Confidential Application

We thank you for considering our skilled nursing facility. To assist us in assessing whether we can meet your needs, we would like to review your medical needs and assess the financial resources available to pay for that care. Once determined, we can then establish a clear understanding of the services you will receive and the financial responsibility you will be undertaking.

We require this information of all residents, regardless of their method of payment or length of stay. Completing this form prior to admission day will aid us in helping you to make the best decisions, and will expedite the admission process.

All information will be kept confidential, and if you choose our facility, this form will become part of your admission agreement.

General Information

Prospective Resident's Name: JONES, Lawrence G (CITY) Telephone: 617/552.3912

Home Address: c/o M.J. Connolly 50 Tarleton Rd City/State/Zip: Newton Ctr MA 02459

Age: 85 DOB: 1922·07·08 Sex: ✓ Male ____ Female

Social Security #: 191·14·9552 Medicare #: 191·14·9952A BCBS Medex XXG984140159

Resident is now at: ____ Home ____ Hospital ____ Nursing Home

Identify Institution if applicable: Name: Goddard House Assisted Living / Brookline

How Long: new

Personal Physician's Name: John R. Anderson

Address: 300 Mt Auburn St / 517 ~~Cambridge MA 02138~~

Telephone: 617/868.0847

If you are not the prospective resident: Your Name: M.J. Connolly

Address: 50 Tarleton Rd Newton Ctr MA 02459

Telephone (Day/Evening): 617/552.3912 cnnmjebc.edu

Relationship to prospective resident: colleague / health proxy / durable POA

How did you hear about us? Bob O'Toole, Informed Eldercare Decisions

Legal Representative * (copies of agreements should be provided at time of admission)

Type of Legal Representative * Durable POA / Health proxy

Name: W.J. Connolly Telephone: (day/eve) 617/552.3912

Address: 50 Tarleton Rd Newton Ctr MA 02459 Relationship to Resident: colleague / "next of kin"

Type of Legal Representative * _____

Name: _____ Telephone: (day/eve) _____

Address: _____ Relationship to Resident: _____

* Conservator / Legal Guardian..... If the resident is incapacitated and unable to make medical decisions or financial decisions
* Power of Attorney.....If a capacitated resident has given power of attorney or if an incapacitated resident has given durable power of attorney
* Responsible Party or Guarantor.....If a responsible party personally assumes financial responsibility for the resident's charges
* Agent..... If the resident has an agent who ensures that the residents funds are used to cover charges

Financial Information

Does resident have any insurance that will cover care provided in a skilled nursing facility?

___YES ✓ NO

If yes, please identify: Company: _____ Policy#: _____

Address: _____

Telephone: _____ Agent's Name: _____

Income

Salary $ — Social Security Check $ 1779.— + /mo

Pension / Annuity $ 3195.34 + /mo IRA $ —

Disability Check $ — Rental Income $ —

Other $ ≈300-500/mo dividends Total Income $ 4974.34 + dividends

Cash Assets

Bank: Cambridge Trust Co (CTC) / Cambridge Savings Bank (CSB) / Citizens (CTz)

Location: (Cambridge MA)

Checking Account # CTC 38217501 CTz ~~1240-918443~~ 120037·593·6 Balance in Account $ CTC ~180,000 / CTz ~ 5,000 / CSB ~140.000 + Schwab cash acct 1249·3660 ~63,700

CSB 35·014505 CTC 1511 8120

Savings Account # ↓ | ~~CTz~~ CTz 1240·918443 Balance in Account $ CTC ~ 88,000 / CTz ~63,000

Certificates of Deposit? ___YES ✓NO If yes, approximate amount $ _____

Financial Information Continued...

Real Estate Assets

Does the resident own a home? ✓ YES ___NO If yes, approximate value $ 450,000

Does the resident own any other property? ___YES ___NO

If yes, what, and where is property located? 246 Brattle St #2 Cambridge MA

Life Insurance Cash Value

Does resident have life insurance policies with cash value? ___YES ___NO not known

Company Name _____ Approximate amount of cash value $_____

Agent's Name _____ Telephone _____

Annuities $ _____

Securities

Does the resident have stocks and bonds? ✓ YES ___NO

Approximate value of all securities $ ~290,000

Agent handling securities Schwab

Address _____

Phone 647/210.7436 Brian Trentsh

Estimated Monthly Costs: To be completed with nursing facility staff. We will work with you to estimate the resident's basic monthly costs based on his or her primary coverage. The monthly cost can be used to determine advance payment.

Private: Daily room rate of $_____ x 30 Days = $ _____

Medicaid or Estimated monthly net income or County Welfare, or monthly liability amount from case-worker Out of State Welfare

Name / Phone _____ $ _____

Medicare: Coinsurance Rate of $ _____ x 30 Days = $ _____

Long Term Care or Commercial Insurance: Coinsurance rate of $ _____ x 30 Days = $ _____

MONTHLY COST $ _____

Authorization

I hereby state that to the best of my knowledge, the information on this form is true, accurate and complete. I understand that if any information has been falsely represented, it may be sufficient cause for denying admission or discharging the resident from the center. In addition, I authorize the nursing center to verify the information on this form.

Resident or Conservator or Legal Guardian _____ **Date** _____

Power of Attorney _____ **Date** 2008-02-01

Financial Agent _____ **Date** _____

Agent _____ **Date** _____

Nursing Center _____

By: Name / Title _____ **Date** _____

Witness* _____ **Date** _____

Witness* _____ **Date** _____

* Only required if resident signs with a mark