



**710 Eagle Ave – PO Box 1119**  
**Kremmling, Co. 80459**  
**Phone (970)724-3530**  
**Fax (970)724-3813**

Thank you for your interest in Cliffview!

We are a non-profit assisted living residence, serving the community since 1994. We are managed by Middle Park Health and owned by Grand County Housing Authority. We have beautiful landscaping and have recently replaced the roof and upgraded the building. We accept private pay and Colorado Medicaid residents.

We offer twenty-four-hour oversight, medication administration, a vibrant activity program, beauty shop, home-cooked meals with local beef and fresh produce from our garden (seasonally), laundry, and housekeeping services. We enjoy an excellent reputation in the community, and have positive relationships with the physicians, the Health Department, all Middle Park Health Campuses, physical therapists, and occupational therapists in the area.

We offer semi-private for husband and wife and private rooms. Our base rates are as follows:

Larger room for couple	\$3,425.00 per person
Private	\$3,980.00 per person

These rates include all of the above services, including cable T.V. access, (beauty shop fees are extra).

We have an excellent staff; many who have worked here for years. Staff continuity is crucial to quality care.

We encourage residents to furnish their rooms with their own things. They may hang pictures on the walls and decorate as they wish.

Please call me if you have any questions.

Thank you!

Sincerely,

Karrie Sellke  
Administrator



## Cliffview Assisted Living Residence

### Consumer Information Sheet

#### Resident Information:

Owned By: Grand County Housing Authority  
Operated By: Middle Park Health  
CNO: Amy Binkley  
Residence Administrator: Karrie Sellke  
Address: 710 Eagle Avenue/PO Box 1119  
Kremmling, CO 80459  
Phone: 970-724-3530  
Fax: 970-724-3813  
Email: [ksellke@middleparkhealth.org](mailto:ksellke@middleparkhealth.org)

Number of Units: 24  
Unit Types: Standard and large studio apartments  
Private baths with walk-in shower

#### Payment Information:

Payment: Due in advance of move-in and by the 5th of each month thereafter

Rate Structure: Security Deposit Required  
See Rates and Services List  
Private Pay & Medicaid Home and Community Based Services-MI & EBD Approved Waivers accepted.

## **Who is Eligible for Residency?**

**Our services are available to disabled older adults and seniors who need supportive services. Skilled nursing services are not provided.**

### **To qualify individuals:**

Must be independently mobile.

Must be able to manage own bowel & bladder needs, or Service Level 3

May not be impaired, confused or violent to the extent that basic communication is not possible or there is danger to self or others.

May not have an infectious disease.

Must be able to meet their own personal hygiene needs with reminders or limited assistance.

May not have a physical illness or substance abuse problem which cannot be managed.

May not require chemical or physical restraints at any time.

If needed, must be able to complete finger sticks, draw up insulin, and give your own injections, unless an external provider is able to do this.

May not require a therapeutic diet (except texture changes)

May not require routine assistance with mobility or transfers from sitting to standing, bed to chair, etc.

Must manage own catheter or colostomy care if needed.

### **Services included with the basic monthly rate:**

#### **Meals**

Breakfast, lunch and dinner are served in the dining room daily.

Snacks available

Therapeutic diets are not available.

Guest meals available for an extra charge

#### **Housekeeping**

Trash emptied daily.

Weekly room cleaning

#### **Laundry Services**

Personal laundry and linen service weekly

#### **Medication Administration**

Medications are administered by qualified medication administration persons (QMAP) according to physicians' orders. QMAPs may not administer injections, tube feedings, psychotropic medications on a PRN (as needed) basis, or other skilled services.

#### **Social & Recreational Activities**

Group activity outings, games, music programs.

Full monthly activity calendar

Bus outings

### **Room Amenities**

Furnished rooms available

Water, gas, and electricity are included in fees.

Lockable door

### **Transportation**

Our staff can assist with arrangements for outside transportation to medical appointments.

### **Personal Care Services**

Monitoring of health status and coordination of health-related services is provided for all residents as needed.

Services are based on an individualized resident care plan and may include assistance or reminders for bathing, dressing, hair and nail care, shaving, dental hygiene, health related appointment management, and oxygen use. Reminders for meals, medications, activities are provided occasionally as needed.

Individuals must be independently mobile and self-manage bowel and bladder care.

### **Facility Amenities**

Close to medical facilities

Outdoor seating and large yard

Phone hookups provided by CenturyLink at their quoted rate

### **Smoking**

Smoking is allowed in a designated area only. Residents are assessed upon admission and regularly thereafter to assure they are able to handle smoking materials safely.

### **Pets allowed with approval (deposit required)**

Service/Companion Animals welcome with certain conditions.

### **Staffing Patterns**

Awake staff is available 24 hours a day for protective oversight and emergency response.

From 7 AM until 7 PM there is at least 1 staff present for each 10 residents. These might include the administrator, cook, maintenance supervisor and personal care providers, at least one of whom is trained to administer medications and is certified in first aid. From 7 PM to 7 AM there is at least 1 staff member present for every 16 residents, at least one of whom is trained to administer medications and is certified in first aid.

## **Physical Environment Safety Features**

- ✓ Automatic fire alarm system and pull system
- ✓ Automatic fire sprinklers
- ✓ Emergency Response Call System
- ✓ Outdoor access door alarms

## **Move Out Information:**

We may terminate our occupancy agreement upon 30-day notice in writing for the following reasons:

- We are no longer able to meet your identified needs.
- You have failed to fulfill your financial obligations to us.
- We cannot protect you from harming yourself or others.
- You fail to comply with the Resident Occupancy Agreement, including house rules.

You may terminate this agreement with a 30-day written notice.

Exceptions to the written 30-day notice policy include:

- a medical emergency, or
- when we are not able to prevent you from harming yourself or others
- changes in your medical condition require an increase in care necessary to protect your health and safety
- requests from you or your representative for additional services to be added to your Resident Care Plan.

Discharges shall be coordinated with the resident, the resident's family or legal representative or other agency as needed.

Make a Difference in the Life of an Elderly Person.

Remember Cliffview when choosing to make a charitable donation.

Cliffview Residence is owned by Grand County Housing Authority managed by Middle Park Health



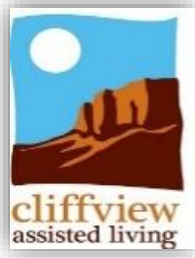
## How to Apply for Assisted Living

To ensure that we are able to meet the unique needs of each applicant, please complete the following four-part admission process. This includes:

1. An **application**, including a financial disclosure of your income and assets. This is used to determine eligibility for our assisted housing program. You may also be asked to verify your income and assets.
2. A **medical history** which is completed by your physician. It includes information about medications, health requirements and personal care needs. This history must be current (within 30 days of moving in) and be received prior to moving in.
3. A **personal interview and assessment** with the staff to assess the applicant's needs and our ability to provide the appropriate assistance at our community.
4. A **background check** will be completed on all applicants for housing at Cliffview Assisted Living.

**Security Deposit:** Each resident is required to make a \$780.00 security deposit. This deposit is refundable when a move-in does not occur due to illness or failure to meet the occupancy criteria, or at the time of move-out according to the terms of the Resident Occupancy Agreement.

**Room Hold:** To hold a unit prior to move-in, a room hold charge of 75% of the daily rate is required.



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How did you hear about Cliffview? \_\_\_\_\_

## ASSISTED LIVING RESIDENCE APPLICATION

### CONTACT INFORMATION:

Date: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Email \_\_\_\_\_

Present Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County: \_\_\_\_\_

How long at this address? \_\_\_\_\_

Telephone: \_\_\_\_\_ Cell \_\_\_\_\_ email \_\_\_\_\_

Spouse/Partner Name \_\_\_\_\_ Phone \_\_\_\_\_ email \_\_\_\_\_

Name of Legal Representative (if applicable) \_\_\_\_\_

Address of Legal Representative \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Past Occupation: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Gender \_\_\_\_\_

### INSURANCE INFORMATION:

Are you currently on Medicare Part-A? Yes \_\_\_ No \_\_\_ Part-B? Yes \_\_\_ No \_\_\_ Part-C? Yes \_\_\_ No \_\_\_

Are you currently with an HMO? Yes \_\_\_ No \_\_\_ Which one? \_\_\_\_\_ HMO Number: \_\_\_\_\_

Do you have Medicaid Health and Community Based Services (HCBS)? Yes \_\_\_ No \_\_\_ Application in Process \_\_\_ Number \_\_\_\_\_

Do you have a caseworker or a social worker? \_\_\_ Yes \_\_\_ No? If yes, please provide the following information:

Name \_\_\_\_\_ Organization \_\_\_\_\_ Contact information \_\_\_\_\_

**FINANCIAL INFORMATION:**

This facility is managed by Middle Park Health. Cliffview Assisted Living is dedicated to providing, affordable, homelike environment where seniors of all income levels can live independently in comfort and security while receiving the services they need. To achieve cost effectiveness, we have utilized various sources of funding that require that we verify financial income and asset information on every potential resident. In cooperation with this policy, please provide answers to the following questions:

Who will be responsible for paying the fees at Cliffview?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

**ASSET INFORMATION:** Income from each of these assets must be detailed in the Income Information section below. Please list all checking, savings and investment accounts (including IRA's, Keogh accounts and certificates of deposit) including assets disposed of during the last two years. Also list the value of other assets including real estate, stocks, bonds, trusts or other assets. Attach additional information if needed.

Type of Asset	Financial Institution	Address and Phone Number	Account Number	Balance

**INCOME INFORMATION:** For each type of income you receive, list the source of the income, the address and phone number related to the source and the amount which can be expected to be received during the next twelve months. Include all sources of such as wages, social security, pension, interest, and income from alimony or rental properties. Verification of income must be provided in the form of bank statements that show consistent direct deposit of Social Security, VA benefits, other pensions, social security or other benefits. Quarterly interest statements for a 1 year period or a copy of the last year's IRS Income Tax Return may be used to estimate income.

Source of Income	Address and Phone	Monthly	Annually

**RENTAL HISTORY:** Please complete the following rental history. Start with your current or most recent address, include places where you lived, but were not listed on the lease and where you lived under a different name for at least the last three years.

Address	City	State	How long?
Landlord Name	Landlord Phone	Evicted?	Monthly Rent
Address	City	State	How long?
Landlord Name	Landlord Phone	Evicted?	Monthly Rent
Address	City	State	How long?
Landlord Name	Landlord Phone	Evicted?	Monthly Rent

**ETHNICITY of head of household:**

Hispanic  Non-Hispanic **RACE**

**of head of household:**

White  Black  American Indian or Alaskan Native  Asian/Pacific Islander

**SIGNATURE:**

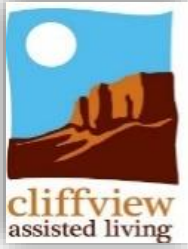
The above statements are true to the best of my knowledge. The applicant authorizes Cliffview Assisted Living, to verify all information provided on this application and to execute all further forms required to assist in this verification process. Applicant certifies that statements made in this application are true and complete and that false statements may result in a denial of this application

\_\_\_\_\_

\_\_\_\_\_

Signature of Person Completing

Date



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### MEDICAL HISTORY

Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

Medical Release Authorization: \_\_\_\_\_  
(Resident/legal representative signature)

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician Address: \_\_\_\_\_

Dear Dr. \_\_\_\_\_,

The above named individual has hereby signed authorization for you to assist in the evaluation for placement in our assisted living residence. Please complete and return this form, releasing any pertinent documents that may be helpful in providing care at our residence.

Diagnosis: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current medical problems: \_\_\_\_\_  
\_\_\_\_\_

Medical/Surgical history: \_\_\_\_\_  
\_\_\_\_\_

Dietary restrictions (therapeutic diets not available): \_\_\_\_\_  
\_\_\_\_\_

Can applicant monitor his/her own dietary restrictions? Yes \_\_\_ No \_\_\_

History of destructive, aggressive or violent behavior or mental illness: \_\_\_\_\_  
\_\_\_\_\_

Blood Press. \_\_\_\_\_ Pulse \_\_\_\_\_ Resp. \_\_\_\_\_ Temp \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Date of Immunizations: Flu \_\_\_\_\_ Pneumovax \_\_\_\_\_ Tetanus \_\_\_\_\_

Date of last PPD \_\_\_\_\_ Results: \_\_\_\_\_

Date of last chest XRay: \_\_\_\_\_ Results: \_\_\_\_\_

Does applicant presently suffer from any communicable disease? Yes \_\_\_ No \_\_\_

If yes, please describe: \_\_\_\_\_

Current Medications and Treatments:

Drug:

Dose:

Directions:

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PRN Medications:

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Allergies:

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Does applicant have any of the following conditions? If so, please describe below:

Incontinence Yes \_\_\_ No \_\_\_

Ambulating Problems Yes \_\_\_ No \_\_\_

Sensory Deficits Yes \_\_\_ No \_\_\_

Colostomy Care Yes \_\_\_ No \_\_\_

Foley Care Yes \_\_\_ No \_\_\_

Recent Falls Yes \_\_\_ No \_\_\_

Oxygen Yes \_\_\_ No \_\_\_

Flow rate: \_\_\_\_\_

Assistive Devices: Yes \_\_\_ No \_\_\_

Other Concerns:

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\_\_\_ I authorize the ALR staff to possess and supervise the administration of medications for this applicant according to the prescribed directions included here. These medications have been reviewed and approved.

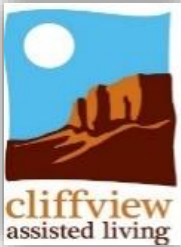
\_\_\_ This resident may self-administer all medications

To the best of your knowledge, could this individual function in assisted living without the benefit of skilled services on a regular basis? Yes \_\_\_ No \_\_\_

Dr. \_\_\_\_\_ Signature \_\_\_\_\_ Date: \_\_\_\_\_

Please call if you have questions.

Sincerely, \_\_\_\_\_



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CRIMINAL RECORDS CHECK DISCLOSURE AND CONSENT FORM-ACF

1. A criminal records check through Colorado Bureau of Investigation will be conducted on all Applicants for housing at any Cliffview Assisted Living.
2. If the Applicant has resided in Colorado for less than five (5) years, out of state criminal background checks will be made for the last 10 years as available from prior state(s) of residency.
3. If criminal records check reveals that an Applicant has a criminal record of any of the following, the application for housing will be denied:
  - a) Any applicant that is currently engaged in illegal use of drugs or for which the owner has reasonable cause to believe that an applicant's illegal use or pattern of illegal use of a drug may interfere with the health, safety, and right to peaceful enjoyment of the property by other residents.
  - b) Any applicant who is subject to a state sex offender lifetime registration requirement. National sex offender registry search is conducted on all applicants.
  - c) If there is reasonable cause to believe that the applicant's behavior, from abuse or pattern of abuse of alcohol, may interfere with the health, safety, and right to peaceful enjoyment by other residents.
  - d) Any record of criminal history or violent criminal history including: murder, attempt to commit murder, threatening with a deadly weapon, sexual assault, crimes against an at risk adult for ten (10) years preceding the date of application including but not limited to charges and/or convictions, felonies and/or misdemeanors against other persons, property, or crimes that could pose serious risk to the safety of vulnerable adults.
  - e) Conviction (at any time) for a felony involving violent physical actions on the part of the applicant.
  - f) Three (3) or more convictions on misdemeanor charges within the last two (2) years of the applicant.
  - g) The applicant may be allowed residency if the conviction results in jail/prison time requirement is satisfied at least 5 years prior to the application decision, or if the conviction results in parole/probation requirement that is satisfied at least 5 years prior to the admission decision.

I acknowledge that a telephonic facsimile (FAX) or photographic copy of this document shall be as valid as the original. This release enables most federal, state and county agencies to permit information about me to be released.

I hereby authorize, without reservation, any law enforcement agency, institution, or information service bureau contacted by Cliffview Assisted Living or its representative to furnish the information.

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Signature of Applicant (Required)                      Date                      Email (Required)

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Print Name (Required)                                              Birthdate (Required)

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Social Security Number                      Phone Number                      Male                      Female

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Address (Please do not give a Post Office Box)

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City                      County                      State                      Zip Code

**If you have lived outside the State of Colorado in the last 5 years you must provide your prior address for out of state information requirements:**

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Address (Please do not give a Post office Box)

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City                      County                      State                      Zip Code

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Phone number where you can be reached or left a message