Shalom Park

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: _____

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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? ________________________________

____

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HEALTH DATA

Physician's Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

What special medical equipment or supplies are you currently using?

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

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:

_____

_____

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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: R ☐ /L ☐ ☐ Deaf

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*)

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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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EXPECTATION FOR CARE

What is your expectation from Shalom Park regarding care of your loved one? Please describe in few sentences.

Signature: _____ Date: _____

Printed Name: _____

Relationship to Applicant: _____

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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).

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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.

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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 ☐ No

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: _____

12. Do you have a Financial Power of Attorney? ☐ Yes ☐ No

*If yes, please provide a copy of the Financial Power of Attorney.
*If no, attached is a sample of Financial Power of Attorney that you may utilize.

Please note that Financial Power of Attorney will be required prior to admission.

If you have any questions, please contact Business Office at 303.400.2124 or 303.400.2339 or via email at shalombilling@shalomcares.net.

I certify that the foregoing statement isa 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**

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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)*:

- ☐ Durable Medical Power of Attorney
- ☐ Financial 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.

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