Application

Concordia at Sumner

Pre-Admission Application

Information will be held confidential. Please complete all information.

Name of Applicant _____ Phone (____)_____

Address _____ City _____ State _____ Zip _____

Township/ Borough _____ County _____

Date of Birth _____ Age _____ Birthplace _____

Marital Status (circle one): Single Widowed Married Divorced Remarried

Social Security No. _____ Medicare No. _____

U.S. Citizen? _____ Immigration date _____ Naturalization date _____

Health Insurance Provider _____ Group _____ ID No. _____

Access No. _____ Pace No. _____

Long Term Care Provider _____ Group _____ ID No. _____

Are you a veteran? _____ Spouse? _____ Branch? _____ Discharge date _____

Choice of Entrance Plan _____ Wedding Anniversary Date _____

Do you have a valid driver's license? _____ Vehicle: make/model/yr. _____

Vehicle #2: make/model/yr._____

Name of Spouse _____ If deceased, date _____

Spouse: Date of Birth _____ Age _____ Birthplace _____

Spouse: Social Security No. _____ Medicare No. _____

Spouse: A veteran? _____ Branch? _____ Discharge date _____

Please list two individuals who are able to serve as Emergency Contacts for you:

Name _____

Address _____

City _____ State ___ Zip _____

Home Phone (___)_____

Work Phone (___)_____

Cell Phone (___)_____

Relationship to Applicant _____

Name of Spouse _____

Name _____

Address _____

City _____ State ___ Zip _____

Home Phone (___)_____

Work Phone (___)_____

Cell Phone (___)_____

Relationship to Applicant _____

Name of Spouse _____

Children (not listed as emergency contacts)

Name _____ Spouse _____

Address _____ City _____ State _____ Zip _____

Home Phone (____)_____ Work Phone (____)_____

Name _____ Spouse _____

Address _____ City _____ State _____ Zip _____

Home Phone (____)_____ Work Phone (____)_____

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

Primary Physician _____ Phone No. (___) _____

Address _____ City _____ State _____ Zip _____

Hospital of choice for medical care _____

Spouse's Primary Physician _____ Phone No. (___) _____

Address _____ City _____ State _____ Zip _____

Hospital of choice for medical care _____

Clergy _____ Phone No. (___) _____

Place of worship _____ Phone No. (___) _____

Address _____ City _____ State _____ Zip _____

Ambulance Membership (Name of Company) _____

Pharmacy _____ Phone No. (___) _____

Funeral Director _____ Phone No. (___) _____

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

Formal education completed _____ Other _____

Primary lifetime occupation _____ Age at retirement _____

Area where raised _____ Area where resided as adult _____

Activities and Hobbies _____

Religious or Community involvement _____

Group memberships _____

Pets _____

For our records, please attach a photograph of yourself. Also provide copies of your Living Will, Power of Attorney, and Medical cards.

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	$ _____	_____	_____
CDs	$ _____	_____	_____
Money Market Funds	$ _____	_____	_____
Stocks	$ _____	_____	_____
Bonds	$ _____	_____	_____
Annuities, etc.	$ _____	_____	_____
Property	$ _____	_____	_____
Other assets	$ _____	_____	_____
House (market value)	$ _____	_____	_____
Life Insurance (cash value)	$ _____	_____	_____
Money owed to applicant	$ _____	By whom _____	

Liabilities	Amount	To whom
Debts owed by applicant:	$ _____	_____
	$ _____	_____
Property, cash or income ceded:	$ _____	_____
(within the past 5 years)	$ _____	_____

The undersigned does declare each of the foregoing statements to be true, that all assets have been disclosed, and that no material assets have been divested in the past 60 months. I understand the information submitted in this application constitutes consideration for residence and shall become a part of any subsequent agreement between the applicant and the facility. This form does not in itself create a contractual obligation between the applicant and Concordia. **The submission of any false information or the failure to disclose any material information in this application could result in the termination of your residency agreement and your discharge from the facility at the discretion of Concordia.**

_____	_____	_____	_____
Applicant	Date	Witness	Date
_____	_____	_____	_____
Applicant	Date	Witness	Date

Individual Acknowledgment

State of Ohio)
County of Summit)SS

On this _____ day of _____ , 20 _____ , before me a Notary Public, the undersigned officer, personally appeared _____ _____ , known to me (or satisfactorily proven) to be the person(s) whose name(s) is/are subscribed to the within instrument, and acknowledged and that he/she executed the same for the purposes therein contained.

In Witness whereof, I hereunto set my hand and official seal.

_____
Notary Public

970 Sumner Parkway • Copley, OH 44321 • Phone: **330.664.1000** • www.concordiaatsumner.org

Concordia Lutheran Ministries is a CARF-CCAC accredited Aging Services Network, one of the most financially secure senior care providers in the country, as well as one of the largest. Concordia at Sumner provides a continuum of care that includes assisted living, rehabilitation services, retirement living, and skilled nursing.

Concordia at Sumner

We put our Faith in Caring

Application Date: Date Approved: Occupancy Date:

☐ 1 Bedroom ☐ 2 Bedroom Unit Type: