

The Gardens at St. Elizabeth

Greetings!

We are so pleased that you have decided to take the next step towards becoming a new neighbor here at The Gardens at St. Elizabeth! We hope that we can be helpful to you and your family during this exciting new transition. Below you will see an outline of our move-in process.

Step One – Submit application and physician’s report.

You will need to:

- Fill out Resident Information Packet and Confidential Financial Application
- Have your physician fill out and sign the Physician’s Confidential Medical Report
- Make a copy of your state Identification Card/Drivers License and Health Insurance Card
- Deliver the above completed items to the Marketing Department via:
 - Fax: 303-964-3815
 - Email: Melissa.Santistevan@chilivingcomm.org or Lesley.Lauro@chilivingcomm.org
 - Mail or Deliver: Attn: Marketing Dept. 2835 W. 32nd Ave. Denver, CO 80211

Step Two – Schedule an entrance interview.

Marketing will work with you to schedule an assessment with our Resident Care Coordinator for Independent Living and our Nursing Staff for Assisted Living. The entrance interview will help us to understand what services, if any, you may need to live comfortably in your new apartment and to be sure that The Gardens at St. Elizabeth will be a good fit for your needs.

Step Three – Choose your new apartment!

Once the assessment is complete and level of care is determined, you may choose an apartment and sign a month to month lease.

The lease signing takes between 45 minutes to an hour. The Marketing department will give you a list of items you will need to bring to complete the lease paperwork.

After the lease is signed, you are free to start planning your move.

Step Four – Welcome Home!

We’re so happy you’re moving in! Please let us know what day/time you plan to move in or bring in furniture and other items so we do not schedule multiple moves at the same time.

All new residents will have orientation throughout the first 5-10 days with each of our departments here at The Gardens. A representative from each department will stop by your apartment and visit with you to find out more about your and what services are important to you. Please feel free to ask any questions you may have.

Please let us know if you need any additional information. Again, we are so happy that you have decided to become a new neighbor at The Gardens at St. Elizabeth. Please let us know if we can do anything further to help make this process run smoothly for you and your family!

With Warmest Regards,
The Gardens at St. Elizabeth

The Gardens at St. Elizabeth

Resident Information

Independent Living, Assisted Living and Respite Care

PERSONAL INFORMATION

Name: _____

Last Permanent Address: _____

Moving in from: _____

Date of Birth: _____ Move-in Date: _____

Age: _____ Gender: _____ Marital Status: _____

Religion: _____ Place of Worship: _____

Occupation: _____ Race: _____

Social Security #: _____

BIRTHPLACE INFORMATION

Birth City: _____ County: _____ State: _____

Mother's Maiden Name: _____ Father's Name: _____

INSURANCE INFORMATION

Please provide copy of all insurance card(s), including Medicare and Medicaid if applicable, when you submit your application.

Medicare #: _____ Medicare HMO #: _____

Medicaid #: _____ Railroad Retirement #: _____

Veteran's Status: _____ Veteran's #: _____

1) Primary Insurance Company: _____

Policy #: _____ Group #: _____

2) Secondary Insurance Company: _____

Policy #: _____ Group #: _____

Resident's Name _____

CONTACT INFORMATION

Primary/Emergency Contact Name: _____

Primary/Emergency Contact Address: _____

Primary/Emergency Contact Home Phone: _____

Primary/Emergency Contact Work Phone: _____

Primary/Emergency Contact Cell Phone: _____

Relationship to Resident: _____

Alternate Contact Name: _____

Alternate Contact Address: _____

Alternate Contact Home Phone: _____

Alternate Contact Work Phone: _____

Alternate Contact Cell Phone: _____

Relationship to Resident: _____

If more space is needed to list additional contacts, please attach separate sheet.

BILLING INFORMATION (Please indicate where you would like us to send your monthly statements after you move to our community.)

___ Please send bill to me in my apartment or unit

___ Please send bill to:

Name: _____

Street Address: _____

City, State, Zip: _____

Daytime Phone: _____ Relationship to applicant: _____

MEDICAL INFORMATION

Primary Physician: _____

Primary Physician Address: _____

Primary Physician Phone: _____

Primary Physician Fax Number: _____

Resident's Name _____

Alternate Physician: _____

Alternate Physician Address: _____

Alternate Physician Phone: _____

Alternate Physician Fax Number: _____

Dentist Name: _____ Dentist Phone: _____

Allergies: _____

Preferred Hospital: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Funeral Home Name: _____ Funeral Home Phone: _____

Advance Directives (please check all that you currently have in place):

- | | |
|--|--|
| <input type="checkbox"/> Living will | <input type="checkbox"/> MOST Form |
| <input type="checkbox"/> Do not resuscitate | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Medical Power of Attorney | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Financial Power of Attorney | |

I hereby declare that all of the information contained herein is true and complete to my best knowledge and belief.

Signature of applicant: _____ Date: _____

Thank you for providing the above information. Please return this application, along with a copy of your photo ID, Health Insurance Card(s) and copies of your Advance Directives, to the Marketing Department at The Gardens at St. Elizabeth.

For staff use only:

Apartment type: _____ Apartment number: _____

Monthly rent: _____ Move-in special: _____

Mailbox number: _____ Date key given: _____

Apartment phone: _____ Medical record number: _____

Financial Application - REQUIRED FOR ADMISSION

Name: _____ Current Telephone Number: _____
 Current Address: _____ Apt. Number: _____
 City: _____ State: _____ Zip Code: _____

Financial Data

Monthly Income:

1st Person 2nd Person

Social Security \$ _____ \$ _____
 Pension/Retirement \$ _____ \$ _____
 (sole survivor _____%)
 Annuity \$ _____ \$ _____
 Investment
 Income/Dividends \$ _____ \$ _____
 Other \$ _____ \$ _____
Total Monthly Income \$ _____ \$ _____

Total Combined Monthly \$ _____

Assets:

Real Estate -
 Primary Residence \$ _____
 Other Real Estate \$ _____
 Balance of Checking/Savings \$ _____
 Money Market/ CD's \$ _____
 Stocks & Bonds \$ _____
 Mutual Funds \$ _____
 Cash Value of Life Insurance \$ _____
 Market Value of Vehicle(s) \$ _____
Total Assets: \$ _____

Liabilities:

Real Estate -
 Primary Resident \$ _____
 Other Real Estate \$ _____
 Home Equity \$ _____
 Credit Card
 Balances \$ _____
 Other \$ _____
Total Liabilities: \$ _____

I hereby declare that all statements made herein are true and complete according to my best knowledge and belief.

Applicant

Date

Executive Director

Date

PHYSICIAN'S CONFIDENTIAL MEDICAL REPORT

Applicant Name: _____ Birth Date: _____

1) Medical History

Please indicate all current or recent (past 5 years) medical conditions of applicant with a check mark.

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma/COPD | <input type="checkbox"/> Alzheimer's |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dementia |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Vascular disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Heart Disease | |
| <input type="checkbox"/> Communicable disease (describe): _____ | | |
| <input type="checkbox"/> Other (describe): _____ | | |

Allergies: Yes No

If yes, please describe: _____

2) Current Diagnosis/Problems

Primary Diagnosis: _____

Secondary Diagnosis: _____

3) Recent hospitalizations/Surgeries (past 5 years) (please describe): _____

Are there any known safety issues (i.e. frequent falls): Yes No

If yes, please explain: _____

Applicant's Name _____

4) Behavior

Please indicate all current or behavioral conditions of applicant with a check mark.

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> No behavior problems | <input type="checkbox"/> Abusive |
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Disruptive |
| <input type="checkbox"/> Wanders | |

Mental or Emotional Disorder, past or present: Yes No

If yes, please explain: _____

Substance Abuse: Yes No

If yes, please explain): _____

5) Orientation

Please indicate all current orientation issues of applicant with a check mark.

- | | |
|---|---|
| <input type="checkbox"/> Oriented | <input type="checkbox"/> Disoriented to time |
| <input type="checkbox"/> Disoriented to place | <input type="checkbox"/> Disoriented to person(s) |

6) Ambulation

Please indicate all current ambulation issues of applicant with a check mark.

- | | | |
|--|-------------------------------------|---|
| <input type="checkbox"/> Walks alone | <input type="checkbox"/> Cane | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Uses crutches | <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Electric scooter |

7) Level of Service Considerations

What level of care is appropriate for your patient?

Independent Living:

- Resident is completely self-sufficient in their own apartment. Weekly housekeeping, transportation, daily safety checks along with the option to purchase up to three meals a day if needed is available. A successful Independent Living Resident is capable of providing for themselves, physically and mentally and can interact socially with other residents.

Assisted Living:

- Resident needs assistance and supervision with some or all activities of daily living on a routine basis. Bathing, dressing, reminders/cueing, medication administration, laundry can be provided along with weekly housekeeping, transportation and three meals each day.

Palliative or Hospice Care:

- Resident needs the same care provided above with Palliative or Hospice Care for additional support.

Adult Day Program:

- Day Program participants may need assistance and supervision with some or all activities of daily living on a routine basis. Day program provides participants with a daytime safe home-like environment including social interaction, exercise program, assistance with activities of daily living, medication administration a hot meal and snacks.

Applicant's Name _____

8) Medications

In order to provide the appropriate level of services to your patient, should he or she move into our community, it is important that we obtain **complete information** on residents' medications, as outlined below, and that this form be **signed by a physician**.

IF YOU CHOOSE TO SUBMIT YOUR OFFICE'S COMPUTER -GENERATED MEDICATION LIST FOR THIS APPLICANT, PLEASE MAKE SURE ALL OF THE INFORMATION REQUESTED ON CHART BELOW IS INCLUDED. Thank you!

Name of Medication/Drug	Dosage	Route	Frequency	Diagnosis	Refills

Check box if medication refills are appropriate from 1 year of this forms completion.

Must facility administer applicant's medications? Yes No

Is applicant on oxygen? Yes No

O2 order: _____

Does the applicant requires assistance with oxygen? Yes No

Physician's Name (please type or print) _____

Physician's office address _____

City _____ State _____ Zip Code _____

Physician's Phone _____ Physician's Fax _____

Physician's Signature _____ **Date** _____

Please fax this form to the attention of Admissions Department at 303-964-3815.