Park
❒ Absolut Care of Gasport
❒ Absolut Care of Three Rivers
❒ Absolut Care of Westfield
❒ Orchard Brooke Assisted Living

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

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