Application and Financial Disclosure Agreement to a Concordia Personal Care, Assisted Living, or Nursing Care Facility

(hereinafter referred to as "Facility")

The financial information disclosed in this agreement is true to the best of my (signer's) knowledge. I confirm that I will not divest the funds disclosed herein; that I have disclosed all available funds in this agreement; and will ensure the funds are available to support in paying for the applicant's care in this facility. To the extent these funds are distributed and/or moved or transferred to other family members, by whatever means, is a breach of this agreement since those funds are intended to be used to pay for the applicant's care. The facility reserves the right to immediately terminate this agreement if it is found that these funds have been moved as described above or not properly identified in this agreement. If the facility needs to hire counsel to enforce this aspect of the agreement, signer is responsible for facility's attorney's fees and costs.

This Financial Disclosure/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 the Applicant while at this Facility.

WHEREAS, the information and disclosures provided in this Financial Disclosure/Application Agreement and/or Resident Representative are made for the purpose of providing the necessary information to evaluate the Applicant for admission to the Facility.

WHEREAS, the Facility relies on this Financial Disclosure/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 the 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/Financial Disclosure Agreement confidential and include this 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/Financial Disclosure 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/Disclosure Agreement.

Information will be held CONFIDENTIAL. Please COMPLETE ALL INFORMATION

Applicant's Full Name _____

Maiden Name, if applicable_____

Date of Birth_____ Age_____ Marital Status_____

Current Address_____

City_____ State_____ Zip Code_____

Phone _____ Cell Phone_____

Email Address_____

Occupation_____ Spouse's Name_____

Spouse's Phone Number_____ Date of Birth_____

Spouse's Address, if different_____

City_____ State_____ Zip Code_____

Social Security Number_____

Are you a veteran? ____ Spouse? ____ Branch _____ Discharge Date_____

By disclosing this information, you may be entitled to additional benefits. If that is the case, a Concordia staff member will contact you.

Have you completed an application for a Concordia Facility within the last 60 months? _____

If yes, please provide the approximate date of the application and the Facility name:

Primary Physician _____

Pharmacy_____

Do you have a Living Will? _____

THERFORE, the Applicant and/or Resident Representative provide the following information to the Facility for consideration in the Admission/Financial Disclosure Agreement 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.

Please list all individuals serving as a financial/medical resident representative for you, by disclosing their information you are providing permission to this Facility to communicate with these individuals related to your financial disclosure prior to, during, and after your stay. If you would like to opt out, check here: ☐

Name:		**Relationship:**
Address:		
Home Phone:	**Business:**	**Cell:**
If Power of Attorney check type: ☐ **Other** ______________________	**Durable** ☐ **Health Care** ☐	**Limited** ☐ **Financial** ☐ **Financial and Health Care** ☐

Name:		**Relationship:**
Address:		
Home Phone:	**Business:**	**Cell:**
If Power of Attorney check type: ☐ **Other** ______________________	**Durable** ☐ **Health Care** ☐	**Limited** ☐ **Financial** ☐ **Financial and Health Care** ☐

Name:		**Relationship:**
Address:		
Home Phone:	**Business:**	**Cell:**
If Power of Attorney check type: ☐ **Other** ______________________	**Durable** ☐ **Health Care** ☐	**Limited** ☐ **Financial** ☐ **Financial and Health Care** ☐

Name:		**Relationship:**
Address:		
Home Phone:	**Business:**	**Cell:**
If Power of Attorney check type: ☐ **Other** ______________________	**Durable** ☐ **Health Care** ☐	**Limited** ☐ **Financial** ☐ **Financial and Health Care** ☐

Financial Disclosure

Applicant's Name_____

	Self	Spouse
Social Security	$_____	$_____
Supplemental Social	$_____	$_____
Security Pension	$_____	$_____
Veteran's Benefits	$_____	$_____
Interest	$_____	$_____
Mortgage/Rent IRA	$_____	$_____
Trust Account Other	$_____	$_____
Other Income	$_____	$_____

Total Monthly Income $_____

Assets	Value	Names on Account	Location
Checking Account			
Savings Account			
CD's			
Money Market Funds			
Stocks/Bonds			
Annuities, etc.			
Trusts			
House/Real Estate			
Additional Property			
Other Assets			
Life Insurance			
IRA/ 401K /403B, etc.			
Money Owed to Applicant			

Are your funeral expenses paid? Choose option

Other Accounts

Account Name	Names on Account and Location	Value

Liabilities

Debts Owed by Applicant:	Amount:	To Whom:

Property, cash, income, or any other assets transferred within the past five years:	Amount:	To Whom:

Applicant and/or Resident Representative acknowledge that he/she/they understand that the information and disclosures provided in the Application/ Financial Disclosure 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 the Application/Financial Disclosure 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/ Financial Disclosure Agreement may result in rejection of the Applicant's application and/or termination of the Admission Agreement after admission at any time the Facility learns of the false information, misrepresentation, or lack of disclosure.

I understand that if I misrepresent, hide, or withhold facts that I will be required to pay privately.

In the event of an emergency or disaster event or for various reasons a safe discharge is required, the following location(s) would be available:

_____

Applicant and/or Resident Representative understands 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 Long Term Care policies.

Applicant and/or Resident Representative understands that the Facility may require additional documentation regarding payment for future care.

Prior to admission the Facility will require the following documentation: medical documentation, a copy of the Living Will/Power of Attorney, insurance cards, list of medications, and additional documents as requested.

Therefore, the parties, intending to be legally bound, hereby, have signed this Application/Financial Disclosure Agreement on this the _____ day of _____, 20_____

Printed Name of the Applicant_____

Printed Name of the Resident Representative _____

Printed Name/Position Facility Representative_____

Signature Applicant _____

Signature of Resident Representative (if applicable) _____

Signature of Facility Representative_____