WINDEMERE NURSING & REHABILITATION CENTER
AN AFFILIATE OF MARTHA'S VINEYARD HOSPITAL, MASSACHUSETTS GENERAL HOSPITAL, & A MEMBER OF PARTNERS HEALTHCARE
ONE HOSPITAL ROAD · POST OFFICE BOX 1747 · OAK BLUFFS, MA 02557 · TEL: 508-696-6465 · FAX: 508-696-8004

Financial Guaranty

Windemere Nursing and Rehabilitation Center

In consideration of the admittance of _____, hereinafter called "RESIDENT", to Windemere Nursing and Rehabilitation (WNR), I hereby guarantee full payment, exclusively and solely from RESIDENT'S available funds, for any medical, physician, or ancillary services not reimbursable by RESIDENT'S insurance coverage(s) or benefits, until medical assistance "MassHealth/Medicaid" coverage is necessary. I further acknowledge that I may not misuse or transfer any RESIDENT'S funds or countable assets that could otherwise be available for RESIDENT'S medical care, and that in the absence of said misuse or transfer will not be responsible for any medical payments on behalf of RESIDEN from my personal funds or resources.

Further, I as the responsible Party or Authorized Agent agree to act in good faith with Windemere on financial matters, and to cooperate with Windemere and the Division of Medical Assistance in the completion and filing of an application for Long Term Care Medicaid when necessary, and agree to cooperate with any additional Medicaid Determination compliance or on-going MassHealth actions.

Windemere's private pay bills are payable in advance, starting on the day of admission and due the first of each month thereafter. Please see included room rate sheet. Windermere reserves the right to change its rates as it deems necessary, in which case we shall provide you with at least sixty (60) days advance notice in writing, sent to the undersigned at the address printed below, or to such other address as the undersigned may submit in writing to Windemere.

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Resident's Signature	Date
Resident's Agent/Responsible Party or Authorized Agent Signature	Date
Resident or Agent - Please print name	Witness Signature
Street/Mailing Address	Please Print Name
City/State/Zip Code	Date