APPLICATION AGREEMENT
TO A CONCORDIA LUTHERAN MINISTRIES
PERSONAL CARE OR NURSING CARE FACILITY

This Application Agreement is entered into by ____________________, (hereinafter referred to as “Applicant”), and/or the Applicant’s legal representative and/or representative individual, ____________________, (hereinafter referred to as “Resident Representative”) who has lawful access to Applicant’s income and financial resources available to pay for services provided to Applicant at a Concordia Lutheran Ministries Personal Care or Nursing Care facility (hereinafter referred to as the “Facility”).

WHEREAS, the information and disclosures provided in this Application Agreement by the Applicant and/or Resident Representative are made for the purpose of inducing a Concordia Lutheran Ministries Personal Care and/or Nursing Care facility (hereinafter referred to as 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 Applicant’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 Resident Representative 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 Resident Representative has made in this Application Agreement.

THEREFORE, the Applicant and/or Resident Representative provide the following information to the Facility for consideration in the Admission Application review process. The Applicant and/or Resident Representative 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.
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__________________________

2
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 ____________________________________________________________

<table>
<thead>
<tr>
<th>Monthly Amount</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td>Social Security $___________________</td>
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<tr>
<td>Supplemental Social Security $___________________</td>
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<tr>
<td>Pension $___________________</td>
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<tr>
<td>Veteran’s benefits $___________________</td>
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<tr>
<td>Interest (list source) $___________________</td>
</tr>
<tr>
<td>Mortgage/Rental income $___________________</td>
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<tr>
<td>IRA income $___________________</td>
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<tr>
<td>Trust income $___________________</td>
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<tr>
<td>Other income (list source) $___________________</td>
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</tbody>
</table>

**Total monthly income** $___________________

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<thead>
<tr>
<th>Assets</th>
<th>Value</th>
<th>Names on Account</th>
<th>Location</th>
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</thead>
<tbody>
<tr>
<td>Checking Account $ __________</td>
<td>___________________</td>
<td>________________</td>
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</tr>
<tr>
<td>Savings Account __________</td>
<td>___________________</td>
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<tr>
<td>CD’s</td>
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<td>Money Market Funds</td>
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<td>Stocks</td>
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<tr>
<td>Bonds</td>
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<tr>
<td>Annuities, etc.</td>
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<tr>
<td>Trusts</td>
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<tr>
<td>House</td>
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<tr>
<td>Property</td>
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<tr>
<td>Other Assets</td>
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<tr>
<td>Life Insurance (cash value)</td>
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</tbody>
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<thead>
<tr>
<th>Liabilities</th>
<th>Amount</th>
<th>To whom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Debts owed by applicant:</td>
<td>$_____________</td>
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<td>$_____________</td>
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<tr>
<td>$_____________</td>
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</tbody>
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Property, cash, income or any other assets transferred within the past five years:

| $_____________ | | |
| $_____________ | | |
| $_____________ | | |
| $_____________ | | |
Applicant and/or Resident Representative acknowledge that he/she/they understand that the information and disclosures provided in this Application Agreement do not obligate any Facility to accept the Applicant for admission and are used only in the admission decision-making process.

By signing below, the Applicant and/or Resident Representative 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 Resident Representative 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 Applicant. Facility does not accept assignment of benefits for LTC policies.

Applicant and/or Resident Representative 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      Resident Representative (if any)

_____________________________
Concordia Representative

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