Kavod
ASSISTED LIVING
AT CHERRY CREEK

Dear Prospective Resident,

Welcome! We are so glad to hear about your interest in Assisted Living at Kavod Senior Life! We pride ourselves in offering the highest quality housing, support and amenities at competitive prices, affordable or otherwise. Our campus is known for its wonderful location in Cherry Creek and the variety of services we offer.

All of our Assisted Living apartments are private one-bedroom or studio units with private bathrooms. Our support services include three nutritious meals per day, a full calendar of social activities and events, medication monitoring, and much, much more. Most important, our staff provide the relational warmth, care and comfort that makes Kavod feel like home.

Enclosed is more information about all the specific services we provide and our eligibility criteria. We encourage you to set up a tour, ask lots of questions, and even come join us for a meal or activity to get to know us better. We are confident you will enjoy your time with us and find us to be a loving, supportive community.

Please call us at 720.382.7833 to set up your tour or email us at Info@KavodSeniorLife.org. We will be happy to help you in any way we can. You may also find information on our web site at www.KavodSeniorLife.org/faqs.

We look forward to hearing from you!

Warmly,

Christy Martinez

Christy Martinez
Director of Assisted Living

Assisted Living Program Admission Policy

Overview: Kavod Assisted Living (AL) is a service of Kavod Senior Life, a non-profit organization governed by a Board of Directors representing the Denver community. The mission of Kavod Senior Life is to provide life-enriching experiences to older adults through a broad range of housing and support services that reflect the spiritual, social, and cultural values of Jewish tradition.

To support older adults with limited incomes, Kavod's Independent Living apartments are regulated and subsidized by the Department of Housing and Urban Development (HUD). AL, however, is not HUD subsidized. We accept private pay, Long Term Care insurance, Veterans Pension, and Medicaid. Kavod Senior Life does not accept outside InnovAge applications. We will accept applications from current Independent Living residents with InnovAge.

Services Provided: The following services are included in the basic rent price.

-Weekly housekeeping and laundry
-Minimum of 5 wellness checks per day
-Dressing and bathing assistance
-Trash removal and bed-making daily
-3 Kosher style meals per day
-Medication monitoring & assistance
-Reminders for daily activities, meal times and appointments

Eligibility Criteria: The criteria for eligibility include the following:

- 62 years of age or older
- Able to ambulate independently at least 150 feet
- Able to perform or be willing to receive assistance with activities of daily living, such as dressing, personal hygiene and bathing
- Cannot be profoundly disoriented to time, person and place with safety concerns requiring a secure environment
- Cannot require a therapeutic diet, more than a one-person transfer assistance, or restraints
- Cannot have a history of conduct that would pose a danger to self/others

Admission Process: Ten apartments are available for residents on Colorado First (Medicaid) Long Term Care (LTC) waiver program. When one of these apartments become open, applications will be prioritized as follows: 1) one year market rate AL resident, 2) one year market rate Kavod Senior Living resident, 3) other current Kavod Senior Living residents, and 4) non-residents.

Admission to the program will be granted to those whose needs can be met by the services provided by Kavod Assisted Living. Criteria for acceptance are defined by Colorado Department of

Public Health and Environment (State) regulations, Board policy, and assessment of functional ability by professional staff as required by policy and procedure.

Required Documentation: Please submit the following documents along with valid ID to schedule the mandatory pre-admission assessment:

	Application
	Medicaid Applicants only - case manager release
	Credit and Background Inquiry Release
	Applicant/Family Evaluation
	Physician Evaluation Release & contact info
	How did you hear about us questionnaire
	Supplement to Application - Additional Contact Person

Upon receipt of all required forms, the applicant will be placed on the wait list. When a unit becomes available, credit, background, and landlord verifications will be initiated. After approval, the applicant will be called to schedule the assessment.

Market Rate Apartment Costs and Service Fees:

Flat rate pricing = no incontinence management care, no escorts, does not use oxygen

Apt. Size	Square Ft.	Single Occupancy	Double Occupancy
Studio	373	$3,800	- - -
Small 1 Bedroom	460	$3,900	$7,300
Large 1 Bedroom	570	$4,100	$7,700

Additional services may be provided after assessment on a tiered system:

Tier 1 : Escorts Only	$250/month
Tier 1: Incontinence Management Only	$450/month
Tier 1 : Oxygen Only	$250/month
Tier 2: Escorts and Oxygen	$500/month
Tier 2: Escorts and Incontinence Management	$700/month
Tier 2: Oxygen and Incontinence Management	$700/month
Tier 3 : Escorts, Incontinence Management, and Oxygen	$950/month

Retainer: Prospective residents may place a hold on an available apartment in Assisted Living for up to two weeks with a $200 retainer deposit. The $200 will be credited to the prospective resident's first month's rent at his/her time of move-in. The deposit is non-refundable unless the prospective resident is denied entrance into the program based on the results of the functional assessment conducted by Kavod staff. At the end of two weeks, the prospective resident must either start paying the apartment rent or forfeit his/her hold on the apartment.

Frequently Asked Questions

Q: How much does Assisted Living cost?

A: As of January 2022, Assisted Living prices range from $3,800.00 – $4,100.00 depending on the apartment rented. This price is subject to change, so please contact Kavod's Leasing Coordinator for current rates at 303.399.1146.

Q: What if I cannot afford to pay privately?

A: We accept Long Term Care Insurance, Veterans Pension, and Medicaid.

Q: How do I apply for Medicaid assistance?

A: Eligibility for Medicaid (Health First Colorado) is determined by the State of Colorado and can take 8-12 weeks to process. Please contact the Denver Department of Human Services online at Colorado.gov/PEAK or by phone at 1-800-221-3943 to apply for Medicaid services. Kavod is unable to lease apartments to applicants with Medicaid pending.

Q: Do you have two-bedroom apartments?

A: No. Our apartments consist of studio and one-bedroom units.

Q: Do you have to be Jewish to live at Kavod Assisted Living?

A: No. We pride ourselves on being a community open to all, regardless of religious affiliation or ethnic background. In fact, the residents of Kavod are a diverse group of individuals from all walks of life.

Q: Will I lose my independence if I move into Assisted Living?

A: No. Assisted Living services are designed to help residents with Activities of Daily Living (or ADL's), such as housekeeping, laundry, and meal preparation. Providing assistance in these areas allows our residents to be more independent and choose to spend time on activities they enjoy.

Some of the oversight we provide is in place to keep our residents safe and to comply with regulations from the Colorado Department of Public Health and Environment. For example, Assisted Living residents are required to eat meals in the dining area based on individual care plan, comply with state mandates surrounding medications, and report to their caregiver if leaving the facility. While each facility has different protocols surrounding these items, all Assisted Living facilities follow these guidelines to stay in good standing.

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Application

Office Use Only
Date Received Complete: _____
Time: _____
Staff Initials: _____

** All applications and information will be reviewed on an impartial basis and will be kept confidential. Proper documentation (proof of age and or ID) should be provided during the application process. All information will be verified.**

APPLICANT #1 (Head of Household)

Last Name First Name Middle Name

Current Street Address City State Zip Code

/ / M / F / Prefer not to Respond

Age Date of Birth City of Birth Sex (circle one)

Social Security Number Telephone Number

Citizenship Status

☐ US Citizen ☐ Legal Immigrant ☐ Non-legal Immigrant

APPLICANT #2

Last Name First Name Middle Name

Current Street Address City State Zip Code

/ / M / F / Prefer not to Respond

Age Date of Birth City of Birth Sex (circle one) Relationship to Applicant #1

Social Security Number Telephone Number

Citizenship Status

☐ US Citizen ☐ Legal Immigrant ☐ Non-legal Immigrant

Please indicate what size apartment you are interested in:

☐ Studio ☐ One Bedroom ☐ No Preference

Do you or any member of the household require special physical accommodations?

☐ Accessible Apartment ☐ Assisted Living ☐ Other _____

Do you have a pet? *Pets are permitted, but Pet Agreement requirements must be met. Pet Agreement is available upon request.*

☐ Yes ☐ No

Do you own a vehicle for which a parking space will be required?

☐ Yes ☐ No

Are you or any member of the household currently employed?

☐ Yes – FT or PT? ☐ No

Have you or any member of the household been evicted within the last five years?

☐ Yes ☐ No

Have you or any member of the household ever been convicted of a felony?

☐ Yes ☐ No

Are you or any member of the household subject to any state lifetime sex offender registration requirement?

☐ Yes ☐ No

Have you ever been convicted of a drug or alcohol related offense?

☐ Yes ☐ No

Will you need a rent supplement (Medicaid) if approved for residency at Kavod Assisted Living?

☐ Yes ☐ No

Please list all states you or any member of the household has lived:

_____

_____

Kavod Assisted Living is an indoor smoke-free community. No smoking is allowed in any of the buildings, including residents' apartments. Smoking is allowed outside in designated areas of the grounds. Are you a smoker?

☐ Yes ☐ No

Will you be able to comply with Kavod nonsmoking policy?

☐ Yes ☐ No

Are you currently residing in an assisted living, nursing home or rehabilitation center? **

☐ Yes ☐ No

If yes, list the case manager/discharge planner that is assisting with the transfer of care process:

_____

_____

***Please be advised that Kavod Senior Life will require documentation from the current facility as part of the comprehensive assessment that is completed to ensure that Kavod Senior Life's level of care is safe and appropriate.*

Lead Warning Statement

Housing built before 1978 may contain lead-based paint. Lead from paint, paint chips, and dust can pose health hazards if not managed properly. Lead exposure is especially harmful to young children and pregnant women. Before renting pre-1978 housing, lessors must disclose the presence of known lead-based paint and/or lead-based paint hazards in the dwelling. Lessees must also receive a federally approved pamphlet on lead poisoning prevention.

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Medicaid Applicants: In addition to the application and checklist materials, we are now required to have the following items in order to process your application:

Medicaid Case Number: _____

Case Manager Name: _____ Phone: _____

Case Manager Long Term Care Service Plan: Please attach or have case manager fax the Long Term Care Service Plan to 720.382.7850 or 720.382.7845.

As this information is Protected Health Information (PHI), we are unable to obtain these documents without your permission. These documents are required as part of the comprehensive assessment that must be completed to ensure our level of care is safe and appropriate as well as ensure that each resident is making an informed choice regarding their next home. If you are unable to attach this document and would like to provide permission for us to request the document, please sign permission form below.

Case Manager Assessment
Consent for Release of Information

I hereby authorize release of my Case Manager assessment information to **_____.** **I understand that I do not have to sign this consent if it is not clear to me who will provide the information or who will receive the information.** **/ /**
Applicant's Signature or Legal Representative **Date Signed** **/ /**
Patient's Name Printed **Birth Date**

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Consent for Landlord Reference

Please provide housing contact information for the **past five (5) years**; you may use an additional page if necessary. These references will be contacted by Kavod leasing personnel. Rental history screening will also include verification for those who were homeowners or lived with parents, guardians, or other relatives; if this applies to you, please provide contact information for family members, guardians, and friends whom you have lived with in the past five (5) years.

Current Landlord:

_____ / / to / /
Name Telephone Number Fax Number Dates of Residency

_____
Street Address City State Zip Code

Former Landlord:

_____ / / to / /
Name Telephone Number Fax Number Dates of Residency

_____
Street Address City State Zip Code

Former Landlord:

_____ / / to / /
Name Telephone Number Fax Number Dates of Residency

_____
Street Address City State Zip Code

Former Landlord:

_____ / / to / /
Name Telephone Number Fax Number Dates of Residency

_____
Street Address City State Zip Code

Former Landlord:

Name	Telephone Number	Fax Number	/ / to / / Dates of Residency

Street Address	City	State	Zip Code

Former Landlord:

Name	Telephone Number	Fax Number	/ / to / / Dates of Residency

Street Address	City	State	Zip Code

I hereby give permission to the listed landlords to provide Kavod Senior Life information regarding my residency.

I understand that I do not have to sign this consent if it is not clear to me who will provide the information or who will receive the information.

Applicant's Signature	Date Signed

Applicant's Name Printed

Information provided in this application will be used to determine eligibility according to occupancy standards. If such information provided is false or materially misleading, then Owner shall have the option to terminate Resident's right to possession upon (3) days' notice to quit.

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Financial Data

This information must be completed to be considered for residency at Kavod Senior Life.

Sources of *Monthly* Income:

Social Security	$
Supplemental Security Income	$
Pensions/Benefits - Source	$
Interest (Monthly) - Source	$
Dividends (Monthly) - Source	$
Gross Wages	$
Rental Income	$
Other Income	$
Total Monthly Income	**$**

Assets:

Checking Account(s)	Average Balance	$
Savings Account(s)	Average Balance	$
Market Value of Stocks		$
Market Value of Bonds		$
Market Value of Real Estate	(List Separately)	$
Cash Surrender Value of Life Insurance		$
Other Assets (Cash on Hand; Collectibles; etc)		$
Total Assets		**$**

Medical Expenses:

Supplemental Health Insurance	$
Medical Expenses not Covered by Insurance	$
Other Unusual Medical Expenses	$
Total Medical Expenses	**$**

Please describe any unusual circumstances which may affect your income, assets, or medical expenses over the next twelve (12) months.

I understand that if I meet the eligibility criteria for residency at Kavod Senior Life, I will be contacted for an assessment. I hereby certify that all information contained on this application is correct and complete to the best of my knowledge. I understand that any material misrepresentation will result in my being ineligible for consideration. I understand that it is my responsibility to provide verifying documentation for all information contained within this application when requested by the organization.

Signature of Applicant #1 Date

Signature of Applicant #2 Date

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Credit and Background Inquiry Release

In connection with my application for residency at Kavod Senior Life ("Kavod"), I hereby authorize Kavod and/or its designated resident screening provider and/or its employees to obtain information concerning my past credit information, criminal information, tenant- landlord history, and/or past addresses, in accordance with the Fair Credit Reporting Act and all state and federal laws.

I hereby authorize any of the following sources, including but not limited to: landlords; public or privately-owned utilities; current or past creditors; governmental housing agencies; credit reporting agencies; criminal and court reporting agencies; and/or government or court agencies providing criminal or court records; to release any information to Kavod, its resident screening provider, and/or employees concerning my credit, criminal, tenant-landlord history, and/or past addresses.

I understand that should I lease an apartment, Kavod and its agent(s) shall have continuing right to review my credit information, criminal information, rental application, payment history and occupancy history for account review purposes and for improving application review methods.

I further release and discharge all liability from all companies, agencies, officials, officers, and other persons, who, in good faith, provide to Kavod the above-mentioned information as requested in order to successfully complete a background investigation for my application of residency. I will allow a photocopy of this authorization to be as valid as the original.

Print Full Name:_____

Social Security #: _____ Date of Birth*: _____

Driver's License: State: _____ Number: _____

**Date of Birth is being requested for the purpose of identification in obtaining accurate retrieval of records and will not be used for discriminatory purposes.*

(continued next page)

Credit and Background Inquiry Release

Current Address: _____

City, State, Zip _____

Previous Address(es) During Past 5 Years:

_____

_____

_____

_____

_____

Applicant's Signature:_____

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Applicant/Family Self-Evaluation

Applicant's Name: _____ **Age:** _____

What are your present living arrangements? _____

_____

What type of assistance do you currently receive? _____

_____

How soon are you looking to move into Assisted Living?

_____

In which areas would you benefit from assistance?		
Activity of Daily Living (ADL)		**Type of Assistance**
Taking medication	☐ Yes ☐ No	
Preparing meals	☐ Yes ☐ No	
Dressing/Undressing	☐ Yes ☐ No	
Grooming	☐ Yes ☐ No	
Showering/bathing	☐ Yes ☐ No	
Housekeeping/Laundry	☐ Yes ☐ No	
Incontinence Management	☐ Yes ☐ No	
Oxygen Management	☐ Yes ☐ No	
Escort Assistance	☐ Yes ☐ No	
Community Involvement	☐ Yes ☐ No	

Physical Health:

Do you have any significant health concerns we should be aware of?

_____

_____

Do you have diet restrictions? ☐ Yes ☐ No Any difficulty swallowing? ☐ Yes ☐ No

If yes, please specify.

_____

_____

Mobility:

Do you utilize any of the following: ☐ Cane ☐ Walker ☐ Scooter ☐ Wheelchair

Able to ambulate independently 150 feet? ☐ Yes ☐ No

Able to transfer independently? ☐ Yes ☐ No

Able to go up/down stairs independently? ☐ Yes ☐ No

Cognitive Health:

How would you describe your memory? (Check one)	
☐	Good memory for present day events – no difficulty remembering names, places, or scheduled appointments. Do not become confused in unfamiliar place.
☐	Fair memory for present day events – little help required for remembering names or appointments. May become confused in unfamiliar place.
☐	Poor memory for present day events – Require a lot of reminders with names, scheduling and remembering appointments. Almost always confused in unfamiliar place.
☐	Extremely Poor memory – Do not remember familiar people or names. Others must schedule and supervise appointments. Do not know where he/she at most of the time.

Do you experience depression or anxiety? ☐ Yes ☐ No

If yes, is it: ☐ Mild ☐ Moderate ☐ Severe Do you take medications for it? ☐ Yes ☐ No

If yes, please explain:

_____

History of any of the following:

☐ Suicidal/self-abuse ☐ Substance Abuse ☐ Hoarding Behavior ☐ Resistance to Care
If yes, please explain:

_____

General Information:
Is anyone assisting with bill paying or managing your finances?
If yes, please provide name and phone number: *(If POA or Conservator, please provide copy)*

_____

Are you currently receiving Medicaid benefits?
*If yes, LTC case manager*_____ *Contact Information*: _____

Additional Information you would like us to be aware of:

_____

_____

Evaluation Completed By: _____ Date: _____

Applicant Signature: _____ Date: _____

Thank you for completing the survey!

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Dear Applicant:

Kavod Assisted Living is very interested in knowing how you heard about us. Please check off the appropriate sources of information listed below. You may check more than one.

___ Friend

___ Relative

___ Resident

___ Brochure

___ Agency, i.e. HUD – specify: _____

___ Senior Resource Guide/Blue Book

___ Newspaper, specify: _____

___ Kavod Website

___ Internet Site, i.e. SeniorHousing.net – specify: _____

___ Internet Search, i.e. Google

___ Other, specify: _____

Current Zip Code | Completed Month/Year

Your Name (optional) | Telephone Number (optional)

Thank you for helping us gather this important information.

Sincerely,

Kavod Senior Life

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SUPPLEMENT TO APPLICATION
Additional Contact Person or Organization

Applicant Name:_____
Applicant Mailing Address: :_____
Applicant Telephone: :_____

Name of Additional Contact Person or Organization:

Address: :_____
Telephone: :_____
Email: :_____
Relationship to Applicant:
_____MPOA _____POA
Reason to contact: (check all that apply)
_____ Emergency _____ Change in lease terms
_____ Unable to contact you _____ Change in house rules
_____ Eviction from unit _____ Late payment of rent

Name of Additional Contact Person or Organization:

Address: :_____
Telephone: :_____
Email: :_____
Relationship to Applicant:
_____MPOA _____POA
Reason to contact: (check all that apply)
_____ Emergency _____ Change in lease terms
_____ Unable to contact you _____ Change in house rules
_____ Eviction from unit _____ Late payment of rent

Signature of Applicant: _____

Date: _____

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Instructions for Physician's Evaluation and Consent for Release of Medical Information

Applicant Instructions:

Please include your physician's name and contact information in the box below.

Please sign the Consent for Release of Information

Please include your date of birth with release

Please turn in the entire physician evaluation to Kavod Senior Life staff for processing. Alternatively, you may turn the physician evaluation in to your doctor's office for processing.

Name of Medical Professional		Telephone Number	
Street Address	City	State	Zip Code

Physician's Office Instruction:

Per your patient's release of information, please complete the physician evaluation.

Your patient is either a current resident of Kavod Senior Life or a prospective resident of our Assisted Living licensed by the Colorado Department of Public Health and Environment. The license requires that our facility provide non-medical care and supervision to meet the needs of that person. Our Assisted Living requires the following information to assist us in determining whether this person is appropriate for care in our non-medical facility. It is important that all questions be answered completely. Please attach additional pages if needed. **Our facility does not provide skilled nursing or dementia specific care.**

Please fax completed evaluation as soon as possible to 720.382.7850 or 720.382.7845.

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Physician Name _____

Physician Phone _____

Dear Doctor: _____

Your patient, _____, has applied for residency in an Assisted Living unit. Our program is designed to provide our residents with assistance maintaining Activities of Daily Living within a non-medical setting.

Services Provided:

- Three (3) meals daily with snacks as needed
- Housekeeping once a week
- Laundry (personal and linen) once a week
- Bathing support twice a week
- Medication monitoring per Physician's orders
- Memory support – daily reminder of activities, meals, and appointments
- Scheduling of appointments
- Care coordination
- Friendly visiting and volunteer opportunities
- An assortment of daily activities

Eligibility Criteria (Our Assisted Living is not a medical facility and does not offer skilled nursing care):

- Successfully ambulate independently at least 150 feet.
- Able to perform or be willing to receive assistance with activities of daily living, such as dressing, personal hygiene and bathing.
- Safe within an unlocked community (cannot wander).
- Cannot require a therapeutic diet, more than a one-person transfer assistance, or restraints.
- Cannot have a history of conduct that would pose a danger to self/others.

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 thoroughly as possible.

We are unable to process your patient's application until these forms are completed and are received by our office. Your prompt assistance is greatly appreciated. If you have any questions about our program, please contact me at 720.382.7825.

Sincerely,

Christy Martinez

Christy Martinez
Director of Assisted Living

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Physician's Evaluation
Consent for Release of Medical Information

I hereby authorize release of medical information to _____. **I understand that I do not have to sign this consent if it is not clear to me who will provide the information or who will receive the information.** **/ /**
Applicant's Signature or Legal Representative **Date Signed** **/ /**
Patient's Name Printed **Birth Date**

Patient Diagnosis - to be completed by Physician

Note to Physician: The person named above is either a current resident or a prospective resident of our Assisted Living licensed by the Colorado Department of Public Health and Environment. The license requires that our facility provide non-medical care and supervision to meet the needs of that person. Our Assisted Living requires the following information to assist us in determining whether this person is appropriate for care in our non-medical facility. It is important that all questions be answered completely. Please attach additional pages if needed. ***Our facility does not provide skilled nursing or dementia specific care.***

Date of Exam:	Height:	Weight:	Blood Pressure:

Tuberculosis (TB) Test:

Date TB Test given:	Date TB Test read:	Type of TB Test:	TB Test is: ☐ Negative ☐ Positive
Action taken if positive:			
Chest X-ray results:			

Patient/Resident Diagnosis:

_____

_____

Allergies (medications/food): ☐ Yes ☐ No
If yes, please explain reaction:

_____

Physician's Evaluation

Physical Health Status	**Yes**	**No**	**Unknown**	**Explain**
Auditory impairment				
Visual impairment				
Wears dentures				
Regular diet status				
Contagious/infectious disease				
Use of alcohol/cigarettes				
Substance abuse problems				
History of skin condition				
Bowel incontinence				Self-manage ☐ Yes ☐ No
Bladder incontinence				Self-manage ☐ Yes ☐ No
Motor impairment/paralysis				
Able to ambulate 150 feet independently				Assistive device?
Mental Condition	**Yes**	**No**	**Unknown**	**Explain**
Mild cognitive impairment				
Dementia				If yes, stage:
Confused/ disoriented				
Aggressive behavior				
Wandering behavior				
Sundown behavior				
Depression				
Anxiety				
Suicidal/ self-abuse				If yes, when:
Hospitalization for psychiatric condition				If yes, when:
Able to follow instructions				
Able to communicate needs				
At risk if allowed direct access to personal grooming and hygiene items				
Capacity for Self-Care	**Yes**	**No**	**Unknown**	**Explain**
Able to bathe/shower self				
Able to dress/groom self				
Able to feed self				
Able to care for own toileting needs				
Able to leave facility unassisted				
Able to self-manage heating pad				
Medication Management	**Yes**	**No**	**Unknown**	**Explain**
Able to self-administer prescribed meds				
Able to self-administer PRN medications				
Able to understand/request a PRN med				
Able to perform own glucose testing				Not applicable
Able to administer own injections				Not applicable
Able to manage own oxygen				Not applicable

Prescribed Medications – including OTC (please print)	Dosage	Route	Frequency	Function

PRN Medications (please print)	Dosage	Route	Frequency	Function

***** A signed/dated attached medication sheet will be accepted if more space is required.***

Recent Hospitalizations/Surgeries:

_____

_____

Length of time resident has been your patient: _____

Physician's Name and Complete Address (please print):

_____

_____

_____

Telephone: _____ Fax: _____

_____ _____

Physician's Signature Date

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