



## CONCORDIA LUTHERAN MINISTRIES APPLICATION AGREEMENT

This Application Agreement is made between Concordia Lutheran Ministries, a Pennsylvania nonprofit corporation, operating the nursing facility known as **Concordia Lutheran Ministries** (hereinafter the "Facility") and \_\_\_\_\_ (hereinafter referred to as "Applicant") and/or the Applicant's legal representative and/or representative individual, \_\_\_\_\_ (hereinafter referred to as "Responsible Person") who has lawful access to Applicant's income and financial resources available to pay for nursing care services provided to Applicant.

WHEREAS, the information and disclosures provided in this Application Agreement by the Applicant and/or Responsible Person are made for the purpose of inducing Concordia Lutheran Ministries to consider the Applicant for admission into the Facility.

WHEREAS, Concordia Lutheran Ministries relies on this Application Agreement, among other factors, for determining whether to admit the Applicant into the Facility in accordance with the terms and conditions of the Nursing Facility Admission Agreement (hereinafter "Admission Agreement").

WHEREAS, Concordia Lutheran Ministries shall keep all information and disclosures in this Application Agreement confidential and include the Application Agreement as part of the Admission Agreement.

WHEREAS, the Applicant and/or Responsible Person authorizes Concordia Lutheran Ministries to obtain financial information from the financial institutions or other institutions identified on this Application Agreement and agrees to execute any releases requested by Concordia Lutheran Ministries for the purpose of verifying any and all representations regarding Applicant's financial resources and assets that Applicant and/or Responsible Person has made in this Application Agreement.

THEREFORE, the Applicant and/or Responsible Person provides the following information to Concordia Lutheran Ministries for consideration in the Admission Application review process. The Applicant and/or Responsible Person acknowledge and attest that the following information and disclosures are true and correct to the best of his/her/their knowledge and belief, and that no assets have been divested within the past 60 months.

Applying for (check one)

- Nursing       Assisted Living       Rehabilitation Therapy       Respite Care

Information will be held confidential. **Please complete all information.**

Last name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Maiden \_\_\_\_\_  
Current Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_  
Level of Education Completed \_\_\_\_\_ Lifetime Occupation \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Phone \_\_\_\_\_ Birth Date \_\_\_\_\_  
Address (if different) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_ Medicare # \_\_\_\_\_ Effective Date \_\_\_\_\_  
Health Insurance Provider \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_  
Medicare Part D Plan Name \_\_\_\_\_ Plan # \_\_\_\_\_ Effective Date \_\_\_\_\_  
Medicaid # \_\_\_\_\_ Access # \_\_\_\_\_ PACE # \_\_\_\_\_  
Long Term Care Provider \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_  
Are you a veteran? \_\_\_\_\_ Spouse? \_\_\_\_\_ Branch \_\_\_\_\_ Discharge Date \_\_\_\_\_

Please list all individuals serving as responsible party for you:

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Relationship to applicant \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Relationship to applicant \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Children (not listed as responsible individuals on previous page)

Name \_\_\_\_\_ Spouse \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Name \_\_\_\_\_ Spouse \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

(If additional space is needed to list other children, please use an attachment).

Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Hospital of choice for medical care \_\_\_\_\_

Pastor \_\_\_\_\_ Phone \_\_\_\_\_  
Church \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Ambulance Membership (Name of Company) \_\_\_\_\_  
Pharmacy \_\_\_\_\_ Phone \_\_\_\_\_

Funeral Director \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Do you have a Pre-Paid Funeral arrangement?  Yes  No  Pending  
Do you have a Living Will?  Yes  No A Power of Attorney?  Yes  No

\_\_\_\_\_  
Name of P.O.A. for Health Care/relationship

\_\_\_\_\_  
Name of P.O.A. for Financial/relationship

List any special dietary restrictions

Height \_\_\_\_\_ Weight \_\_\_\_\_

List any allergies to medicine

List any allergies to food

## FINANCIAL DISCLOSURE

**Name of Applicant** \_\_\_\_\_

	<b>Monthly Amount</b>
Social Security	\$ _____
Supplemental Social Security	\$ _____
Pension	\$ _____
Veteran's Benefits	\$ _____
Interest (list source)	\$ _____
Mortgage/Rental Income	\$ _____
IRA Income	\$ _____
Trust income	\$ _____
Other Income (list source)	\$ _____
<b>Total Monthly Income</b>	<b>\$ _____</b>

<b>Assets</b>	<b>Value</b>	<b>Names on Account</b>	<b>Location</b>
Checking Account	\$ _____	_____	_____
Savings Account	\$ _____	_____	_____
CD's	\$ _____	_____	_____
Money Market Funds	\$ _____	_____	_____
Stocks	\$ _____	_____	_____
Bonds	\$ _____	_____	_____
Annuities, etc.	\$ _____	_____	_____
Trusts	\$ _____	_____	_____
House	\$ _____	_____	_____
Property	\$ _____	_____	_____
Other Assets	\$ _____	_____	_____
Life Insurance (cash value)	\$ _____	_____	_____

<b>Liabilities</b>	<b>Amount</b>	<b>To Whom</b>
Debts owed by applicant:	\$ _____	_____
	\$ _____	_____
	\$ _____	_____
	\$ _____	_____
Property, cash, income or any other assets transferred within the past five years:	\$ _____	_____
	\$ _____	_____
	\$ _____	_____
	\$ _____	_____

Applicant and/or Responsible Person acknowledge that he/she/they understand that the information and disclosures provided in this Application Agreement do not obligate Concordia Lutheran Ministries to accept the Applicant for admission and are used only in the admission decision making process.

By signing below, the Applicant and/or Responsible Person certifies that the information and disclosures provided in this Application Agreement are true, correct and complete to the best of his/her/their knowledge and belief. Any false information, misrepresentation of information or lack of disclosure in this Application Agreement may result in the rejection of the Applicant's application and/or the termination of the Admission Agreement after admission at any time Facility learns of the false information, misrepresentation or lack of disclosure.

Therefore, the parties, intending to be legally bound hereby, have signed this Application Agreement on this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_ .

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Applicant

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Responsible Person (if any)

\_\_\_\_\_  
Authorized Representative  
CONCORDIA LUTHERAN MINISTRIES