JOHN A. McCOLL FAMILY HEALTH CENTER is a Skilled Nursing Community where the skilled level of care is often referred to as “convalescent care.” Skilled nursing care is designed for the individual who requires 24-hour supervision and frequent assistance to accomplish minimal “Activities of Daily Living” (ADL’s) and who may be confined to a wheelchair or bed.

TEAM NURSING AT JOHN A. McCOLL FAMILY HEALTH CENTER

JOHN A. McCOLL FAMILY HEALTH CENTER provides 24-hour nursing services by licensed staff, seven days a week. Upon admission to the Health Center, the resident is introduced to the Charge Nurse who is responsible for coordinating the resident’s care. Conferences, referrals, transfers and other services which are provided by nursing, personnel, physicians, and family members to meet the changing needs of the resident, are also coordinated by the Charge Nurse.

Room and Board Rates per Day

*Effective September 1, 2017– August 31, 2018*

<table>
<thead>
<tr>
<th>Room</th>
<th>3 beds</th>
<th>2 beds</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>$264</td>
<td>$292</td>
<td>$498</td>
</tr>
</tbody>
</table>

The above rates are subject to change upon thirty (30) days written notice. The above rates include:

1. Three meals per day in the dining room or tray service, plus snacks order.
2. Daily assistance with “Activities of Living” (i.e., dressing, bathing, ambulation, personal hygiene and needs).
3. Daily housekeeping service.
4. Dispensing of medication as prescribed by physician.
5. 24-hour supervision and service by licensed personnel (Registered Nurses, Licensed Vocational Nurses, and Certified Nursing Assistants).
6. Planned recreational and occupational therapy programs.
7. Furnished rooms, including bed, chair, wardrobe, night stand, over bed table and bulletin boards.
8. Facilities for physical therapy.
10. Support group meetings.
11. Activities program.
APPLICATION FOR RESIDENCY

NAME ___________________________ DATE OF BIRTH ___________________ AGE ___________

PRESENT ADDRESS ___________________ TELEPHONE ____________________________

CITY ______________________________ ST ___________ ZIP __________________________

MARITAL STATUS: ☐ Married ☐ Widowed ☐ Divorced ☐ Single

SOCIAL SECURITY NUMBER ___________________ MEDICARE NUMBER ________________

OTHER INSURANCE ____________________________

NAME OF INSURANCE COMPANY ____________________________

PLACE OF BIRTH ___________________________ CITIZENSHIP _______________________

FATHER'S LAST NAME _____________________________

MOTHER'S MAIDEN NAME _____________________________

PREVIOUS OCCUPATION ____________________________

RELIGIOUS DENOMINATION ___________________________ ☐ Active ☐ Inactive

PLACE OF WORSHIP OR MINISTER'S NAME ____________________________

NAME OF FACILITY ADMITTED FROM ____________________________

DATE OF ADMISSION ____________________________

REQUEST ADMISSION BY THE FOLLOWING DATE ____________________________

PRIVATE PAY ACCOMMODATIONS: ☐ Private ☐ Double room ☐ Triple room
NAME(S) AND COMPLETE ADDRESS OF ATTENDING PHYSICIAN

PHYSICIAN ___________________________  TELEPHONE ____________________________
ADDRESS ___________________________ CITY ___________________  ST ________  ZIP _____________

ALTERNATE PHYSICIAN

PHYSICIAN ___________________________  TELEPHONE ____________________________
ADDRESS ___________________________ CITY ___________________  ST ________  ZIP _____________

DENTIST ___________________________  TELEPHONE ____________________________
ADDRESS ___________________________ CITY ___________________  ST ________  ZIP _____________

PHARMACY ___________________________  TELEPHONE ____________________________
ADDRESS ___________________________ CITY ___________________  ST ________  ZIP _____________

HOW DID YOU FIRST LEARN OF THE JOHN A. McCOLL FAMILY HEALTH CENTER?

☐ Newspaper or other Advertisement (Please specify name): ________________________________

☐ Yellow Pages

☐ Church  Church Name: ________________________________

        Church Address: ________________________________

                          ________________________________

                      Ministers Name: ________________________________

☐ Open House (Date): ________________

☐ Physician (Name): ________________________________

☐ Current Resident: ________________________________

☐ Family Member (Relationship and name): ________________________________

☐ Friend (Name): ________________________________

☐ Other (Please explain): ________________________________
LEGAL/RESPONSIBLE (GUARANTOR) PERSON

NAME _________________________________ RELATIONSHIP ________________________________
ADDRESS ______________________________ WORK PHONE ________________________________
CITY/ST __________________ ZIP _______ HOME PHONE ________________________________

PERSON(S) TO NOTIFY IN CASE OF EMERGENCY

NAME _________________________________ RELATIONSHIP ________________________________
ADDRESS ______________________________ WORK PHONE ________________________________
CITY/ST __________________ ZIP _______ HOME PHONE ________________________________
NAME _________________________________ RELATIONSHIP ________________________________
ADDRESS ______________________________ WORK PHONE ________________________________
CITY/ST __________________ ZIP _______ HOME PHONE ________________________________

BILLING DATA

Please check the following services desired. A charge will be added to your monthly bill. Laundry and incontinence fees are not optional.

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wheelchair rental</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Geriatric chair rental</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Trust account</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Beauty Shop</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Billed to you directly</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

There is a minimum two week charge for equipment rentals.

BILL TO:

NAME ______________________________ TELEPHONE ________________________________
ADDRESS ___________________________ CITY ______________ ST _________ ZIP _______________
INTERMENT PLANS
MORTUARY NAME __________________________________________ TELEPHONE ________________
ADDRESS _________________________  CITY __________________ ST _______  ZIP ________________

LEGAL DOCUMENTATION
The following documents are recommended to be on file for all residents of the Health Center. Please review and provide the following:

1. Durable Power of Attorney for Health Care    □ YES    □ NO
2. Conservator Information   □ YES    □ NO
   If yes:
   NAME __________________________________________
   ADDRESS __________________________________________
   CITY _____________________________  STATE ________________  ZIP _________________
   TELEPHONE (_______)______________________________

3. Directive to Physician    □ YES    □ NO
4. Power of Attorney (fiduciary)    □ YES    □ NO
5. Living Will    □ YES    □ NO

Please return this form along with the Financial Disclosure Form and other requested documents to:
John A. McColl Family Health Center
Admissions Department
235 Nutmeg Street
San Diego, CA 92103
Financial Disclosure to St. Paul’s Senior Services

St. Paul’s Senior Services (St. Paul’s) respects the privacy of every applicant and does not desire to intrude into any applicant’s personal financial circumstances other than to have assurance that the necessary amounts needed to provide for the applicant’s extended lodging, food, health care and personal needs are available to the potential resident.

The applicant and/or responsible party understands that St. Paul’s will rely on the financial information regarding the applicant’s assets, liabilities, income and expenses in making its determination as to whether the applicant will be admitted to St. Paul’s facilities and that St. Paul’s would not admit the resident to the facilities but for the accuracy and truthfulness of such information. The applicant and/or responsible party understands that the resident may be discharged by St. Paul’s if it discovers that any such information has been misrepresented or omitted by the resident/responsible party, regardless of whether such misrepresentations or omission could have been discovered earlier by St. Paul’s.

Financial Statement

Applicant Name: ___________________________   Social Security #: ___________________

**Monthly Income:**

- Social Security: $______________
- Pensions: $______________
- Interest Income: $______________
- Annuity (lifetime_____ or years ending_____): $______________
- Trust (Name____________________): $______________
- Family Support: $______________
- VA Aid & Attendance: $______________
- Long Term Care Policy (lifetime____ or cap____): $______________
- Other: ___________: $______________

**Monthly Expenses:**

- Health Insurance: $______________
- Prescriptions, medical expenses: $______________
- Living expenses: $______________
- Auto/mortgage/rent (continuing): $______________
- Other: ___________: $______________

**Current Assets:**

- Checking Account: $______________
- Savings Account: $______________
- Stocks/Bonds (currently accessible?): $______________
- Trust (Name____________________): $______________
- 401K (penalty for withdraw?): $______________
- Real Estate – residence: $______________
- Other (vacation/rental): $______________
- Other:____________________: $______________

I DECLARE UNDER PENALTY OF PERJURY that the foregoing financial information is a true statement of facts known by me, and that it is submitted as part of an application for residency at St. Paul’s facilities. I also declare that all of the above assets are available to the Applicant to provide for the future needs of the Applicant, and that none of the assets will be transferred to another individual or individuals to avoid liability for those needs.

_________________________    _________________________  OR   ____________    _____________________________
Date             Applicant for Residency                 Date  Financially Responsible Party