

The *Granville*

Assisted Living Center

Where dignity and respect count

Dear Applicant,

Thank you for expressing an interest in The Granville Assisted Living Center.

To continue the process for admittance, please complete, sign and return the following enclosed documents as soon as possible:

- (1) Application For Residency
- (2) Consent to Release Medical Information
- (3) Income and Asset Verification Forms

Feel free to contact us at any time if you have questions. We all look forward to your moving into our beautiful community to begin a mutual relationship centered around a warm and caring environment.

Sincerely,

Vennita Jenkins
Administrator

encl.

THE GRANVILLE ASSISTED LIVING CENTER

Admission Procedure

To better understand the procedures necessary to complete the admittance process, please review the following steps:

STEP ONE: Since all of our Residents must meet certain income guidelines as well as physical ability guidelines, the first packet you receive will contain several forms which must be filled out, signed and returned to us. The first step is to fill out the Application For Residency Form as completely and accurately as possible.

The Consent to Release Medical Information also must be signed and returned to us. This Form will allow us to contact your physician regarding the general status of your health, the medications you are taking, and the appropriateness of our facility for meeting your needs.

To verify that income guidelines are met, we must have a separate Income or Asset Verification Form for **EACH** and **EVERY** source of income (social security, pension, etc.) and **EACH** and **EVERY** location of assets (bank, investment company, etc.). We will mail these out to the agency or institution you indicate, **and then we must receive them back in our office before we can proceed with the admittance process.**

STEP TWO: Once the physician statement and the verification forms have been mailed out, completed and returned to our office, our Administrator, will call you and set up an appointment for an assessment.

STEP THREE: The next step is signing the Residency Agreement. This is the legal document required before move-in. It will spell out the financial terms, services provided by the facility, and how to terminate the Agreement. In addition, you will receive copies of our Admission and Discharge Procedures, Resident Rights, House Rules, and Grievance Procedures. At this time, we will let you know your move-in date and we will need a check for your first and last month's rent. If you move in the middle of the month, the amount will be prorated.

STEP FOUR: Finally, when you move in, you will meet with our Resident Services Director to develop a personal plan of care. This will identify the Resident's needs and the services the Facility will provide to meet those needs.

If you have any questions, please contact Vennita Jenkins, Administrator. Welcome to The Center. We look forward to having you as part of our community!

THE GRANVILLE ASSISTED LIVING CENTER
Application for Residency

Date _____

I. GENERAL INFORMATION

Name _____ Maiden Name _____

Phone (____) _____

Current Address _____

City, State, Zip _____

Date of Birth ____/____/____

Age _____

Social Security # _____-_____-_____

Sex M F
(please circle)

Marital Status Single / Married / Widowed / Divorced

How did you hear about The Granville: Prime Time for Seniors/ Yellow Pages/
Seniors Blue Book/ Senior Housing Locator/ Other _____

Present Living Arrangements House / Apartment
(please circle)

Alone / With Relatives

Other _____

Is the applicant a full time or part time student? Yes No
Have you been convicted of a felon in the past 10 years? Yes No

Primary Contact for Application Process

Name _____ Relationship _____

Address _____

City/State/Zip _____

Phone (____) _____ Work Phone (____) _____

*Power of Attorney Yes / No

Name _____

*Guardianship Yes / No

Address _____

*Conservatorship Yes / No

City/State/Zip _____

Phone _____

*Please attach copies of documentation showing POA, guardianship, and/or conservatorship, if applicable.

II. MEDICAL INFORMATION

Diagnosis (you must include any mental illness diagnosis): _____

Allergies: _____

Medications -- Prescribed

_____	_____
_____	_____
_____	_____
_____	_____

Non-Prescription Medications (such as pain relievers, antacids, vitamins)

_____	_____
_____	_____
_____	_____
_____	_____

Please continue on back if more space is needed.

INSURANCE INFORMATION

Medicare# _____

Medicaid# _____

Veteran's Administration# _____

HMO Provider? Kaiser Secure Horizons TLC Other _____
(circle if applicable)

Supplemental Health Insurance Carrier _____
Policy# _____

Appl. Name: _____

EMERGENCY INFORMATION CONTACT SHEET

Resident Name: _____ Apt. #: _____
Date of Birth: _____ Soc. Sec. #: _____
Next of kin: _____ Next of kin phone number _____

Emergency Contact

1. Name _____ Relationship _____
Address _____ City/State/Zip _____
Phone (_____) _____ Work Phone (_____) _____
e-mail address _____
2. Name _____ Relationship _____
Address _____ City/State/Zip _____
Phone (_____) _____ Work Phone (_____) _____
e-mail address _____
3. Name _____ Relationship _____
Phone (_____) _____ Work Phone (_____) _____

Physician Name and Clinic

Address _____
City/State/Zip _____ Phone _____
Hospital Preference _____
Diagnosis _____
Allergies _____
Living Will Yes _____ No _____ (If yes, please attach)
Do Not Resuscitate Order Yes _____ No _____ (If yes, please attach)
Durable Medical Power of Attorney Yes _____ No _____ (If yes, please attach)
Religious Preference _____ Clergy's Name _____
Phone #: _____
Burial Arrangements _____

III. PHYSICAL STATUS

1. Are you able to walk without assistance? Yes No

Are you able to walk with a cane? _____ walker? _____

Explain any mobility difficulties _____

2. Are you able to bathe without assistance? Yes No

Explain any bathing difficulties _____

3. Are you able to dress without assistance? Yes No

Explain any dressing difficulties _____

4. Are you able to eat without assistance? Yes No

Explain any eating difficulties _____

5. Are you able to handle all of your toileting needs without assistance? Yes No

Explain any toileting difficulties _____

6. Other Information Regarding Physical Status:

IV. FINANCIAL INFORMATION

1. **HOUSEHOLD INCOME** (Please write YES or NO in every space provided below. Fill in monthly amounts as applicable.)

DO YOU RECEIVE?

<u>YES/NO</u>	<u>Income Source</u>	<u>Amount per month</u>
_____	Social Security	_____
_____	V A Pension	_____
_____	Retirement/Pension	_____
_____	Old Age Pension	_____
_____	Alimony	_____
_____	SSI	_____
_____	Rental Property	_____
_____	Other_____	_____

Please list any other sources of income: _____

2. **HOUSEHOLD ASSETS** (Please write YES or NO in every space provided below. List amount of asset where applicable.)

<u>YES/NO</u>	<u>Asset</u>	<u>Asset Value</u>
_____	Checking Account(s)	_____
_____	Savings Account(s)	_____
_____	Cds	_____
_____	Stocks	_____
_____	Bonds	_____
_____	IRAs	_____
_____	Installment Notes	_____
_____	Property	_____
_____	Money Market	_____
_____	Other_____	_____

Please list any other asset: _____

For each source of income and each source of assets, fill in a Verification Form (address of the institution, account number (if applicable) and your signature only), return all of them to the office with your application.

Case Manager Name_____

Phone Number_____

County_____

I hereby certify that all information contained on this application is correct and complete to the best of my knowledge and that any misrepresentation of material will result in my being ineligible for admission.

I agree to give The Granville Assisted Living Center the authority to investigate any income and/or asset sources necessary to determine eligibility and to verify the above stated information.

Applicant's Signature

Date

Responsible Party Signature

Date

It is illegal to discriminate against any person based on race, religion, sex, national origin, familial status or handicap.

EQUAL HOUSING OPPORTUNITY

THE GRANVILLE ASSISTED LIVING CENTER
1325 VANCE Street
LAKEWOOD, CO 80214
(303) 247-4400
Fax (303) 274-4100

Applicant's Consent to Release
Medical Information

I hereby authorize any physician, clinic or hospital to answer fully any request from The Granville Assisted Living Center for medical or psycho-social information concerning me as an applicant or while I am a Resident.

Printed Name

Signature

Date

Instructions for Income/Asset Verification

Enclosed with your application are several Verification Forms for various sources of income and various assets. These forms must be completed by a third party. **DO NOT FILL IN THE AMOUNTS** of income or assets on any of these sheets.

On the verification sheets, do the following items only:

1. Complete the name and address for the institution at the top of the applicable sheets.
2. Complete **account type** and **account numbers** where applicable. **DO NOT include financial amounts or interest rates.**
3. Include Name of Recipient and Social Security number, where applicable.
3. Sign and date the authorization to release information at the bottom of each applicable verification sheet (below the dotted line).
It is best if the authorization is signed by the applicant directly rather than a POA or other responsible party. **For Social Security authorization, it is mandatory that the release authorization is signed by the applicant.** Social Security will not accept a POA signature.

DO NOT fill in any other blanks. DO NOT sign the line "Verified By:". These items are to be completed by the institution itself.

Return the verification Forms directly to The Granville Assisted Living Center.

When returning the application and verification, please include a most recent copy of the following items:

1. Bank Statements, showing deposits, withdrawals and final balance.
2. Exhibit E/ Asset Certification form completed with amounts and signature from applicant or POA.
3. Broker statements for stocks, bonds, mutual funds.
4. Appraisals or most recent property tax bill for any property owned by the applicant.
5. Any document proving asset value for any other asset.
6. For income sources such as rent or loan payments, a copy of the lease or promissory note.

If you have any questions regarding income and asset verification, please contact the Financial Analyst, at The Granville Assisted Living Center, 274-4400.

THE GRANVILLE ASSISTED LIVING CENTER
1325 VANCE STREET
LAKEWOOD, CO 80214
(303) 274-4400
Fax (303) 274-4100

Verification Form for Social Security Income

The Social Security Administration
8000 South Park Lane
Littleton, CO 80120

We are required to verify the income of all individuals applying for admission as Residents of The Granville Assisted Living Center for the frail elderly of our community. Laws under which these housing units are financed and administered restrict occupancy to low-income persons.

To comply with this requirement, we ask your cooperation in supplying information regarding the income or assets of the person listed below. This information will be used only in determining their eligibility status and will be held in strict confidence.

Joe Whitney
Financial Analyst

Gross \$ _____

Current Monthly Social Security Benefit Net \$ _____

Verified By: _____

Title: _____ Date: _____

Name of Recipient _____

Social Security #: _____

I authorize the release of verification of Social Security Income to The Granville Assisted Living Center.

Signature

Date

THE GRANVILLE ASSISTED LIVING CENTER
1325 VANCE STREET
Lakewood, CO 80214
(303) 274-4400
Fax (303) 274-4100

Verification Form for Stocks and Bonds

To: _____

Date: _____

Institution _____

Address _____

City, State, Zip _____

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To comply with this requirement, we ask your cooperation in supplying information regarding the income or assets of the person listed below. This information will be used only in determining their eligibility status and will be held in strict confidence.

Your prompt return of the information will be greatly appreciated. A self-addressed envelope is enclosed for your convenience.

Sincerely,

Joe Whitney
Financial Analyst

Type of Asset	Value of Asset	Annual Income from Asset
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Verified by:

Title: _____ Date: _____

Name of Recipient _____

I hereby authorize you to release confidential information as requested above to The Granville Assisted Living Center.

Signature

Date

THE GRANVILLE ASSISTED LIVING CENTER
1325 VANCE STREET
Lakewood, CO 80214
(303) 274-4400
Fax (303) 274-4100

Verification Form for Pensions

To: _____ Date _____
Institution _____
Address _____
City, State, Zip _____

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To comply with the requirement, we ask your cooperation in supplying information regarding the income or assets of the person listed below. This information will be used only in determining their eligibility status and will be held in strict confidence.

Your prompt return of the information will be greatly appreciated. A self-addressed envelope is enclosed for your convenience.

Sincerely,

Joe Whitney
Financial Analyst

Pension Information

Current Monthly Gross Amount of Pension \$

Effective Date of Current Amount _____/_____/_____

Is an increase planned in the next 90 days? ___No ___Yes
If yes, when?_____ Please give amount: \$

Verified by: _____

Title: _____ Date: _____

Name of Recipient _____

I hereby authorize you to release confidential information as requested above to The Granville Assisted Living Center.

Signature

Date

THE GRANVILLE ASSISTED LIVING CENTER
1325 VANCE STREET
Lakewood, CO 80214(303) 274-4400
Fax (303) 274-4100

Verification Form for Annuities

To: _____ Date _____

Institution _____

Address _____

City, State, Zip _____

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To comply with the requirement, we ask your cooperation in supplying information regarding the income or assets of the person listed below. This information will be used only in determining their eligibility status and will be held in strict confidence.

Your prompt return of the information will be greatly appreciated. A self-addressed envelope is enclosed for your convenience.

Sincerely,

Joe Whitney
Financial Analyst

Annuity Information

Current Monthly Gross Amount of Annuity \$

Effective Date of Current Amount _____/_____/_____

Is an increase planned in the next 90 days? ___No ___Yes

If yes, when?_____ Please give amount: \$

Verified by: _____

Title: _____ Date: _____

Name of Recipient _____

I hereby authorize you to release confidential information as requested above to The Granville Assisted Living Center.

Signature

Date

THE GRANVILLE ASSISTED LIVING CENTER
1325 VANCE STREET
Lakewood, CO 80214
(303) 274-4400
Fax (303) 274-4100

Verification Form for Public Assistance

Date _____

Department of Social Services
Address _____

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Your prompt return of the information will be greatly appreciated. A self-addressed envelope is enclosed for your convenience.

Sincerely,

Joe Whitney
Financial Analyst

Old Age Pension (OAP) Monthly Amount	\$ _____
Aid to the Needy and Disabled (AND) Monthly Amt.	\$ _____
Aid to the Blind Monthly Amount	\$ _____
Home Care Allowance (HCA)	\$ _____
Supplemental Security Income	\$ _____
Other Income (Specify) _____	\$ _____

Verified By: _____

Title: _____ Date _____

Name of Recipient _____

Social Security # _____

I hereby authorize the release of confidential information as requested above to The Granville Assisted Living Center.

Signature

Date

THE GRANVILLE ASSISTED LIVING CENTER
1325 VANCE STREET
LAKWOOD, CO 80214
(303) 274-4400
Fax (303) 274-4100

Verification Form for Bank Accounts

TO: _____ Date _____
 Institution _____
 Address _____
 City, State, Zip _____

We are required to verify the income of all individuals applying for admission as Residents of The Granville Assisted Living Center for the frail elderly of our community. Laws under which these housing units are financed and administered restrict occupancy to low-income persons.

To comply with the requirement, we ask your cooperation in supplying information regarding the income or assets of the person listed below. This information will be used only in determining their eligibility status and will be held in strict confidence.

Your prompt return of the information will be greatly appreciated. A self-addressed envelope is enclosed for your convenience.

Joe Whitney
 Financial Analyst

Account Number	Account Type	Interest Rate	Current Balance	Avg. 6 Mos. Bal.	Maturity Date

Verified By: _____

Title: _____ Date _____

Name of Recipient _____

 I hereby authorize the release of confidential information as requested above to The Granville Assisted Living Center.

Signature

Date

THE GRANVILLE ASSISTED LIVING CENTER
1325 VANCE STREET
Lakewood, CO 80214
(303) 274-4400
Fax (303) 274-4100

Physician Evaluation

Date _____

RE: _____

Dear Dr. _____:

Your patient has applied for residency at The Granville Assisted Living Center. This Center will provide limited, supplemental, non-medical service.

Staff at this center provide the following types of service:

1. Three meals a day plus snacks
2. Weekly housecleaning and laundry
3. Medication administration
4. Minimal dressing and bathing assistance

In order to reside here, residents must:

1. Be able to perform activities of daily living with the assistance provided.
2. Be willing to accept necessary assistance from staff.
3. Be able to maintain an odor free environment and person, independently.

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 completely as possible.

Your patient's application will be considered when we have received your completed forms. Your prompt assistance is greatly appreciated. If you have any questions, please call me.

Sincerely,

Jaime Tafoya
Medication Coordinator

Adm003(10/09)

adm002(8/07)

THE GRANVILLE ASSISTED LIVING CENTER
1325 VANCE STREET
Lakewood, CO 80214
(303) 274-4400
Fax (303) 274-4100

Physician Evaluation

1. Patient's Name _____
DOB _____ Height _____ Weight _____
Blood Pressure _____
Nutritional Status _____

2. List Significant Diagnosis/Medical Problems

3. Does patient suffer from any communicable diseases?
Yes___ No___

If yes, explain: _____

4. Medications

Routine medications including prescription and over the counter drugs

Name of Drug	Dosage	Frequency	Reason

List Known Rx Allergies. _____

List Any Known Food Allergies _____

Please list any drugs that the patient may have on a **PRN basis**:

Name of Drug	Dosage	Frequency	Reason

5. Treatments/Therapies _____

6. Can Patient safely self-medicate? Yes___ No___

7. To your knowledge, how often has patient fallen in the past year? _____

8. Does patient appear to be oriented to person, place and time? Yes___ No___

9. To your knowledge, has patient had any history of confusion or wandering? Yes___ No___

If yes, please explain _____

10. To your knowledge, has patient had any history of mental illness or abnormal behavior? Yes___ No___

If yes, please explain _____

11. Does the patient have a history of any drug or alcohol abuse? Yes___ No___

If yes, in your opinion, is this a current problem?
Yes___ No___

12. Is patient in control of bladder? Yes___ No___

13. Is patient in control of bowel? Yes___ No___

14. Does patient require assistance in:
(please check)

Bathing _____ Mobility _____ Eating _____ Dressing _____

Daytime Toileting _____ Nighttime Toileting _____

Other_____

15. Does the patient require the use of any device to assist with ambulation, such as a cane, walker, crutches or wheelchair?
Yes___ No___

If yes, please indicate_____

16. What was the date the patient was last seen by you?

17. How long has the patient been under your care?

18. Does this person have any restrictions in their ability to participate in the program's activities? Yes _____ No _____

If yes, please explain _____

18. Is patient an appropriate applicant for an assisted living center? Yes___ No___

Signature

Date

Printed Name

Adm003(10/09)

Address

(_____) _____

Phone

(_____) _____

Fax