GLENMONT

-- A Christian Science Nursing Facility --

Dear Applicant,

Glenmont is grateful for the opportunity to offer financial assistance or deferred payment arrangements to patients who are working on demonstrating financial supply. Financial assistance is primarily offered to patients who are eligible for Medicaid.

Glenmont is reliant on generous donors to provide the support that can be offered in the form of financial assistance. Patients and their families are expected to commit the patient's monthly income stream to Glenmont. Qualifications for financial assistance are explained in the Admission documents.

If you have any questions regarding the completion of this application, please call or email:

Lydia Manfreda, Administrator
Phone: 614-876-0084, ext. 103
email: lmanfreda@glenmontcsn.com

OR

Sara Thorndike, Director of Finance
email: sthorndike@glenmontcsn.com

Warmest regards,

Lydia D. Manfreda, LHNA
Glenmont Administrator

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Application for Financial Assistance or Deferred Payment

Date of Application _____

Name of Patient_____

Address _____

City _____ State _____ Zip _____

Telephone _____

Financial Power of Attorney:

Name _____

Address _____

City _____ State _____ Zip _____

Telephone _____

Healthcare Financial Power of Attorney:

Name _____

Address _____

City _____ State _____ Zip _____

Telephone _____

Do you have a health insurance policy that covers care in a Christian Science nursing facility? If yes, include policy details below. Attach a copy of the insurance policy with this application.

_____

Have you ever applied for Medicaid? If yes, include details below:

_____

Do you have Medicare coverage?

_____

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If you are a Journal-listed Practitioner, have you applied for financial assistance from The Mother Church, your branch church, or your Association?

_____

Have you made a previous request for financial assistance, either at Glenmont or elsewhere? Please provide details.

_____

Please share with us any other information that may be helpful in considering this application.

_____

_____

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STATEMENT OF INCOME AND EXPENSES

Income

Salary _____
Employer & Address_____
Retirement (pension, 401k, 403b, annuities) _____
Social security _____
Veterans' Benefits _____
Investment Income (dividends, interest, etc.) _____
Rental Income _____
Trust Income _____
All other, including assistance from others _____
Describe _____
Total **_____**

Expenses

Payments on debts _____
Normal living expenses _____
Aid given to relatives or friends _____
All other _____
Describe _____
Total **_____**

STATEMENT OF ASSETS AND LIABILITIES

Assets

Cash (checking & savings) _____
Securities (current market value) _____
Real estate (estimated market value) _____
Life insurance (face value & current cash value) _____
Company and Policy No._____
All other _____
Describe _____

Total **_____**

Liabilities

Mortgages or loans _____
Credit card debt _____
Unpaid current bills _____
All other _____
Describe _____
Total **_____**

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Have you transferred any assets (gifts, real estate, stock, bank accounts) to anyone in the last 5 years? If yes, provide details below, including recipient name, description of assets, amount of assets and date of transfer.

_____

_____

Have you created any trusts in the last 5 years? If so, is your trust obligated to pay your debts before making distributions to trust recipients? Provide details below, including type of trust, amount and trust date.

_____

_____

Attach copies of the following documents to this application:

- Health insurance policies (as requested above)
- Life insurance policies
- Last three months' bank statements
- Tax returns for last two years
- Current investment statements for marketable securities, retirement funds, and any other investments

The information contained in this application is complete and accurate.

_____ _____

Signature of Patient Date

_____ _____

Signature of Financial Power of Attorney Date

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Request for Deferred Payment

☐ I will continue to pay Glenmont $_____ per month after I discharge from Glenmont.

☐ I will pay the balance due to Glenmont under the following conditions

_____

_____

☐ I expect full payment to be made by (date)_____

_____ _____

Signature of patient Date

_____ _____

Signature of Financial Power of Attorney Date

Internal Use Only by Financial Assistance Committee:

_____

_____

_____

4599 Avery Rd., Hilliard, OH 43026 614-876-0084; 614-876-7095 (fax)

-- A not for profit, tax exempt organization --
Accredited by The Commission for the Accreditation of Christian Science Nursing Organizations/Facilities; Licensed by the State of Ohio; and Certified by the Center for Medicare/Medicaid Services as a Religious Nonmedical Healthcare Institution

February, 2016