Pre-Admission Application
Concordia of the South Hills

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 (check 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)	$_____	$_____
Total monthly income	**$** 0.00	**$** 0.00

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

	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.

EQUAL HOUSING OPPORTUNITY

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 _____

EQUAL HOUSING OPPORTUNITY

Application Date: Date Approved: Occupancy Date:

☐ 1 Bedroom ☐ 2 Bedroom Unit Type: