Mail this application to:

The name of the waitlist I'm applying for is: _____

Some waitlists are closed: Before sending this application, check http://www.housingworks.net/ to see what is open

You must answer every question on this application: respond to questions that are not applicable by writing "N/A".
Incomplete applications may be returned or discarded.

Name of HoH: _____

Long-Term Mailing Address _____

City/State/Zip: _____
(this address should ideally work for the next 3-5 years):

Phone(s): _____ _____ _____ -

Email: _____

The **SSN** for the head of household is: _____

Does the HoH have a **Social Security Number** (SSN)? ☐ Yes ☐ No *If "Yes" you must provide it above).*

What is your **date of birth**? _____ What is your **gender**? _____

Race (white, black, asian, etc)? _____

What was your **mother's last name** when she was born? *Protects your privacy)*_____

How many people will be living in the unit? _____ people. What **unit size** are you seeking?_____BR

Describe your **Income Sources** (Job, Food Stamps, SSI, TAFDC, etc.) _____

What is your family's **ANNUAL** income? $_____ (do NOT write *an hourly, weekly, or monthly amount!)*

☐ YES ☐ NO Do you have a **rental voucher** or **some other form of regular rental assistance**?

Specify: ☐ Section 8 ☐ MRVP ☐ AHVP ☐ Homebase ☐ _____

☐ YES ☐ NO Do you need a **wheelchair accessible unit** (or a "no-steps" unit)?

☐ YES ☐ NO Do you need **reasonable accommodations** due to a disability, either during the application period or tenancy? _____

☐ YES ☐ NO Are you or any member of your household subject to a lifetime registration requirement under a **State Sex Offender Registration** program?

☐ YES ☐ NO **Priority/Preference Status:** If there is a section in this application that asks about priorities and preferences, did you claim any?

Office Only: Date/Time Stamp

THE DANA HOME
2027 Massachusetts Avenue
Lexington, MA 02421
781-861-0131

ADMISSIONS APPLICATION

Date: _____

Social Security No.: _____

A. Introductory information

1. Name: _____

2. Present Address: _____

How long at this address? _____

3. Telephone Number: ( ) _____

4. Previous Address: _____

5. Date of Birth: _____

6. Birthplace: _____

7. U.S. Citizen? YES ____ NO ____ Certificate Number: _____

8. Maiden Name: _____

9. Father's Full Name: _____

10. Mother's Full Name: _____

11. Current Marital Status:

Single_____Married_____Widowed_____Divorced_____Separated_____

12. Number of Children:

Name	Address	Home Phone	Work Phone

13. Other Relatives or Interested Friends:

Name	Address	Home Phone	Work Phone

B. Background Information

1. Education:

a. High School: _____

b. Other: _____

2. Occupations: _____

_____

_____

_____

When last employed? _____

3. Membership in Organizations: _____

_____

_____

_____

4. Recreational Intercsts and Hobbies: _____

_____

_____

_____

_____

5. Religious Affiliation: _____

Contact Person: _____

6. Cemetery: _____

Deed held by: _____

Burial Insurance: _____

Funeral Director: _____

C. Medical Information:

1. Name of your primary physician: _____

Address: _____

Phone: _____

2. Date of last treatment or examination: _____

3. List hospitalizalion(s) within the last ten years: _____

_____

_____

_____

4. Are you currently taking any medication? Yes _____No_____

   If yes. list name(s) of medications: _____

   _____

   _____

5. Do you know of any condition (injury, disease, impairment) affecting your physical or mental health which is not referred to on the accompanying report by your physician? Yes No If yes, please describe: _____
   _____

(PLEASE NOTE: *Any known physical or* *mental* *condition not disclosed prior to admission way be grounds for termination of residency.)*

6. Please describe any special dietary needs: _____
   _____

7. Please check those activities with which you now need some assistance:

   _____ Taking medication on a scheduled basis
   _____ Using a tclephone
   _____ Climbing stairs
   _____ Walking
   _____ Getting out of bed
   _____ Bathing or showering
   _____ Preparing meals on a daily basis
   _____ Dressing
   _____ Getting in and out of a car
   _____ Bladder or bowel control
   _____ Personal and/or grocery shopping
   _____ Laundry

8. Have you made provision for:

Do Not Resuscitate(DNR)/Comfort Care Directives	Yes ____	No ____
Health Care Proxy	Yes ____	No ____
Power of Attorney	Yes ____	No____

9. Have you ever been a resident of another retirement or nursing home?

Facility Name Dates

_____

_____

D. Hospital and Medical Benefit Coverage

1. Do you have any coverage for hospital and medical expenses? Yes ____ No ____

Medicare No.: _____

MedEx No.: _____

Other Medical Coverage: _____

Prescription Plan: _____

E. Declaration of Finances

You are asked to complete the following financial section of the application. Should you at any time have questions or concerns, please contact tile Administrator. This statement must be *updated at the time of admission and periodically thereaftem; when requested to do so.*

The home respects the privacy of every applicant and does not wish to intrude into any applicant's personal financial circumstances other than to determine i/ia! the fina,icial requirements for the applicant's personal and medical iieeds can he adequaie/v met.

Disclosure is not required of the applicant's total estate, but rather only of sufficient assets to cover monthly charges, and personal needs and obligations. ***A SIGNED STATEMENT OF FINANCIAL RESOURCES FROM A TRUST OFFICER OR OTHER FINANCIAL ADVISOR SETTING FORTH SUBSTANTIALLY IDENTICAL INFORMATION TO THAT REQUESTED BELOW MAY BE SUBMITTED IN LIEU OF COMPLETION OF SECTION E OF THIS FORM.*** *All financial information will remain confidential.*

The following advisors and their firms (give names and addresses) may be consulted regarding my application for admission:

Bank: _____
Address:_____
Telephone: _____

Investment Advisor: _____
Address:_____
Telephone: _____

Attorney: _____
Address:_____
Telephone: _____

Trustee: _____
Address:_____
Telephone: _____

Individual responsible for paying bill (with resident funds)

Name: _____ Driver'sLicense No._____

Relation to Applicant: _____

Home Address: _____

_____

Home Phone: _____ Work Phone: _____

Fax: _____ Email: _____

I. Assets

(a) Real **Property:**

Real estate location	Net Value (current value minus mortgage balance)	Held jointly?
_____	_____	_____
_____	_____	_____
_____	_____	_____

a: Total Real Estate Value: _____

(b) Bank Accounts:

Name of Financial Institution	Account Type	Current Balance	Estimated Annual Income
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(c) **Investment Accounts:**

Location	Type (mutual fund, stock)	Current Balance	Estimated Annual Income
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(d) life **Insurance:**

Does the applicant have life insurance policies with cash value? Yes _____ No _____

a. Approximate cash value $_____

b.Annuities $_____

c. Company Name _____

(e) **Long Term Care Insurance:**

Does the applicant have long term care insurance? Yes _____ No _____

(if No please proceed to section 2)

a. Approximate cash value $_____

b. Length of benelit _____

c. Company Name _____

2. Resources

(a) Monthly Income		**(b) Assets**	
Social Security	$ _____	Savings	$ _____
Pensions	S _____	Bonds	$ _____
Annuities	$ _____	Stocks/Investments	S _____
Interest & Dividends	$ _____	Annuities	$ _____
Other	$ _____	Real Estate	$ _____
(indicate source) _____		Mortgage Balance	$ _____
Other	$ _____	Long Term Care Ins.	$ _____
(indicate source)_____ _____		Life Insurance indicate full amount, i.e., amount available to others upon your death	$ _____
Total Monthly Income*	$ _____	**Total Assets**	$ _____

(*) We request income tax returns fir the three most recent years.

(c) Are any of the above assets held jointly? No ____Yes ____ If Yes, please explain: _____

_____

_____

(d) Are all of the above assets intended for the care of the applicant? No ____Yes ____

If No, please explain _____

_____

(e) Are there any obligations against, or restrictions on, any of these assets? No ____Yes ____

If Yes, please explain: _____

_____

(f) Are any of these assets held in trust? No ____Yes ____ If Yes, please explain:_____

_____

_____

a. Trust Officer's Name and Address: _____

_____

_____

(g) Have you made any substantial gifts or transfers to any person(s) or organizations in any of the previous three (3) years? No ____Yes ____ (if No please proceed to section 3)

a. Please describe the nature of the contribution(s) mentioned above _____

_____

_____

3. Annual Expenses

Health/Medical Insurance $ _____

Prescriptions $ _____

Federal & State Taxes $ _____

Estimated Personal Expenses $ _____

(i.e. clothing, gifts, subscriptions, memberships, personal grooming, credit cards. etc.)

Automobile Expenses $ _____

(i.e. maintenance, insurance, registration. etc.)

Other $ _____

Total Annual Expenses $ _____

Is it your belief that your income and assets (remaining after payment of Entry Fee) will be adequate to meet your Monthly Fee to the Home and your other living expenses during your residence at the Home'? Yes ____No ____If No, please explain: _____

_____

_____

_____

_____

These statements are true to the best of my/our knowledge and belief. I/We agree that we will not make substantial gifts or transfer assets or surplus income such that my/our remaining assets will become insufficient to meet my/our financial obligation to the Home.

Signature: _____ Date: _____

(Applicant)

Signature: _____ Date: _____

(Person listed in Section E of Declaration of Finance)

Word: paula/stephie/dana home/resident forms admissions application

The Dana Home of Lexington

Pre-Admission Medical Requirements

Please Note:

Prior to admission to The Dana Home, each potential resident is required to:

1. Obtain a copy of Chest XRay results (current within one year)
2. Obtain copy of Pneumonia shot record.
3. Have the resident's physician complete the medical pre-admission form.
4. Submit all items to Dana Home. (Chest XRay results, shot record, completed medical pre-admission form)

Upon receipt of these items, the Nurse Practitioner will then arrange for a pre-admission assessment visit.

THE DANA HOME
2027 Massachusetts Avenue
Lexington, MA 02421
781-861-0131

Revised 2-1-05

MEDICAL PRE-ADMISSION FORM

Name: _____ Date of Birth: _____

Current Address: _____

Date of Most Recent Physical Exam: _____

Current Primary Diagnosis: _____

Current Secondary Diagnosis: _____

_____

MEDICAL HISTORY

Height:_____ Weight: _____ B.P.:_____ T: _____ P: _____ R: _____

Diet: _____ Restrictions: _____

Allergies:Food: _____ Medications: _____ Other: _____

If yes, please explain further: _____

_____

MEDICATIONS

Prescription	Non-Prescription

PAST AND CURRENT MEDICAL HISTORY

Check all diseases that have a relationship to current ADL status, cognitive status, behavior status, medical treatments or risk *of* death. If any are current/active, please elaborate

•

HEART CIRCULATION

Arteriosclerotic heart disease ____
Cardiac dysrhythrnias ____
Congestive heart failure ____
Hypertension ____
Hypotension ____
Peripheral vascular disease ____
Other cardiovascular disease ____

NEUROLOGICAL

Alzheimer's ____
Dementia other than Alzheimer's ____
Aphasia ____
Cerebrovascular ____
Multiple sclerosis ____
Parkinson's disease ____

OTHER

Allergies _____
Anemia _____
Arthritis _____
Cancer _____
Osteoporosis _____
Seizure disorder
Urinary Tract Infections _____

PULMONARY

Emphysema/Asthma/COPD ____
Pneumonia ____

SENSORY

Cataracts ____
Glaucoma ____

PSYCHIATRIC

Anxiety disorder ____
Depression ____
Manic depressive

INJURIES: _____

_____

_____

HOSPITALIZATIONS:

DATE	DESCRIPTION
_____	_____
_____	_____
_____	_____

OPERATIONS: _____

_____

ILLNESSES REQUIRING ATTENTION OF A PHYSICIAN IN THE PAST YEAR:

_____

DIET: *(restrictions & allergies)*

_____

SPECIFIC TREATMENTS AND FREQUENCY:

_____

SPECIAL EQUIPMENT OR THERAPY *(PT, OT, Speech-please indicate if patient is receiving and should continue)*

_____

HAS THE PATIENT EVER BEEN TREATED FOR A NERVOUS OR MENTAL DISORDER? If yes, where and when did treatment take place?

_____

ORIENTED TO TIME, PLACE, PERSON? _____ If No, please explain.

_____

LEVEL OF ORIENTATION AND MANAGEMENT: _____

_____

PLEASE CHECK ANY OF THE FOLLOWING WHICH OFFER ANY PROBLEMS OR APPLY TO PATIENT:

1.	Skin	_____	6.	Tuberculosis	_____
2.	Mouth	_____	7.	Artificial Limb	_____
	Dentures	_____	8.	Joint abnormality	_____
	Full	_____	9.	Speech Defect	_____
	Partial	_____	10.	Gait abnormality	_____
	Fit well	_____	11.	Vertigo	_____
3.	Vision	_____	12.	Physical weakness	_____
	Glasses	_____	13.	Periods of depression	_____
	Blind	_____	14.	Diabetes	_____
	Other	_____		Seizures	_____
4.	Hearing	_____		Controlled	_____
	Deaf	_____		Diet	_____
	Partially Deaf	_____		Medicine	_____
	Hearing Aid	_____		Both	_____
5.	Nutritional Deficit	_____			

If any of these are checked, please explain further, referring, to it by number.

_____

_____

Pneumococcal vaccine? No ____ Yes ____ Date: _____

Chest X-Ray (fixed, not portable) Date: _____ Results: _____

Mantoux test (initial skin test) Date: _____ negative ____mm positive ____ mm

Mantoux test(second skin test) Date: _____ negative ____mm positive ____ mm

Have you discussed Advanced Directives or DNR with patient? Yes ____ No ___

What is the outcome of this discussion?

_____

_____

Is the patient, in your opinion, able to perform activities of daily living with minimum assistance? Yes ____ No ___If there is a deficit, please explain: _____

_____

_____

PHYSICIAN: _____

ADDRESS: _____

PHONE: _____ FAX: _____

SIGNATURE: _____ DATE: _____

Physician Responsible for Resident, if other than above:

PHYSICIAN: _____

ADDRESS: _____

PHONE: _____ FAX: _____

THE DANA HOME
2027 Massachusetts Avenue
Lexington, MA 02421
781-861-0131

The Home is a Level IV rest home.

Level IV: a facility that provides or arranges to provide in addition to the minimum basic care and services, a supervised supportive and protective living environment and support services incident to old age for residents having difficulty in caring for themselves and who do not require medically related services on a routine basis. This facility's services and programs seek to foster personal well-being, independence, an optimal level of psychosocial functioning, and integration of residents into community living.

Is the patient, in your opinion, able to function safely at the Home? Yes ____ No____

If No, please explain: _____

_____

_____

PHYSICIAN: _____
ADDRESS: _____
PHONE: _____ FAX: _____
SIGNATURE: _____ DATE: _____

Physician Responsible for Resident, if other than above:

PHYSICIAN: _____
ADDRESS: _____
PHONE: _____ FAX: _____

THE DANA ROME
2027 Massachusetts Avenue
Lexington, MA 02421

RESIDENCY AGREEMENT
RESIDENTIAL CARE FACILITY

This Agreement is entered into this _____ day of____200_. between the **DANA HOME**, a Massachusetts non-profit organization (hereinafter referred to as the "Home") and _____ (hereinafter referred to as "Resident").

The Home operates and maintains a licensed residential care facility for men and women at _____ The Resident has applied for admission to the Home and the Home has approved the Resident's application.

Therefore, the Home and Resident agree as follows:

SECTION 1. ACCOMMODATION SERVICES AND FACILITIES

Upon the Resident's occupancy of the accommodations described below, the Home will provide services and facilities on the following terms:

A. Accommodations. The Resident has selected room number _____. The Resident may continue to reside in the selected room as long as he or she meets the criteria for the level of care and services permitted under the licensure for that room as determined by the Home's Medical Director, or may be relocated to another room by the Home. Any such relocation will take place only after discussion with the Resident (and/or Resident's Family or Sponsor) and after giving due consideration to the preferences, physical and social needs and available resources of the Resident.

The Home will supply window treatments as well as bedspread, linens and floor covering for each room. Resident may elect to provide any of the foregoing furnishings provided such furnishings are of the approved size and type. The Resident will, if possible, supply all other furnishings. Upon request, the Home will also provide (strike those that are not applicable):

- Chest of drawers
- Bedside table or cabinet
- Reading Lamp
- Chair

B. Meals. The Home will provide three (3) meals a day for all Residents at prescribed times. The Home will ensure that meals are balanced and nourishing. Tray service in the Resident's room (for meals other than breakfast) will be provided only when the Resident is confined to the room **for** health reasons. *Extended tray service (for **meals other** than breakfast) beyond **one week will result in** additional charges. **See** Appendix A for a **schedule of fees.*** The Home will endeavor to meet the requirements of special diets requested by the Resident's consulting physician or if none, by the Home's Medical Director, upon written order by either, and reserves the right to charge additional fees for specialized diets.

C. Housekeeping. The Home will provide routine cleaning and maintenance in each room weekly. Resident will be responsible for maintaining his/her room in neat condition. *Daily **bed making or cleaning, when Resident is unable or** unwilling **to** perform **these tasks, will result in additional charges.***

D. Medical Services. The Home is licensed and has facilities to provide limited health care, to include: administration of prescribed drugs; routine check-ups and other visits by the Home's Medical Director as necessary and as required by state regulations; arranging for hospital care; assisting in preparation and filing of claims for Medicare, and for other insurance or reimbursement plans; and emergency care including summoning of physicians, rescue service, police, ambulance or other emergency transportation to the nearest medical facility.

The Resident shall be responsible for the expenses associated with hospitalization, routine and special dental care, eyeglasses, hearing aids, laboratory services, prescription and nonprescription drugs, incontinence products and all medical or mental health services and/or equipment not covered or reimbursed by insurance.

E. Supportive Services. Under its license as a residential care facility, the Home may provide supportive services at an additional charge for residents who require assistance to remain as independent as possible in their rooms. Supportive services include help with dressing, personal grooming, toileting, and ambulating. A schedule of supportive services and fees may be found in Appendix A to this Agreement.

F. Special Services. Residents may, subject to prior approval by the Home, arrange for special therapy equipment and treatment as prescribed by the Resident's primary care physician. Each case shall be determined on its own merits. The Home's approval or disapproval shall be based, in each case, on whether or not the facilities and the personnel of the Home are adequate to accommodate such special services without detrimental effect on the Home or on other residents. Requests for special services shall be reviewed and determined by the Medical Director and Executive Director. The Resident will be responsible for all expenses for special services to the extent not covered by Medicare and/or other insurance.

G. Funeral. The Home is not responsible for Resident's funeral services or burial. Resident is encouraged to make suitable arrangements for same, preferably on a pre-paid basis.

H. Activities. The Home provides recreational programs and other entertainment for the benefit of all Residents. Each Resident is invited to indicate his or her preferences and to request programs. The Home will endeavor to meet such requests whenever feasible.

I. **Transportation**. The Dana Home does not provide transportation for medical, health or personal reasons. The Dana Home will assist residents and families in identify transportation options.

SECTION 2. RESIDENT'S RIGHTS

A. Each resident shall be entitled to all of the rights and privileges contained in the Home's *Retirement Facility Resident Rights* as amended from time to time, a copy of which, in present form, is presented to the Resident upon admission.

The Resident shall be further entitled to all rights accorded residents of long term care facilities contained in the regulations of the Office of the Massachusetts Attorney General, 940 CMR 4:00 Resident, or his/her Responsible Party, shall sign Appendix B to this Agreement, "Resident Acknowledgement and Consent", concerning policies, notifications, and disclosures either by law or by the Board of Directors of the Home.

A. The Resident may choose his/her own physician for medical services or designate the Home's Medical Director as his/her physician while residing in the Home. Ini either case, medical services provided by a physician shall be at the Resident's expense. Resident agrees to accept treatment by the Home's Medical Director in the event of failure by Resident's designated physician to respond in a timely manner to the Home nursing stafFs request for information or consultation.

B.The Resident agrees to provide prompt notice to the Executive Director of the nature and extent of any treatment, including prescribed medications, provided to the Resident by a physician other than the Medical Director. The record of such consultation and/or treatment must become part of the Resident's medical record.

C. Each Resident shall have the right to present written complaints or requests directly to the Home's Board of Directors. However, the.complain or request must first be presented in writing to the Executive Director with sufficient time for the Executive Director to respond and seek to resolve the issue to the satisfaction of the Resident.

SECTION 3. FINANCIAL TERMS

A. Upon execution of this Agreement by Resident and the Home, there shall be paid to the Home by the Resident an Administrative Fee of $500.00 (Five Hundred Dollars) which shall óover in part the cost of the Home for room preparation, admission and orientation.

B. The basic monthly charge for Room _____ is $_____ which is due and payable on the first day of each month of residency. The basic charge includes accommodations, meals, weekly laundry and housekeeping services, activities, and medication administration.

C. If Resident requires any of the additional services described in Section 1 E above, Resident shall pay the fee associated with these services together with the basic monthly charge on the first day of each month of residency.

D. The monthly fee will be charged as long as the personal effects of the Resident remain in the room.

E. The Home reserves the right to adjust its fees at any time upon giving Resident sixty (60) days notice in advance of the effective date of new fees.

SECTION 4. RESIDENTS DUTIES AND OBLIGATIONS

A. It is the obligation of each Resident of the Home to observe and perform all of the terms, rules, procedures and duties contained in the Home's Resident's Manual and this Agreement. A copy of the "Resident's Manual", in current form, is furnished to each Resident upon entry to the Home.

B. The Resident agrees to reimburse the Home to the extent that the Home may pay or be called upon to pay others for damage to or loss of property or injury caused by the Resident's improper act or neglect.

C. The Resident agrees to maintain health insurance as specified by the Home at time of entry and to apply for medical insurance, medical reimbursement or medical subsidy, including Supplemental Security Income (SSI), Emergency Assistance to Elderly, Disabled and Children (EAEDC), Medicaid or equivalent, if eligible and requested by the Home.

D. The Resident agrees not to make any gifts or transfers of Resident's assets or Resident's income if such gifts or transfers would materially reduce Resident's ability to pay Resident's current or future living or health care expenses and/or Resident's current or future financial obligations to the Home. Resident agrees to notify the Home's Executive Director of any material change in Resident's ability to meet his/her financial obligations to the Home.

E. Resident agrees to provide the Home's Executive Director with copies of any and all Resident's Advance Directives, Health Care Proxies, Powers of Attorney and the like and to promptly notify the Executive Director of all changes to such documents.

SECTION 5. TRANSFERS.

The Home may arrange for the transfer of the Resident to a hospital, nursing home or other health care ficility upon determination by the Home's Medical Director or by the Resident's primary care physician that the Home cannot provide proper care for the Resident. The cast of such care elsewhere shall be borne solely by the Resident. The Home agrees to hold the Resident's room for up to three (3) months, provided that the Resident continues to timely pay the applicable Monthly Fee. If the Resident has not, in the opinion of the Home's Medical Director, recovered or improved sufficiently by the end of three (3) months so that the Home's staff and facilities are adequate to provide proper care, the Home shall be under no further obligation to bold the Resident's room. This Agreement shall be terminated upon written notice to the Resident that the Home is no longer holding Resident's room.

The Resident may, at any time following such transfer, notify the Home of his/her release of his/her former accommodation at which time his/her Monthly Fee obligation shall end. In the event, following transfer, that the Home ceases to hold the Resident's room as above provided, or in the event that following transfer the Resident releases the room, the Resident's request thereafter to return shall be accompanied by and treated as an initial application for entry. In such event, however, the Resident shall, if his/her application is approved, be excused from paying the Administrative Fee.

SECTION 6. TERMINATION

A. The Resident may terminate his/her residency by notice to the Home which shall become effective thirty (30) days thereafter. The act of departure without such notice shall be deemed to constitute such notice, which shall become effective thirty (30) days thereafter.

B. The Home may terminate residency for any of the following reasons:

(a) the Resident does not uphold the terms of this agreement;
(b) the Resident does not observe the rules and provisions of the Home contained in the Resident's Manual, as such is amended by the Home from time to time;
(c) the Resident fails to cooperate with the Executive Director and the Home's staff in thcir efforts to carry out the objectives and purposes of the Home or Resident fails to respect the rights and privileges of other Residents; or,
(d) the Resident has transferred to another facility and has not recovered or improved sufficiently to return to the Home within ninety (90) days.

Termination by the Home shall be by action of the Executive Director and shall be effective 30 days following the notice in writing to the Resident. The Executive Director shall, when possible, inform the Resident in advance that the Executive Director is considering terminating his/her residency in order that the Resident will have the opportunity to meet his/her obligations or otherwise satisfy the Home's concerns.

SECTION 7. RESIDENT SUBSIDY

Notwithstanding Paragraph B of Section 6, it is the policy of the Home that residency shall not be automatically terminated by reason of Resident's inability to pay Resident's Monthly Fees if the Resident would otherwise be able and entitled to continue to live and receive proper care at the Home. In such event, the Resident may make application to the Board of Directors of the Home for a reduction in the fee in accordance with the policies and procedures of the Home. Any decision to reduce the Resident's Monthly Fee shall be solely at the discretion of the Board of Directors of the Home. The Resident agrees to provide complete and accurate financial information to the Home as part of the Resident's application for a reduced fee. The Home shall determine that the Resident's inability to pay the Monthly Fee has not resulted from disposition, gift or transfer of his/her funds contrary to the terms of this Agreement.

Resident further agrees to apply for Social Security, Supplemental Social Security Income, Medicare, Medicaid or other benefit programs upon request of the Home and to turn over to the Home upon receipt of any and all such payments to the extent of his/her Monthly Fee obligation, less any portions withheld by statute or regulation for the personal use of the Resident.

Notwithstanding the above provisions, the Home hereby informs Resident that the Home presently does not accept public reimbursement and that Resident may be transferred or discharged from the Home if Resident ceases to be a private resident.

If by reason of this Paragraph the Home shall, during the Resident's stay at the Home, receive less in Monthly Fees and other charges than the Home would otherwise have been entitled to receive, Resident agrees that the Home shall have a claim to the extent of such deficiency against any assets that he/she may later acquire or which may come into his/her estate at or following his/her death or which others may receive by reason of his/her death. The Home shall have no claim regarding any deficiency in payment which may result from the Home's acceptance of public reimbursement in lieu of Resident's own payment of Monthly Fees or other charges.

SECTION 8. CARE OF RESIDENT'S PROPERTY

In the event of the Resident's death, the Home may remove from Resident's room and store all property belonging to the Resident. The Home shall exercise reasonable care in safekeeping the Resident's property for up to ninety (90) days until delivery of such can be made to those legally entitled to the same. The Home shall have no responsibility to store or care for such Resident property after 90 days and may dispose of any such property after such time as it sees fit.

SECTION 9. MISCELLANEOUS PROVISIONS

A. In the case of injury to the Resident caused by the act or neglect of another, if the Home shall as a result incur additional expense, the Resident's claim shall be subrogated to that of the Home and the Resident hereby assigns to the Home all associated rights of recovery, and the Home may enforce such rights and claims by bringing an action or actions in its name or in the name of the Resident.

B. The Resident shall designate a person to be his/her Power of Attorney and shall complete a Health Care Proxy. A copy of these documents shall be maintained on file by the Home.

C. The Resident shall designate in writing a person, who may or may not be the Sponsor, to be the Resident's guardian or conservator should the need arise. Such designation shall be maintained on file by the Home until the Home, after consultation with the Home's Medical Director, determines that the guardian or conservator is needed.

D. Some of the rooms offered by the Home may be designated for occupancy by a single sex and the Home's decision with respect to acceptance of application and its administration of its residency program are both governed accordingly. Otherwise, the Home maintains a policy of non-discrimination *with* respect to race, color, gender, sexual orientation, nation of origin, religious belief, and with respect to any other basis prohibited by law.

E. If is understood that the Resident's acceptanco into the Home may be supported by a Responsible Party nominated by Resident under a sponsorship undertaking separate from this Agreement.

SECTION 10. SPECIAL INDIVIDUAL PROVISIONS.

Any additional provisions not previously included in this Agreement that are mutually acceptable to the Resident and the Home may be entered here. If none, enter "none".

_____

_____

_____

Initialed: _____

_____

I hereby state that I have read, do understand and agree to be bound by the terms of the above Resident Agreement.

Entered into this _____ day of_____2_____

Resident: _____
The Home

By: _____

Title: _____

Dana Home of Lexington

Fee Schedule

Tier I Basic Monthly Fee

$2500 — 2900	Single Rooms
$3700	Suite

Tier II Supportive Services

$450/month (Up to 1 hour/day of service)

Other

$10 a day for Extended Tray Service *

- See Residency Agreement, Section lB

Updated January 2006

THE DANA HOME
2027 Massachusetts Avenue
Lexington, MA 02421

APPENDIX B
RESIDENT ACICNOWLEDGEMENT AND CONSENT

This is to certify that I have received the following policies, notifications and disclosures:

1. 940 CMR 4.00 Regulations concerning Long Term Care Facilities promulgated by the Attorney General of the Commonwealth of Massachusetts

2. Retirement Facility Resident Rights

3. Schedule of Services and Fees

4. Resident Manual

5. Miscellaneous policies:
   - Cardiopulmonary Resuscitation/Do Not Resuscitate Policy
   - Transportation Policy

6. List of names, addresses and telephone numbers of:

   - Department of Public Health, Division of Health Care Quality
   - Division of Medical Assistance
   - State Long Term Care Ombudsman
   - Attorney General, Medicaid Fraud Unit and Consumer Protection Division
   - Local legal services office

_____
Name of Resident or Responsible Party

_____

Signature of Resident or Responsible Party

Date: _____ Date of Receipt _____

TIIE DANA HOME
2027 Massachusetts Avenue
Lexington, MA 02421

APPENDIX C

INDEMNIFICATION AND RELEASE OF RESPONSIBILITY

I, _____, release the Home, its management and its personnel, of any responsibility for any deterioration in my physical or mental health condition.

I also release and indemnify the Home from liability resulting from any accident that may occur while 1 am away from the Home on field trips, doctor visits, shopping or otherwise outside the confines of the Home property.

I also release the Home from any responsibility for my loss of any personal property, e.g., eyeglasses, hearing aids, dentures, clothing, jewelry or money.

This release will remain in effect from this date until the termination of my residency at the Home.

Date: _____ _____
Resident

_____
Witness

Housing History, Page 1

Note: **you can often locate landlord information by using the Tax Assessor's website in each town (or by calling the Tax Assessor's phone number in most towns**: To determine if there is an online Tax Assessor page for a town search the web like this: "Tax Assessor, Boston MA" or "Property Assessment, Dallas TX".

CURRENT RESIDENCE **DATES YOU LIVED THERE:**

Name on the lease _____ _____to:_____ or present

Address you lived at: _____
Street and Apt# City State Zip

Landlord's Name and Address _____

Landlord Tel: _____

Did this landlord bring any court action against the leaseholder or you? ☐ Yes ☐ No

Did this landlord return your security deposit? (check one) ☐ Yes ☐ No ☐ N/A

PRIOR RESIDENCE **DATES YOU LIVED THERE:**

Name on the lease _____ _____to_____

Address you lived at: _____
Street and Apt# City State Zip

Landlord's Name and Address _____

Landlord Tel: _____

Did this landlord bring any court action against the leaseholder or you? ☐ Yes ☐ No

Did this landlord return your security deposit? (check one) ☐ Yes ☐ No ☐ N/A

RESIDENCE BEFORE THAT **DATES YOU LIVED THERE:**

Name on the lease _____ _____to_____

Address you lived at: _____
Street and Apt# City State Zip

Landlord's Name and Address _____

Landlord Tel: _____

Did this landlord bring any court action against the leaseholder or you? ☐ Yes ☐ No

Did this landlord return your security deposit? (check one) ☐ Yes ☐ No ☐ N/A

Housing History, Page 2

RESIDENCE BEFORE THAT **DATES YOU LIVED THERE:**

Name on the lease ______________________________ ______________to_____________

Address you lived at: ____
Street and Apt# City State Zip

Landlord's Name and Address ____

Landlord Tel: ____________________

Did this landlord bring any court action against the leaseholder or you? ☐ Yes ☐ No

Did this landlord return your security deposit? (check one) ☐ Yes ☐ No ☐ N/A

RESIDENCE BEFORE THAT **DATES YOU LIVED THERE:**

Name on the lease ______________________________ ______________to_____________

Address you lived at: ____
Street and Apt# City State Zip

Landlord's Name and Address ____

Landlord Tel: ____________________

Did this landlord bring any court action against the leaseholder or you? ☐ Yes ☐ No

Did this landlord return your security deposit? (check one) ☐ Yes ☐ No ☐ N/A

RESIDENCE BEFORE THAT **DATES YOU LIVED THERE:**

Name on the lease ______________________________ ______________to_____________

Address you lived at: ____
Street and Apt# City State Zip

Landlord's Name and Address ____

Landlord Tel: ____________________

Did this landlord bring any court action against the leaseholder or you? ☐ Yes ☐ No

Did this landlord return your security deposit? (check one) ☐ Yes ☐ No ☐ N/A

Housing History, Page 3

RESIDENCE BEFORE THAT **DATES YOU LIVED THERE:**

Name on the lease ______________________________ ______________to_____________

Address you lived at: ____
Street and Apt# City State Zip

Landlord's Name and Address ____

Landlord Tel: ____________________

Did this landlord bring any court action against the leaseholder or you? ☐ Yes ☐ No

Did this landlord return your security deposit? (check one) ☐ Yes ☐ No ☐ N/A

RESIDENCE BEFORE THAT **DATES YOU LIVED THERE:**

Name on the lease ______________________________ ______________to_____________

Address you lived at: ____
Street and Apt# City State Zip

Landlord's Name and Address ____

Landlord Tel: ____________________

Did this landlord bring any court action against the leaseholder or you? ☐ Yes ☐ No

Did this landlord return your security deposit? (check one) ☐ Yes ☐ No ☐ N/A

RESIDENCE BEFORE THAT **DATES YOU LIVED THERE:**

Name on the lease ______________________________ ______________to_____________

Address you lived at: ____
Street and Apt# City State Zip

Landlord's Name and Address ____

Landlord Tel: ____________________

Did this landlord bring any court action against the leaseholder or you? ☐ Yes ☐ No

Did this landlord return your security deposit? (check one) ☐ Yes ☐ No ☐ N/A