APPLICATION CHECK LIST

Please return the following items:

- ❑ Application Fee ($3,000)
- ❑ Application with Privacy Notice Acknowledgement
- ❑ Financial Survey with supporting financial documents
- ❑ Comprehensive Medical Evaluation & last 12 months medical history (completed by primary care physician)
- ❑ Applicant's Advanced Directives and/or:
- ❑ Healthcare Power of Attorney document & accompanying notice of activation (if applicable)
- ❑ Durable Financial Power of Attorney document
- ❑ If an assessment has not already been scheduled with a member of the Home's Health Resources team, a visit will need to be scheduled to complete the application process.

WHAT'S NEXT?

Once your application is reviewed by the Board of Trustees Admissions Committee you will be notified of an approval/denial. The application process is generally completed within 2 business days of the in-person assessment. You will be contacted if we have any questions or require additional information to complete your application.

The WSL admission agreement requires that the first and second month's Basic Fee, the first month's Care Service Plan Fee, and the Advance Payment be made at the time of signing. You will receive two invoices with your welcome package.

CHECK # ______________ $AMOUNT ________________ RECEIVED BY: ____ DATE:____________

(for office use only)

APPLICATION FOR SUPPORTED RESIDENTIAL CARE

Applicant's Name: ____ Date of Birth:_______________

SS#:_____-_____-__________ Medicare #:_______________________________

Current Address:____ Telephone:__________________

City:____________________________________ State:____________ Zip:_________________

Applicant's Email address:____

Primary Care Physician: ____ Phone:______________________

HCPOA (for Healthcare): ____ Phone: __________________

DPOA (For Finances): ____ Phone: __________________

____ __________________

APPLICANT OR AUTHORIZED REPRESENTATIVE SIGNATURE **DATE**

APPLICATION FOR:

Suite Type: ____

Anticipated Admission Date: ____

ACKNOWLEDGEMENT OF RECEIPT: NOTICE OF PRIVACY PRACTICES

Effective as of September 23, 2013

By signing below you acknowledge that you have received, read and understand Wentworth Senior Living's Notice of Privacy Practices ("Notice"). This Notice provides information about how we may use and disclose your Protected Health Information. If you have any questions about the Notice, please contact the WSL Privacy Officer at Wentworth Senior Living, 346 Pleasant Street, Portsmouth, NH 03801, or you may call 603-436-0169.

ACKNOWLEDGEMENT OF RECEIPT: I acknowledge receiving, reading and understanding Wentworth Senior Living's Notice of Privacy Practices.

_________________________________ _________________________

Signature of Applicant Date

OR

I,____, hereby certify that I am the Authorized Representative of the above named Applicant and warrant that I have the authority as the Applicant's (Example: POA, Guardian) _____________________________________ to sign this Acknowledgement if Receipt.

__________________________________ ___________________

Signature of Authorized Representative Date

COMPREHENSIVE MEDICAL EVALUATION

This document must be completed by a physician within 30 days prior to admission to Wentworth Senior Living. If the applicant has not been seen by a physician within the last 12 months, an appointment is required prior to admission to the Wentworth Senior Living.

Please fax with 12 months of medical records to: (603) 436-2040

Last ________________________________ First ________________________________ MI __________

DOB: ________________________ Date of last physical exam: _________________________

BP: ______________ P: _____________ R:_______________ Weight:_______________________

Pertinent Medical/Social/Behavioral History: ____

____

____

Medical Diagnoses:____

____

Medication Orders (attach additional sheet if necessary):____

____

May self-administer medications without supervision:
Yes____ No____

May keep emergency medications on person:
Yes____ No____

Dietary order: ____

May engage in physical activity/exercise programs as tolerated: Yes____ No____

Activity Limitations: ____

Allergies: ____

Communicable Diseases: Yes____ List:____ No_____

Date of last flu vaccine: _______________ Pneumovax given: Yes____ Date___________ No_____

May receive annual flu vaccine: Yes____ No____ May receive pneumovax: Yes____ No____

T.B. Test Completed: Date__________ Result___________

HCPOA Activated: Yes____ No____
(Please attach notice of activation)

Code Status order: Full Code______ DNR______

Portable DNR Available: Yes_____ No_____

Physician name: ___________________________________

Office Address: ____

Office Phone: ____________________________________ Fax: ___________________________________

PHYSICIAN MUST COMPLETE THIS SECTION **Admit to Supported Residential Care: Yes_______ No_______**

Physician's Signature: ____ **Date:** _______________

APPLICANT FINANCIAL INFORMATION FORM

As part of the process of consideration for admission to Wentworth Senior Living, we will assess your financial resources. This Financial Information Form is designed to provide us with certain basic
financial data that is integral to that assessment. Therefore, it is extremely important that you provide accurate and comprehensive information in completing this form.

APPLICANT NAME(S): ____ **DATE:** ________________

1. Do you understand and agree that Wentworth Senior Living may rely upon the accuracy of the information provided in this form as a part of the overall process of consideration for admission? .... Yes [ ] No [ ]

2. Do you understand and agree that Wentworth Senior Living may request additional information to verify or supplement the information provided in this form, and that the accuracy of such verification or supplemental information may be relied upon as a part of the overall process of consideration for admission? .... Yes [ ] No [ ]

3. Have you transferred any assets not including transfers to your revocable living trusts that remain under your control? If yes, please explain on Page 4. ...... Yes [ ] No [ ]

4. Do you have assets held in a trust? If yes, provide the following information
concerning such trust. If you have more than one trust, provide the same information for each additional trust on Page 4. .... Yes [ ] No [ ]

a. Name of trust: ____

b. Is the trust and irrevocable trust? .... Yes [ ] No [ ]

c. Are you the trustee of the trust? .... Yes [ ] No [ ]

d. Are you the beneficiary of the trust? .... Yes [ ] No [ ]

e. Are there any restrictions over your rights to make distributions of principal and/or income from the trust? .... Yes [ ] No [ ]

f. Does the trust provide for the payment of your Estate's debts? .... Yes [ ] No [ ]

g. Does the trust provide for a spendthrift clause that prevents the attachment of trust assets by your Estate's creditors? .... Yes [ ] No [ ]

h. Does the trust provide for administration under the laws of the State of New Hampshire? .... Yes [ ] No [ ]

5. Do you have long-term care insurance? If yes, provide the following information concerning such policy. If you have more than one long-term care
insurance policy, provide the same information for each additional policy on Page 4. .... Yes [ ] No [ ]

a. Name of insurance company: ______________________________

b. Does the policy cover assisted living (enhanced housing)? .... Yes [ ] No [ ]

c. What is the policy's daily rate for each type of coverage? $__________.______

d. How many months does the policy provide coverage? (if lifetime, indicate so) __________

e. How many months before coverage begins (exclusionary period)? __________

6. Did you experience any significant change in your financial position, income, other support, or expenses during the past 18 months? If yes, please explain on Page 4. .... Yes [ ] No [ ]

7. Do you anticipate any significant change in your financial position, income, other support, or expenses during the next 18 months? If yes, please explain on Page 4. .... Yes [ ] No [ ]

8. Do you anticipate making any gifts of more than $10,000 or incurring any direct or indirect obligation to provide financial assistance to another during the next 18 months? If yes, please explain on Page 4. .... Yes [ ] No [ ]

9. Please provide a summary of your current sources of income and support:

<u>Monthly</u> income from:	First Person	Second Person
Social security (net of Medicare premiums and other deductions)	$	$
Pension	$	$
Annuity (Please list the account balance in #11)	$	$
Other retirement programs	$	$
Investment interest and dividends	$	$
Other sources of income (explain on Page 4)	$	$
Other sources of support (explain on Page 4)	$	$

10. Please provide a summary of your current expenses:

<u>Monthly</u> expenses for:	First Person	Second Person
Housing *(mortgage, taxes, insurance, upkeep, etc.)* ***(Will expenses continue after moving to WSL?* Explain on Page 4)**	$	$
Variable expenses *(clothing, medical, personal expenses)*	$	$
Fixed expenses *(federal and state income taxes, etc.)*	$	$
Other expenses *(dependents, debts, etc.)* **(Explain on Page 4)**	$	$

11. Please provide a summary of your assets:
*** Indicate if the asset is owned by you individually (I), jointly with your spouse (JS), jointly with another (JO), or by your trust (T); otherwise, explain the ownership on Page 4.**

Fair market value of:	Ownership*	Current Value	1 Year Ago
Checking and savings accounts	______	$ ______	$ ______
Certificates of deposit	______	$ ______	$ ______
Annuities	______	$ ______	$ ______
Stocks, bonds, and mutual funds	______	$ ______	$ ______
Life insurance policy value	______	$ ______	$ ______
Residence	______	$ ______	$ ______
Other real estate	______	$ ______	$ ______
Business interests **(explain on Page 4)**	______	$ ______	$ ______
Other assets **(explain on Page 4)**	______	$ ______	$ ______

Please attach the most recent statements of your accounts to back up the information provided above. Wentworth Senior Living reserves the right to request your most current tax return and a statement of accounts referencing your liquid assets.

12. Do you anticipate the sale of any of your real estate on the market in the next 18 months? If yes, explain on Page 4. .... Yes [ ] No [ ]

13. Please provide a summary of your liabilities:

Outstanding balance of:	Current Balance	1 Year Ago
Mortgage(s) on residence or other real estate	$ ______	$ ______
Other loans or liabilities payable (explain on Page 4)	$ ______	$ ______
Unpaid bills, credit cards, and taxes	$ ______	$ ______

14. Are you a guarantor for the loan(s) and/or other debt(s) of another person or entity? If yes, explain on Page 4. .... Yes [ ] No [ ]

15. Did any other person(s) assist you with the completion of this Financial Information Form? **If yes, please provide the name(s) on Page 4.** .... Yes [ ] No [ ]

I, ____(print), hereby affirm that the information submitted on this Financial Information Form, and all supplemental schedules hereto, is true and correct to the best of my knowledge and belief.

____
Signature of First Applicant or
Applicant's Authorized Representative

____
Signature of Second Applicant or
Applicant's Authorized Representative

____
Date

____
Date

Supplemental Schedules (include the reference number from Pages 1 through 3):

WENTWORTH SENIOR LIVING
NOTICE OF PRIVACY PRACTICES
Effective as of September 23, 2013

This Notice Describes How Medical Information About You May Be Used And Disclosed And How You Can Get Access To This Information. Please Review It Carefully.

The privacy practices described in this notice apply to Wentworth Senior Living ("Company"). The Company is required by the federal law known as the Health Insurance Portability and Accountability Act (referred to as the HIPAA Privacy Rule) to take reasonable steps to ensure the privacy of your personally identifiable health information (*Protected Health Information*) and to inform you about:

- the Company's uses and disclosures of *Protected Health Information*;
- your privacy rights with respect to your *Protected Health Information*;
- your right to file a complaint with the Company and to the Secretary of the U.S. Department of Health and Human Services; and
- the person or office to contact for further information about the Company's privacy practices.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Except as otherwise provided in this notice or otherwise permitted under the HIPAA Privacy Rule, uses and disclosures of *Protected Health Information* will be made only with your written authorization subject to your right to revoke such authorization. If you provide the Company authorization to use or disclose PHI about you, you may revoke that permission, in writing, at any time by sending a notice of revocation to the Privacy Officer at the address provided below. If you revoke your permission, the Company will no longer use or disclose PHI about you for the reasons covered by your written authorization. The Company will not be able to reverse any disclosures made prior to your revocation.

The Company may contact you to provide appointment reminders or information about treatment
alternatives or other health-related benefits and services that may be of interest to you.

Note: Special rules may apply with respect to the use and disclosure of genetic and HIV testing information. You may contact the Privacy Officer for more information about these rules.

USES AND DISCLOSURES THAT REQUIRE YOUR WRITTEN AUTHORIZATION

Your written authorization is generally required before the Company will use or disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Company may use and disclose such notes when needed by the Company to defend against litigation filed by you.

To the extent the Company uses and discloses your Protected Health Information for certain marketing purposes, it will obtain your specific authorization to the extent required by law. Additionally, any disclosures that constitute the sale of your Protected Health Information will also require your specific authorization unless otherwise permitted or required by law.

USES AND DISCLOSURES TO CARRY OUT TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

The HIPAA Privacy Rule permits the Company and its respective Business Associates to use and disclose *Protected Health Information* without your consent, authorization, or opportunity to agree or object, to carry out Treatment, Payment and Health Care Operations.

- *Treatment* is the provision, coordination or management of health care and related services. For example, the Company may disclose your Protected Health Information to your primary care provider to assist in the coordination of your care.

- *Payment* includes but is not limited to actions to make coverage determinations and payment (including Medicare/insurance eligibility and coverage, and billing). For example, the Company may submit its charges for payment to your insurance carrier or Medicare for payment.

- *Health Care Operations* include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, and working with vendors to coordinate your care. For example, the Company may share your medical records with peer review committees to assess and improve the level of care you are receiving.

USES AND DISCLOSURES THAT REQUIRE THAT YOU BE GIVEN AN OPPORTUNITY TO AGREE OR DISAGREE PRIOR TO THE USE OR RELEASE

Disclosure of your *Protected Health Information* to family members, other relatives and your close personal friends is allowed if:

- the information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

OTHER USES AND DISCLOSURES FOR WHICH CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT IS NOT REQUIRED

Use and disclosure of your *Protected Health Information* is allowed without your consent, authorization or request under the following circumstances:

- When required by law.
- When permitted for purposes of public health activities, including if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
- When authorized by law to report information about certain abuse, neglect or domestic violence to public authorities.
- For public health oversight activities authorized by law.
- For certain judicial or administrative proceedings.
- For certain law enforcement purposes

- To a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law; and funeral directors, consistent with applicable law.
- The Company may use or disclose *Protected Health Information* for research, subject to conditions.
- For the purpose of facilitating organ, eye or tissue donation or transplantation.
- When consistent with applicable law to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- To the extent necessary to comply with workers' compensation or other similar programs established by law.

REQUIRED USES AND DISCLOSURES

Upon your request, the Company is required to give you access to certain *Protected Health Information* in order to inspect and copy it. Under certain circumstances, however, the Company may deny your request.

Use and disclosure of your *Protected Health Information* may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Company's compliance with the privacy regulations.

RIGHTS OF INDIVIDUALS

In the event any of the following provisions require you to submit a written request to exercise such right, you must submit such request to the Privacy Officer, **Wentworth Senior Living, 346 Pleasant Street, Portsmouth, NH 03801.**

RIGHT TO REQUEST RESTRICTIONS AND CONFIDENTIAL COMMUNICATIONS OF PROTECTED HEALTH INFORMATION

You may request that the Company restrict uses and disclosures of your *Protected Health Information* to carry out Treatment, Payment or Health Care Operations, or to restrict uses and disclosures to persons identified by you who are involved in your care or payment for your care. The Company is not required to agree to your request, however, unless otherwise required by law, the Company must permit a request for a restriction on disclosures to another health plan for purposes of payment or health care operations where the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.

The Company will accommodate reasonable requests to receive communications of *Protected Health Information* by alternative means or at alternative locations.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your *Protected Health Information* or to request confidential communications of *Protected Health Information*.

RIGHT TO INSPECT AND COPY PROTECTED HEALTH INFORMATION

You have a right to request to inspect and obtain a copy of your *Protected Health Information* contained in a "Designated Record Set," for as long as the Company maintains the *Protected Health Information*.

- "Designated Record Set" includes enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan, or other information used in whole or in part by or for the

Covered Entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the Designated Record Set.

The requested information will be provided within 30 days. A single 30-day extension is allowed if the Company or its Business Associates are unable to comply with the deadline. The Company will charge a reasonable, cost-based fee to cover the cost of providing copies.

You or your personal representative will be required to complete a form to request access to the *Protected Health Information* in your Designated Record Set. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your rights to review this denial and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

RIGHT TO AMEND PROTECTED HEALTH INFORMATION

You have the right to request the Company amend your *Protected Health Information* or a record about you in a Designated Record Set for as long as the *Protected Health Information* is maintained in the Designated Record Set.

The Company has 60 days after the request is made to act on the request. A single 30-day extension is allowed. If the request is denied in whole or part, the Company must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your *Protected Health Information.*

You or your personal representative will be required to complete a form to request amendment of the *Protected Health Information* in your Designated Record Set. Any request for an amendment must be in writing and provide a reason to support a requested amendment.

RIGHT TO RECEIVE AN ACCOUNTING OF PROTECTED HEALTH INFORMATION DISCLOSURES

Upon your written request, the Company will also provide you with an accounting of disclosures by the Company of your *Protected Health Information* during the six years prior to the date of your request. However, such accounting need not include *Protected Health Information* disclosures made: (1) to carry out Treatment, Payment or Health Care Operations except in the case of certain medical reasons; (2) to individuals about their own *Protected Health Information*; (3) prior to the compliance date; or (4) based on your written authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Company will charge a reasonable, cost-based fee for each subsequent accounting.

RIGHT TO NOTIFICATION OF BREACH OF UNSECURED PROTECTED HEALTH INFORMATION

In the event that a breach occurs with regard to your Protected Health Information, you have the right to be notified of the breach.

RIGHT TO PAPER COPY OF ELECTRONIC NOTICE OF PRIVACY PRACTICES

If you received this notice in electronic format, upon your written request, the Company will provide you with a paper copy at no cost.

A NOTE ABOUT PERSONAL REPRESENTATIVES

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your *Protected Health Information* or allowed to take any action for you.

The Company retains discretion to deny access to your *Protected Health Information* to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

THE COMPANY'S DUTIES

The Company is required by law to maintain the privacy of *Protected Health Information* and to provide patients with notice of its legal duties and privacy practices. This notice is effective beginning **September 23, 2013** and the Company is required to comply with the terms of this notice. However, the Company reserves the right to change its privacy practices and to apply the changes to any *Protected Health Information* received or maintained by the Company prior to that date.

If a privacy practice is changed, a revised version of this notice will be either mailed to you or posted on our website. In the event the revised notice is mailed to you, it shall be provided by first class mail to your last known address. Any revised version of this notice will be distributed/published within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Company or other privacy practices stated in this notice.

MINIMUM NECESSARY STANDARD

When using or disclosing *Protected Health Information* or when requesting *Protected Health Information* from another Covered Entity, the Company will make reasonable efforts not to use, disclose or request more than the minimum amount of *Protected Health Information* necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual or pursuant to your authorization;
- disclosures for compliance made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law; and
- uses or disclosures that are required for the Company's compliance with legal regulations.

YOUR RIGHT TO FILE A COMPLAINT WITH THE COMPANY OR THE HHS SECRETARY

If you believe that your privacy rights have been violated, you may complain to the Company in care of the following officer: Privacy Officer, **Wentworth Senior Living, 346 Pleasant Street, Portsmouth, NH 03801**, or you may call 603-436-0169.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201.

The Company will not retaliate against you for filing a complaint.

ADDITIONAL INFORMATION

If you have any questions regarding this notice or the subjects addressed in it, you may contact the following officer: Privacy Officer, Wentworth Senior Living**, 346 Pleasant Street, Portsmouth, NH 03801**, or you may call 603-436-0169.

The HIPAA Privacy Rule is set out at 45 Code of Federal Regulations Parts 160 and 164. These regulations and additional information about the HIPAA Privacy Rule are available at http://www.hhs.gov/ocr/hipaa/.