

## 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					
Current Address		City	S	tate	_ Zip
Phone	Birth Date	Age	Ma	rital Stat	us
Cell phone	e-mai	address			
Level of Education Complete	d	Lifetime C	Occupation		
Spouse's Name					
Address (if different)					
					5.
Social Security#					Date
Health Insurance Provider		Group#		D#	
Medicare Part D Plan Name		Plan #		Effective	Date
Medicaid #	<i>F</i>	Access #		Pace #	
Long Term Care Provider		Group#		D#	
Are you a veteran? Sp		nch			

Please list all individuals serving as responsible party for you:

Name				
Address				
City		State		_ Zip
Home Phone e-mail address	Work Phone		Cell Phone _	·
Relationship to applicant		_ Spouse's na	ame	

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		
Name Address	City	· · · · · · · · · · · · · · · · · · ·	State	_ Zip
Home Phone	Work		Cell	
e-mail address				
Name		Spouse		
Name Address	Citv	_ 0p0000	State	Zip
Home Phone	Work		Cell	
e-mail address				
(If additional space is needed to list other child	dren, plea	se use an attachme	ent)	
Primary Physician	Phone		Fax	
Address	City		State	Zip
Hospital of choice for medical care				•
Pastor		Phone		
Church		Phone		
ChurchAddress	_ City		State _	Zip
Ambulance Membership (Name of Company) Pharmacy		Phone		
Funeral Director		Phone		
Address	City	State	e Zip	
Do you have a Pre-Paid Funeral arrangement	-		-	
Do you have a Living Will? Yes N	lo /	A Power of Attorne	y? Ye	es No
Name of P.O.A. for Health Care/relationship	- <u>-</u> N	lame of P.O.A. For	Financial/	relationship
List any special dietary restrictions:	F	leight	We	ight
List any allergies to medicines:	L	ist any allergies to	foods:	
	_			
	_	· · · · · · · · · · · · · · · · · · ·		

## **Financial Disclosure**

## Name of Applicant \_\_\_\_\_

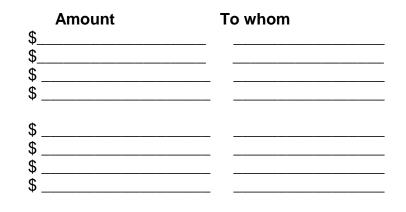
	Monthly Amount
Social Security	\$
Supplemental Social Security	\$
Pension	\$
Veteran's benefits	\$
Interest (list source)	\$
Mortgage/Rental income	\$
IRA income	\$
Trust income	\$
Other income (list source)	\$
Total monthly income	\$

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

Liabilities

Debts owed by applicant:

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