

GLENMONT

-- A Christian Science Nursing Facility --

Dear Applicant,

Glenmont is grateful for the opportunity to assist with financial assistance or deferred payment arrangements to patients who are working on demonstrating financial supply. Financial assistance is also offered by the National Fund for Christian Science Nursing (nfcsn.org).

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, if possible, to Glenmont. Qualifications for financial assistance are explained in the Admission documents.

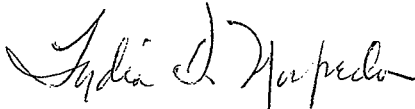
If you have any questions regarding the completion of this application, please call or email:

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

OR

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

Warmest regards,



Lydia D. Manfreda
Glenmont Administrator

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

GLENMONT

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Application for Financial Assistance or Deferred Payment

Date of Application _____

Individual completing 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:

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.

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STATEMENT OF INCOME & EXPENSES

Please list all the following sources of income that apply at this time:

Income:

<u>Type of Income</u>	<u>Monthly Income Amount</u>	<u>Name of Provider or Institution Holding Account</u>
Salary or Wages	\$ _____	_____
Social Security	\$ _____	Social Security Administration
Social Security Disability Income (SSDI)	\$ _____	Social Security Administration
Welfare and/or Food Stamps	\$ _____	State of _____
Rental Income	\$ _____	_____
Pension plan income	\$ _____	_____
Veteran's Benefits	\$ _____	_____
Annuity payment	\$ _____	_____
Payment from 401(k), 403(b) or IRA Investment Account	\$ _____	_____
Payment from 401(k), 403(b) or IRA Investment Account	\$ _____	_____
Payment from Private Investment Account	\$ _____	_____
Other Income (assistance from others, etc.)	\$ _____	_____
Total Monthly Income	\$ _____	

Please list all of your current expenses:

<u>Type of Expense</u>	<u>Monthly Amount of Expense</u>
Payments on debts (mortgages, credit card payments, car payments, etc.)	\$ _____
Normal Living Expenses	\$ _____
Aid given to relatives or friends	\$ _____
All Other - Describe _____	\$ _____
Total Monthly Expenses	\$ _____

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STATEMENT OF ASSETS & LIABILITIES

Please list all of your current assets:

Real Estate Owned:

House or condominium

Names of Owner(s) of this property _____

What is the amount of the mortgage remaining on this property? \$ _____

What is the monthly payment you make on this property? \$ _____

What is the estimated market value of this property? \$ _____

Other real estate

Names of Owner(s) of this property _____

What is the amount of the mortgage remaining on this property? \$ _____

What is the monthly payment you make on this property? \$ _____

What is the estimated market value of this property? \$ _____

Other property assets:

Automobile Boat Motorcycle Other _____

Names of Owner(s) of these assets _____

Do you make monthly payments on any of these and if so, how much each month? \$ _____

Estimated market value of these assets - \$ _____

Bank and Investment Accounts:

Checking Account - Balance \$ _____ as of _____ (date)

Name of Institution where account is held _____

Names of Owner(s) of this account _____

Savings Account - Balance \$ _____ as of _____ (date)

Name of Institution where account is held _____

Names of Owner(s) of this account _____

Trust Account - Balance \$ _____ as of _____ (date)

Name of Institution where account is held _____

Names of Owner(s) or Trustees of this account _____

Retirement Account (401k, 403b, IRA, etc.) - Balance \$ _____ as of _____ (date)

Name of Institution where account is held _____

Retirement Account (401k, 403b, IRA, etc.) - Balance \$ _____ as of _____ (date)

Name of Institution where account is held _____

Private Investment Account - Balance \$ _____ as of _____ (date)

Name of Institution where account is held _____

Names of Owner(s) of this account _____

Life insurance - Face Value \$ _____ Current Cash Value \$ _____

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Please list all of your current liabilities:

<u>Type of Liability</u>	<u>Total Amount of Liability</u>
Mortgages or loans	\$ _____
Credit card debt	\$ _____
Unpaid current bills	\$ _____
All other – Describe _____	\$ _____
Total Liabilities	\$ _____

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

October 2020