CHI Living Communities

Home is here.℠

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 Kristin.Killin@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.

Independent Living residents will be visited by a Resident Red Carpet Host to welcome you and provide you with information you may need. Our Wellness Coordinator will visit all new residents within the first few days to give you an orientation to the community and answer your questions. The Resident Care Coordinator, and Nursing Staff, as well as all other staff, are able to answer questions you may have about the community!

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

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Denver, CO 80211
303-964-3804

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):

___ Living will

___ Do not resuscitate

___ Medical Power of Attorney

___ Financial Power of Attorney

___ MOST Form

___ Other __________________________

___ None of the above

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: _______________

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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	$_______	$_______
Invenstment 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 Assests:	**$** _____________

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

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Denver, CO 80211
Phone: 303-964-3804
Fax: 303-964-3815

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.

☐ Arthritis	☐ Asthma/COPD	☐ Alzheimer's
☐ Cancer	☐ Diabetes	☐ Dementia
☐ Hypertension	☐ Kidney disease	☐ Osteoporosis
☐ Parkinson's disease	☐ Vascular disease	☐ Stroke
☐ Thyroid problems	☐ Heart Disease	

☐ Communicable disease (describe):

____

☐ Other (describe): ____

____

Mental or Emotional Disorder, past or present: ☐ Yes ☐ No

If yes, please explain: ____

____

Substance Abuse: ☐ Yes ☐ No

If yes, please explain): ____

____

Allergies: ☐ Yes ☐ No

If yes, please describe: -____

Are there any known safety issues, i.e. frequent falls, unsafe cooking practices, etc.?

☐ Yes ☐ No

If yes, please explain: ____

____

2) Behavior

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

☐ No behavior problems	☐ Abusive
☐ Aggressive	☐ Disruptive
☐ Wanders	

Applicant's Name ____

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

☐ Oriented ☐ Disoriented to time
☐ Disoriented to place ☐ Disoriented to person(s)

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

☐ Walks alone ☐ Cane ☐ Walker
☐ Uses crutches ☐ Wheelchair ☐ Electric cart

5) Current Diagnosis/Problems

Primary Diagnosis: ____

____

Secondary Diagnosis: ____

____

6) Recent hospitalizations/Surgeries (past 5 years) (please describe): __________________

____

____

____

7) Level of Service Considerations
Has the applicant been successfully living independently? ☐ Yes ☐ No

If no, what types of assistance are needed (check all that apply)?

☐ Bathing ☐ Dressing and/or grooming ☐ Shopping
☐ Preparing meals ☐ Ambulation/walking ☐ Cuing/re-direction
☐ Transfers bed/chair/toilet ☐ Incontinence management
☐ Other (please describe): ____

____

____

Do any of the applicant's diagnoses/impairments require monitoring by staff? ☐ Yes ☐ No

If yes, please explain: ____

____

____

Applicant Name: ____

8) Please fill out the medication list on this page and fax back with this report.

MEDICATION LIST

Dear Physician,

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. PLEASE SIGN AND DATE EVERY PAGE GENERATED. Thank you!

Name of Medication/Drug	Dosage	Route	Frequency	Diagnosis

Must facility administer applicant's medications? ☐ Yes ☐ No

Is applicant on oxygen? ☐ Yes ☐ No

Does the applicant requires assistance with oxygen? ☐ Yes ☐ No
O2 order: ____

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.