



Applicant's past trade or profession: \_\_\_\_\_

Applicant's hobbies or interest:

Past: \_\_\_\_\_ Present: \_\_\_\_\_

Clubs/Organizations: \_\_\_\_\_

Religious Preference:

Please specify: \_\_\_\_\_

Children's Names/Addresses:

Number of children: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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

Power of Attorney – Durable Medical     Power of Attorney - Financial

Legal Guardian/Conservator

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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

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

Power of Attorney – Durable Medical     Power of Attorney - Financial

Legal Guardian/Conservator

**Why do you desire admission to Shalom Park?** \_\_\_\_\_

\_\_\_\_\_

**HEALTH DATA**

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

What special medical equipment or supplies are you currently using?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Walker          | <input type="checkbox"/> Incontinence supplies | <input type="checkbox"/> Oxygen          |
| <input type="checkbox"/> Wheelchair      | <input type="checkbox"/> Catheter              | <input type="checkbox"/> Other (specify) |
| <input type="checkbox"/> Mechanical lift | <input type="checkbox"/> Ostomy                | _____                                    |

Medications (include non-prescription drugs taken on a regular basis):

\_\_\_\_\_  
\_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Average Weight: \_\_\_\_\_

Do you have special dietary needs? \_\_\_\_\_

Food Allergies: \_\_\_\_\_

Appetite:     Good                       Fair                       Poor

Alcohol Use:  Yes  No              Does applicant smoke?  Yes  No

Past physical history (include surgeries and hospitalizations):

\_\_\_\_\_  
\_\_\_\_\_

Present conditions/diagnoses:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please check current levels of functioning:

Mental:

- Alert       Confused       Forgetful       Makes Needs Know

Mobility:

- Independent       Cane/Walker       Wheelchair

Eating:

- Feeds Self       Needs Assistance       Total Assistance       Feeding Tube

Toileting:

- Independent       1 Person Assistance       2 Person Assistance

Bladder:

- Continent       Incontinent       Catheter

Bowel:

- Continent       Incontinent       Colostomy

Hearing:

- Adequate       Impaired       Hearing Aids:       Deaf  
R  /L

Dental Care:

- Dentures - Upper       Dentures - Lower       Partial Plate - Upper       Partial Plate - Lower

Bathing preference:

- Bath       Shower

Vision:

Please describe your vision: \_\_\_\_\_

*(please note if you wear glasses)*





# Shalom Park

## FINANCIAL STATEMENTS

Please note: Shalom Park will rely on the information that you include in this financial statement to determine your eligibility for admission to Shalom Park. Based on the information provided, Shalom Park will calculate the reasonable duration of private pay funds available to pay for rent and any services provided by Shalom Park. Failure to provide complete and accurate information may result in denial or subsequent withdrawal of your application. As part of the admission process, we request the answers to the financial questions indicated below. This information will allow us to assist with the Medicaid application, insurance coverage, etc.

\_\_\_\_\_  
Applicant Name

**1. Please list savings and checking accounts and all other cash:**

Name of Institution	Balance	Savings/Checking
_____	_____	_____
_____	_____	_____
_____	_____	_____

\*Please provide the most recent bank statement for the above account(s). If you are receiving Medicaid benefits, please also provide a “closed” bank statement for bank account(s) closed within the past year.

**2. Please list all investments other than cash (i.e. stocks, bonds, C.D.’s, securities, etc.)**

Type of Investment	Cash Value	As of Date
_____	_____	_____
_____	_____	_____

\*If you receive Medicaid benefits, please provide the most current Award Letter for the above resource(s).

**3. Please list income from Social Security, pension, VA, real estate, loans, dividends and other sources:**

Type of Income	Account #	Income per Month
_____	_____	_____
_____	_____	_____

\*If you receive Medicaid benefits, please provide the most current Award Letter for the above resource(s).

**4. Please list all personal property (real estate, automobile or other). In whose name(s) is it recorded?**

Type of Property	Name/Address	Value
_____	_____	_____
_____	_____	_____

**5. Please list any debts, obligations, mortgages, liens, etc. that may affect the above asset or income situation:**

Amount of Debt	Creditor
_____	_____
_____	_____

**6. Please list all life insurance policies and beneficiaries:**

Name of Company: \_\_\_\_\_

Cash Value: \_\_\_\_\_

Beneficiary: \_\_\_\_\_

Name of Company: \_\_\_\_\_

Cash Value: \_\_\_\_\_

Beneficiary: \_\_\_\_\_

\*If you receive Medicaid benefits, please provide a current policy with showing the cash value of the above policy.

**7. Please list any long-term care insurance policies:**

Name of company: \_\_\_\_\_

Cash benefit per day: \_\_\_\_\_

Is there an exclusion period? \_\_\_\_\_

Is there an expiration date? \_\_\_\_\_

\*Please provide a copy of all long-term care insurance policies.

**8. Transfer of Assets: Has there been a transfer, sale or gift of real estate, personal property, cash or other assets in the last 60 months?**  Yes  No

If yes, please provide the following information:

Item Transferred	Approximate Value	To Whom	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**9. Is there a trust account involved?**  Yes

If yes, please provide the name and bank address:

\_\_\_\_\_  
\_\_\_\_\_

Trust Officer Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

**10. Does applicant have a prepaid funeral/burial account?**  Yes  No

If yes, what is the value? \_\_\_\_\_

\*If you receive Medicaid benefits, please provide the current policy showing the cash value of the above policy.

**11. Please state the total income for the year, as is appears on the applicant's latest tax return.**

**Year:** \_\_\_\_\_, **amount as it appears on tax return:** \_\_\_\_\_

I certify that the foregoing statement is accurate to the best of my knowledge and that I can, if requested, submit documentation to substantiate all assets, debts, income and other information provided above.

\_\_\_\_\_  
Signature Date

Subscribed and affirmed before me in the county of Arapahoe, State of Colorado,  
this \_\_\_\_\_, day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Notary Public Official Seal Commission Expiration Date: \_\_\_\_\_





## **LEGAL DOCUMENTATION NEEDED**

Please attach copies of the following documents to your Shalom Park application (*please ensure that both the front and back of cards are copied*):

- Power of Attorney, Durable Medical Power of Attorney, Guardianship, Conservator (if applicable)
- Current History & Physical from your physician
- All Insurance Cards
- Green Card (if applicable)
- Long-Term Care Insurance Policy

Once your application is received and prior to any move-in, Shalom Park will conduct two evaluations:

1. Financial review.
2. Functional assessment to determine Shalom Park's ability to provide care.

You will be advised when the timing is appropriate to schedule the assessment.