TANGLEWOOD GROUP Where caring and community come together.					
	560 Fa	irmount Avenue	P: (716) 483-2876		
<b>— —</b> 1			F: (716) 483-2832		
-			ignolia Day Care		-
			rs in Care Home	-	
PLEA		LL QUESTION	S AS COMPLETLY A	AS POSSIBLE	
Name				Phone	
Where is applicant present	lv?				
Where is applicant present					
Facility name (if any)					
How long have you lived in	the above add	lress?			
Home address if diffrent fro	om above				
-					
		Birthpl			
Date of Birth			ace	US Citize	n? Yes No
Date of Birth			ace	US Citize	n? Yes No
Date of Birth	leMarı	riedWi	aceSepa	US Citize	n? YesNo Divorced
Date of BirthSing Marital StatusSing Name of spouse (ev	leMari	riedWi 1)	aceSepa	US Citize	n? YesNo Divorced
Date of BirthSing Marital StatusSing Name of spouse (ev Date of spouse's bi	leMari	riedWi 1)	aceSepa	US Citize	n? Yes No Divorced
Date of BirthSing Marital StatusSing Name of spouse (ev Date of spouse's bi Give nearest relatives:	leMari ven if deceased rth	riedWi l) death	ace Sepa	US Citize	n? YesNo Divorced
Date of Birth Sing Marital Status Sing Name of spouse (ev Date of spouse's bi Give nearest relatives: Name	leMari	riedWi 1) death	ace Sepa dowed Sepa marriage Relationship	US Citize	n? YesNo Divorced Phone
Date of Birth Sing Marital Status Sing Name of spouse (ev Date of spouse's bi Give nearest relatives: Name Street	leMarr	riedWi 1)death death	ace Sepa dowed Sepa marriage Relationship B	US Citize	n? YesNo Divorced Phone
Date of Birth Sing Marital Status Sing Name of spouse (ev Date of spouse's bi Give nearest relatives: Name Street Name	leMari	riedWi 1) death State _	ace Sepa dowed Sepa marriage Relationship B Relationship B	US Citize	n? YesNo Divorced Phone Phone
Date of Birth Sing Marital Status Sing Name of spouse (ev Date of spouse's bi Give nearest relatives: Name Street Street Street	leMari ven if deceased rth City	riedWi 1) death State _ State _	ace Sepa dowed Sepa marriage Zip B Relationship Zip B	US Citize	n? YesNo Divorced Phone Phone
Date of Birth Marital Status Sing Name of spouse (ev	leMari ven if deceased rth City	riedWi 1) death State _ State _	ace Sepa dowed Sepa marriage Zip B Relationship Zip B Relationship B	US Citize	n?YesNo Divorced Phone Phone Phone
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Date of Birth Sing Marital Status Sing Name of spouse (ev Date of spouse's bi Give nearest relatives: Name Street Name Street Street Street Were you ever in the U. S. A	leMari ven if deceased rth City City Armed Services	riedWi l)death State State s?State	ace Sepa dowed Sepa marriage Zip B Relationship Zip B Relationship Zip B Relationship B	US Citize	n?YesNo Divorced Phone Phone Phone
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Date of Birth Sing Marital Status Sing Name of spouse (ev Date of spouse's bi Give nearest relatives: Name Street Street Name	leMari ven if deceased rth City City Armed Services I	riedWi l)death death State State State State State State	ace Sepa dowed Sepa marriage Relationship B Relationship B Relationship B Relationship B Zip B	US Citize	n?YesNo Divorced Phone Phone Phone

# II. FINANCIAL DATA

Cash Assets	
Bank:	Bank:
Checking Acct#	Savings Acct #
Account Balance \$	Account Balance \$
Certificate of Deposit?YesNo If Yes, app	roximate amount
Real Estate	
Applicant owns a home?YesNo Appr	oximate value \$
Applicant owns other propertiesYesN	o Approximate value \$
Does Applicant receive any rental income? Ye	sNo
Does Applicant have a Life Estate or Life Use of a prop	perty?YesNo Approximate value \$
Rental income per month \$	Per Year \$
Securities	
Does applicant have stocks and bonds? Yes	
Does applicant have an Annuity or IRA?Yes	
If yes approximate value of all securities	
Life Insurance	
Does Applicant have life insurance policies?Yes	No
Face Value: \$	Cash Value: \$
Annuities: \$	Company Name:
Other Income	
Social Security \$	SSI \$
	VA Pension \$
	Other \$ Type:
Burial	
 Does applicant have a prepaid burial fund?Yes	No Is it Irrevocable?YesNo
Bank holding the burial:	
If yes, approximate value \$	
Funeral Home (address and phone number)	
Liabilities	
	t owed
	nt owed
Other (home equity, etc)YesNo	If yes, amount owed

## Divesting

Has applicant/financial	representative tra	ansferred assets	s or property in the past 60 months to someone
other than yourself?	YesNo I	lf yes, Value \$	Date of Transfer
Has applicant given gif	ts of money in the	last 60 months	5?
YesNo	If yes, Value \$		Date of Gift
Has applicant issued ar	y Promissory Note	es?	
Yes No	If yes, Value \$		Date of Issue
Has applicant been a pa	art of a Personal Ca	are Agreement?	?
YesNo	If yes, describe		Date of Agreement
Additional Financial In	formation		

#### Trusts

Has Applicant been the settlor or grantor of any trust or trusts? \_\_\_\_\_ Yes \_\_\_\_\_ No Is Applicant the current, contingent and/or discretionary beneficiary of any trust or trusts? \_\_\_\_\_ Yes \_\_\_\_\_ No

If the answer to any of the preceding questions in this section Trusts is "yes", please provide a full copy for all such trust(s) with any amendments thereto.

### Person Assisting with Finances

Name:	_ Telephone #:
Address:	_ Work #

#### Council

Are you currently working with an attorney or other firm for \_\_\_\_\_ Estate Planning \_\_\_\_\_Medicaid Planning If yes, please list name of firm \_\_\_\_\_

#### **III. STATISTICAL DATA**

Social Security Number:	Medicaid Number:		
Medicare Number:		Part A	Part B
Other Insurance:	Prescription Coverag	ge:	
Who shall be notified in case of serious illness or death?	(Include business ph	one if appropria	ate)
Name:	Telephone #:		
Address:	Work #		
IV. SOCIA	L DATA		

What are your present living arrangements? \_\_\_\_\_\_

Do you prepare your own meals and care for your own person without assistance?

Why do you desire residence?         Are you receiving any assistance at home at this time?         Yes, briefly discribe:         Ageny Name:				
Are you receiving any assistance at home at this time?YesNo If yes, briefly discribe:	Are you on a special diet? Specify			
If yes, briefly discribe:	Why do you desire residence?			
Ageny Name:Address	Are you receiving any assistance at home at this time? Yes No			
V. MENTAL HEALTH DATA         Do you have a history of a mental health diagnosis? YesNo         Type of diagnosis? Name Metal Health Doctor:         Type of diagnosis? Name Metal Health Doctor:         How often do you see your Mental Health doctor?         When was the last date and how long were you hospitalized for your mental health issues?         Where?	If yes, briefly discribe:			
Do you have a history of a mental health diagnosis?YesNo Type of diagnosis?Name Metal Health Doctor:	Ageny Name: Address			
Type of diagnosis?	V. MENTAL HEALTH DATA			
How often do you see your Mental Health doctor?	Do you have a history of a mental health diagnosis? Yes No			
How often do you see your Mental Health doctor?	Type of diagnosis? Name Metal Health Doctor:			
When was the last date and how long were you hospitalized for your mental health issues?				
Where?				
Education – circle highest year completed: Grade school – 1 2 3 4 5 6 7 8 High School – 1 2 3 4 Further training – specify				
Grade school – 1 2 3 4 5 6 7 8 High School – 1 2 3 4 Further training – specify				
Further training – specify	Education – circle highest year completed:			
What has been your occupation(s)?	Grade school – 1 2 3 4 5 6 7 8 High School – 1 2 3 4			
What has been your occupation(s)?	Further training – specify			
How long since you were a wage earner?				
How long since you were a wage earner?	What has been your occupation(s)?			
Please check all that apply Health Care Proxy Living Will POA DNR/Advance Directive Medicaid Managed Care 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 Tanglewood 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				
Health Care ProxyLiving Will POA DNR/Advance DirectiveMedicaid Managed Care 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 Tanglewood 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				
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may result in an interruption in payment or in qualification for benefits for payment of expenses incurred by				
the resident.	the resident.			

# Representations, Warranties and Indemnification Agreement

Upon satisfactory review of the Admission Application, including the representations and warranties made herein, The Tanglewood Group will consider the Resident for admission.

The Resident and Designated Representative each acknowledge The Tanglewood Group's reliance on the statements made by them in the Admission Application and the promises made herein and agree to Indemnify and hold The Tanglewood Group harmless from any and all liability, loss, expense, and/or damage which the Tanglewood Group may incur by reason of any misrepresentation contained in either document or their noncompliance with other document.

The Resident and Designated Representative represent and warrant to The Tanglewood Group that the Resident's assets are fully and accurately disclosed on the Admission Application and that there have been no transfers of the Resident's ownership interest in any assets or resources with the past 60 months for which fair payment has not been received other than those listed.

The Resident and Designated 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.

The Resident and Designated Representative, collectively and individually, represent and warrant to The Tanglewood Group that all assets listed in Section II Financial Data are titled and held solely in the name of the Resident, except as otherwise specifically stated in said Section II Financial Data.

The Resident and Designated Representative, collectively and individually represent and warrant to The Tanglewood Group that neither the Resident nor the Designated Representative has caused a transfer of any assets of Resident to a trust or trusts. The Resident and Designated Representative represent, warrant and agree that neither Resident nor Designated Representative, for a term of at least five consecutive years hereafter, will cause assets of the Resident to be transferred to a trust or to any other transferee for less than fair and adequate consideration. Any transfer by Resident and/or Designated Representative of assets owned, in full or in part, by the Resident to a trust that is not fully revocable and/or which does not include a retained unconditional and unlimited power in favor of the Resident to cause the Trustee to distribute the full corpus of such trust(s) to Resident shall be deemed a transfer for less than fair and adequate consideration.

Resident and Designated Representative, collectively and individually, warrant and represent to each Tanglewood Group adult care facility identified on the first page of this Admissions Agreement, collectively and individually a "Facility", that (i) Resident has sufficient net assets and will have sufficient net assets to fully pay the Facility for all rent, charges and expenses due the Facility pursuant to its Admissions Agreement with Resident on a private pay basis, and without medicaid, SSI or other third party/governmental reimbursement program for a term of at least two (2) years from the date of this Admission Application and (ii) Resident and the Designated Representative will not voluntarily permit or authorize any transfer, gift or depletion of the Resident's assets and/or any increase of the Resident's liabilities other than those asset transfers/increases to liabilities resulting from for the daily and customary living expenses of the Resident.

#### (\_\_\_\_ Initials)

All representations, warranties, promises and covenants of the Resident and the Designated Representative contained herein shall survive any subsequent entry by The Tanglewood Group and Resident and/or Designated Representative into any residency agreement for admission of Resident into any Tanglewood Group facility as identified on the first page hereof.

The Resident and Designated 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 he Resident will be able to pay his/her obligations to The Tanglewood 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.

The Designated Representative represents, warrants and promises to the The Tanglewood Group that he/she will not accept transfer of or retain any assets from the Resident for less than fair and adequate consideration, outright and/or in trust, for a term of 60 months on and after the date of this application. All such assets received by the Designated Trust shall be held by the Designated Representative for the benefit of The Tanglewood Group.

If the Resident is denied timely Medicaid coverage due to the willful or negligent failure of Resident and/or Designated Representative to abide by this Agreement, they agree to indemnify and hold The Tanglewood 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 Tanglewood Group unconditionally all amounts that The Tanglewood Group would have received had a timely Medicaid pick-up date occurred.

The representations, warranties, promises and covenants of the Resident and Designated Representative contained herein in favor of The Tanglewood Group shall inure to the benefit of, collectively and individually, The Tanglewood Group and each of its' affiliated facilities identified at the top of the first page of this application.

I have reviewed the information contained herein, and represent that it is factually true, accurate and complete. I understand that The Tanglewood 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 Designated Representative upon The Tanglewood Group's admission of the Resident pursuant to this Admission Application, the terms and provisions of which are hereby agreed to the

day of	_ , 20 by The Tanglewood Group and
(Please Print)	("Resident")
and (Please Print)	("Designated Representative")
Applicant's/Resident's Signature	/Date
Representative's Signature	/ Date

It is the policy of Tanglewood Manor to admit and treat all patients without regard to race, creed, color, national origin, sex, handicap, or source of payment.