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SHALOM PARK NURSING HOME - RESIDENT APPLICATION

Date of Application:

Applicant’s Name:

 First Middle Last

Address:

City: State: Zip Code: Phone:

How long at this address?

Birth Date: Age: Biological Gender:  M  F Gender Identity:

Birth Place:

Social Security Number: Medicare Number:

Medicaid Number:

Medicare Part D prescription drug plan: Subscriber Number:

Private/Supplemental Insurance Carrier: Subscriber Number:

HMO Senior Plan: Subscriber Number:

Where does applicant presently reside?

 Another Nursing Home?

 Assisted Living? 

 Other:

Facility: Date of Admission:

Relationship Status: Married  Single Widowed  Divorced  Partnered

Significant Other’s Name:

Significant Other’s Address (if different from applicant’s):

City: State: Zip: Phone:

Applicant’s highest level of education:

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:

Power of Attorney – Durable Medical  Power of Attorney - Financial Legal Guardian/Conservator

Name:

Address: City: State: Zip:

Home Phone: Work Phone:

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?

* Walker
* Wheelchair
* Mechanical lift
* Incontinence supplies
* Catheter
* Ostomy
* Oxygen
* Other (specify)

Date of Covid vaccination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ We will need a copy of the vaccination card

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*)

**EMOTIONAL AND MENTAL STATUS**

Psychiatric diagnoses:

Psychotropic medications (including anti-depressants):

Temperament and personality:

Check all that apply:

* Fearful
* Suspicious
* Hallucinates
* Combative
* Agitated
* Depressed
* Sad
* Anxious
* Unkempt
* Uncooperative
* Angry
* Delusions
* Demanding
* Steals
* Packing/unpacking
* Wanders
* Verbally Abusive

Room Preference:

* Private Room
* Shared Suite

**How did you hear about Shalom Park?**

Desired date of admission:

The information I have provided in this application is current and correct to the best of my knowledge.

I authorize Shalom Park to conduct a pre-admission assessment of this applicant upon receipt of this application and to review the applicant’s medical records to determine if Shalom Park can meet this applicant’s individual needs.

Signature: Date:

Printed Name:

Relationship to Applicant:

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**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\_\_\_\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Commission Expiration Date: \_\_\_\_\_\_\_\_\_\_\_

Notary Public Official Seal

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## 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

 Copy of Covid vaccination card

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.