



Dear Prospective Resident,

Welcome! We are so glad to hear about your interest in Assisted Living at Kavod Senior Life! 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 in Cherry Creek and the variety of services we offer.

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, and much, much more. Most important, our staff 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
Director of Assisted Living

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Assisted Living Program Admission Policy

Overview: Kavod Assisted Living (AL) is a service of Kavod Senior Life, a non-profit organization governed by a Board of Directors representing the Denver community. The mission of Kavod Senior Life is to provide 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.

To support older adults with limited incomes, Kavod’s Independent Living apartments are regulated and subsidized by the Department of Housing and Urban Development (HUD). AL, however, 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 Independent Living residents with InnovAge. Ten apartments are available for residents on Colorado First (Medicaid) Long Term Care (LTC) waiver program. When one of these apartments become open, applications will be prioritized as follows: 1) one year market rate AL resident, 2) one year market rate Kavod Senior Living resident, 3) other current Kavod Senior Living residents, and 4) non-residents.

Services Provided: The following services are included in the basic Assisted Living fee.

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

Market Rate Apartment Costs and Service Fees:

Flat rate pricing = no incontinence management care, no escorts, does not use oxygen

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

Additional services may be provided after assessment on a tiered system:

Tier 1 : Escorts Only	\$250/month
Tier 1: Incontinence Management Only	\$450/month
Tier 1 : Oxygen Only	\$250/month
Tier 2: Escorts and Oxygen	\$500/month
Tier 2: Escorts and Incontinence Management	\$700/month
Tier 2: Oxygen and Incontinence Management	\$700/month

Retainer: Prospective residents may place a hold on an available apartment in Assisted Living for up to two weeks with a \$200 retainer. The \$200 will be credited to the prospective resident's first month's assisted living fee at time of move-in. The retainer 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 assisted living fee or forfeit the hold on the apartment.

Eligibility Criteria: The criteria for eligibility include the following:

- Must be 62 years of age or older.
- Must have financial resources to pay assisted living fees for a minimum of 12-months.
- Kavod does not have and cannot modify units for ADA mobility accessibility. Applicant must be able to ambulate independently at least 150 feet (assistive devices may be used).
- Must be able to eat independently and cannot require a therapeutic diet.
- May require assistance or supervision in one or more of the following areas: laundry, housekeeping, shopping, dressing, bathing, medication administration.
- May need assistance to plan organize, and carry out daily routines.
- Cannot be profoundly disoriented to time, person and place with safety concerns requiring a secure environment such as wandering or exit seeking.
- Must not require more than a one-person transfer assistance, or restraints or similar services specifically for the mentally ill.
- Exhibiting behavior problems disturbing to other residents is inappropriate for this facility. If the behavior problems can be controlled because of behavior management, medication, family, home health agency, or mental health intervention, the resident may be permitted to remain.
- Must have control of bowel and bladder or be capable of managing incontinent condition by use of appropriate products or be willing to accept assistance at a fee.
- Residents having a colostomy, ileostomy, urinary catheter, or other medical need; must be capable of caring for that device for him/herself for at least 3-6 months.
- Cannot have a history of conduct that would pose a danger to self/others
- If applicant/resident is diabetic, must be stable and able to self-manage blood glucose levels and administration of insulin. In accordance with regulations, Kavod staff may only monitor resident with self-administration.
- Must not require 24-hour medical or nursing services or be bedfast.
- Must not have a communicable disease or infection unless resident's receiving medical or drug treatment for the condition.

Admission Process:

Admission to the program will be granted to those whose needs can be met by the services provided by Kavod Assisted Living. 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.

Upon receipt of all required forms, the applicant will be placed on the wait list. When a unit becomes available and a retainer is received, credit, background, and landlord verifications will be initiated. After approval, the applicant or family member will be called to schedule an in-person assessment.

The Assisted Living Director, Wellness Coordinator and Care Coordinator will complete a mini profile at the in-person assessment prior to acceptance in order to assess care levels and a personalized care plan for each resident. This plan will identify the resident’s needs and the services that the facility will provide to meet those needs. If a resident has difficulty with one or more of the admission criteria, a care plan to meet the needs will be developed with resident, staff and family involvement. If the need cannot be met with the services available, then the prospective or current resident would not qualify for residency. Upon admission, a personalized care plan for each resident will be done. This plan will identify the resident’s needs and the services that the facility will provide to meet those needs.

Required Documentation: Please submit the following documents along with valid ID to schedule the mandatory pre-admission assessment:

Completed Application including the Credit and Background inquiry release.
Applicant/Family Evaluation
Physician Evaluation Release & contact info
Physical including full skin assessment - within 30 days of move-in
Physicians order to admit to Assisted Living - within 30 days
Medical History (typed notes from previous visits)
Updated Medication List from physician with signature & date - Any OTC items & supplements used such as: antacids, vitamins, ointments, ibuprofen, acetaminophen, Nyquil, etc. must be added to the medication list by the PCP list as need/PRN - All meds require <u>dosage, frequency & diagnosis, along with PCP signature and date</u>
MOST Form (Medical Orders for Scope of Treatment / CPR or DNR, signed and dated by resident & their Primary Care Physician) -Original MOST Form must come with resident on move-in date, it will be placed in their chart and a copy in their apartment
POA / MPOA
Living Will, Photo ID, Medical Insurance Cards, COVID card

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Frequently Asked Questions

Q: How much does Assisted Living cost?

A: As of January 2022, 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 two-bedroom apartments?

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

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

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.



Application

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

**** All applications and information will be reviewed on an impartial basis and will be kept confidential. Proper documentation (proof of age and or ID) should be provided during the application process. All information will be verified.****

APPLICANT #1 (Head of Household)

Last Name	First Name	Middle Name	
Current Street Address / /	City	State	Zip Code
Age	Date of Birth	City of Birth	M / F / Prefer not to Respond
Social Security Number			Telephone Number
<u>Citizenship Status</u>			
<input type="checkbox"/> US Citizen	<input type="checkbox"/> Legal Immigrant	<input type="checkbox"/> Non-legal Immigrant	

APPLICANT #2

Last Name	First Name	Middle Name	
Current Street Address / /	City	State	Zip Code
Age	Date of Birth	City of Birth	M / F / Prefer not to Respond
Social Security Number			Telephone Number
<u>Citizenship Status</u>			
<input type="checkbox"/> US Citizen	<input type="checkbox"/> Legal Immigrant	<input type="checkbox"/> Non-legal Immigrant	
			Relationship to Applicant #1

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, but 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 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

Will you need a rent supplement (Medicaid) if approved for residency at Kavod Assisted Living?

- Yes No

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

Application

Kavod Assisted Living is an indoor smoke-free community. 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 policy?

Yes

No

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

Yes

No

If yes, 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.*



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: _____

Case Manager Name: _____ Phone: _____

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.

**Case Manager Assessment
Consent for Release of Information**

<p>I hereby authorize release of my Case Manager assessment information to</p> <p>_____.</p>	
<p>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.</p>	
<p>Applicant's Signature or Legal Representative</p>	<p>_____/_____/_____ Date Signed</p>
<p>Patient's Name Printed</p>	<p>_____/_____/_____ Birth Date</p>



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
Street Address		City	State	Zip Code

Former Landlord:

Name	Telephone Number	Fax Number	/ / to / /
Street Address		City	State Zip Code

Former Landlord:

Name	Telephone Number	Fax Number	/ / to / /
Street Address		City	State Zip Code

I hereby give permission to the listed landlords to provide Kavod Senior Life 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	

Information provided in this application will be used to determine eligibility according to occupancy standards. If such information provided is false or materially misleading, then Owner shall have the option to terminate Resident's right to possession upon (3) days' notice to quit.



Financial Data

This information must be completed to be considered for residency at Kavod Senior Life.

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		\$ _____

Financial Data

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 Senior Life, 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 the organization.

Signature of Applicant #1 Date

Signature of Applicant #2 Date



Credit and Background Inquiry Release

In connection with my application for residency at Kavod Senior Life ("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)

Credit and Background Inquiry Release

Current Address: _____

City, State, Zip _____

Previous Address(es) During Past 5 Years:

Applicant's Signature: _____



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?

In which areas would you benefit from assistance?		
Activity of Daily Living (ADL)		Type of Assistance
Taking medication	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Preparing meals	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dressing/Undressing	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Grooming	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Showering/bathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Housekeeping/Laundry	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Incontinence Management	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Oxygen Management	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Escort Assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Community Involvement	<input type="checkbox"/> Yes <input type="checkbox"/> 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)	
<input type="checkbox"/>	Good memory for present day events – no difficulty remembering names, places, or scheduled appointments. Do not become confused in unfamiliar place.
<input type="checkbox"/>	Fair memory for present day events – little help required for remembering names or appointments. May become confused in unfamiliar place.
<input type="checkbox"/>	Poor memory for present day events – Require a lot of reminders with names, scheduling and remembering appointments. Almost always confused in unfamiliar place.
<input type="checkbox"/>	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, LTC 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!



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 Senior Life

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Additional Contact Person or Organization release form

Applicant Name: _____
Applicant Mailing Address: : _____
Applicant Telephone: : _____

Name of Additional Contact Person or Organization: _____

Address: : _____
Telephone: : _____
Email: : _____
Relationship to Applicant: _____

_____ MPOA _____ POA

Reason to contact: (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Emergency | <input type="checkbox"/> Change in lease terms |
| <input type="checkbox"/> Unable to contact you | <input type="checkbox"/> Change in house rules |
| <input type="checkbox"/> Eviction from unit | <input type="checkbox"/> Late payment of rent |

Name of Additional Contact Person or Organization: _____

Address: : _____
Telephone: : _____
Email: : _____
Relationship to Applicant: _____

_____ MPOA _____ POA

Reason to contact: (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Emergency | <input type="checkbox"/> Change in lease terms |
| <input type="checkbox"/> Unable to contact you | <input type="checkbox"/> Change in house rules |
| <input type="checkbox"/> Eviction from unit | <input type="checkbox"/> Late payment of rent |

Signature of Applicant or POA: _____

Date: _____

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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

Please include your date of birth with release

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 720.382.7850 or 720.382.7845.



Physician Name _____
Physician Phone _____

Dear Doctor: _____

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

Services Provided:

- 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.
- Safe within an unlocked community (cannot wander).
- Cannot require a therapeutic diet, more than a one-person 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 program, please contact me at 720.382.7825.

Sincerely,

A handwritten signature in cursive script that reads "Christy Martinez".

Christy Martinez
Director of Assisted Living



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:
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Tuberculosis (TB) Test:

Date TB Test given:	Date TB Test read:	Type of TB Test:	TB Test is: <input type="checkbox"/> Negative <input type="checkbox"/> Positive
Action taken if positive:			
Chest X-ray results:			

Patient/Resident Diagnosis:

Allergies (medications/food): Yes No

If yes, please explain reaction:

Physician's Evaluation

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 <input type="checkbox"/> Yes <input type="checkbox"/> No
Bladder incontinence				Self-manage <input type="checkbox"/> Yes <input type="checkbox"/> 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

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