



1510 17TH STREET
DENVER, CO 80202-1202
303-595-4464
FAX 303-595-9225
TDD 1-800-659-2656



WWW.SENIORHOUSINGOPTIONS.ORG

OUR MISSION: TO PROVIDE AND PROMOTE QUALITY AFFORDABLE HOUSING & CARING SUPPORTIVE SERVICES IN COLORADO

The Barth Hotel Phone 303-534-7142 Fax 303-534-3828 Cinnamon Park Phone 303-772-2882 Fax 303-772-8318
Cliffview Phone 970-724-3530 Fax 970-724-3813 Madison House Phone 970-565-2047 Fax 970-565-2587
Mesa Vista Phone 970-285-1844 Fax 970-285-6351 Park Hill Phone 303-388-9437 Fax 303-370-1063

ASSISTED LIVING RESIDENCE APPLICATION

CONTACT INFORMATION:

Date: _____ SS Number: _____
Name: _____ Maiden Name _____ Sex: _____ Marital Status: _____ Age: _____ Date of Birth: _____
Present Address: _____ City _____ State _____ Zip _____ County: _____
Telephone: _____ Cell _____ email _____
Spouse's Name _____ Phone _____ email _____
Name of Legal Representative (if applicable) _____
Address of Legal Representative _____ City _____ State _____ Zip _____
Past Occupation: _____ Place of Birth: _____

INSURANCE INFORMATION:

Are you currently on Medicare Part-A? Yes ___ No ___ Medicare Part-B? Yes ___ No ___ Medicare Number: _____
Are you currently with an HMO? Yes ___ No ___ Which one? _____ HMO Number: _____

Do you have Medicaid Health and Community Based Services (HCBS)? Yes ___ No ___ Application in Process ___

Do you have a caseworker or a social worker? ___ Yes ___ No? If yes, please provide the following information:

Name _____ Organization _____ Contact information _____

FINANCIAL INFORMATION:

This facility is owned and/or operated by Senior Housing Options Inc. a non profit 501 (c) (3) charitable organization dedicated to providing affordable, homelike environments where seniors of all income levels can live independently in comfort and security while receiving the services they need. To achieve cost effectiveness, we have utilized various sources of funding that require that we verify financial income and asset information on every potential resident. In cooperation with this policy, please provide answers to the following questions:

Who will be responsible for paying the fees at the Assisted Living Residence?

Name: _____ Relationship: _____

Address: _____ City _____ State _____ Zip: _____

ASSET INFORMATION

Income from each of these assets must be detailed in the Income Information section below. Please list all checking, savings and investment accounts (including IRA's, Keogh accounts and certificates of deposit) including assets disposed of during the last two years. Also list the value of other assets including real estate, stocks, bonds, trusts or other assets. Attach additional information if needed.

Type of Asset	Financial Institution	Address and Phone Number	Account Number	Balance

INCOME INFORMATION

For each type of income you receive, list the source of the income, the address and phone number related to the source and the amount which can be expected to be received during the next twelve months. Include all sources of such as wages, social security, pension, interest, and income from alimony or rental properties. Verification of income must be provided in the form of bank statements that show consistent direct deposit of Social Security, VA benefits, other pensions, social security or other benefits. Quarterly interest statements for a 1 year period or a copy of the last year's IRS Income Tax Return may be used to estimate income.

Source of Income	Address and Phone	Monthly	Annually

ETHNICITY:

Please provide the following information for statistical purposes only. As responses are optional:

Male Female

Hispanic Non Hispanic African American Caucasian American Indian or Alaskan Native

SIGNATURE:

The above statements are true to the best of my knowledge. The applicant authorizes Senior Housing Options Inc. to verify all information provided on this application and to execute all further forms required to assist in this verification process. Applicant certifies that statements made in this application are true and complete and that false statements may result in a denial of this application

Signature of Person Completing

Date



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CRIMINAL RECORDS CHECK DISCLOSURE AND CONSENT FORM-ACF

1. A criminal records check through Colorado Bureau of Investigation will be conducted on all Applicants for housing at any Senior Housing Options managed building.
2. If the Applicant has resided in Colorado for less than five (5) years, out of state criminal background checks will be made for the last 10 years as available from prior state(s) of residency.
3. If criminal records check reveals that an Applicant has a criminal record of any of the following, the application for housing will be denied:
 - a) Any applicant that is currently engaged in illegal use of drugs or for which the owner has reasonable cause to believe that a applicant's illegal use or pattern of illegal use of a drug may interfere with the health, safety, and right to peaceful enjoyment of the property by other residents.
 - b) Any applicant who is subject to a state sex offender lifetime registration requirement. National sex offender registry search is conducted on all applicants.
 - c) If there is reasonable cause to believe that the applicant's behavior, from abuse or pattern of abuse of alcohol, may interfere with the health, safety, and right to peaceful enjoyment by other residents.
 - d) Any record of criminal history or violent criminal history including: murder, attempt to commit murder, threatening with a deadly weapon, sexual assault, crimes against an at risk adult for ten (10) years preceding the date of application including but not limited to charges and/or convictions, felonies and/or misdemeanors against other persons, property, or crimes that could pose serious risk to the safety of vulnerable adults.
 - e) Conviction (at any time) for a felony involving violent physical actions on the part of the applicant.
 - f) Three (3) or more convictions on misdemeanor charges within the last two (2) years of the applicant.
 - g) The applicant may be allowed residency if the conviction results in jail/prison time requirement is satisfied at least 5 years prior to the application decision, or if the conviction results in parole/probation requirement that is satisfied at least 5 years prior to the admission decision.

I acknowledge that a telephonic facsimile (FAX) or photographic copy of this document shall be as valid as the original. This release enables most federal, state and county agencies to permit information about me to be released.

I hereby authorize, without reservation, any law enforcement agency, institution, or information service bureau contacted by Senior Housing Options or its representative to furnish the information.

Signature of Applicant (Required) _____ Date _____

Print Name (Required) _____ Birth Date (Required) _____

Social Security Number _____ Phone Number _____ Male _____ Female _____

Address: (Please do not give a Post Office Box) _____

City _____ County _____ State _____ Zip _____ Code _____

If you have lived outside the State of Colorado in the last 5 years you must provide your prior address for out of State information requirements:

Address (do not use PO Box) _____

City _____ County _____ State _____ Zip Code _____

Phone number where you can be reached or left a message _____

**This document is available in other formats upon request. Signature still required*



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MEDICAL HISTORY

Applicant Name: _____ Date: _____

Medical Release Authorization: _____
 (Resident/legal representative signature)

Physician Name: _____ Phone: _____

Physician Address: _____

Dear Dr. _____,

The above named individual has hereby signed authorization for you to assist in the evaluation for placement in our assisted living residence. Please complete and return this form, releasing any pertinent documents that may be helpful in providing care at our residence.

Diagnosis: _____

Current medical problems:

Medical/Surgical history:

Dietary restrictions (therapeuticdiets not available):

Can applicant monitor his/her own dietary restrictions? Yes ___ No ___

History of destructive, aggressive or violent behavior or mental illness:

Blood Press. _____ Pulse _____ Resp. _____ Temp _____ Height _____ Weight _____

Date of Immunizations: Flu _____ Pneumovax _____ Tetanus _____

Date of last PPD _____ Results: _____

Date of last chest X-ray: _____ Results: _____

Does applicant presently suffer from any communicable disease? Yes ___ No ___

If yes, please describe: _____

Current Medications and Treatments:

Drug:

Dose:

Directions:

PRN Medications:

Which medications would you like to be notified of if refused? _____

Allergies:

Does applicant have any of the following conditions? If so, please describe below:

Incontinence Yes ___ No ___

Ambulating Problems Yes ___ No ___

Sensory Deficits Yes ___ No ___

Colostomy Care Yes ___ No ___

Foley Care Yes ___ No ___

Recent Falls Yes ___ No ___

Oxygen Yes ___ No ___

Flow rate: _____

Assistive Devices: Yes ___ No ___

Other Concerns:

____ I authorize the ALR staff to possess and supervise the administration of medications for this applicant according to the prescribed directions included here. These medications have been reviewed and approved.

____ This resident may self-administer all medications

To the best of your knowledge, could this individual function in assisted living without the benefit of skilled services on a regular basis? Yes ___ No ___

Dr. _____ Signature _____ Date: _____

Please call if you have questions.

Sincerely, _____