State of Alaska
Department of Health
Division of Health Care Services
Residential Licensing

Application for License to Operate an Assisted Living Home

*Please read this application carefully and answer **ALL** applicable questions. Incomplete applications will be returned to the applicant for completion.* If you have questions regarding any information requested on this application, please contact: (907) 334-2400 to speak with a licensing specialist.

1. **Proposed Name of Assisted Living Home:** _____

2. **Applicant:** The applicant is the individual or legal entity responsible for operation of the proposed assisted living home and will be the owner on the license.

   Name of Applicant: _____
   Name of Person Completing App. _____
   Mailing Address: _____
   City: _____ State: _____ Zip Code: _____
   Physical Address: _____
   City: _____ State: _____ Zip Code: _____
   Email Address: _____
   Phone Number: _____ Fax Number: _____

3. **Is the applicant an association, corporation, or other entity? Yes: ☐ No: ☐**
   If **Yes**, please complete the Association, Corporation, or other entity Worksheet attached to this application.

4. **Is the applicant a Government Agency? Yes: ☐ No: ☐**
   If **Yes**, please complete the Government Agency Worksheet attached to this application.

5. **Ownership Interest:** Please attach a copy of your business license, any corporation documents, and complete the Ownership Interest Worksheet.

6. **Does the Applicant own the property of the proposed location? Yes: ☐ No: ☐**
   If **No**, Please identify the owner of the premises in which the proposed assisted living home will be located.

   Name: _____
   Title: _____
   Mailing Address: _____
   City: _____ State: _____ Zip Code: _____
   Physical Address: _____
   City: _____ State: _____ Zip Code: _____
   Email Address: _____
   Phone Number: _____ Fax Number: _____

7. **Physical Address of the Proposed Assisted Living Home:** *A physical location MUST be identified PRIOR to submission of an application. Changes in the proposed physical location during the licensing process may require a new application and associated fees. Applications that do not specify a physical location will be returned as incomplete.*

   Street: _____

   City: _____ State: AK Zip Code: _____

8. **Mailing Address of the Assisted Living Home:**

   Street: _____

   City: _____ State: AK Zip Code: _____

9. **Telephone numbers:** *Please provide us with at least two telephone numbers. The website phone number will be posted on the website listing of licensed facilities. If you do not enter a website phone number here, no phone number will be listed on the website unless a request is submitted in writing. The facility phone number is the number that will be used by residents if they need to make a call and by staff if they need to contact emergency services. These may be the same telephone number:*

   Website Phone Number: _____

   Facility Phone Number: _____

   Administrator Phone Number: _____

10. **Total number of individuals the home intends to serve:**
    The total number of individuals the home intends to serve may be less than or equal to the maximum occupancy allowed by the fire department but may not be more than the maximum occupancy allowed by the fire department.

    Number of Residents: _____

11. **Type of License the individual wants to operate:**

    ☐ Adults age 18 years of age or older who have a mental health or developmental disability (DD/MH).

    Or,

    ☐ Adults age 18 years of age or older who have physical disability, are elderly, or suffering from dementia, but who are not chronically mentally ill (SS).

12. **Does the Applicant currently hold, or ever previously held, any other licenses or certifications issued by the Department?**
    Yes: ☐ **No:** ☐ (Example: Child Care License, Foster Care License, Medicaid certification, or etc.)
    If **Yes,** please list below with their expiration dates:

13. **Administrator:** Please identify the individual who will be serving as the Administrator of the proposed Assisted Living Home and complete an Administrator Designation Questionnaire and attach it to the application:

    Name: _____

14. **Designee:** Please identify the individual who will be serving as the Designee of the proposed Assisted Living Home and complete a Designee Designation Questionnaire and attach it to the application:
    (A designee is required, this individual serves as the Administrator if they are unavailable)

    Name: _____

15. **Resident Manager:** Please identify the individual who will be serving as the Resident Manager of the proposed Assisted Living Home and complete a Resident Manager Designation Questionnaire and attach it to the application:*(A resident manager is required if the administrator does not manage the daily operations of the assisted living home)*
Name:_____

16. **Is the Home seeking a variance? Yes:** ☐ **No:** ☐
If **Yes**, please attach a completed general variance application to this application.
(*Variance applications can be obtained by contacting our office at 907-334-2400.)*

17. **Will there be any other individuals residing at the Assisted Living Home, other than the Administrator and residents? Yes:** ☐ **No:** ☐
If **Yes**, please complete the Household Member Worksheet attached to this application.

18. **The following, as applicable, are required to be attached to your application.**

☐ 1. Completed Application for License to Operate an Assisted Living Home.
- ☐ Must be notarized.
- ☐ Must include fee.
- ☐ Complete (if applicable) Association, Corporation, or other entity Worksheet.
- ☐ Complete (if applicable) Government Agency Worksheet.
- ☐ Complete Ownership Interest Worksheet.

☐ 2. Administrator Designation Questionnaire completed by the individual being appointed Administrator.
- ☐ Completed Administrator Designation Questionnaire.
- ☐ Documentation the individual meets the requirements in 7 AAC 75.230.
- ☐ Copy of government issued photo identification.
- ☐ Documentation of Clearance from Active Tuberculosis (TB).
- ☐ 3 Character and 2 Employer References (See attached form).
- ☐ Copies of Current CPR & first aid.

☐ 3. Designee Designation Questionnaire completed by the individual being appointed Designee.
- ☐ Completed Designee Designation Questionnaire.
- ☐ Copy of government issued photo identification.
- ☐ Documentation of Clearance from Active Tuberculosis (TB).
- ☐ 3 Character and 2 Employer References (See attached form).
- ☐ Copies of Current CPR & first aid.

☐ 4. Resident Manager Designation Questionnaire completed by the individual being appointed Resident Manager. (If Applicable)
- ☐ Completed Resident Manager Designation Questionnaire.
- ☐ Documentation the individual meets the requirements in 7 AAC 75.230.
- ☐ Copy of government issued photo identification.
- ☐ Documentation of Clearance from Active Tuberculosis (TB).
- ☐ 3 Character and 2 Employer References (See attached form).
- ☐ Copies of Current CPR & first aid.

☐ 5. Completed Projected Budget Guidelines and 3 Month Budget. This must be a 6 month budget if you currently own and operate another licensed assisted living home or you are applying for an assisted living home with eleven (11) or more residents. This must include:
- ☐ Copies of current billing statements from utilities to verify the amounts reported in the 3 month budget.
- ☐ Documentation of current bank statements that verify there is the three month financial reserve as required by 7 AAC 75.085.

☐ 6. Universal Precautions Policy - Create and Submit the Home's Universal Precautions (see enclosed guide lines and 7 AAC 10.1045 for information on what is required to be included).

☐ 7. Staff Plan and Staff Responsibilities – Complete the attached sample Staff Plan and Create and Submit Staff Responsibilities (Job Descriptions) (see enclosed sample form and 7 AAC 75.080 (b) (11) for information on what is required to be included).

☐ 8. Personnel Practices – Create policies you will require your staff to comply with. This is similar to an employee handbook. (See 7 AAC 75.210 (a) (3) for information on what is required).

☐ 9. Disaster Preparedness Plan – Create and Submit the Home's Disaster Preparedness Plan (see 7 AAC 10.1010 (e)-(l) for information on what is required to be included). See also the enclosed sample emergency evacuation drill form.

☐ 10. Emergency Evacuation Plan/Floor Plan – Create a clear diagram of each level of the home that identifies all the walls, doorways, and windows and include a key that identifies all of the following items:

- ☐ Location of smoke detectors.
- ☐ Location of Carbon Monoxide (CO) detectors.
- ☐ Location of fire extinguisher.
- ☐ Location of Disaster Kit.
- ☐ Location of First Aid Kit.
- ☐ Location of the meeting place outside the home.
- ☐ Arrows showing evacuation routes used in an emergency.

☐ 11. Documentation is required to verify with the owner of the property is aware and give permission for use of the property as an assisted living home. Please attach documentation.

☐ 12. Restraint Policy and Restraint Assessment– Create and Submit the Home's Restraint Policy and Procedure (see 7 AAC 75.295 for information on what is required to be included, see enclosed sample Restraint Assessment for item required).

☐ 13. List of Services Offered – Create and Submit the Home's List of Services Offered (see enclosed sample form and 7 AAC 75.080 (b) (8) for information on what is required to be included).

☐ 14. Prohibition of Abuse, Neglect, or Exploitation Policy – Create and Submit the Homes Policy and Procedure (see 7 AAC 75.220 for information on what is required to be included).

☐ 15. Employee Orientation - Create and Submit a form on how the Home will document Employees Orientation (see enclosed sample form and see 7 AAC 75.210 (a) (3) and 7 AAC 75. 240 (b) for information on what is required to be included).

☐ 16. Notice of Resident Rights– Create and Submit the documentation the Home will use (see enclosed sample form and AS 47.33.300 for information on what is required to be included).

☐ 17. Notice of Protection from Retaliation– Create and Submit the documentation the Home will use (see enclosed sample form see AS 47.33.350 for information on what is required to be included).

☐ 18. Grievance Procedure – Create and Submit the documentation the Home will use (see enclosed sample form and AS 47.33.340 for information on what is required to be included).

☐ 19. House Rules – Create and Submit the documentation the Home will use (see enclosed sample form and AS 47.33.060 for information on suggested items to include).

☐ 20. Residential Service Contract – Create and Submit the documentation the Home will use (see enclosed sample form and AS 47.33.210 for information on what is required to be included).

☐ 21. Assisted Living Plan & Physician Statement – Create and Submit the documentation the Home will use (see enclosed sample forms and AS 47.33.220 and AS 47.33.230 for information on what is required to be included).

☐ 22. Controlled Substance Policy – Create and Submit the Home's policy and procedure for controlled substances, include the form the Home will use to document controlled substance managed by the Home. (See enclosed sample form and 7 AAC 10.1070 (c) (3) for information on what is required to be included).

☐ 23. Acceptance and Management of Residents' Money - **Will the Home accept and manage Resident's money? Yes:** ☐ **or No:** ☐ If **Yes,** the Home must create a written policy for the management of money and create a written authorization to be signed the resident or the resident's representative or representative payee. (See enclosed sample authorization form and AS 47.33.040. (b) and 7 AAC 75.310. (a)- (j).for information required to be included in the policy and written authorization)

☐ 24. Plant Notification – **only required if the home has poisonous plants and the Department has approved them to remain in the home.** If the home has poisonous plants, you must create a form to notify residents and/or their representatives of the poisonous plants in the home and safety plan for those with impaired cognition (see 7 AAC 10.1095 for information on what is required to be included).

☐ 25. Animal Notification – **only required for homes with animals present.** If the home has animals, you must create a form to notify residents and/or their representatives that animals are in the home. (See 7 AAC 10.1090 for information on what is required to be included).

☐ 26. Firearm Notification – **firearms are not allowed in homes with 6 or more residents.** If the home has firearms, or you will allow firearms, you must create a form to notify residents and /or representatives that firearms are in the home. (See 7 AAC 10.1080 for information on what is required to be included).

☐ 27. Communal Use Nonprescription Drug Policy – **only required for a home with 3 or more residents** and homes providing communal use of commonly used nonprescription medication. Create and Submit the Home's policy (See 7 AAC 10.1070 (g) (4) for information on what is required to be included).

☐ 28. Change of Use Permit/Certificate of Occupancy – **only required for homes in the Municipality of Anchorage with 3 or more residents or for buildings that have multiple assisted living homes operating in them.** (See the enclosed flyer on Change of Use Permit/Certificate of Occupancy requirement).

☐ 29. Fire Inspection Report – **only required for homes with 6 or more residents, or 3 or more resident in the Fairbanks Municipality.** Contact your local fire authority to find out what they require.

☐ 30. Incontinence Care Procedures – **only required for 6 or more resident** Create and Submit the Home's policy and procedure for incontinence care (see 7 AAC 10.1055 for information on what is required to be included).

☐ 31. Business Plan – **only required if applying for a home with 11 or more residents or to operate multiple homes** (see 7 AAC 75.080 (b) (13) for information on what is required to be included).

☐ 32. Kitchen/Food Service Inspection – **only required for homes with 6 or residnets.** In the Municipality of Anchorage, contact Food Safety and Sanitation at (907) 343-4200. Outside the Municipality of Anchorage, contact the DEC Food Safety and Sanitation Program at (907) 269-7501.

☐ 33. Water source - **Does your facility utilize Public Water:** ☐ **or Well Water:** ☐**?**
If the facility utilizes Well Water, the Department of Environmental Conservation (DEC) Drinking Water Program may monitor your water system, if individuals occupying the building during a week are more than 25 (including residents and weekly staff). Please contact your local DEC Water Program to register your Well Water.

☐ 34. Wastewater - **only required if your facility will utilize Well Water:** Applicants with wastewate systems (septic) are required to contact DEC Wastewater Program to verify that wastewater systems meet the distance of separation required from their water system. Submit documentation you're in compliance. For further information contact Division of Water (907) 465-5180 or your local DEC office.

☐ 35. Background Checks – When we receive your application, we will contact the Background Check Program (BCP) and request an account be set up. The BCP will notify you via e-mail what your account is, your password, and how to enter individual's information to request a background check.
Do not submit anything for the background check until you have received this e-mail and have begun entering individuals. The e-mail will include a phone number and e-mail address if you have any further questions. You will need to get a background checks for all employees and every household member residing in the home who is at least 16 years of age.

19. Application fees: Please include check or money order with this application.

☐ **Licensure for one or two residents:** 1 or 2 = $25.00= $25.00

☐ **Licensure for three (3) or more residents:** _____ x $25.00=_____

(For example, to apply for licensure to service five (5) residents, the fee is calculated as follows: $25.00 for each resident for a total of $125.00).

Total fee enclosed:_____

This is to certify that this applicant agrees:

To comply with applicable licensing statutes and regulations, including but not limited to AS 47.05, AS 47.32, AS 47.33, 7 AAC 10 and 7 AAC 75.To keep records necessary to demonstrate compliance with the statutes and regulations governing licensure of assisted living homes and to make such records available to the Department of Health, or its authorized representatives, upon request. To permit representatives of the Department of Health access to inspect the assisted living home, review records, including files of individuals who received services from the assisted living home; interview staff; and interview individuals receiving services from the assisted living home. I attest that I am a citizen or national of the United States, an alien lawfully admitted for permanent residence, or an alien authorized by the Immigration and Naturalization Service to work in the United States. By my signature below, I certify that the information contained in this application and applicable attachments is true, accurate, and complete.

Signature of Applicant:_____ Date:_____

Printed Name of Applicant:_____

Notarized by:

Signature of Notary for State of Alaska: _____

Printed Name of Notary:_____

My Commission Expires:_____

Submit Completed Application to:

State of Alaska
DOH/Division of Health Care Services
Residential Licensing
4601 Business Park Blvd, Bldg K
Anchorage, AK 99503

State of Alaska
Department of Health
Division of Health Care Services
Residential Licensing

Application for License to Operate an Assisted Living Home: Association, Corporation, or other Entity Worksheet

Please provide the following information for each member of its board or governing body and the executive director of the board or governing body. Please attach additional sheets as necessary.

Name: _____

Title: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Physical Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Phone Number: _____ Fax Number: _____

Name: _____

Title: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Physical Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Phone Number: _____ Fax Number: _____

Name: _____

Title: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Physical Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Phone Number: _____ Fax Number: _____

State of Alaska
Department of Health
Division of Health Care Services
Residential Licensing

Application for License to Operate an Assisted Living Home: Government Agency Worksheet

Please respond to this question ONLY if the applicant is a government entity. Please list the Chief Executive Officer of the applicable governmental unit or subunit.

Name: _____

Title: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Physical Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Phone Number: _____ Fax Number: _____

State of Alaska
Department of Health
Division of Health Care Services
Residential Licensing

Application for License to Operate an Assisted Living Home:
Ownership Interest Worksheet

Please provide a copy of your business license and corporation documents. Please provide the following information for all individuals with ownership interest of the Assisted Living License.

Name: _____

Title: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Physical Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Phone Number: _____ Fax Number: _____

Name: _____

Title: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Physical Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Phone Number: _____ Fax Number: _____

Name: _____

Title: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Physical Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Phone Number: _____ Fax Number: _____

State of Alaska
Department of Health
Division of Health Care Services
Residential Licensing

Administrator/ Designee/ Resident Manager Designation Questionnaire

1. Name of the Assisted Living Home to which the Individual will be associated:

_____

2. This person is proposed to be: ☐ **Administrator** ☐ **Designee** ☐ **Resident Manager**

3. Name of the Individual: _____

4. Applicants Date of Birth (MM/DD/YYYY): _____

5. Driver's License Number, if any: _____

6. Physical Address: Street: _____

City: _____ State: _____Zip Code: _____

7. Mailing Address: Street: _____

City: _____ State: _____Zip Code: _____

8. Email Address: _____

9. Primary Phone Number for Applicant:_____

10. Alternative Phone Number for Applicant (If applicable): _____

11. Applicant must submit detailed documentation evidencing they meet at least one of the following criteria, please include documentation highlighting experience and any other relevant documentation (*select all that apply*):

For Individuals serving in a Home of 1-10 Residents:

☐ Documentation of a baccalaureate or higher degree in gerontology, health administration, or another health-related field, demonstrating to the Department's satisfaction that such degree work is an equivalent to the required experience; ***OR***

☐ Documentation of completion of an The Alaska Core Competencies or an approved management or administrator training course by the Department and at least one year of documented experience relevant to the population of residents to be served as a care provider, if the administrator will be providing direct care in the home, ***OR***

☐ Documented completion of a certified nurse aide training program approved by the Board of Nursing under 12 AAC 44.830, or that is equivalent in content to the requirements of 12 AAC 44.835(c), and have at least one year of documented experience relevant to the population of residents to be served, as a care provider, ***OR***

☐ At least two years of documented experience, relevant to the population of residents to be served, as a care provider, with documented skills or training relevant to the population of residents to be served, ***OR***

☐ Sufficient documented experience in an out-of-home care facility, and sufficient training, education, or other similar experiences to fulfill the duties of an administrator of the type and size of home where the individual is to be employed and to meet the needs of the population of residents to be served.

For Individuals serving in a Home of 11 or more Residents:

☐ The individual must complete an approved management or administrator training course and have at least two years of documented experience, relevant to the population of residents to be served, as a care provider, if the administrator will be providing direct care in the home; ***OR***

☐ The individual must complete a certified nurse aide training program that the Board of Nursing has approved under 12 AAC 44.830, or that is equivalent in content to the requirements of 12 AAC 44.835(c) and have at least two years of documented experience, relevant to the population of residents to be served as a care provider; ***OR***

☐ The individual must have at least five years of documented experience, relevant to the population of residents to be served, as an administrator or staff supervisor of a home serving 10 or fewer residents; ***OR***

☐ The individual must submit proof that the individual is a licensed or practical nurse or a registered nurse with documented experience relevant to the population of residents to be served.

12. Please Attach the Following Documentation:

☐ Copy of government issued ID.

☐ Evidence the Applicant is free of active pulmonary tuberculosis (TB).

☐ Current CPR and first aid.

☐ Three (3) Character References, unrelated to the applicant (ensure the individuals name, address, and phone number is listed, Applicant can use the attached reference form or submit alternative documentation).

☐ Two (2) Employer References, (ensure the individuals name, address, and phone number is listed, Applicant can use the attached reference form or submit alternative documentation).

I attest that I am a citizen or national of the United States, an alien lawfully admitted for permanent residence, or an alien authorized by the Immigration and Naturalization Service to work in the United States. By my signature below, I certify the information contained in this application and applicable attachments is true, accurate, and complete

_____ _____

Signature of Individual Identified on Item #3 Date

_____

Printed Name of Individual Identified on Item #3

For Residential Licensing Only:

Approved by: _____ Approved Date: _____

State of Alaska
Department of Health
Division of Health Care Services

General Variance Application for Residential Licensing:
AS 47.32 and 7 AAC 10.9500

Facility Type:

☐ Assisted Living Home ☐ Maternity Home ☐ Residential Child Care Facility ☐ Residential Child Care Facility

Specialization, if Applicable for Children's Residential Facilities:

☐ Emergency Shelter Care ☐ Emergency Shelter Care for Runaways ☐ Supervised Transitional Living

☐ Pregnancy and Parenting Adolescents ☐ Substance Use Treatment for Children ☐ Wilderness and Adventure Experience

Population License Type, if an Assisted Living Home:

☐ Those who have a physical disability, who are elderly, who have dementia, but who are not chronically mentally ill.

☐ Those who have a mental or developmental disability.

Name of Facility:_____

Administrator:_____

Name of person completing the request on behalf of the Administrator:_____

Facility Physical Address:_____

Facility Mailing Address:_____

Facility Contact Phone Number:_____ Facility Fax Number:_____

License Details (If Applicable): ☐ N/A, the entity is not currently licensed.

Current License Dates:_____ to_____ License Number:_____ Capacity:_____

To complete your request for a general variance the following items must be addressed. Instructions regarding the application are attached. Please add additional pages if needed.

1. Which regulation or statute are you requesting a variance from that cannot be met?

2. Provide a description of the reason your facility is unable to meet the requirement, a description of how your facility is not or will not be in compliance, and the extent to which compliance with the requirement will impose any substantial economic, technological, programmatic, legal, or medical hardship on the entity or recipients of services:

3. What is the period of time variance requested?

4. What are your proposed alternative ways to meet the requirement?

5. How will the health, safety and welfare of the residents will be protected if the variance is approved?

6. What is your plan to achieve compliance before variance expires?

7. What assurance are there the conditions do not present an imminent danger to the health, safety, or welfare of recipients of services?

8. If your request for a variance involves fire safety or another state or municipal requirement, you must attach evidence that the request has been reviewed and approved by the appropriate authority.

☐ Yes, it is attached. ☐ No, it is not attached. ☐ N/A, this requirement does not apply to me.

If you checked yes, please provide a list of attached items:

9. Provide a list of names of the recipients of services who would be affected by the variance, and the names and addresses of any representatives of those recipients of services.

10. For an Assisted Living Home, assurance that the notice requirements of 7 AAC 10.9515 (See FAQ) will be met.

☐ Yes, I provided notice. ☐ No, I did not provide notice. ☐ N/A, this requirement does not apply to me.

Please attach a copy of the Notice provided:

☐ Yes, the notice is attached. ☐ No, the notice is not attached. ☐ N/A, this requirement does not apply to me

11. If requested by the department attach any additional information requested by the department:

☐ Yes, the notice is attached ☐ No, the notice is not attached ☐ N/A, this requirement does not apply to me

If you checked yes, please provide a list of attached items

Signature of Administrator or Designee:_____

Printed Name of Administrator or Designee:_____ **Date:**_____

General Variance Application Instructions:

1. Identify the regulation you are requesting the variance for. (example - 7 AAC 75.210 (c) (2))

2. Explain why you are not able to meet the regulations you identified in #1.

3. Identify the amount of time you would like this variance to be approved for. (The Department may not approve a variance beyond the Homes current licensing period. When the license expires, the variance will need to be renewed with the Home's license. This will require you to submit a new variance request)

4. Identify any alternative ways the regulation you identified in #1 could be complied with.

5. Since the Home is requesting a variance for the regulation in #1, the Home needs to submit a plan that explains how they will ensure the health, welfare, and safety of the residents will be protected.

6. Submit a plan showing how the Home intends to comply with the regulation identified in #1 and therefore will no longer need the variance. (Keep in mind there are some variances where the Home may never be able to comply with the regulation identified in #1 – talk with your Licensing Specialist if you have questions about this)

7. Submit an assurance that the conditions that would be present, since the Home cannot comply with the regulation identified in #1, would not present an imminent danger to the health, safety, or welfare of the residents.

8. If the regulation identified in #1 is related to fire safety, or is also required by another state of Municipal agency, then the Home needs to submit documentation showing those other agencies have reviewed and approve the Homes request for a variance of the regulation identified in #1.

9. Submit a list of the residents this variance request would affect.

10. Submit documentation that all the residents and/or guardians have or will be informed of the Home's variance request, what the variance is for, and how to contact the department to provide comment.

11. If the Department has asked you to submit anything else, you will list it here.

State of Alaska
Department of Health
Division of Health Care Services
Residential Licensing

Application for License to Operate an Assisted Living Home: Household Member Worksheet

If you indicated other individuals will be residing at the Assisted Living Home, Please provide their name, date of birth, and relationship, of any individuals, of any age, that will be residing in the Assisted Living Home. This does not include the Administrator or residents. Please included required documentation. Add additional pages if needed. (Please note: all household member over the age of 16 years old will be required to complete a background check and be associated with the facility; follow the instructions at the end of New Home Assisted Living Home Application).

Name: ______________________________ Date of Birth (DD/MM/YYYY): ______________

Relationship: ______________________________

- ☐ Copy of government issued photo identification (if applicable)
- ☐ Documentation of Clearance from Active Tuberculosis (TB)

Name: ______________________________ Date of Birth (DD/MM/YYYY): ______________

Relationship: ______________________________

- ☐ Copy of government issued photo identification (if applicable)
- ☐ Documentation of Clearance from Active Tuberculosis (TB)

Name: ______________________________ Date of Birth (DD/MM/YYYY): ______________

Relationship: ______________________________

- ☐ Copy of government issued photo identification (if applicable)
- ☐ Documentation of Clearance from Active Tuberculosis (TB)

Name: ______________________________ Date of Birth (DD/MM/YYYY): ______________

Relationship: ______________________________

- ☐ Copy of government issued photo identification (if applicable)
- ☐ Documentation of Clearance from Active Tuberculosis (TB)

Name: ______________________________ Date of Birth (DD/MM/YYYY): ______________

Relationship: ______________________________

- ☐ Copy of government issued photo identification (if applicable)
- ☐ Documentation of Clearance from Active Tuberculosis (TB)

REFERENCE FORM FOR PERSON SEEKING ASSOCIATION WITH HOME

REFERENCE TYPE (Select one or both): EMPLOYER ☐ and/or ☐CHARACTER

Name of Assisted Living Home & Phone _____

This is a reference for _____ of _____,
Name of Applicant Address of Applicant

_____ whom I have known for ____ ____ in the capacity of _____
City State Year(s) Month(s)

_____ for employment with _____
(Friend, Co-Worker, Employer, etc.) NOT A RELATIVE☐ Name of Home

I know this person: ☐ Very Well ☐ Casually ☐ Not Well Enough to Give a Reference

Please answer the following questions:

1. Can you attest to the good character, maturity, and sound judgment of the applicant? ☐ Yes ☐ No

   If No, please explain:_____

   _____

2. How would you assess the applicant's ability to provide good care to the disabled or elderly adult?
   Check one: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

3. List those qualities which you believe will enable the applicant to work successfully (or unsuccessfully) with the disabled or elderly:

   _____

   _____

4. If a vulnerable adult needed placement in an assisted living home, how would you feel about the applicant taking care of him/her?

   ☐ Very Enthusiastic ☐ Somewhat Enthusiastic ☐ Worried ☐ Wouldn't Want

Comments: _____

_____

_____

_____ __

_____ _____ _____/_____
Print Name of Reference Signature of Reference Date Area Code Telephone Number

_____
Address of Reference City State Zip Code

Assisted Living Home

Projected Budget Guidelines

The projected budget guidelines is intended to be used when filling out the projected budget worksheet for any new assisted living home applications or when requested to do so by the Department. Please read through the guidelines carefully before filling out your home(s) projected budget and ensure that all required documents/statements are submitted as a part of your projected budget.

Home information

Name of the Home:_____

Physical Address:_____

Phone:_____

Owner:_____

Name of Person filling out Projected Budget:_____

Title/Position:_____

Three Month Budget

7 AAC 75.085. INSPECTION OF FINANCIAL RECORDS. If requested by the licensing agency, the home shall allow the agency to inspect the home's financial records to determine whether the home has sufficient financial resources to operate for a minimum of three months without considering resident income.

Yes/No

○/● Are you licensed for or intend to be licensed for one Home serving fewer than 11 residents?

If you answer yes please complete a three month Projected Budget.

Six Month Budget

7 AAC 75.080. APPLICATION FOR LICENSE; MODIFICATION. (a) A person may not begin operation of an assisted living home until that person has obtained a probationary or standard license from the appropriate licensing agency. A person may not move the location or make a major modification of a licensed assisted living home, or increase the number of residents the home is licensed to serve until that person has obtained approval for a modification of its license from the licensing agency. An application under this section must be made on a form supplied by the licensing agency. A person may not apply for a license to operate one or more additional homes until each current home has passed the probationary period and been issued a standard license. For purposes of this subsection, "major modification" means a change to the home that, during construction of the modification, would adversely affect the residents, services to residents, or emergency evacuation of residents (13) a business plan, if applying to operate a home licensed for 11 or more residents or to operate multiple homes; the plan must include a description of the plan, services offered, the location of the business, a management and personnel plan, and projected detail of anticipated monthly expenses for six months;

Yes/No

◉/○ Are you licensed for or intend to be licensed for more than one Home?

◉/○ Are you licensed for or intend to be licensed for one Home serving 11 or more residents?

If you answered yes to either question please complete a six month Projected Budget.

If you are licensed for or intend to be licensed for multiple Homes please complete a projected budget for each of your Homes.

The Following Documents must be attached to the each projected budget worksheet if applicable (please check the a box to indicate if you have included the required document)

Yes/ No/ (n/a) Not Applicable

◉/○/○ Mortgage Statement- If you own the home in which the assisted living home is located please include a copy of your most recent monthly mortgage statement.

◉/○/○ Home Owners Insurance – If you own your home please include a copy of your most recent home owner insurance statement.

Who is your Insurance Carrier:_____

Yes/ No/ (n/a) Not Applicable

Rental Contract – If you rent the home in which the assisted living home is located please include a copy of your rental agreement and ensure it indicates your monthly rent.

Who is your Land Lord:_____

Renters Insurance- If you rent please include a copy of your most recent renters insurance statement.

Who is your Insurance Carrier:_____

Workman's Compensation Insurance- please include a copy of your most recent workman's compensation insurance statement/estimate. Contact (907) 269-4002 with questions regarding Workman's compensation Insurance.

Who is your Insurance Carrier:_____

Liability Insurance- please include a copy of your most recent liability insurance statement/estimate.

Who is your Insurance Carrier:_____

Telephone– Please include a copy of your most recent monthly statement or a contract indicating the rate for the Home's land line and any cell phones associated with facility.

Who is the Service Provider:_____

Internet- Please include a copy of your most recent monthly statement or a contract indicating your rate.

Who is the Service Provider:_____

Cable/ Satellite TV- Please include a copy of your most recent monthly statement or contract indicating your rate.

Who is the Service Provider:_____

Gas/ Heating - Please include a copy of your most recent Gas/Heating statement

Who is the Service Provider:_____

Yes/ No/ (n/a) Not Applicable

Electrical - Please include a copy of your most recent Electrical statement

Who is the Service Provider:_____

Refuse -Please include a copy of your most recent Refuse statement

Who is the Service Provider:_____

Waste and Water- Please include a copy of your most recent Waste and Water statement *(please check N/A if you are on well and septic)*

Who is the Service Provider:_____

Vehicle Payment-Please include a copy of your most recent Vehicle Payment statement for all vehicles associate with your Home.

Vehicle Insurance Please include a copy of your most recent Vehicle Insurance statement

Who is your Insurance Carrier:_____

Please provide an accurate estimate of the following expenses on your projected budget

Vehicle Gas – This should include the total cost for gasoline used by vehicles operate by the Home each month each month.

Food – This should include an estimate for the total cost of food (three meals and one snack daily) which will be used by the Home on a monthly basis once the Home is at full capacity.

Household Supplies- This should include an estimate for the total cost of household supplies that will be used by the Home on a monthly basis once the Home is at full capacity. Household supplies includes, but is not limited to

- Laundry Supplies (detergent, dryer sheets etc)
- Toilet Paper
- Paper Towels
- Cleaning Supplies (soap, Windex, dishwasher detergent etc)
- Ice melt

Employee Salary/Payroll- This should include all expense related to the Home's employees (wages, benefits, and insurance exc.) and should reflect the costs associated with staffing the Home once the Home is at capacity and fully staffed. Ensure positions are paid at least minimum wage.

Please List each position at the Home and the total monthly expenses for each position.

Position	Monthly Cost
1._____	1._____
2._____	2._____
3._____	3._____

(Please use more paper if necessary)

Contracted Services- This should include an estimated costs for any contracted services you intend to bring into the Home. This could include, but is not limited too

- Cleaning Services
- Snow Removal
- Lawn Maintenance
- Nursing Services
- Activities

Please provide a list of contracted Services and their associated costs.

Service	Cost
1._____	1._____
2._____	2._____
3._____	3._____

(Please use more paper if necessary)

Miscellaneous- This should include any costs associated with operating your Home which is not included in one of the above categories. Please indicate what those costs and services are below.

Service	Cost
1._____	1._____
2._____	2._____
3._____	3._____

(Please use more paper if necessary)

Once you have determined the total monthly expenses for each item list above please input those costs into the Projected Budget Worksheet provided by the Department (see attached). Then add up each month's total expenses at the bottom of each column and tally the total three month expense for each item at the end of the rows. Once you have determined each month's total expenses and the three month expense for each item tally up the total expenses at the end of the row and the bottom of the column labeled Total. If you are required to complete a six month budget divide this final total in half. This will give you an estimated cost for three months of operation.

Savings/Assets

In addition to providing the Department with a three or six month projected budget each Home, upon request, shall submit proof that they have sufficient assets and savings to operate the Home for a minimum of three months without considering resident income (7 AAC 75.085). All finical statements must reflect that the funds in the account belong to the applicant, licensee or owner or the Home.

Assets and Savings accepted by the Department

Below is a list of items the Department will accept as proof of assets and savings.

- Current Checking account statements
- Current Savings account statements
- Small business line of credit

Please note that if a review your assets and savings show a recent or unexplained large deposit of funds you will be expected to provide the Department with an explanation as to the source of those funds.

Assets and Savings not accepted by the Department

Due to lack of immediate accessibility, penalties, interest, security and taxes, the following items will not be accepted by the Department as proof of assets when considering a Homes ability to cover three months worth of expenses without consideration for resident income.

- 401 (k)
- ROTH IRA
- Mutual Funds
- Ownership in Stocks/Bonds
- Life Insurance Policy
- Cash on Hand
- Credit Cards

If you wish to use the funds listed above as proof of assets or savings you are more than welcome to withdraw the funds or deposit them into a checking and/or savings account used by the Home.

Submission

Please submit this document, the require attachments, the projected budget worksheet and your proof of assets and savings with your new home application or to the licensing specialist who requested your budget.

Verification of Information

By signing below you are indicating that the items you are submitting as a part of your projected budget are the actual or copies of the actual documents and expenses associated with the operation of your assisted living home. You also understand that submitting fraudulent or false documentation may result in the denial of your application or enforcement actions.

Name:_____ Title:_____

Signature:_____ Date:_____

ASSISTED LIVING HOME
PROJECTED BUDGET WORKSHEET FORM

Home Name:_____

Savings/Assets Total: _____

Budget Category	Month 1	Month 2	Month 3	TOTAL
Mortgage or Rent				
Real Estate Taxes				
Home Insurance				
Workman's Compensation/ Liability Insurance				
Telephone/ TV/Internet				
Gas/Heating				
Electric				
Refuse				
Waste and Water				
Vehicle payments/Vehicle Insurance				
Vehicle Gas				
Food				
Household/Cleaning Supplies				
Employee Salaries/Payroll				
Contracted Services				
Miscellaneous				
Total				

Print Name:_____ **Date:**_____

Signature:_____

Universal Precautions/Standard Precautions Policy

Home's must create their own policy, but may use this as a guide

For more information on Universal Precautions/Standard Precautions please visit the CDC website at http://www.cdc.gov/

Universal precautions/standard precautions are minimum infection prevention practices that apply to all resident care, regardless of suspected or confirmed infection status of the person. These practices are designed to protect the health care worker and the resident from spreading infection among residents. These precautions include:

1. Hand hygiene;
2. Use of personal protective equipment (for example, gloves, gowns , masks);
3. Safe handling of potentially contaminated equipment or surfaces in the resident environment;
4. Respiratory hygiene, cough etiquette; and,
5. Safe injection practices. (If facility has personnel approved for medication injection)

Hand Hygiene

Hands should be cleaned after touching blood, body fluids, secretions, excretions, contaminated items; immediately after removing gloves; between resident contacts.

Use soap and water when hands are visibly soiled (for example, blood, body fluids, dirt) or after caring for persons with known or suspected infectious diarrhea. Otherwise the preferred method of hand decontamination is with an alcohol-based hand rub.

Personal Protective Equipment

- Gloves — For touching blood, body fluids, secretions, excretions, contaminated items; for touching mucous membranes and nonintact skin.
- Gown — During procedures and resident-care activities when contact of clothing/exposed skin with blood/body fluids, secretions and excretions is anticipated.
- Mask — During procedures and resident-care activities likely to generate splashes or sprays of blood, body fluids, and secretions.

Soiled Resident-Care Equipment

Handle in a manner that prevents transfer of microorganisms to others and to the environment; wear gloves if visibly contaminated; perform hand hygiene

Environmental Control

Use procedures for routine care, cleaning, and disinfection of environmental surfaces, especially frequently touched surfaces in resident-care areas.

Textiles and Laundry

Handle in a manner that prevents transfer of microorganisms to others and to the environment.

Resident Placement

Prioritize for single-resident room if person is at increased risk of transmission, is likely to contaminate the environment, does not maintain appropriate hygiene, or is at increased risk of acquiring infection or developing adverse outcome following infection.

Resident Resuscitation

Use mouthpiece, resuscitation bag, or other protective ventilation devices to prevent contact with mouth and oral secretions.

Respiratory Hygiene/Cough Etiquette

This process is to provide source containment of infectious respiratory secretions in symptomatic people. Instruct symptomatic persons to cover mouth/nose when sneezing/coughing; use tissues and dispose in no-touch receptacle; observe hand hygiene after soiling of hands with respiratory secretions; wear surgical mask if tolerated or maintain spatial separation, greater than 3 feet if possible.

(If facility has personnel approved for medication injection)

Needles and Other Sharps

Do not recap, bend, break, or hand-manipulate used needles; use safety features when available; place used sharps in puncture-resistant container.

ASSISTED LIVING HOME STAFFING PLAN

State of Alaska
Department of Health
Division of Health Care Services
Residential Licensing

Home Name: _____ Physical Location: _____

Please complete this form by describing a complete staffing plan for the Home. The staff plan must include management, caregivers, volunteers, contract personnel, intermittent nursing services and any other employees of the Home. Please also attach descriptions of each position's responsibilities and an organizational chart.

ONSITE SCHEDULE

Position/Title	Name	Days of the Weeks	Hours

I have submitted a complete staffing plan and am prepared to modify the proposed staff plan to meet the terms of an individual residential services contract or an assisted living plan.

_____
Printed Name of Owner or Administrator

_____ _____
Signature of Owner or Administrator Date

RECORD OF EVACUATION DRILL

Assisted Living Homes

Required frequency: once every three months for each shift (7 AAC 10.1010)

Name of Home _____ Date of Drill _____

Street Address _____ Time Start _____

Time End _____

Total Time _____

Employees on duty at time of drill:
Attach additional pages as necessary

_____

_____

_____

Other individuals present in the Home at the time of the drill:
Do not include residents under this heading, but include any other individuals associated with the Home, Visitors, Care Coordinators, children of home residents, etc.

_____

_____

_____

Residents who were present but did not participate and reason for nonparticipation:

_____

_____

If the drill was postponed when is the rescheduled date of drill? _____

Actions taken by employees_____

_____

_____

Response by residents in care_____

_____

_____

_____

Where Policies followed? YES / NO Why not? _____

_____

What policy revisions will occur? _____

Was drill ineffective? YES / NO What were the factors? _____

_____

Suggestions for improving effectiveness of drills_____

_____

_____

_____ _____

(Signature of Person Completing Form) (Date)

Restraint Assessment

Resident Name _____ Assessment Date: _____

Physician _____ Contact: _____

Legal Representative _____ Contact: _____

Emergency Contact _____ Contact: _____

Assessment

Does this person use or need restraints? Yes [ ] No [ ]

Has this person previously required the use of a physical restraint? Yes [ ] No [ ]

If yes, when was a physical restraint last used?

What types of restraint(s) is currently or has been used?

When was the restraint ordered?

Who ordered the restraint?

What behavior(s) require or have required restraints to be used?

How is the restraint used?

When should the restraint be terminated?

How often should you evaluate the restraint when in use?

Are there any less restrictive alternatives other than restraint that can be used?

What supports might help this resident to minimize the use of time outs or physical restraint?

Is this outlined in the resident's current Plan of Care or Assisted Living Plan that is agreed upon and signed by the resident's team? Yes [ ] No [ ]

Person Completing this Assessment Signature:_____

Resident/Resident Representatives Signature:_____

Attention: Attach doctors' orders and special instructions for the restraints to this form.

Common Type of Restraints

Self-release safety belts
Lap-top trays
Wedge chair cushions
Concave mattresses.
Bedside rails

Name of Assisted Living Home
Location of Home

Services Offered

Describe

- Location and general environment of the Home
- Furnishings and storage provided
- Towels and bedding provided
- Population served and how many residents served in the Home
- The general staffing plan
- Meal service and times served
- Assistance with activities of daily living (ADLs) such as walking, transferring from bed and chair, eating, dressing, bathing and toileting
- Assistance with self administration of medication and/or assistance with administering medications

Describe, if applicable

- Assistance with instrumental activities of daily living (IADLs) such as: laundry, cleaning of bedroom and living areas; food preparation, managing money, making appointments, using public transportation, writing letters, using the telephone, recreational or leisure activities in the home
- Monitoring or escorting to community events
- Monitoring or escorting to medical or health related appointments
- Transportation provided by or arranged for by the Home to events or appointments
- Intermittent nursing services provided by the Home

Employee Orientation Check List

Employees Name:_____

Hire Date:_____

Start Date:_____

Employee Orientation
Pursuant to 7 AAC 75.240 (b) an administrator shall ensure and document that each care provider, within the first 14 days of employment has been oriented to the following;

Topic	**Staff Initials**	**Administrators /Trainers Initials**	**Date Complete**
Policies and Procedures			
Emergency Procedures			
Fire Safety			
Resident Rights			
Prohibition against abuse, neglect, exploitation, and mistreatment of residents			
Recognition of abuse, neglect, exploitation, and mistreatment of residents			
Reporting requirements			
Universal precautions for infection control and biohazards			
State regulations and statutes			
Resident interaction and care			
House Rules			
Sanitation			
Duties and Responsibilities			
Medication Management/Security			
Physical Plant Layout			

(If employee was oriented to other items/topics please attach)

Employee Experience

Before caring for a resident without direct supervision, a care provider shall receive the orientation required in 7 AAC 75.240 (b) and, unless the care provider has sufficient documented experience working with the population of residents to be served, shall work under the direct supervision of the administrator or an experienced care provider who is at least 21 years of age for not less than three complete work days.

Direct supervision must be documented in the personnel file of the supervised care provider.

Does the employee have documented experience working with the population of resident's served? No/Yes Describe:_____

_____

_____

_____

Days working under Direct Supervision

Date	Number of Hours	Employee Initials	Supervisors Initials

Resident's Care Needs

Pursuant to 7 AAC 75.210 (c) each caregiver must have adequate training to implement the Home's general staffing plan and meet the specific resident needs as defined in their residential service contracts and assisted living plans.

Has this employee been trained on resident's specific care needs? No/Yes – Summary: _____

_____

Does this employee have access to information regarding the resident specific care needs? No/Yes

Summary: _____

When was this completed? _____

Employee Signature:_____ Date:_____

Administrator Signature_____ Date:_____

State of Alaska
Department of Health
Division of Health Care Services
Residential Licensing

NOTICE OF RESIDENT'S RIGHTS and PROHIBITED ACTIONS BY THE ASSISTED LIVING HOME

AS 47.33.300, AS 47 47.33.320, & AS 47.33.330

AS 47.33.300. RESIDENT'S RIGHTS:

(a) A resident of an Assisted Living Homes has the right to:

(1) live in a safe and sanitary environment free from abuse and discrimination;

(2) be treated with consideration and respect for personal dignity, individuality, and the need for privacy, including privacy in

(A) medical examination or health-related consultation;

(B) the resident's room or portion of a room;

(C) bathing and toileting, except for any assistance in those activities that are specified in the resident's assisted living plan;

(D) the maintenance of personal possessions and the right to keep at least one cabinet or drawer locked;

(3) possess and use personal clothing and other personal property, unless the home can demonstrate that the possession or use of certain personal property would be unsafe or an infringement of the rights of other residents;

(4) engage in private communications, including

(A) receiving and sending unopened correspondence;

(B) having access to a telephone, or having a private telephone at the resident's own expense; and

(C) visiting with persons of the resident's choice, subject to the visiting hours established by the home and consistent with AS 47.33.060; and

(D) having access to the Internet provided by the home, subject to availability to the home in the community, and having a private device to access the Internet at the resident's own expense;

(5) close the door of the resident's room at any time, including during visits in the room guests or other residents;

(6) at the resident's own expense unless otherwise provided in the residential services, participate in and benefit from community services and activities to achieve the highest possible level of independence, autonomy, and interaction with the community;

(7) manage the resident's own money;

(8) participate in the development of the resident's assisted living plan;

(9) share a room with a spouse if both are residents of the home;

(10) have a reasonable opportunity to exercise and to go outdoors at regular and frequent intervals when weather permits;

(11) exercise civil and religious beliefs;

(12) have access to adequate and appropriate health care and health care providers of the residents own choosing, consistent with established and recognized standards within the community;

(13) self-administer the resident's own medications, unless specifically provided otherwise in the resident's assisted living plan;

(14) receive meals that are consistent with cultural preferences and religious or health-related restrictions;

(15) receive the prior notice of the home or the home's intent to terminate the services contract of the resident required by AS 47.33.090 and AS 47.33.360;

(16) present to the home grievances and recommendations for change in the policies, procedures, or services of the home without fear of reprisal or retaliation;

(17) at the resident's own expense unless otherwise provided in the residential services contract, have access to and participate in advocacy or special interest groups;

(18) at the resident's own expense unless otherwise provided in the residential services contract, intervene or participate in, or refrain from participating in, adjudicatory proceedings held under this chapter, unless provided otherwise by other law;

(19) reasonable access to home files relating to the resident, subject to the constitutional right of privacy of other residents of the home;

(20) receive information in a language the resident understands;

(21) receive quality care; in this paragraph, “quality care” means care of a resident in accordance with the resident’s assisted living plan, plan of care, personal preferences, and health care providers’ recommendation;

AS 47.33.320. ACCESS TO ASSISTED LIVING HOME:

An assisted living home shall allow advocates and the representatives of community legal services programs access to the home at reasonable times to, subject to the resident's consent:

(1) visit with a resident of the home and make personal, social, and legal services available to the resident;

(2) distribute educational and informational materials to advise a resident or resident's representative of applicable rights; and

(3) assist a resident or a resident's representative in asserting legal rights or claims.

AS 47.33.330 PROHIBITIONS:

(a) An Assisted Living Home, including staff of the home, may not;

(1) deprive a resident of the home of the rights, benefit, or privileges guaranteed to the resident by law;

(2) enter a resident’s room without first obtaining permission, except

(A) during regular, previously announce, fire, sanitation, or other licensing inspections;

(B) when a condition or situation presents an imminent danger;

(C) as required by the resident’s assisted living plan to provide services specified in the residential services contract; or

(D) for other vital health or safety reasons;

(3) impose religious beliefs or practices upon a resident or require a resident to attend religious services;

(4) place a resident under physical restraint unless the resident's own actions present an imminent danger to the resident or others;

(5) place a resident under chemical restraint; this paragraph does not prevent a resident from voluntarily taking tranquilizers, or other medication, prescribed by a licensed physician;

(6) compel a resident to perform services for the home, except as contracted for by the resident and the home or as provided for in the resident's assisted living plan; or

(7) restrain, interfere with, coerce, discriminate against, or retaliate against a resident for asserting a right specified by this chapter or by other law;

(b) An assisted living home may not physically restrain a resident unless the home has a written physical restraint procedure that has been approved by the licensing agency. The home shall terminate the physical restraint as soon as the resident no longer presents an imminent danger.

(c) An owner, administrator, employee, or agent of an assisted living home may not act as a representative of a resident.

- I have read these rights and prohibitions or had them read to me in a language that I can understand.
- I understand these rights and prohibitions and have had my questions answered regarding them.
- I have also received a copy of this form complete with my signature.

Resident Name Printed: _____

Resident Signature: _____ Date: _____

Representative Name Printed: _____

Representative Signature: _____ Date: _____

Home Representative Name Printed: _____

Home Representative Signature: _____ Date: _____

State of Alaska
Department of Health
Division of Health Care Services
Residential Licensing

Notice of Protection from Retaliation and Resident's Grievance,
Policy and Procedure AS 47.33.340, AS 47.33.350

1. Protection from Retaliation. Under AS 47.33.350, an Assisted Living Home may not take retaliatory action against a resident of the home if the resident, or the resident's representative:

a. exercises a right provided by AS 47.33, 7 AAC 75, or by law;

b. appears as a witness, or refuses to appear as a witness, in an adjudicatory proceeding regarding the home;

c. files a civil action alleging a violation of assisted living licensing statues; or

d. claims a violation of assisted living licensing statutes before a state or federal agency having jurisdiction over the home or its employees.

2. Resident's Grievance Policy and Procedure. Under AS 47.33.340, an Assisted Living Home must establish a written grievance procedure for handling complaints of residents. The procedure must provide for the following rights of residents:

a. the right to present both a written and oral explanation of the resident's grievance;

b. the right to have an advocate or representative of the resident's choice attend meetings concerning the resident's grievance; and

c. the right to be notified in writing, within 30 days after the filing of the grievance, of the final decision of the home regarding the grievance.

The grievance policy/procedure is as attached.

I have read, or had read to me, in a language that I can understand, the foregoing Notice of Protection from Retaliation, Grievance Policy and Procedure; and I was given a copy of this notice at the time I began residency at (Assisted Living Home Name).

_____ _____
Resident or the Resident's Representative Date

_____ _____
Assisted Living Home Representative Date

SAMPLE RESIDENT GRIEVANCE PROCEDURES

STANDARD:

All residents or their representatives have the right to pursue a grievance with regards to their participation in the assisted living home. The (Assisted Living Home Name) will hear and attempt to resolve all grievances in a fair and timely manner.

PROCEDURES:

1. The aggrieved person, or person acting on his/her behalf will meet with the person against whom the complaint is directed, or with the person who is most involved in the conditions resulting in the complaint. This meeting will be informal and designed to provide a solution that will not require further discussion. Cases of verbal or physical abuse shall be reported directly to the Administrator/Owner.

2. If a solution cannot be reached, the aggrieved (or representative) may ask the Supervisor for an appointment. The meeting must be held within five (5) days of receipt of the grievance. The aggrieved (and/or representative) and the Supervisor will discuss the problem, and will attempt to reach a solution satisfactory to all parties.

3. If a solution cannot be reached, an appointment may be scheduled with the Administrator/Owner. The request for the meeting with the Administrator/Owner must be made within five (5) days of the meeting with the Supervisor. The Administrator/Owner will be supplied with notes from the previous meeting and will discuss the situation with the aggrieved (and/or representative) privately, and will attempt to reach a solution satisfactory to all parties. The Administrator/Owner shall remain the last and final avenue for the hearing of resident grievances.

4. A written summary of the formal grievance heard by the Administrator/Owner will be recorded, which includes the nature of the grievance and a remediation/correction plan.

Residents will be informed of their right to be represented by an advocate and/or protection and advocacy such as Disability Law Center of Alaska. A signed release of information will be required in order for (Assisted Living Home Name) staff to discuss the grievance with such advocates.

HOUSE RULES
AS 47.33.060

The following House Rules were adopted by _____ on_____, 20____
(Assisted Living Home)

1. Times and Frequency of use of the telephone_____
_____

2. Hours for viewing and volume for listening to TV, radio, and other electronic equipment that could disturb other residents
_____

3. Visitors _____
_____

4. Movement of residents in and out of the home_____
_____
_____

5. Use of personal property _____
_____
_____

6. Use of tobacco and alcohol _____
_____
_____

7. Physical, verbal or other abuse of other residents or staff _____
_____
_____

8. Possession or use of personal weapons_____
_____

9. Other_____
_____

I have read, or had read to me, in a language that I can understand, the foregoing House Rules, and I was given a copy of the House Rules before I entered into a residential service contract with _____.

(Assisted Living Home)

RESIDENT OR
RESIDENT'S REPRESENTATIVE

_____

DATE:_____

REPRESENTATIVE OF
ASSISTED LIVING HOME

_____

Title: _____

DATE:_____

STATE OF ALASKA
DEPARTMENT OF HEALTH
Division of Health Care Services
Residential Licensing

Sample Residential Services Contract

(Do not Use)

Disclaimer: This is a sample Residential Services Contract intended only to outline the basic requirements of AS 47.33.210. The Department makes no representation as to legal sufficiency or adequacy of this document under Alaska law. Each Assisted Living Home is encouraged to retain independent legal counsel for purposes of developing a Residential Services Contract. The Department may not provide legal advice to an Assisted Living Home.

Assisted Living Home Information

Name:_____
Physical Address:_____
Mailing Address: _____
Assisted Living Home phone number :_____

Resident Information:

Name:_____
Name of Resident's Representative (if any)_____
Representative's phone number _____

This agreement is made and entered into by and between _____ (hereinafter "the Home") and _____ (hereinafter "Resident") on this _____ day of _____, 20___.

SERVICES AND ACCOMODATIONS

The parties to this contract agree as follows:

The Assisted Living Home will provide assisted living services to aid the Resident in the performance of the activities of daily living or to meet the resident's need for personal assistance, which the Home will provide or obtain for the resident in accordance with the Resident's Assisted Living Plan. (Describe each service provided. Examples: none needed, monitor, prompting, some physical assistance, total physical assistance, daily, once a week, etc.)

Activities of daily living

a) Bathing _____
b) Toileting _____
c) Eating/Meal service _____
d) Mobility/Transfers _____
e) Dressing _____

Personal Assistance

a) Housecleaning _____
b) Meal preparation _____
c) Shopping _____
d) Scheduling appointments _____
e) Health Appointments _____
f) Community activities _____
g) Transportation _____
h) Personal money assistance _____

Health Related Services

a) Medications _____
b) Intermittent nursing services _____

Accommodations

___private apartment
___private room
___shared room with one other resident

Furnishings provided by Home

_____
_____

RATE

The rate for the services described above shall be **$**_____**.**

Monthly Rate Due Date – Payment is due on the _____ of each month.

The Home may not increase the rate charged for services unless the Home notifies the resident or the resident's representative of the increase in writing at least 30 days before the increase is to take effect.

RIGHTS, DUTIES AND OBLIGATIONS OF RESIDENT

Notwithstanding the rights, duties and obligations of the Resident pursuant to Alaska law, the Resident hereby further agrees that:

- The Resident shall notify the Home of any absence of the Resident from the property for a period of overnight or longer.
- Resident may not operate any business or commit any illegal act on the Home's premises.
- Resident understands and agrees to abide by the Home's rules. Resident acknowledges having received a copy of the Home's rules and having had the Home's Rules explained to him/her in a language or manner which the Resident understands.

TERMINATION OF CONTRACT

Termination by Resident - The Resident must give the Home at least 30 days written notice of intent to terminate this Residential Services Contract. The monthly rate shall be prorated based upon the effective date of the termination of the Residential Services Contract.

Termination by Home - The Home will not terminate this Residential Services Contract with a Resident of the Home against the Resident's will, except:

(1) for medical reasons;
(2) for engaging in a documented pattern of conduct that is harmful to the Resident, other residents, or staff of the Home;
(3) for violation of the terms of the residential services contract, including refusal to pay costs incurred under the contract.
(4) when emergency transfer out of the home is ordered by the Resident's physician;
(5) when the Home is closing; or
(6) when the Home can no longer provide or arrange for services in accordance with the Resident's needs and the Resident's assisted living plan.

At least 30 days before terminating the Residential services contract with a Resident under (2), (3), (5), or (6) of this section, the Home shall provide written notice of the proposed contract termination to the Resident or the Resident's representative, and to the Resident's service coordinator, if any.

The termination notice shall set forth the following:

1. The basis for the termination;

2. The Resident's right to contest the termination in the manner provided for in this Residential Services Contract, which must include an offer by the Home to participate in a case conference.

Case Conference - Before terminating this Residential Services Contract with Resident, the Home shall participate in a case conference if requested by the Resident or the Resident's representative. The case conference shall include the Resident, the Resident's representative, if any, the Resident's advocate, if any, the Resident's service coordinator, if any, the Home administrator, and appropriate care providers who all may discuss the appropriateness of the contract termination.

Relocation - If a Home terminates a Residential Services Contract with a Resident, the Home shall cooperate with the Resident, the Resident's service coordinator, if any, and the Resident's representative, if any, in making arrangements to relocate the Resident.

ADVANCE PAYMENTS

Pursuant to AS 47.33.030, the Home may not require Resident or Resident's Representative to make an advance payment to the Home except as security for performance of the Residential Services Contract or as advance rent for the immediately following rental period as the rental period is defined in this Residential Services Contract.

Resident has remitted to the Home the sum of $_____ on the _____ day of _____, 20____, as (check one):

_____ Security for performance of this Residential Services Contract;

OR

_____ Advance rent for the immediately following rental period commencing on the _____ day of _____, 20___.

By accepting the advance rent specified herein, the Home, pursuant to AS 47.33.030 hereby agrees as follows:

- The Home shall promptly deposit the advance payment specified herein in a designated trust account, in a financial institution, separate from other money and property of the Home;
- The Home will not represent on a financial statement that the advance payment specified herein is part of the assets of the Home;
- The advance payment specified herein shall only be used for the account of Resident;
- The name and address of the depository where the advance payment specified herein is held is as follows:

  _____
  _____
  _____

The Home may withhold from Resident the advance payment specified herein as follows:

- Charges for damages to the Home resulting from other than normal use;
- Sums reasonably necessary to compensate the Home for services provided to Resident under the terms and conditions of this Residential Services Contract when such amounts are due and owing and have not been paid by Resident in accordance with the terms and conditions of this Residential Services Contract;
- Charges for cleaning needed to return Resident's room to a condition similar to that prior to occupancy by Resident; and
- Damages to which the Home is entitled as a matter of law.

REFUND OF ADVANCE PAYMENTS
Resident acknowedges receipt of a copy of the Home's policy regarding the refund of unused advance payments. Resident acknowledges and understands that Resident is entitled to a prorated refund of the unused portion of an advance payment. The Home will return to Resident the Advance Payment specified herein within fourteen (14) days of the date this Residential Services Contract was terminated, less any amount withheld subject to the terms and conditions specified herein.

CONTRACT AUTHORITY
This contract is interpreted in accordance with the laws of the State of Alaska.

_____ _____
Administrator or **Designee** Date

X_____ _____
Signature of **Resident** or **Resident's Representative** Date

_____
Printed Name of Resident's Representative if not signed by Resident

Original to: Resident file
Copies to: Resident and representative, if any

ASSISTED LIVING PLAN

(Must be completed within 30 days of admission of Resident)

Resident Information

First Name _____

Last Name _____

Date of Birth _____

Assisted Living Home Information

Address _____

City _____ State AK

Zip Code _____

Facility Contact _____

Facility Phone _____

Date of this Plan _____

Resident Contacts

Care Coordinator/Case Manager/Program Specialist

Name _____

Agency _____

Address _____ State _____ Zip Code _____

Telephone _____

Alt Telephone _____

Legal Representative

Name _____

Agency _____

Address _____ State _____ Zip Code _____

Telephone _____

Alt Telephone _____

Resident's Emergency Contact

Name _____

Agency _____

Address _____ State _____ Zip Code _____

Telephone _____

Alt Telephone _____

Section 1 Resident Strengths/Limitations/Conditions/Diagnosis

Primary Diagnosis

Secondary Diagnosis

Hospice/DNR/Comfort One

Wound Care

Physical Disabilities and Impairments that are Relevant to the Resident's Service Needs

Resident's Strengths/Abilities and Limitations in Performing the Activities of Daily Living

Section 2 Resident Preferences

Roommates

Living environment

Food

Recreational activities

Religious affiliation

Relationships/visitation with friends, family members, and other

Resident Name _____

Section 3 Service Needs

Activities of Daily Living

Dressing

Activity/Plan for Care	Frequency of Care/Assistance	Expected Outcome

Eating

Activity/Plan for Care	Frequency of Care/Assistance	Expected Outcome

Walking/Ambulation/Transfers

Activity/Plan for Care	Frequency of Care/Assistance	Expected Outcome

Toileting

Activity/Plan for Care	Frequency of Care/Assistance	Expected Outcome

Hygiene/Bathing

Activity/Plan for Care	Frequency of Care/Assistance	Expected Outcome

Medication and Health Services

Applicant requires the following assistance with medication, (check all that apply)

- ☐ No Assistance
- ☐ Reminder to take
- ☐ Reading Label
- ☐ Opening Bottle
- ☐ Observing the Self Administration of Medication
- ☐ Directing or guiding the hand of the resident as the self-administer medication
- ☐ Administration of Medication

If administration of medication is required describe the task

If administration of medication is provided by staff attach special instructions, resident/representative permission, and delegation

Other Health services provided by the Home

Health Service	**How it will be met**

If the health service requires a nurses delegation please attach

Instrumental Activities of Daily Living

Laundry

Activity/Plan for Care	Frequency of Care/Assistance	Expected Outcome

Cleaning

Activity/Plan for Care	Frequency of Care/Assistance	Expected Outcome

Food/Meals (include diet restrictions/needs)

Activity/Plan for Care	Frequency of Care/Assistance	Expected Outcome

In Home Supervision (bed checks, turning schedule, type/frequency of monitoring)

Activity/Plan for Care	Frequency of Care/Assistance	Expected Outcome

Wandering or Elopement Risk/Interventions

Activity/Plan for Care	Frequency of Care/Assistance	Expected Outcome

Mental/Emotion Health Summary

Behavioral Health Interventions

Use of Restraints

(Includes bedrails, self-releasing safety belts, lap-top trays, wedge cushions, concave mattress).

Type	Frequency	Use	Safety

If restrains are used Attach Physician's recommendations/orders

Training for Independent Living

Legal Situation

Financial Assistance/Resident money Management Agreement

If the home is assisting the resident with managing money attach the residential money management agreement and authorization.

Transport/Escort Services

Day Care or Day Activities

Ability to Navigate Community Independently

Other Personal Assistance Needs

Resident Name _____

Risk Assessment

The Resident (or the resident's guardian/representative) and the Home have identified the following risks associated with specific interventions identified in this plan, have evaluated such risks, and have agreed to this plan recognizing these risks.

Signatures

I have participated in the planning of my own care; and have read, or had read to me, in a language that I can understand the foregoing plan of care; and agree with my plan of care.

Resident or Resident's Representative

Signature _____ Date _____

Care Coordinator/Case Manager/ Program Coordinator

Signature _____ Date _____

Service Providers (as appropriate)

Signature _____ Date _____

Assisted Living Home Representative

Signature _____ Date _____

Licensed Nurse (If Health Services Provided)

Signature _____ Date _____

Resident Name _____

ATTACHMENTS (Indicate if the Plan includes any of following)

☐ Physician's statement

☐ Separate Nurse Review of Health Services

☐ List of Residents Current Medication

☐ DNR/Comfort One/Advanced Health Care Directives

QUARTERLY EVALUATIONs OF ASSISTED LIVING PLAN

(If Health Related Services are provided, an evaluation is required every three months)

Date Review Required	Date Completed	Signature of Administrator	*Signature of Resident or Representative

NOTE Signature signifies that a copy of revisions, if any, have been received and a copy is attached to this plan.

Resident Name _____

Assisted Living
Physician's Statement

The Physician's Report must be completed and signed by a physician, physician's assistant or advanced nurse practitioner. Attach additional information as needed.

Applicant Information

Residents First Name:_____

Residents Last Name:_____

Date of Birth:_____

Primary Physician's Name:_____

Medical History and Current Medical Problems

Primary Diagnosis: _____

_____

Secondary Diagnosis_____

_____

Chronic Conditions (including behavioral health): _____

_____

Medication

Applicant requires the following assistance with medication, (check all that apply):

[ ] No Assistance
[ ] Reminder to take
[ ] Reading Label
[ ] Opening Bottle
[ ] Observing the Self Administration of Medication
[ ] Directing or guiding the hand of the resident as the self-administer medication
[ ] Administration of Medication

If administration of medication is required describe the task:_____

_____

_____

Residents Complete Current Medication Regimen

Medication	Dosage	Reason prescribed	Means of Administration and Level of Assistance

If Medication Regimen is not listed please attach

Current Therapy Regimen

Does the resident follow any therapy regimen that is necessary to maintain or increase their functioning, mobility, or independence – No Yes - Describe:_____

_____

_____

Assistive Devices, Technology, Equipment or Special Diet Used

Hearing impairment? No Yes - Describe: _____

_____

Vision impairment? No Yes - Describe: _____

_____

Mobility/Ambulation impairments? No Yes - Describe: _____

_____

_____

Special Diet needed? No Yes - Describe: _____

_____

Medical Equipment or devices used? No Yes – Describe: _____

_____

_____

Use of Restraints (Bedrails, self-releasing safety belts, lap-top trays, wedge cushions, concave mattress, other) No Yes - Describe: _____

_____

_____

Required Assistance with Activities of Daily Living

(Please indicate to what level of frequency the individual requires (independent, occasional, often, or always) and indicate the extent of the assistance (minimum, moderate, or maximum)).

Frequency/ Extent	Independent	Occasional	Often	Always	Minimum	Moderate	Maximum
Bathing/ Hygiene							
Dressing							
Grooming							
Toileting							
Eating							
Transferring/ Ambulating							

Safety

Allergies? No Yes - Describe: _____

Disoriented? No Yes - Describe: _____

Memory Problems? No Yes - Describe: _____

Drug or alcohol use? No Yes - Describe: _____

At risk of causing harm to self or others? No Yes - Describe: _____

Wound Care/Prevention? No Yes - Describe: _____

Hospice/DNR/Comfort One? No Yes - Describe: _____

Please describe any additional information of significance

Additional recommendations for Care

Primary Physicians Signature:_____ **Date:**_____

Controlled Substance Log

Resident: _____

Medication/Dosage: _____

Date Received: _____

Amount Received: _____

DATE	TIME	DOSAGE GIVEN	STAFF INITIALS	REMAINING	DATE	TIME	RECONCILLIATION	STAFF INITIALS

NAME (printed)	Signature	Initials

Money Management Authorization
(Name of Home)

Resident Name: _____ Date: _____

I, (Legal Representative), authorize (Assisted Living Home) to manage (Resident)'s monthly allowances with the following conditions:

1. Monthly Allowances held and managed by the Home cannot exceed $100 total per month.

2. The Home shall receive resident's allowance in the following way (pick one):
   - ☐ Monthly on (Date) in the amount of $(000.00)
   - ☐ Bi-Monthly on (Date) in the amount of $(000.00)
   - ☐ Weekly on (Day) in the amount of $(000.00)
   - ☐ Other: (Specify)

3. The Home shall receive the resident's allowance in the form of (pick one):
   - ☐ Cash
   - ☐ Check
   - ☐ Credit/Debit Card (in Resident's name)
   - ☐ Other: (Specify)

4. The Home shall maintain a money management log to be reviewed upon request.

5. Receipts of how the resident's allowance has been spent will be the responsibility of (pick one):
   - ☐ The Home
   - ☐ The Resident

6. I, (Legal Representative), request copies of each month's receipts and money management log.
   - ☐ Yes
   - ☐ No

I understand the monthly allowance is to be used for the resident's choosing. The Home cannot restrict or dictate how the resident can or cannot spend his/her money. If there are certain restrictions, I understand they must be outlined and agreed upon in the resident's assisted living plan or plan of care.

If there is a special circumstance for an item to be purchased outside of the allotted $100 per month, documented arrangements will be made with the Home regarding the item, how much and timeline to purchase the item.

Legal Representative Name: _____ Date: _____

Legal Representative Signature: _____

Administrator's Signature: _____

Witness Signature: _____

7 AAC 75.310. ACCEPTANCE AND MANAGEMENT OF RESIDENTS' MONEY.

(a) Before an assisted living home accepts the money of a resident for safekeeping and management, the home shall obtain written authorization from the resident or the resident's representative or representative payee. The authorization must

(1) be attested to by a competent witness who has no pecuniary interest in the home or its operations, and who is not connected to the home or its operations in any manner;

(2) indicate exactly which or how much of the resident's money the assisted living home is authorized to manage; and

(3) provide for an amount not to exceed $100 a month that the assisted living home may keep on hand for the resident to use to meet that resident's day-to-day needs, unless the resident has other sources of money for that purpose.

(b) A home shall establish a system for residents to request withdrawals from the daily-needs money that the home controls. The home shall advise the resident of the available balance of the daily-needs money at the time of each withdrawal and shall keep a record of all withdrawals and balances.

(c) After receiving authorization from the resident or resident's representative to manage the resident's money for the resident, the assisted living home shall

(1) promptly deposit all of the resident's money that the home is authorized to manage, except the money in the resident's daily needs fund, in an interest-bearing designated trust account in a bank, savings and loan association, or licensed escrow agent, insured by the Federal Deposit Insurance Corporation (FDIC), separate from other money and property of the home; and

(2) provide in writing to the resident, or the resident's representative, the account number and the name and address of the financial institution in which the resident's money has been deposited.

(d) An assisted living home that is authorized to manage the money of more than one resident may deposit it in a common designated residents' trust account only if the home has the capability of tracking the account activity specific to each resident, and then issuing a detailed statement of each resident's money to those residents whose money is commingled in the same account. Those statements shall be provided at least quarterly.

(e) When managing the money of a resident, the assisted living home shall, in accordance with the resident's assisted living plan, spend money only to meet the needs of the resident.

(f) When managing the money of residents through deposits in separate trust accounts, the assisted living home shall

(1) provide each resident or the resident's representative with a copy of each written account statement from the financial institution in which the money has been deposited; and

(2) provide each resident or the resident's representative, without charge, a written, itemized statement, at least quarterly, of all financial transactions involving the resident's money being managed by the home.

(g) Upon a written request by the resident or the resident's representative, the assisted living home shall return to the resident or the resident's representative, within three business days, as much of the resident's money as requested, including any interest accrued from deposits. The money may be returned by means of a check.

(h) Upon a voluntary or involuntary termination of the resident's assisted living contract, the assisted living home shall, within three business days, return to the resident or the resident's representative at least 90 percent of the resident's money, less any accrued charges, whether the money is in a designated trust account or in the resident's daily-needs account. The home shall return all remaining money belonging to the resident within 60 calendar days after termination of the contract.

(i) An assisted living home shall provide a complete accounting of the resident's money to the personal representative, as defined in AS 13.06.050, of a resident's estate within 30 days after the resident's death. In the absence of a personal representative, the home shall provide the accounting and the deceased resident's assets to the public administrator appointed under AS 22.15.310.

(j) If a home or the entity operating the home is sold, the home shall provide the buyer with written verification of all resident money the home is authorized to manage and obtain a signed receipt for such money from the new owner. (Eff. 7/1/95, Register 134)

CHANGE OF USE

THE MUNICIPALITY OF ANCHORAGE HAS NEW REQUIREMENTS FOR NEW ASSISTED LIVING HOMES!!!

Do you want to apply for an Assisted Living Home License for three (3) or more residents? Or in a building with multiple Assisted Living License? Is it proposed to be located within the Municipality of Anchorage?

If yes, you must first complete a Change of Use Permit process within the Municipality BEFORE applying for an Assisted Living Home License. Your approval permit MUST accompany your application.

To apply for a Change of Use Permit, please go to the following address and request a change of use permit explaining your plan to apply for an assisted living home license within the Municipality of Anchorage. The following office will provide you with all the information regarding the process and any associated fees and timeframes for completing the process.

4700 Elmore Road

Anchorage, AK 99507

Phone (907) 343-8301

Fax (907) 343-8214

You must complete the process with the Municipality of Anchorage BEFORE applying for an assisted living home license.

If you have any questions about whether or not these requirements apply to you, please contact the Municipal office identified above.