Concordia
Lutheran Health and Human Care

CONCORDIA LUTHERAN HEALTH AND HUMAN CARE
APPLICATION AGREEMENT

This Application Agreement is made between Concordia Lutheran Health and Human Care, a Pennsylvania non-profit corporation, operating a facility located at _____ (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 the Facility to consider the Applicant for admission into the Facility.

WHEREAS, the Facility 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 applicable Facility Admission Agreement (hereinafter "Admission Agreement"), and specifically relies on the understanding that the assets and income listed will be available and used for payment for Resident's care at the Facility, including any level of care or service line the Applicant may be admitted to or subsequently transferred to within the Facility.

WHEREAS, the Facility 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 the Facility to obtain financial information from the financial institutions or other institutions identified on this Application Agreement and agrees to execute any releases requested by the Facility 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 provide the following information to the Facility 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.

EQUAL HOUSING OPPORTUNITY

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 _____
Cell phone_____ e-mail address_____

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 _____
e-mail address _____
Relationship to applicant _____ Spouse's name_____

Name _____
Address _____
City _____ State _____ Zip_____
Home Phone _____ Work Phone _____ Cell Phone _____
e-mail address _____
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 _____
e-mail address_____

Name _____ Spouse _____
Address _____ City _____ State ____ Zip_____
Home Phone _____ Work _____ Cell _____
e-mail address _____

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

Primary Physician _____ Phone _____ Fax _____
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 medicines:
_____
_____
_____

List any allergies to foods:
_____
_____
_____

Financial Disclosure

Name of Applicant _____

	Monthly Amount
Social Security	$_____
Supplemental Social Security	$_____
Pension	$_____
Veteran's benefits	$_____
Interest (list source)	$_____
Mortgage/Rental income	$_____
IRA income	$_____
Trust income	$_____
Other income (list source)	$_____
Total monthly income	**$**_____

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

Liabilities	**Amount**	**To whom**
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 the Facility 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.

Applicant and/or Responsible Person understand that the applicant may be required to apply his/her monthly income directly to the Facility as payment for services rendered by the Facility.

All monthly fees must be paid when due regardless of the timing of receipt of any Long Term Care insurance benefits by Resident. Facility does not accept assignment of benefits for LTC policies.

Applicant and/or Responsible Person understand that the Facility may require additional documentation regarding payment for future care.

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 Health and Human Care