National Health Care Associates Inc.

APPLICATION FOR ADMISSION

Please find enclosed our written application form. As soon as you substantially complete and return the form to us, your name will be placed on our waiting list for admission to the center. Your name will only be placed on our waiting list after you substantially complete and return this written application form to us. Any questions, call our Admissions Department.

National Health Care Associates Inc.

Please CHECK OFF the center below that you desire to be admitted to as a resident:

CONNECTICUT:

- Bethel Health Care Center
- Bloomfield Center for Nursing & Rehabilitation
- Cambridge Health & Rehabilitation Center
- Hebrew Center for Health & Rehabilitation
- Ludlowe Center for Health & Rehabilitation
- Mansfield Center for Nursing & Rehabilitation
- Maple View Center for Health & Rehabilitation
- Marlborough Health & Rehabilitation Center
- Milford Health & Rehabilitation Center
- The Pines at Bristol Center for Health & Rehabilitation
- Regency House Nursing & Rehabilitation Center
- Riverside Health & Rehabilitation Center
- The Cascades Assisted Living
- Village Crest Center for Health & Rehabilitation
- Water's Edge Center for Health & Rehabilitation
- Evergreen Health Care Center
- Stone Bridge Center for Health and Rehabilitation
- The Cascades at Stone Bridge
- Beacon Brook Health Center
- Montowese Health and Rehabilitation Center
- Sharon Health Care Center

NEW YORK:

- Belair Nursing & Rehabilitation Center
- Huntington Hills Center for Health & Rehabilitation
- The Pines at Catskill Center for Nursing & Rehabilitation
- The Pines at Glens Falls Center for Nursing & Rehabilitation
- The Pines at Heartwood Assisted Living Program
- The Pines at Poughkeepsie Center for Nursing & Rehabilitation
- The Pines at Utica Center for Nursing & Rehabilitation

MAINE:

- Augusta Center for Nursing & Rehabilitation
- Brentwood Center for Health & Rehabilitation Center
- Brewer Center for Health & Rehabilitation
- Eastside Center for Health & Rehabilitation
- Kennebunk Center for Health & Rehabilitation
- Norway Center for Health & Rehabilitation Center
- Westgate Center for Health & Rehabilitation Center
- Winship Green Center for Health & Rehab

MASSACHUSETTS:

- Reservoir Center for Health & Rehabilitation

NEW HAMPSHIRE:

- Dover Center for Health & Rehabilitation

VERMONT:

- Pine Heights at Brattleboro Center for Nursing & Rehabilitation
- The Pines at Rutland Center for Nursing & Rehabilitation

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PERSONAL INFORMATION

Applicant's Name _____

Home/Previous Address _____

Present Location/Address _____

If a medical facility, date of admission

Date of Birth _____ Age _____ Birthplace _____ Religion _____

Marital Status _____ Previous Occupation _____ Education _____

Hobbies/Interests (Past & Present) _____ Veteran (spouse of) Yes _____ No _____

_____ Veteran Service # _____

_____ Branch of Service _____

Primary Contact Person _____ Relationship _____

Address: _____

Telephone: Days _____ Evenings _____

POA _____ Conservator: Person _____ Estate _____ (Please include documentation)

Other Involved Parties

Name _____ Relationship _____

Address: _____

Telephone: Days _____ Evenings _____

Name _____ Relationship _____

Address: _____

Telephone: Days _____ Evenings _____

MEDICAL INFORMATION

Name/address of current physician _____

_____ Phone # _____

Names/addresses of all previous physicians and hospitalizations (and dates hospitalized)

_____

_____

_____

Is applicant receiving community services? If so, please list agencies & contact person.

_____

_____

Reason placement is needed _____

Attitude towards placement: Applicant _____ Family _____

Anticipated length of stay _____

Diagnosis _____

Medications _____

What assistance does applicant require with personal care (i.e. dressing, eating, walking, etc.)?

_____

_____

Please list mental limitations or behavioral difficulties and successful management techniques.

_____

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FINANCIAL INFORMATION

Social Security # _____ Medicare # _____ Part A_____

Part B_____

Medicaid (State Assistance) # _____

Does applicant have an application pending for State Medical Assistance (Title 19)? _____

If yes, date application submitted _____ District Office _____ Caseworker_____

Other Medical/Hospital Insurance:

Name of Company	Subscriber/Group #	Type of Insurance
_____	_____	_____
_____	_____	_____
_____	_____	_____

Life Insurance. (List only policies having a cash surrender value and give approximate cash surrender value): _____

_____

Has applicant established an irrevocable burial account? _____

If so, name of funeral home and amount _____

INCOME

Social Security	$ _____/Mo.	
Pensions	$ _____/Mo.	Source _____
VA Benefits	$ _____/Mo.	
Annunities	$ _____/Mo.	Source _____
Interest	$ _____/Mo.	Source _____
Dividends	$ _____/Mo.	Source _____
Other	$ _____/Mo.	Source _____

Do you receive income from or have any interest in any trust? _____

If yes, please describe and provide a copy of the trust instrument.

_____

_____

ASSETS (If any asset is jointly held, please give name of joint owner).

Real Estate

Does applicant own any real estate? Yes _____ No _____

Description of Property	Approximate Value	Name(s) on Deed
_____	_____	_____
_____	_____	_____

Are there any liens or mortgages against the property? Yes _____ No_____

If yes, in the amount of $ _____ payable to _____

Was this real estate your home prior to entering the nursing home? Yes _____ No_____

Is your spouse now living in the home? Yes _____ No_____

Do you have a “life use” of any real estate (any ownership interest, in full or in part, for your lifetime, or the right to occupy property for your lifetime)? Yes _____ No_____

If yes, please describe _____

_____

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Cash Assets

Please list all assets including but not limited to: Savings Accounts, Checking Accounts, Stocks, Bonds, C.D.'s

Name of Institution	Account #	Present Balance

Transfer of Assets

Within sixty (60) months prior to the date of this application, have you given away assets of any kind (cash, securities, real estate, etc.) or transferred assets of any kind (cash, securities, real estate, etc.) for less than fair market value? If so, please describe fully all such gifts or transfers, including the asset transferred, names, addresses and relationship to you of the person to whom the gift or transfer was made, and the value of the gift or transfer.

Gifts or transfers within 60 months: Yes _____ No_____

Please describe _____

_____

_____

_____

Within sixty (60) months prior to the date of this application, have you created any trusts or placed funds or any other assets in a trust that already existed?

Yes _____ No_____ If yes, please describe and provide a copy of the trust instrument.

_____

_____

I hereby certify that this is a true and complete statement of the applicant's current income and assets and any gifts or transfers for less than fair market value in excess of $1,000 and any trusts created or transfers of assets to any trust that they have made within the sixty (60) months prior to the date of this application.

_____

(Applicant)

_____

(Responsible Party)

_____

(Date)