Kavod
ASSISTED LIVING
AT CHERRY CREEK

Dear Prospective Resident,

Welcome! We are so glad to hear about your interest in Kavod Assisted Living! We pride ourselves in offering the highest quality housing, support and amenities at competitive prices, affordable or otherwise. Our campus is known for its wonderful location here in Cherry Creek and the variety of services we offer to every resident.

All of our Assisted Living apartments are private one-bedroom or studio units with private bathrooms. Our support services include three nutritious meals per day, a full calendar of social activities and events, medication monitoring, emergency cords and wristbands, and much, much more. Most important, our staff have been around for a long time and provide the relational warmth, care and comfort that makes Kavod feel like home.

Enclosed is more information about all the specific services we provide and our eligibility criteria. We encourage you to set up a tour, ask lots of questions, and even come join us for a meal or activity to get to know us better. We are confident you will enjoy your time with us and find us to be a loving, supportive community.

Please call us at 720.382.7833 to set up your tour or email us at info@kavodseniorlife.org. We will be happy to help you in any way we can. You may also find information on our web site at www.kavodseniorlife.org/faqs.

We look forward to hearing from you!

Warmly,

Christy Martinez

Christy Martinez
Director of Assisted Living

Assisted Living Program Admission Policy

Kavod Assisted Living (AL) is a section of Kavod Senior Life, a non-profit corporation governed by a Board of Directors representing the Denver Community. Kavod Senior Life provides life-enriching experiences to older adults through a broad range of housing and support services that reflect the spiritual, social, and cultural values of Jewish tradition.

As Kavod Senior Life's primary focus is on serving low-income seniors, Kavod is regulated and subsidized by the Department of Housing and Urban Development (HUD). While Kavod Senior Life is a HUD subsidized facility, Kavod Assisted Living is not HUD subsidized. We accept private pay, Long Term Care Insurance, Veterans Pension, and Medicaid. Kavod Senior Life does not accept outside InnovAge applications. We will accept applications from current Senior Living residents with InnovAge.

Ten slots are available for residents on Colorado First (Medicaid) Home and Community Based Services (HCBS) waiver program. When Medicaid openings are available, the order of priority shall be as follows: 1) One year market rate current AL resident, 2) One year market rate Kavod Senior Living resident, 3) Other current Kavod Senior Living residents, and 4) Non-residents.

Services Provided: Kavod Assisted Living provides the following services:

Weekly housekeeping and laundry services	3 Kosher style meals per day
Minimum of 5 wellness checks per day	Medication assistance
Dressing and bathing assistance	Reminders for daily activities, meal times and appointments
Trash removal and bed-making daily	

Eligibility Criteria: The criteria for eligibility include the following:

- 62 years of age or older
- Successfully ambulate independently at least 150 feet
- Able to perform or be willing to receive assistance with activities of daily living, such as dressing, personal hygiene and bathing
- Continent or capable of managing incontinence without cuing from staff
- Cannot be profoundly disoriented to time, person and place with safety concerns requiring a secure environment
- Cannot require a therapeutic diet, transfer assistance, or restraints
- Cannot have a history of conduct that would pose a danger to self/others

Please be advised that incontinence care, transfer assistance, and escorting to daily activities, appointments or programs is not provided.

Admission Procedure: Admission to the program will be granted to those whose needs can be met by the services provided by AL. Criteria for acceptance are defined by Colorado Department of Public Health and Environment (State) regulations, Board policy, and assessment of functional ability by professional staff as required by policy and procedure.

Please submit the following documents so that an assessment may be scheduled:

	Application – pages 5-12
	Medicaid Applicants only - SEC case manager release – page 8
	Credit and Background Inquiry Release – pages 13-14
	Citizenship Declaration & appropriate documentation – p 17-21
	Applicant/Family Evaluation – pages 23-24
	Physician Evaluation Release & contact info – pages 25-27
	How did you hear about us questionnaire – page 30
	Consent to the Release of Information
	Supplement to Application - Additional Contact Person
	Race & Ethnic Data Reporting form (optional)

Upon receipt of all required forms, the applicant will be placed on the wait list. When a unit becomes available, credit, background, and landlord verifications will be initiated. After approval the applicant will be called to schedule the assessment.

Assisted Living Fees & Apartment Cost

Apt. Size	Square Ft.	Single Occupancy	Double Occupancy
Studio	373	$3,800	- - -
Small 1 Bedroom	460	$3,900	$7,300
Large 1 Bedroom	570	$4,100	$7,700

Retainer: A prospective resident may place a hold on an available apartment in Assisted Living for up to two weeks with a $200 retainer deposit. The $200 will be credited to the prospective resident's first month's rent at his/her time of move-in. The deposit is non-refundable unless the prospective resident is denied entrance into the program based on the results of the functional assessment conducted by Kavod staff. At the end of two weeks, the prospective resident must either start paying the apartment rent or forfeit his/her hold on the apartment.

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Frequently Asked Questions

Q: How much does Assisted Living cost?

A: As of January 2019, Assisted Living prices range from $3,800.00 – $4,100.00 depending on the apartment rented. This price is subject to change, so please contact Kavod's Leasing Coordinator for current rates at 303.399.1146.

Q: What if I cannot afford to pay privately?

A: We accept Long Term Care Insurance, Veterans Pension, and Medicaid.

Q: How do I apply for Medicaid assistance?

A: Eligibility for Medicaid (Health First Colorado) is determined by the State of Colorado and can take 8-12 weeks to process. Please contact the Denver Department of Human Services online at Colorado.gov/PEAK or by phone at 1-800-221-3943 to apply for Medicaid services. Kavod is unable to lease apartments to applicants with Medicaid pending.

Q: Do you have 2 bedroom apartments?

A: No. Our apartments consist of studio and one-bedroom units.

Q: Do you have to be Jewish to live at Kavod Assisted Living?

A: No. We pride ourselves on being a community open to all, regardless of religious affiliation or ethnic background. In fact, the residents of Kavod are a diverse group of individuals from all walks of life.

Q: Will I lose my independence if I move into Assisted Living?

A: No. Assisted Living services are designed to help residents with Activities of Daily Living (or ADL's), such as housekeeping, laundry, and meal preparation. Providing assistance in these areas allows our residents to be more independent and choose to spend time on activities they enjoy.

Some of the oversight we provide is in place to keep our residents safe and to comply with regulations from the Colorado Department of Public Health and Environment. For example, Assisted Living residents are required to eat meals in the dining area based on individual care plan, comply with state mandates surrounding medications, and report to their caregiver if leaving the facility. While each facility has different protocols surrounding these items, all Assisted Living facilities follow these guidelines to stay in good standing.

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Office Use Only
Date Received Complete: _____
Time: _____
Staff Initials: _____

Application

** All applications and information will be reviewed on an impartial basis and will be kept confidential. Proper documentation (social security card and proof of age) should be provided during the application process. All information, including age, legal status, and social security number will be verified.**

APPLICANT #1 (Head of Household)

Last Name | First Name | Middle Name

Current Street Address | City | State | Zip Code

/ / | M / F / Prefer not to Respond

Age | Date of Birth | City of Birth | Sex (circle one)

Social Security Number | Telephone Number

Citizenship Status

☐ US Citizen ☐ Legal Immigrant ☐ Non-legal Immigrant

APPLICANT #2

Last Name | First Name | Middle Name

Current Street Address | City | State | Zip Code

/ / | M / F / Prefer not to Respond

Age | Date of Birth | City of Birth | Sex (circle one) | Relationship to Applicant #1

Social Security Number | Telephone Number

Citizenship Status

☐ US Citizen ☐ Legal Immigrant ☐ Non-legal Immigrant

Please indicate what size apartment you are interested in:

☐ Studio ☐ One Bedroom ☐ No Preference

Do you or any member of the household require special physical accommodations?

☐ Accessible Apartment ☐ Assisted Living ☐ Other _____

Do you have a pet? *Pets are permitted though the Pet Agreement requirements must be met. Pet Agreement is available upon request.*

☐ Yes ☐ No

Do you own a vehicle for which a parking space will be required?

☐ Yes ☐ No

Are you any member of the household currently enrolled as a student at an institution of higher education?

☐ Yes ☐ No

Have you been displaced due to government action or a presidential declared disaster such as Hurricane Katrina?

☐ Yes _____ ☐ No

Are you or any member of the household currently employed?

☐ Yes – FT or PT? ☐ No

Have you or any member of the household been evicted within the last five years?

☐ Yes ☐ No

Have you or any member of the household ever been convicted of a felony?

☐ Yes ☐ No

Are you or any member of the household subject to any state lifetime sex offender registration requirement?

☐ Yes ☐ No

Have you ever been convicted of a drug or alcohol related offense?

☐ Yes ☐ No

Are you presently receiving a rent subsidy from HUD?

☐ Yes ☐ No

Will you need a rent subsidy if approved for residency at Kavod Assisted Living?

☐ Yes ☐ No

Please note: According to HUD Regulations, tenants may have Section 8 assistance on only one residence. This residence must be the applicant's only residence.

Please list all states you or any member of the household has lived:

_____

_____

Kavod Assisted Living is an indoor smoke-free community and no smoking is allowed in any of the buildings, including residents' apartments. Smoking is allowed outside in designated areas of the grounds. Are you a smoker?

☐ Yes ☐ No

Will you be able to comply with Kavod nonsmoking ban?

☐ Yes ☐ No

Are you currently residing in an assisted living, nursing home or rehabilitation center? **

☐ Yes ☐ No

If yes, please list the case manager/discharge planner that is assisting with the transfer of care process:

_____

_____

**Please be advised that Kavod Senior Life will require documentation from the current facility as part of the comprehensive assessment that is completed to ensure that Kavod Senior Life's level of care is safe and appropriate.

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Medicaid Applicants: In addition to the application and checklist materials, we are now required to have the following items in order to process your application:

Medicaid Case Number: _____

SEC Case Manager Name: _____ Phone: _____

SEC Case Manager Long Term Care Service Plan: Please attach or have case manager fax the Long Term Care Service Plan to 720.382.7850 or 720.382.7845.

As this information is Protected Health Information (PHI), we are unable to obtain these documents without your permission. These documents are required as part of the comprehensive assessment that must be completed to ensure our level of care is safe and appropriate as well as ensure that each resident is making an informed choice regarding their next home. If you are unable to attach this document and would like to provide permission for us to request the document, please sign permission form below.

SEC Case Manager Assessment
Consent for Release of Information

I hereby authorize release of my SEC Case Manager assessment information to _____. **I understand that I do not have to sign this consent if it is not clear to me who will provide the information or who will receive the information.** **/ /**
Applicant's Signature or Legal Representative **Date Signed** **/ /**
Patient's Name Printed **Birth Date**

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Consent for Landlord Reference

Please provide housing contact information for the **past five (5) years**; you may use an additional page if necessary. These references will be contacted by Kavod leasing personnel. Rental history screening will also include verification for those who were homeowners or lived with parents, guardians, or other relatives; if this applies to you, please provide contact information for family members, guardians, and friends whom you have lived with in the past five (5) years.

Current Landlord:

Name	Telephone Number	Fax Number	/ / to / / Dates of Residency

Street Address	City	State	Zip Code

Former Landlord:

Name	Telephone Number	Fax Number	/ / to / / Dates of Residency

Street Address	City	State	Zip Code

Former Landlord:

Name	Telephone Number	Fax Number	/ / to / / Dates of Residency

Street Address	City	State	Zip Code

Former Landlord:

Name	Telephone Number	Fax Number	/ / to / / Dates of Residency

Consent for Landlord Reference

Street Address City State Zip Code

Former Landlord:

/ / to / /

Name Telephone Number Fax Number Dates of Residency

Street Address City State Zip Code

Former Landlord:

/ / to / /

Name Telephone Number Fax Number Dates of Residency

Street Address City State Zip Code

I hereby give permission to the listed landlords to provide Kavod Assisted Living information regarding my residency.

I understand that I do not have to sign this consent if it is not clear to me who will provide the information or who will receive the information.

Applicant's Signature Date Signed

Applicant's Name Printed

Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government. HUD and any owner (or any employee of HUD or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person who knowingly or willingly requests, obtains or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than $5,000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages and seek other relief, as may be appropriate, against the officer or employee of HUD or the owner responsible for the unauthorized disclosure or improper use. Penalty provisions for misusing the social security number are contained in the Social Security Act at 208 (a) (6), (7) and (8). Violation of these provisions are cited as violations of 42 U.S.C. Section 408 (a) (6), (7) and (8).

Financial data – This information must be completed to be considered for residency at Kavod Assisted Living.

Privacy Act Statement – The Department of Housing and Urban Development (HUD) is authorized to collect this information by the U.S. Housing Act of 1937 (42 U.S.C. 1437 et. seq.), by Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d), and by the Fair Housing Act (42 U.S.C. 3601-19). The Housing and Community Development Act of 1987 (42 U.S.C. 3543) requires applicants and participants to submit the social security number of each household member who is 6 years old or older.

Purpose: Your income and other information are being collected by HUD to determine your eligibility, the appropriate bedroom size, and the amount your family will pay toward rent and utilities.

Other Uses: HUD uses your family income and other information to assist in managing and monitoring HUD-assisted housing programs, to protect the Government's financial interest, and to verify the accuracy of the information you provide. This information may be released to appropriate federal, state, and local agencies, when relevant, and to civil, criminal, or regulatory investigators and prosecutors. However, the information will not be otherwise disclosed or released outside of HUD, except as permitted or required by law.

Penalty: You must provide all of the information requested by the owner, including all social security numbers you, and all other household members age 6 years and older, have and use. Giving the social security numbers of all household members 6 years of age and older is mandatory, and not providing the social security numbers will affect your eligibility. Failure to provide any of the requested information may result in a delay or rejection of your eligibility approval.

Sources of *Monthly* Income:

Social Security	$
Supplemental Security Income	$
Pensions/Benefits - Source	$
Interest (Monthly) - Source	$
Dividends (Monthly) - Source	$
Gross Wages	$
Rental Income	$
Other Income	$
Total Monthly Income	**$**

Assets:

Checking Account(s)	Average Balance	$
Savings Account(s)	Average Balance	$
Market Value of Stocks		$
Market Value of Bonds		$
Market Value of Real Estate	(List Separately)	$
Cash Surrender Value of Life Insurance		$
Other Assets (Cash on Hand; Collectibles; etc)		$
Total Assets		**$**

Medical Expenses:

Supplemental Health Insurance	$
Medical Expenses not Covered by Insurance	$
Other Unusual Medical Expenses	$
Total Medical Expenses	**$**

Please describe any unusual circumstances which may affect your income, assets, or medical expenses over the next twelve (12) months.

I understand that if I meet the eligibility criteria for residency at Kavod Assisted Living, I will be contacted for an assessment. I hereby certify that all information contained on this application is correct and complete to the best of my knowledge. I understand that any material misrepresentation will result in my being ineligible for consideration. I understand that it is my responsibility to provide verifying documentation for all information contained within this application when requested by Kavod Assisted Living.

Signature of Applicant #1 Date

Signature of Applicant #2 Date

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Credit and Background Inquiry Release

In connection with my application for residency at Kavod Assisted Living ("Kavod"), I hereby authorize Kavod and/or its designated resident screening provider and/or its employees to obtain information concerning my past credit information, criminal information, tenant-landlord history, and/or past addresses, in accordance with the Fair Credit Reporting Act and all state and federal laws.

I hereby authorize any of the following sources, including but not limited to: landlords; public or privately-owned utilities; current or past creditors; governmental housing agencies; credit reporting agencies; criminal and court reporting agencies; and/or government or court agencies providing criminal or court records; to release any information to Kavod, its resident screening provider, and/or employees concerning my credit, criminal, tenant-landlord history, and/or past addresses.

I understand that should I lease an apartment, Kavod and its agent(s) shall have continuing right to review my credit information, criminal information, rental application, payment history and occupancy history for account review purposes and for improving application review methods.

I further release and discharge all liability from all companies, agencies, officials, officers, and other persons, who, in good faith, provide to Kavod the above-mentioned information as requested in order to successfully complete a background investigation for my application of residency. I will allow a photocopy of this authorization to be as valid as the original.

Print Full Name:_____

Social Security #: _____ Date of Birth: _____

Driver's License: State: _____ Number: _____

Date of Birth is being requested for the purpose of identification in obtaining accurate retrieval of records and will not be used for discriminatory purposes.

continued next page

Current Address: _____

City, State, Zip _____

Previous Address(es) During Past 5 years:

_____

_____

_____

_____

_____

Applicant's Signature:_____

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Instructions for Citizenship Declaration

Section 214 of the Housing and Community Development Act of 1980, as amended, prohibits the Secretary of HUD from making financial assistance available to persons other than U.S. citizens or nationals, or certain categories of eligible non-citizens, in the following HUD programs:

a. Section 8 Housing Assistance Payment programs;
b. Section 236 of the National Housing Act including Rental Assistance Payment (RAP); *and*
c. Section 101/Rent Supplement program.

You have applied, or are applying for, assistance under one of these programs; therefore, you are required to declare U.S. Citizenship or submit evidence of eligible immigration status for each of your family members for whom you are seeking housing assistance. You must do the following:

1. Complete a Family Summary Sheet, using the attached blank format to list all family members who will reside in the assisted unit.

2. Each family member (including you) listed on the Family Summary Sheet must complete a Citizenship Declaration. For example, if there are 2 people listed on the Family Summary Sheet, you should have 2 completed copies of the Citizenship Declaration. The Citizenship Declaration has easy-to-follow instructions and explains what, if any other forms and/or evidence must be submitted with each Declaration.

3. Submit the Family Summary Sheet, the Citizenship Declarations, and any other forms and/or evidence with your completed application to:

   Kavod Assisted Living
   Attn: Leasing Coordinator
   22 S. Adams Street
   Denver, CO 80209

This Section 214 review will be completed in conjunction with the verification of other aspects of eligibility for assistance. If you have any questions or difficulty in completing the attached items or determining the type of documentation required, please contact our Leasing Coordinator at 720.382.7833. We are happy to assist you. Failure to provide this information or establish eligible status may result in your not being considered for housing assistance.

If this Section 214 review results in a determination of ineligibility, you will have an opportunity to appeal the decision. Also, if the final determination concludes that only certain members of your family are eligible for assistance, your family may be eligible for pro-ration of assistance. That means that when assistance is available, a reduced amount may be provided for your family based on the number of members who are eligible.

If assistance becomes available and the other aspects of your eligibility review show that you are eligible for housing assistance, that assistance may be provided to you if at least one member of your household has submitted the required documentation. Following verification of the documentation submitted by all family members, assistance may be adjusted depending on the immigration status verified. You will be contacted as soon as we have further information regarding your eligibility for assistance.

Family Summary Sheet

Please list each person who will reside in the apartment.

Member #	Last Name of Family Member	First Name	Relationship to Head of Household	Date of Birth
Head				
2				
3				

Each family member (including you) listed on this Family Summary Sheet must complete a Citizenship Declaration form.

Citizenship Declaration

INSTRUCTIONS: Complete this Declaration for each member of the household listed on the Family Summary Sheet.

Last Name	First Name	Date of Birth
Relationship to Head of Household	Social Security Number	

Admission Number _____ if applicable
(This is an 11-digit number found on DHS Form I-94, Departure Record)

Nationality _____
(Enter the foreign nation or country to which you owe legal allegiance. This is normally, but not always, the country of birth.)

Save Verification Number _____
(to be entered by owner if and when received)

INSTRUCTIONS: Complete the Declaration below by printing or typing the person's first name, middle initial, and last name in the space provided. Then review the blocks shown below and complete either block number 1, 2, or 3:

DECLARATION

I, _____, hereby declare, under penalty of perjury, that I am _____

(print or type first name, middle initial, last name)

_____ 1. A citizen or national of the United States.

Sign and date below and return to the name and address specified in the attached Instructions for Citizenship Declaration. If this block is checked on behalf of a child, the adult who will reside in the assisted unit and who is responsible for the child should sign and date below.

Signature	Date

Check here if adult signed for a child: _____

_____ 2. A non-citizen with eligible immigration status as evidenced by one of the documents listed below:

NOTE: If you checked this block and you are 62 years of age or older, you need only submit a proof of age document together with this form and sign below.

If you checked this block and you are less than 62 years of age, you should submit the following documents:

a. Verification Consent Form

AND

b. One of the following documents:

i. Form I-551, *Alien Registration Receipt Card* (for permanent resident aliens)

ii. Form I-94, *Arrival-Departure Record*, with one of the following annotations:

1. "Admitted as Refugee Pursuant to Section 207";
2. "Section 208" or "Asylum";
3. "Section 243(h)" or "Deportation stayed by Attorney General"; or
4. "Paroled Pursuant to Section 212(d)(5) of the INA."

iii. If Form I-94, *Arrival-Departure Record*, is not annotated, it must be accompanied by one of the following documents:

1. A final court decision granting asylum (but only if no appeal is taken);
2. A letter from an DHS asylum officer granting asylum (if application was filed on or after October 1, 1990) or from an DHS district director granting asylum (if application was filed before October 1, 1990);
3. A court decision granting withholding or deportation; or
4. A letter from an DHS asylum officer granting withholding of deportation (if application was filed on or after October 1, 1990).

iv. Form I-688, *Temporary Resident Card*, which must be annotated "Section 245A" or "Section 210."

v. Form I-688B, Employment Authorization Card, which must be annotated "Provision of Law 274a.12(11)" or "Provision of Law 274a.12."

vi. A receipt issued by the DHS indicating that an application for issuance of a replacement document in one of the above-listed categories has been made and that the applicant's entitlement to the document has been verified.

vii. Form I-151, *Alien Registration Receipt Card*

If block 2 is checked, sign and date below and submit the documentation required above with this declaration and a verification consent format to the name and address specified in the Instructions for Citizenship Declaration. If this block is checked on behalf of a child, the adult who will reside in the assisted unit and who is responsible for the child should sign and date below.

_____ _____

Signature Date

Check here if adult signed for a child: _____

If for any reason, the documents shown in subparagraph 2b are not currently available, please complete the Request for Extension block below.

REQUEST FOR EXTENSION

I hereby certify that I am a non-citizen with eligible immigration status, as noted in block 2 above, but the evidence needed to support my claim is temporarily unavailable. Therefore, I am requesting additional time to obtain the necessary evidence. I further certify that diligent and prompt efforts will be undertaken to obtain this evidence.

_____ _____

Signature Date

Check here if adult signed for a child: _____

_____ 3. I am not contending eligible immigration status and I understand that I am not eligible for financial assistance.

If you checked this block, no further information is required, and the person named above is not eligible for assistance. Sign and date below and forward this form to the name and address listed on the Instructions for Citizenship Declaration. If this block is checked on behalf of a child, the adult who is responsible for the child should sign and date below.

_____ _____

Signature Date

Check here if adult signed for a child: _____

Verification Consent Form

INSTRUCTIONS: Complete this format for each non-citizen family member who declared eligible immigration status on the Citizenship Declaration form. If this form is being completed on behalf of a child, it must be signed by the adult responsible for the child.

CONSENT

I, _____, hereby consent to the following:
(print or type first name, middle initial, last name)

1. The use of the attached evidence to verify my eligible immigration status to enable me to receive financial assistance for housing; and

2. The release of such evidence of eligible immigration status by the project owner without responsibility for the further use or transmission of the evidence by the entity receiving it to the following:

   a. HUD, as required by HUD; and
   b. The DHS for purposes of verification of the immigration status of the individual.

_____ _____

Signature Date

Check here if adult signed for a child: _____

NOTIFICATION TO FAMILY: Evidence of eligible immigration status shall be released only to the DHS for purposes of establishing eligibility for financial assistance and not for any other purpose. HUD is not responsible for the further use or transmission of the evidence or other information by the DHS.

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Applicant/Family Self-Evaluation

Applicant's Name: _____ **Age:** _____

What are your present living arrangements? _____

_____

What type of assistance do you currently receive? _____

_____

How soon are you looking to move into Assisted Living?

_____

Which areas would you benefit from assistance?		
Activity of Daily Living (ADL)		**Type of Assistance**
Taking medication	☐ Yes ☐ No	
Preparing meals	☐ Yes ☐ No	
Dressing/Undressing	☐ Yes ☐ No	
Grooming	☐ Yes ☐ No	
Showering/bathing	☐ Yes ☐ No	
Housekeeping	☐ Yes ☐ No	
Laundry	☐ Yes ☐ No	
Transportation	☐ Yes ☐ No	
Accessing Community	☐ Yes ☐ No	
Community Involvement	☐ Yes ☐ No	

Physical Health:

Do you have any significant health concerns we should be aware of?

_____

_____

Do you have diet restrictions? ☐ Yes ☐ No Any difficulty swallowing? ☐ Yes ☐ No

If yes, please specify.

_____

_____

Mobility:

Do you utilize any of the following: ☐ Cane ☐ Walker ☐ Scooter ☐ Wheelchair

Able to ambulate independently 150 feet? ☐ Yes ☐ No

Able to transfer independently? ☐ Yes ☐ No

Able to go up/down stairs independently? ☐ Yes ☐ No

Cognitive Health:

How would you describe your memory? (Check one)	
☐	Good memory for present day events – no difficulty remembering names, places, or scheduled appointments. Do not become confused in unfamiliar place.
☐	Fair memory for present day events – little help required for remembering names or appointments. May become confused in unfamiliar place.
☐	Poor memory for present day events – Require a lot of reminders with names, scheduling and remembering appointments. Almost always confused in unfamiliar place.
☐	Extremely Poor memory – Do not remember familiar people or names. Others must schedule and supervise appointments. Do not know where he/she at most of the time.

Do you experience depression or anxiety? ☐ Yes ☐ No

If yes, is it: ☐ Mild ☐ Moderate ☐ Severe Do you take medications for it? ☐ Yes ☐ No

If yes, please explain:

_____

History of any of the following:

☐ Suicidal/self-abuse ☐ Substance Abuse ☐ Hoarding Behavior ☐ Resistance to Care
If yes, please explain:

_____

General Information:
Is anyone assisting with bill paying or managing your finances?
If yes, please provide name and phone number: *(If POA or Conservator, please provide copy)*

_____

Are you currently receiving Medicaid benefits?
*If yes, LTCO case manager*_____ *Contact Information*: _____

Additional Information you would like us to be aware of:

_____

_____

Evaluation Completed By: _____ Date: _____

Applicant Signature: _____ Date: _____

Thank you for completing the survey!

Instructions for Physician's Evaluation and Consent for Release of Medical Information

Applicant Instructions:

Please include your physician's name and contact information in the box below.

Please sign the Consent for Release of Information on page 27.

Please include your date of birth with release on page 27.

Please turn in the entire physician evaluation to Kavod Senior Life staff for processing. Alternatively, you may turn the physician evaluation in to your doctor's office for processing.

Name of Medical Professional		Telephone Number	
Street Address	City	State	Zip Code

Physician's Office Instruction:

Per your patient's release of information, please complete the physician evaluation.

Your patient is either a current resident of Kavod Senior Life or a prospective resident of our Assisted Living licensed by the Colorado Department of Public Health and Environment. The license requires that our facility provide non-medical care and supervision to meet the needs of that person. Our Assisted Living requires the following information to assist us in determining whether this person is appropriate for care in our non-medical facility. It is important that all questions be answered completely. Please attach additional pages if needed. **Our facility does not provide skilled nursing or dementia specific care.**

Please fax completed evaluation as soon as possible to:

Kavod Senior Life fax number 720.382.7850 or 720.382.7845

Kavod
ASSISTED LIVING
AT CHERRY CREEK

Physician Name _____

Physician Phone _____

Dear Doctor: _____

Your patient, _____, has applied for residency in our Assisted Living. Our program is designed to provide our residents with assistance maintaining Activities of Daily Living within a non-medical setting.

Services Provided by Kavod Assisted Living:

- Three (3) meals daily with snacks as needed
- Housekeeping once a week
- Laundry (personal and linen) once a week
- Bathing support twice a week
- Medication monitoring per Physician's orders
- Memory support – daily reminder of activities, meals, and appointments
- Scheduling of appointments
- Care coordination
- Friendly visiting and volunteer opportunities
- An assortment of daily activities

Eligibility Criteria (Our Assisted Living is not a medical facility and does not offer skilled nursing care):

- Successfully ambulate independently at least 150 feet.
- Able to perform or be willing to receive assistance with activities of daily living, such as dressing, personal hygiene and bathing.
- Continent or capable of managing incontinence.
- Safe within an unlocked community (cannot wander).
- Cannot require a therapeutic diet, transfer assistance, or restraints.
- Cannot have a history of conduct that would pose a danger to self/others.

In order to ensure that our residents are able to take advantage of this living environment, accurate health information is necessary. Please complete the attached questionnaire as accurately and thoroughly as possible.

We are unable to process your patient's application until these forms are completed and are received by our office. Your prompt assistance is greatly appreciated. If you have any questions about our Assisted Living, please call me at 720.382.7825.

Sincerely yours,

Christy Martinez

Christy Martinez
Director of Assisted Living

Kavod ASSISTED LIVING AT CHERRY CREEK

Physician's Evaluation
Consent for Release of Medical Information

I hereby authorize release of medical information to _____. **I understand that I do not have to sign this consent if it is not clear to me who will provide the information or who will receive the information.** **/ /**
Applicant's Signature or Legal Representative **Date Signed** **/ /**
Patient's Name Printed **Birth Date**

Patient Diagnosis - to be completed by Physician

Note to Physician: The person named above is either a current resident or a prospective resident of our Assisted Living licensed by the Colorado Department of Public Health and Environment. The license requires that our facility provide non-medical care and supervision to meet the needs of that person. Our Assisted Living requires the following information to assist us in determining whether this person is appropriate for care in our non-medical facility. It is important that all questions be answered completely. Please attach additional pages if needed. ***Our facility does not provide skilled nursing or dementia specific care.***

Date of Exam:	Height:	Weight:	Blood Pressure:

Tuberculosis (TB) Test:

Date TB Test given:	Date TB Test read:	Type of TB Test:	TB Test is: ☐ Negative ☐ Positive
Action taken if positive:			
Chest X-ray results:			

Patient/Resident Diagnosis:

_____

_____

Allergies (medications/food): ☐ Yes ☐ No
If yes, please explain reaction:

_____

Physical Health Status	Yes	No	Unknown	Explain
Auditory impairment				
Visual impairment				
Wears dentures				
Regular diet status				
Contagious/infectious disease				
Use of alcohol/cigarettes				
Substance abuse problems				
History of skin condition				
Bowel incontinence				Self-manage ☐ Yes ☐ No
Bladder incontinence				Self-manage ☐ Yes ☐ No
Motor impairment/paralysis				
Able to ambulate 150 feet independently				Assistive device?
Mental Condition	**Yes**	**No**	**Unknown**	**Explain**
Mild cognitive impairment				
Dementia				If yes, stage:
Confused/ disoriented				
Aggressive behavior				
Wandering behavior				
Sundown behavior				
Depression				
Anxiety				
Suicidal/ self-abuse				If yes, when:
Hospitalization for psychiatric condition				If yes, when:
Able to follow instructions				
Able to communicate needs				
At risk if allowed direct access to personal grooming and hygiene items				
Capacity for Self-Care	**Yes**	**No**	**Unknown**	**Explain**
Able to bathe/shower self				
Able to dress/groom self				
Able to feed self				
Able to care for own toileting needs				
Able to leave facility unassisted				
Able to self-manage heating pad				
Medication Management	**Yes**	**No**	**Unknown**	**Explain**
Able to self-administer prescribed meds				
Able to self-administer PRN medications				
Able to understand/request a PRN med				
Able to perform own glucose testing				Not applicable
Able to administer own injections				Not applicable
Able to manage own oxygen				Not applicable

Prescribed Medications – including OTC (please print)	Dosage	Route	Frequency	Function
PRN Medications (please print)	Dosage	Route	Frequency	Function

***** A signed/dated attached medication sheet will be accepted if more space is required.***

Recent Hospitalizations/Surgeries:

_____

_____

Length of time resident has been your patient: _____

Physician's Name and Complete Address (please print):

_____

_____

_____

Telephone: _____ **Fax: _____**

_____ _____

Physician's Signature **Date**

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Dear Applicant:

Kavod Assisted Living is very interested in knowing how you heard about us. Please check off the appropriate sources of information listed below. You may check more than one.

___ Friend

___ Relative

___ Resident

___ Brochure

___ Agency, i.e. HUD – specify: _____

___ Senior Resource Guide/Blue Book

___ Newspaper, specify: _____

___ Kavod Website

___ Internet Site, i.e. SeniorHousing.net – specify: _____

___ Internet Search, i.e. Google

___ Other, specify: _____

_____ /

Current Zip Code | Completed Month/Year

_____

Your Name (optional) | Telephone Number (optional)

Thank you for helping us gather this important information.

Sincerely,
Kavod Assisted Living

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