



General Relief for Assisted Living Home Care
CLIENT ACTIVITY FORM

The GR Program must be notified within ten days of any client changes

Client Last Name: _____ Client First Name: _____

Date of Birth: _____ Name of ALH reporting change: _____

What changed? Check all that apply and explain below

Client moved in (must complete ROI below): _____ Date: _____

Client was absent from the ALH, but did not move out: _____ Dates Absent: _____

Client moved to a new GR ALH: _____ Date: _____

Name of New ALH: _____

Client moved out, doesn't need/want GR: _____ Date: _____

New Address/Location: _____ New Phone Number: _____

Income or Resource Change, describe below and attach supporting documents:

Request for Augmented Rate: describe need for augmented rate in the "Additional Information" text box below
Attach a current Physician's Report (can use pages 7 and 8 of GR-01), or Physician's Statement, or Physical
History report from the most recent office visit

Application for Waiver turned in: _____ Date: _____

Care Coordinator named on waiver application: _____

Client Died

Date: _____

Additional Information: (attach more pages as needed)

Name of Person Filling out Form: _____ Title: _____

Signature: _____ Date: _____

Send this form to: General Relief Program • Division of Senior and Disabilities Services 1835 Bragaw St. Suite 350
Anchorage, Alaska 99508 or by DSM E-Mail only: General.Relief@hss.soa.directak.net, or fax: (907) 269-3648

Release of Information

I _____ authorize _____

(Recipient Name)

(Name of Assisted Living Home)

to release any personal or health care information to Senior and Disabilities Services and I authorize Senior and Disabilities
Services to release any personal, financial or health care information to _____

that is needed to determine my eligibility to receive or continue to _____ (Name of Assisted Living Home)
receive services and other benefits through programs managed by the State.

Signature of Recipient

Date: _____