the BROTHERS of MERCY

ADMISSION QUESTIONNAIRE

DATE: _____

PLEASE COMPLETE ALL SECTIONS

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 Currently Employed?: ❍ Yes ❍ No ❍ Full Time ❍ Part Time ❍ Retired

I: If yes, where: _____ Lifetime Occupation: _____

J: Location of Applicant: _____

K: Previous Nursing Home stays: ❍ Yes ❍ No

If yes, Facility name and dates of stay: _____

_____

L: Primary Doctor: _____

II. RESPONSIBLE PARTY/EMERGENCY CONTACT

The Brothers of Mercy 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 (manage finances for applicant)

Name: _____ Relation: _____

Address: _____

City: _____ County: _____State:_____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email Address: _____

Bank POA: ❍ Yes ❍ No Durable POA: ❍ Yes ❍ No Conservator/Guardian: ❍ Yes ❍ No

Healthcare Proxy: ❍ Yes ❍ No

(If yes, please provide proof document(s))

B. Primary Emergency Contact
Name: _____ Relation: _____
Address: _____
City: _____ County: _____State:_____ Zip: _____
Home Phone: _____ Cell: _____ Work: _____
Email Address: _____
Healthcare Proxy: ❍ Yes ❍ No

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/BS, IHA, 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: _____

IV. STATEMENT OF INCOME

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

_____

Consent to change of address for Monthly Income: ❍ Yes ❍ No
(this only needs to be answered for Long Term Care)

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, 401k, trusts, 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
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 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 _____
_____

F. Has applicant contracted with a placement agency?: ❍ Yes ❍ No
If yes, Name of agency and contact:_____

(Please note that Brothers of Mercy is not contracted with any third party referral agencies. Under no circumstances will any Brothers of Mercy facility pay a referral fee for placement of any resident at any Brothers of Mercy facility.)

VIII. COUNSEL

A. Are you currently working with an attorney or other firm for ❍ Estate Planning ❍ Medicaid Planning?
If yes, please list name of firm:_____

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

I/we acknowledge that the Brothers of Mercy 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 of 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.

Please complete section IX if applying to Sacred Heart Assisted Living

IX. Sacred Heart Home

Do you want to change to Sacred Heart House Physician?: ❍ Yes ❍ No

Hospital of choice? _____

Does the applicant see any specialist? (If so list below)

_____
_____
_____
_____

Any special dietary needs?_____

Any Allergies? (food or medication): _____

Primary Language: _____

Burial Information: _____

REPRESENTATIONS, WARRANTIES AND INDEMNIFICATION AGREEMENT

1. Upon satisfactory review of the questionnaire, including the representations and warranties made herein, the Brothers of Mercy will consider the resident for admission.
2. The resident and representative each acknowledge the Brothers of Mercy's reliance on the statements made by them in the admission questionnaire and the promises made herein and agree to indemnify and hold the Brothers of Mercy harmless from any and all liability, loss, expense, and/or damage which the Brothers of Mercy 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 Brothers of Mercy 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 Brothers of Mercy 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 it's then fair market value and diligently pursue the closing of a sale of the residence. The proceeds of the sale will be held and used solely for discharging Resident's legal obligations, including the obligations to the Brothers of Mercy.
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 Brothers of Mercy 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 Brothers of Mercy harmless of and from any and all loss or damage accessioned by any misrepresentation or failure to qualify for Medicaid and they each agree to pay and reimburse the Brothers of Mercy unconditionally all amounts that the Brothers of Mercy 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 Brothers of Mercy 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 constructed to be a personal guaranty by the representative of the obligations of the resident to The Brothers of Mercy for the room, board and/or care provided to resident at the Brothers of Mercy 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 a factually true, accurate and complete. I understand that the Brothers of Mercy 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 Brothers of Mercy'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 BROTHERS OF MERCY AND (Please Print)_____ "Resident"

and (Please Print) _____ "Representative".

Applicant's/Resident's Signature: _____

Street: _____ City: _____State: _____ Zip: _____

Representative's Signature: _____

Street: _____ City: _____State: _____ Zip: _____

THE BROTHERS OF MERCY DOES NOT DISCRIMINATE IN THE ADMISSION, RETENTION AND CARE OF RESIDENTS BECAUSE OF AGE, RACE, CREED, COLOR, NATIONAL ORIGIN, GENDER, MARTIAL STATUS, SEXUAL PREFERENCE, BLINDNESS, DISABILITY OR HANDICAP.

Authorization for Use or Disclosure of Protected Health Information

Applicant's Name _____ Date _____

I hereby authorize the use and disclosure of my health information as indicated below. I understand that this release is voluntary and that I may revoke this authorization at any time except to the extent that action has been in reliance on this authorization. I also understand that if the individual or organization authorized to receive this information is not required to comply with current privacy regulations, my health information may be disclosed to others and no longer protected by current state and federal privacy regulations.

I hereby authorize my Primary Care Physician and/or any other Physician involved in my care to release the information listed below upon submission of my application to the Brothers of Mercy Campus for the purpose of determining medical needs:

History & Physical Examination Laboratory Reports Transcribed Reports
Medical / Treatment Records Consultant Reports
Other _____

I understand that the individual, organization, or entity receiving my health information may receive financial or in-kind compensation in exchange for using or disclosing the information described above.

Unless otherwise revoked by me, I understand that this authorization will expire 90 days from the date on the Admission Questionnaire or upon the completion of the use of the information for the purpose it was intended, whichever is earlier.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

I understand that I may inspect and copy any information used or disclosed under this authorization. I understand that a fee may be charged for such copying services.

I hereby release the facility, its employees, officers, and health care professionals from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that I may revoke this request at anytime by providing the facility with my written notice of such revocation.

Date _____ Signature of Resident _____

Printed Name of Resident _____

Date _____ Signature of Representative _____

Printed Name of Representative _____

Relationship to Resident _____

Date _____ Signature of Witness _____

Printed Name of Witness _____

A copy of this record must be provided to the person making the request and a copy must be filed in the medical record.

02/20