How to Apply for Assisted Living

To ensure that we are able to meet the unique needs of each applicant, please complete the following admission process.

This includes:

1. An **application**, including a financial disclosure of your income and assets. This is used to determine eligibility for our assisted housing program. You may also be asked to verify your income and assets. In addition, we will request income verification such as SS or SSDI award letters. If you are on HCBS (Medicaid program) we will have to have the PETI/PAR in advance of move in.

2. An **Assisted Living Resident Questionnaire** will be required for each resident.

3. A **medical history** which is completed by your physician. It includes information about medications, health requirements and personal care needs. This history must be current (within 30 days of moving in) and be received prior to moving in.

4. A **personal interview and evaluation** with the staff to assess the applicant’s needs and our ability to provide the appropriate assistance.

5. A **background check** will be completed on all applicants for housing at Senior Housing Options managed property.

6. Please **mail or fax** the application and background check to start the admission process. The manager will contact you for a tour and assessment to discuss your individual needs.

**Security Deposit:** Each resident is required to make a $300.00 security deposit. This deposit is refundable when a move-in does not occur due to illness or failure to meet the occupancy criteria, or at the time of move-out according to the terms of the Resident Occupancy Agreement.

All applications forms can be found online and downloaded from our website at [www.seniorhousingoptions.org](http://www.seniorhousingoptions.org) on the Become a Resident Page.
Please feel free to contact any of our managers if you have questions about admission.

Additional amenities, and admission criteria information can also be found on our website.

**Assisted Living (Private Pay & HCBS Medicaid MI & EBD Approved Waivers Accepted)**

Services provided by assisted living:

- Limited assistance with bathing, dressing and other ADLs
- Medication administration
- 3 home cooked meals
- Snacks and food available 24/7
- Housekeeping
- Laundry and linen service
- Activity programs & bus outings
- 24 hr protective oversight
- Respite care $150/day (up to 30 days)
- Must be a senior or a disabled older adult to qualify
- Pet, service and companion animal friendly

Senior Housing Options, Inc. is non-profit corporation celebrating over 40 years of service. We currently own and/or operate Nine residences in Colorado. We serve over 300 residents in our communities and we strive to assist seniors of low and moderate incomes and adults with disabilities and chronic mental illness.

Our mission is to provide and promote quality affordable housing & services in a caring environment for older adults in Colorado.

Thank you for your interest in Senior Housing Options. Changing homes can be difficult and we are here to help.
Our mission is "To Provide and Promote Quality Affordable Housing & Services in a Caring Environment for Older Adults in Colorado."

1510 17th Street Denver, CO. 80202 PH: 303-595-4644 FAX: 303-595-9225 seniorhousingoptions.org
INSURANCE INFORMATION:
Are you currently on Medicare Part-A? Yes __ No __
Part-B? Yes __ No __
Part-D? Yes __ No __
Are you currently with an HMO? Yes __ No __
Name of HMO? ___________ HMO Number: _____________
Do you have Medicaid Health and Community Based Services (HCBS)? Yes _ No _
Application in Process _Number ___________ 
Do you have a caseworker or a social worker? Yes _ No _
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. In cooperation with this policy, please provide answers to the following questions:
Who will be responsible for paying any fees associated?
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 deferred savings and investment accounts, retirement accounts (including IRA's, Keogh accounts and annuities) and any other assets.
<table>
<thead>
<tr>
<th>Type of Asset</th>
<th>Financial Institution</th>
<th>Address and Phone Number</th>
<th>Account Number</th>
<th>Current Balance</th>
</tr>
</thead>
</table>

**********

Page 2 of 4
<table>
<thead>
<tr>
<th>Financial Institution</th>
<th>Type of Asset</th>
<th>Phone Number</th>
<th>Address</th>
<th>State</th>
<th>City</th>
<th>ZIP</th>
</tr>
</thead>
</table>

**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.

**Name:**
**Address:**
**City:**
**State:**
**ZIP:**

Who will be responsible for paying any fees associated?

**FINANCIAL INFORMATION:** This facility is owned and operated by Senior Housing Options Inc. a non-profit 501(c)(3) charitable organization dedicated to providing

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you have a caseworker or a social worker? Yes __ No __
 Are you currently on Medicare Part A? Yes __ No __
 Are you currently on Medicare Part B? Yes __ No __
 Do you have Medicaid Health and Community Based Services (HCBS)? Yes __ No __
 If you answer Yes, please provide the following information:

**Name**
**Number**

<table>
<thead>
<tr>
<th>HMO Number</th>
<th>Name of HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Race of Head of Household:**
- Black
- Hispanic
- Non-Hispanic
- Other
- Asian/Pacific Islander
- American Indian or Alaska Native

**Ethnicity of Head of Household:**
- Hispanic
- Non-Hispanic

<table>
<thead>
<tr>
<th>Month/Year</th>
<th>Expiry</th>
<th>Contact Name</th>
<th>Contact Phone</th>
<th>Address</th>
<th>City</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Rental History:** Please complete the following rental history. Start with your current or most recent address. Include places where you lived but were not listed on the lease.

<table>
<thead>
<tr>
<th>Monthly Rent</th>
<th>Address</th>
<th>City</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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, pensions, interest, and income from all other employment. Verification of income must be provided in the form of bank statements, W-2's, or other written statements of income. Include all sources of income, including wages, social security, pensions, interest, and income from all other sources.
APPLICATION AUTHORIZING:

I/we authorize management to make any and all inquiries to verify information and to contact previous and current landlords or other sources for verification of information provided in this application.

This includes, but not limited to authorization to obtain criminal background and/or credit information for Senior Housing Options.

APPLICATION CERTIFYING:

The above statements are true to the best of my knowledge. Applicant certifies that statements made in this application are true and complete and that false statements may result in a denial of this application. 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.

Signature of Person Completing Application

Signature of Applicant (if applicable)

Printed Name

Phone/Contact #

Relationship

Date

Signature of Person Completing Application

SIGNATURE(s):
CRIMINAL RECORDS CHECK DISCLOSURE AND CONSENT FORM ALR

Screening for Drug Abuse and Other Criminal Activity – A criminal records search and a registered sex offender search will be conducted on each adult applicant who is 18 years of age or older in the state of Colorado and in other states where the household members are known to have resided.

A criminal records check through Colorado Bureau of Investigation will be conducted on all Applicants for housing at any Senior Housing Options (SHO) managed building. This includes applicants who state on their applications that they do not have criminal record. If a criminal records check reveals that an Applicant has a criminal record and the Applicant failed to indicate the presence of the criminal record on his or her application, then the Applicant’s application for housing will be denied on the basis that the Applicant failed to be truthful when filling out the applications. 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.

Violence Against Women and Justice Department Reauthorization Act of 2005 – VAWA Protections: The property will not consider incidents of domestic violence, dating violence or stalking as serious or repeated violations of the lease or other “good cause” for termination of assistance, tenancy or occupancy rights of the victim of abuse. The property will not consider criminal activity directly relating to abuse, engaged in by a member of a tenant’s household or any guest or other person under the tenant’s control, cause for termination of assistance, tenancy, or occupancy rights if the tenant or an immediate member of the tenant’s family is the victim or threatened victim of that abuse.

The property will request in writing that the victim, or a family member on the victim’s behalf, certify that the individual is a victim of abuse and that the Certification of Domestic Violence, Dating Violence or Stalking, Form HUD-91066, or other documentation as noted on the certification form, be completed and submitted within 14 business days, or an agreed upon extension date, to receive protection under the VAWA. Failure to provide the certification or other supporting documentation within the specified timeframe may result in eviction.

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.

Applicant Signature (Required): ☒ ______________________________ Date: _____ / _____ / _____

Printed Applicant Name (Required): ___________________________ Date of Birth (Required): _____ / _____ / _____

Social Security Number: _____ - _____ - _____ Home/Cell Phone Number: (____) ____ - _____ Sex: ☐ Male ☐ Female

Street Address (Do Not Provide a Post Office Box): _______________________________________________

City: ___________________________ State: ___ Postal Code: _________ Dates of Residence: _____ / _____ TO _____ / _____

[Month] [Year] [Month] [Year]
IF YOU HAVE LIVED OUTSIDE THE STATE OF COLORADO DURING THE PAST 5 YEARS YOU MUST PROVIDE YOUR OUT-OF-STATE ADDRESS(ES) TO MEET VERIFICATION REQUIREMENTS:

STREET ADDRESS (DO NOT PROVIDE A POST OFFICE BOX):

CITY: _______________    STATE: ___    POSTAL CODE: _______    DATES OF RESIDENCE: ______/______ TO ______/______
[MONTH] [YEAR] [MONTH] [YEAR]

COUNTY: ____________________________

STREET ADDRESS (DO NOT PROVIDE A POST OFFICE BOX):

CITY: _______________    STATE: ___    POSTAL CODE: _______    DATES OF RESIDENCE: ______/______ TO ______/______
[MONTH] [YEAR] [MONTH] [YEAR]

COUNTY: ____________________________

Senior Housing Options, Inc. does not discriminate on the basis of disability status in the admission or access to, or treatment or employment in, its federally assisted programs and activities. The person named below has been designated to coordinate compliance with the nondiscrimination requirements contained in the Department of Housing and Urban Development’s regulations implementing Section 504 (24 CFR, part 8 dated June 2, 1988). [Senior Housing Options, Compliance Manager, 1510 17th Street, Denver, CO 80202 303-595-4464, 1-800-659-2656 TDD].

Senior Housing Options, Inc. does not discriminate on the basis of disability status in the admission or access to, or treatment or employment in, its federally assisted programs and activities. The person named below has been designated to coordinate compliance with the nondiscrimination requirements contained in the Department of Housing and Urban Development’s regulations implementing Section 504 (24 CFR, part 8 dated June 2, 1988). [Senior Housing Options, Compliance Manager, 1510 17th Street, Denver, CO 80202 303-595-4464, 1-800-659-2656 TDD].
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 (therapeutic diets not available): ____________________________
________________________________________________________

Can applicant monitor his/her own dietary restrictions? Yes____ No____

History of destructive, aggressive or violent behavior or mental illness:
<table>
<thead>
<tr>
<th>Blood Press.</th>
<th>Pulse</th>
<th>Resp.</th>
<th>Temp</th>
<th>Height</th>
<th>Weight</th>
</tr>
</thead>
</table>


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:

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Directions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PRN Medications:

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
</table>

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

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
</table>

Allergies:

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
</table>

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, ________________________________________________