



## 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 ALR 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 - \$600.00 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.

**Room Hold:** To hold a unit prior to move-in, a room hold charge may be required. Units will not be held for longer than 2 weeks.

All applications forms can be found on line 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.



1510 17th Street Denver, CO. 80202 PH: 303-595-4644 FAX: 303-595-9225 seniorhousingoptions.org

Our mission is "To Provide and Promote Quality Affordable Housing & Services in a Caring Environment for Older Adults in Colorado".

**Please check the Assisted Living Residence you are applying to below:**

- The Barth Hotel (Denver CO) Phone 303-534-7142 Fax 303-534-3828     Cinnamon Park (Longmont CO) Phone 303-772-2882 Fax 303-772-8318
- Mesa Vista (Parachute CO) Phone 970-285-1844 Fax 970-285-6351     Madison House (Cortez CO) Phone 970-565-2047 Fax 970-565-2587
- Parkhill (Denver CO) Phone 303-388-9437 Fax 303-370-1063

## Rental Application

**How did you hear about Senior Housing Options, Inc. Denver CO?** \_\_\_\_\_

**Are you applying for Assisted Living Residence or Apartment Living?** \_\_\_\_\_ (choose one- Mesa Vista Only)

### APPLICANT INFORMATION:

Date: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Present Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County: \_\_\_\_\_

How long at this address? \_\_\_\_\_

Telephone: \_\_\_\_\_ Cell \_\_\_\_\_ email \_\_\_\_\_

Spouse/Partner Name \_\_\_\_\_ Phone \_\_\_\_\_ email \_\_\_\_\_

Name of Legal Representative (if applicable) \_\_\_\_\_

Address of Legal Representative \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Past Occupation: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

**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 \_\_\_ 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 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 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	Current Balance

## 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: \_\_\_\_\_

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

**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 and where you lived under a different name for at least the last five years.

Address	City	State	How long?
Landlord Name	Landlord Phone	Evicted?	Monthly Rent
Address	City	State	How long?
Landlord Name	Landlord Phone	Evicted?	Monthly Rent
Address	City	State	How long?
Landlord Name	Landlord Phone	Evicted?	Monthly Rent

**ETHNICITY of head of household:** \_\_\_\_\_ Hispanic \_\_\_\_\_ Non-Hispanic

**RACE of head of household:** \_\_\_\_\_ White \_\_\_\_\_ Black \_\_\_\_\_ American Indian or Alaskan Native \_\_\_\_\_ Asian/Pacific Islander \_\_\_\_\_ Other

**SIGNATURE(S):**

**APPLICANT 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.**

**APPLICANT 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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant (if applicable)

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Phone/Contact #





**SIGNATURE(s):**

**APPLICANT 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.**

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\_\_\_\_\_  
Signature of Person Completing Application

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant (if applicable)

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Phone/Contact #







1510 17<sup>TH</sup> STREET  
DENVER, CO 80202  
303-595-4464  
303-595-9225 FAX  
1-800-659-2656 TDD



[WWW.SENIORHOUSINGOPTIONS.ORG](http://WWW.SENIORHOUSINGOPTIONS.ORG)

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

**The Barth Hotel Phone 303-534-7142 Fax 303-534-3828**  
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**Cinnamon Park Phone 303-772-2882 Fax 303-772-8318**  
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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 (therapeutic diets 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, \_\_\_\_\_

