

Hello,

Thank you for your interest in *Sophia Snow Place*. Enclosed is a brochure about Supportive Living at Sophia Snow House, residency application and monthly rates for *Supportive Living Suites*.

Sophia Snow House, Inc. is a non-profit licensed residence supporting seniors in a state-of-the art building that can provide you peace-of-mind. Services include 24 hour care, nursing staff on site, private suite with bath, housekeeping, laundry service, personal care, medication administration, activities, transportation, and 3 meals daily in a homelike setting.

We are convenient to the amenities and attractions of downtown Boston, as well as to the city's finest medical centers.

At this time, we are accepting applications. We invite you and your family to tour our lovely residence and experience our caring community. Please feel free to contact me for more information or an appointment to visit Sophia Snow House on my direct line including evenings and weekends at 857-273-4027.

Sincerely,

A handwritten signature in black ink that reads "MC Brown". The letters are cursive and fluid, with a long horizontal stroke at the end.

Mary Celeste Brown
Marketing Director



Supportive Living at Sophia Snow House

What Makes Us Unique?

- ❖ Sophia Snow House has a 150-year history of not-for-profit service to seniors. We can offer robust care focusing on caring for people without the pressure of reporting to stockholders.
- ❖ Sophia Snow House residents receive personal attention from a devoted and loyal staff, many of whom have worked for us for years. There are no additional charges when our staff members stop to chat, listen to concerns, or solve problems for our residents.
- ❖ Our medication administration is well organized, safe and reliable. We don't simply provide "reminders". Our retirement home license permits us to administer physician-prescribed medications directly to residents. Plus it comes at no additional charge.
- ❖ The design of our new building promotes a vibrant community offering both retirement living with assistance and independent living options. Residents enjoy meals, trips and activities as neighbors. Popular spots include the library with a wide-screen TV and an all-season sunroom for visiting or informal dining.
- ❖ Our all-inclusive fee covers all of the essentials (meals, housekeeping, medication administration, activities, transportation and personal care) with no additional or hidden charges. Families appreciate that they can count on a predictable monthly expense in their budgets.
- ❖ Respite Suites available at \$200.00 per day.

Please call 617-325-7900 for additional information.



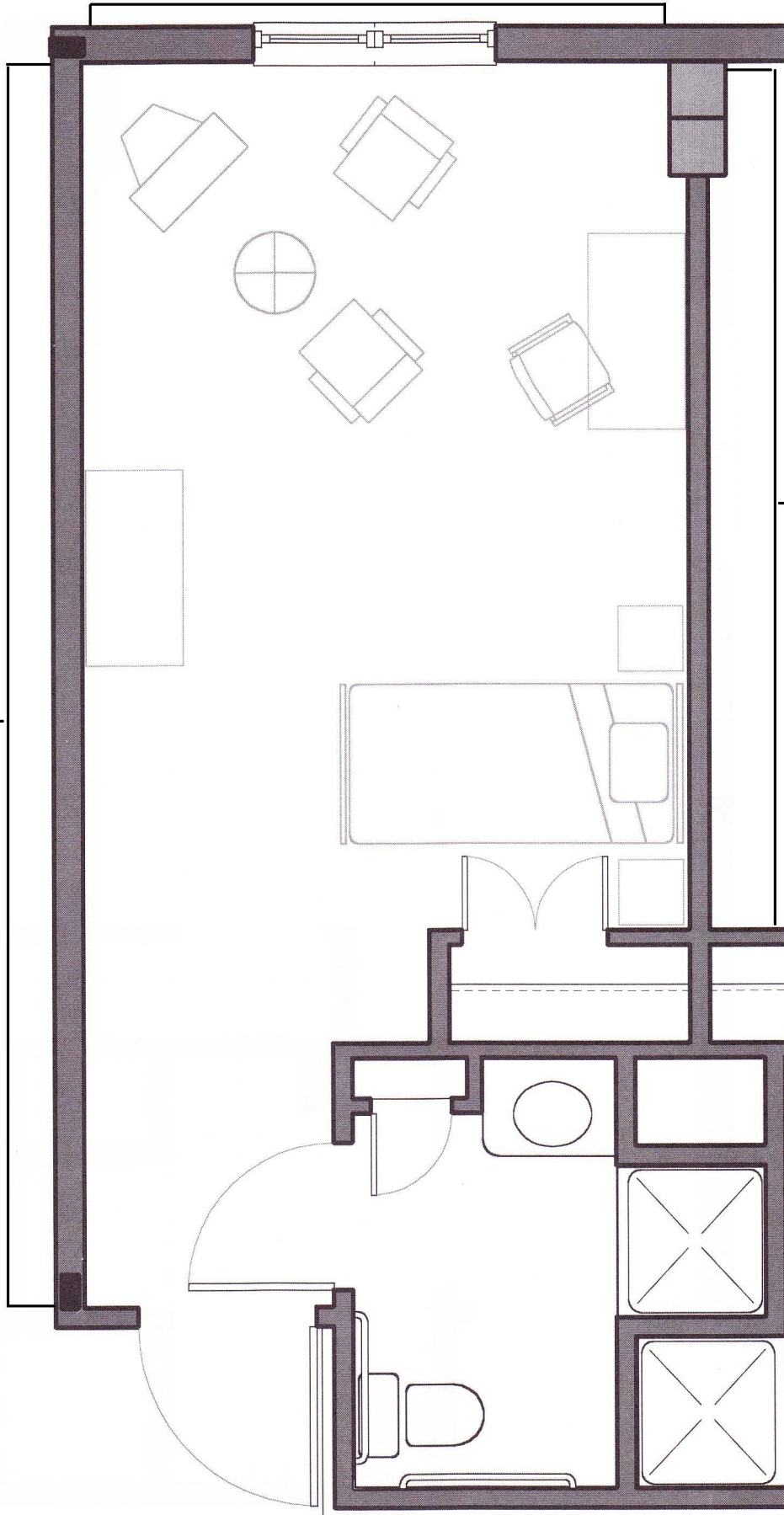


W. : Height top to ledge= 68"
Height ledge to floor=16.5"
Width of ledge=57"

12'2"

25'

17' 10"



STANDARD ROOM

Sophía Snow House Dinner Menu

Garden Salad ♥

Or

Hearty Vegetable Soup ♥

Main Entrée Choices

Stir Fry Chicken with Vegetables

or

Herbed Baked Fish ♥

Vegetable Choices

Steamed Broccoli ♥

or

Roasted Zucchini ♥

Other Sides

Steamed Rice

or

Baked Potato

Dessert

Chocolate Cream Pie

or

Cookies

Alternate Choices Always Available



Retirement Living at Sophia Snow House

Sophia Snow House offers a 400 square foot air-conditioned studio apartment with private bath.

The all-inclusive fee of \$6,055 per month includes the following services:

- Medication administration and coordination
- Licensed by Dept. of Public Health
- 24-hour medical staff
- Onsite nurse supervisor
- Restaurant-style dining
- Daily coffee/tea service
- Complete housekeeping and laundry services
- Assistance with bathing and personal care
- Transportation to nearby medical appointments
- Enriching activities

A one-time non-refundable community fee of \$3,500 is payable upon studio reservation.

In the event that a resident's assets are depleted after a few years, he/she may qualify for a discount fee.

Sophia Snow
House



1215 Centre Street
West Roxbury, MA 02132
617-325-7900

ADMISSIONS APPLICATION

Date: _____

Social Security No.: _____

Are you a US Veteran?: _____

A. Introductory Information

1. Applicant's 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 ___ Veteran? YES ___ NO ___

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 Interests 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 diagnoses and hospitalization(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 may 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 telephone

___ 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 Insurance 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 the Executive Director. This statement must be updated at the time of admission and periodically thereafter, when requested to do so.

Sophia Snow House respects the privacy of every applicant and does not wish to intrude into any applicant's personal financial circumstances other than to determine that the financial requirements for the applicant's personal and medical needs can be adequately 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 Applicant funds), if other than Applicant. Name: _____		
Relation to Applicant: _____		
Home Address: _____ _____		
Home Phone: _____		Work Phone: _____
Fax: _____		Email: _____

1. 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 benefit _____
- c. Company Name _____

2. Resources

(a) Monthly Income

Social Security \$ _____
Pensions \$ _____
Annuities \$ _____
Interest & Dividends \$ _____
Other \$ _____
(indicate source) _____
\$ _____
Other \$ _____
(indicate source) _____

(b) Assets

Checking Accounts \$

Savings Accounts \$ _____ Bonds \$ _____
Stocks/Investments \$ _____
Annuities \$ _____
Real Estate \$ _____

(Indicate value of home
less any outstanding mortgage balances) \$ _____

Long Term Care Ins. (net cash values) _____

Life Insurance- indicate full amount, i.e., amount
available to others upon your death - \$ _____

Total Monthly Income* \$ _____

Total Assets \$ _____

(*) We request a copy of the most recent income tax return.

(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: _____

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 will be adequate to meet your Monthly Fee to Sophia Snow House 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 I/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: _____
(Individual responsible for paying Applicant's bills, if other than Applicant. See Page 6)

