

Pre-Admission Application Concordia at Kennedy



Information will be held confidential. Please complete all information.

Name of Applicant _____ Cell (____) _____

Email Address _____ 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. _____

Health Insurance Provider _____ Group _____ ID No. _____

Long Term Care Provider _____ Group _____ ID No. _____

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

Do you have a valid driver's license? _____ Vehicle Make/Model/Year _____

Name of Spouse _____ If deceased, date _____

Wedding Anniversary Date _____

Spouse Date of Birth _____ Age _____ Birthplace _____

Spouse Social Security No. _____ Medicare No. _____

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

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone (____) _____

Work Phone (____) _____

Cell Phone (____) _____

Email Address _____

Relationship to Applicant _____

Name of Spouse _____

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone (____) _____

Work Phone (____) _____

Cell Phone (____) _____

Email Address _____

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 Care Physician _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

Hospital choice for medical care _____

Spouse's Primary Care Physician _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

Hospital choice for medical care _____

Pharmacy _____ Phone (____) _____

Clergy _____ Phone (____) _____

Place of worship _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

Funeral Director _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

Do you have pre-paid funeral arrangements? YES _____ NO _____ Pending _____

Do you have a Living Will? YES _____ NO _____ A Power of Attorney? YES _____ NO _____

Name of POA for Health Care/Relationship _____

Name of POA for Financial/Relationship _____

Self

Spouse

Formal education completed _____

Formal education completed _____

Other _____

Other _____

Primary lifetime occupation _____

Primary lifetime occupation _____

Age at Retirement _____

Age at Retirement _____

Activities and Hobbies _____

Activities and Hobbies _____

Religious or Community involvement _____

Religious or Community involvement _____

Group memberships _____

Group memberships _____

Financial Disclosure

Monthly Income

	Self	Spouse
Social Security	\$ _____	\$ _____
Pension	\$ _____	\$ _____
Veterans benefits	\$ _____	\$ _____
Interest (list source)	\$ _____	\$ _____
Mortgage/Rental income	\$ _____	\$ _____
IRA or 401(k)/403(b) income	\$ _____	\$ _____
Trust income	\$ _____	\$ _____
Other income (list source)	\$ _____	\$ _____
Total monthly income	\$ _____	\$ _____

Assets

Assets	Value	Names on Account	Location
Checking Account	\$ _____	_____	_____
Savings Account	\$ _____	_____	_____
Money Market Funds	\$ _____	_____	_____
CDs	\$ _____	_____	_____
Investment Account	\$ _____	_____	_____
Annuities	\$ _____	_____	_____
IRA, 401(k), 403(b) etc.	\$ _____	_____	_____
Other assets	\$ _____	_____	_____
House (market value)	\$ _____	_____	_____
Additional Real Estate	\$ _____	_____	_____
Life Insurance (cash value)	\$ _____	_____	_____
Money owed to Applicant	\$ _____	_____	_____

Liabilities

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

Pets _____

Smoker? YES _____ NO _____

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



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 my care in this community. 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 my care. The community 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 community needs to hire counsel to enforce this aspect of the agreement, signer is responsible for community's attorney's fees and costs.

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 five years. 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 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



Application Date:

Date Approved:

Pets:

Studio

1 Bedroom

2 Bedroom