**State of Alaska• Department of Health and Social Services**
**Senior and Disabilities Services**

# Application for General Relief for Assisted Living Home Care Benefits

## Program Overview

The General Relief Assisted Living Home Care Program helps to pay for Assisted Living Home Care for qualified Alaskans facing extreme financial crisis. This is a temporary benefit program. The General Relief Program is a payer of last resort. Applicants must show that they have tried to obtain all other means of payment including using their own resources and applying for Adult Public Assistance and Medicaid to pay for necessary Assisted Living Home Care before the General Relief benefit can be used. This is a program paid for through State of Alaska General Funds. The availability of this funding is subject to legislative appropriation. A wait list will be used when there is not enough funding to serve additional applicants. Full program details including regulations and forms are posted on the Senior and Disabilities Services General Relief Program website (**http://dhss.alaska.gov/dsds/Pages/aps/apsrelief.aspx**). General Relief staff can be reached at 907-269-3666 or 800-478-9996 to answer questions about the program.

## General Relief Assisted Living Home Care Defined

Assisted living care is a range of care which includes more than room and board, but which does not include continuous nursing, medical care, or a secure setting. It encompasses twenty-four hour supportive and protective services and assistance with activities of daily living and is provided in a residential environment which encourages independent living to the extent possible for each resident (7 AAC 47.310). Residents may leave the home as they wish and have the right to refuse medication or services.

## General Relief Eligibility Criteria

The Division of Senior and Disabilities Services will pay for a portion of the cost of assisted living care for vulnerable adults who meet the medical, social, and financial eligibility criteria outlined in 7 AAC 47.330 through 7 AAC 47.360. To be eligible, an individual must:

- Be 18 years of age or older;
- Be a resident of the State of Alaska;
- Have been assessed for eligibility by a care coordinator or other person approved by the Department of Health and Social Services and:
- Have a disability that is attributable to an intellectual disability, cerebral palsy, epilepsy, autism or another condition closely related to an intellectual disability that significantly impairs intellectual functioning and adaptive behavior;
- Have a hearing, speech, visual, orthopedic, or other major health impairment that significantly impedes participation in the social, economic, educational, recreational and other activities generally available to the individual's non-impaired peers in the community; or
- Have a significant deficit in adaptive behavior in the area of self-care, communication of needs, mobility, or independent living, which may be the result of the aging process, an emotional health disturbance, or alcohol or drug dependence;
- Without assisted living care, be subject to, or at risk of, abuse, neglect, self-neglect or exploitation by others;
- Not have income that exceeds the limits permitted in 7 AAC 47.340;
- Not have resources that exceed the amount permitted by 7 AAC 47.350;
- Have applied for the cash assistance programs as required by 7 AAC 47.370(a); and
- Have applied for and exhausted the use of alternative resources.

| Checklist |
|---|
| ***Please ensure all of the following items are complete and submitted as part of the same packet.*** |

- Complete every part of every section of this form; if there is a part that does not apply, so indicate by placing "N/A" in the blank; if there is a part where the information is not available, so indicate by placing "unavailable" in the blank.
- Attach the most recent three months of bank statements
- Applicants claiming $0 income and/or those who are likely to qualify for Adult Public Assistance will be required to attach proof that they have applied for Adult Public Assistance. **The GR application will not be considered complete without this documentation.**
- General Relief will verify that the applicant either has or has not applied for public benefits.
- Applicant must complete the General Relief Contract on pages 9 and 10 of this form. The Applicant must sign and initial this form in person; if the Applicant has a legal decision maker, attach the documents that show the status of the legal decision maker, i.e., court order, signed power of attorney, etc.
- Physician's Report; pages 7 and 8 of this form**;** the physician's report must be dated within 3 months of this application.
- Submit a State approved form UNI-16 Authorization for Release of Information for each person or agency, authorizing General Relief to discuss the application with someone other than the applicant, referrer or legal decision maker.

Applications will be processed by the earliest date placed in the eligibility queue. **If information is missing or unclear, the application will be given a status of *pending* and a letter will be sent requesting the information needed to determine eligibility. If the missing information is not received within 20 days of the date on the letter, the application will be denied. SDS has 30 days to make an eligibility determination once the application is complete. When a waitlist is in effect, the approval date is used to rank applicants. Therefore, it is very important to submit a complete application and respond quickly to requests for information. When notified that GR benefits are approved, the applicant must provide a copy of this application and the approval letter to the ALH for their records and service plan.**

| ***Send Complete Applications*** | | |
|---|---|---|
| By delivery or US mail:<br>Senior and Disabilities Services<br>General Relief Assisted Living Home Care Program<br>1835 Bragaw St. Ste. 350,<br>Anchorage, AK 99508 | By Facsimile:<br>907-269-3648<br>NOTE: Facsimile is the preferred mode of transmission if there is not a registered individual DSM account. | By E-mail: Direct Secure Messaging (DSM):<br>**General.Relief@hss.soa.directak.net**<br>NOTE: You must enter the inpriva portal to use this DSM e-mail address. Also you must have a registered DSM account to send the application to this address. To sign up for DSM please visit this website:<br>**http://inpriva.com/inpriva/index.php/ak-dsm-ss2/** |
| General Relief staff can be reached at 907-269-3666 or 800-478-9996 to answer questions about the application. | | |

## Referrer Contact Information

If someone other than the applicant is assisting with the application, complete this section.

_____ _____
First Name Last Name

Relationship to Applicant: _____
Agency Name: _____ Provider ID: _____
Mailing Address: _____ Suite/Apt.:_____
City: _____ State: _____ Zip Code: _____
Phone work: _____ Phone cell: _____ Other: _____
Fax: _____ DSM: _____

## Applicant Demographic Information

First Name: _____ Middle Initial: _____ Last Name: _____
Mailing Address: _____ Suite/Apt.: _____
City: _____ State: _____ Zip Code: _____
Physical Address: _____ City: _____
Current Location Type: _____ (hospital/my home/friend's house/etc.)
Phone home: _____ Phone cell: _____ Phone work: _____
DOB: _____ Gender: _____ Marital Status: _____
Primary Language: _____ Second Language: _____
Ethnicity: _____ Tribe (if any): _____
Health Insurance/Benefits (list all that apply, for example: IHS, VA, Medicaid):_____

_____

_____

| Where has the Applicant lived in the past 12 months? (Check all that apply) | | | |
|---|---|---|---|
| ☐ | Own Home/With Family | ☐ | Homeless, not in a shelter |
| ☐ | Rented Apartment/Home | ☐ | Jail/Prison |
| ☐ | Group Home | ☐ | Psychiatric Facility |
| ☐ | Assisted Living Home | ☐ | Crisis Stabilization Unit |
| ☐ | Skilled Nursing Facility | ☐ | Residential Treatment |
| ☐ | Shelter | ☐ | Boarding Home |

## Application Narrative

| Applicant First Name | Applicant Last Name |
|---|---|
| | |

| Describe why Assisted Living Home (ALH) care is needed |
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| |

| Describe what independent living, supportive housing or in-home services have already been tried |
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| Describe the services and supervision needed |
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| |

| Describe the expected duration and goals of placement |
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| |

| Describe the applicant's ALH Placement History |
| --- |
| |

| Significant Behavior Information: (Routine, strengths, likes/dislikes, problems areas, safety issues) |
| --- |
| |

| Who will help the applicant with the application for benefits listed in 7 AAC 47.370, including additional paperwork or renewals after placement? |
| --- |

| | |
| --- | --- |
| | |
| Name | Relationship to Applicant |
| | |
| Mailing Address | Phone |

| When a waitlist is in effect, who should GR contact to notify of benefit availability if we cannot locate the applicant after contacting the applicant, legal decision maker and referrer? |
| --- |

| | |
| --- | --- |
| | |
| Name | Relationship to Applicant |
| | |
| Mailing Address | Phone |

## Income and Resources Worksheets

Not all income and resources are counted toward eligibility, but must be disclosed. Please enter $0 and note N/A in comments if this income or resource type does not apply, *7 AAC 47.340 through 7 AAC 47.355*. If an applicant is approved for General Relief benefits and income or resources are later discovered that can be applied to the cost of care, the Department will recalculate the client cost of care for any month that income or resource was available to them and retroactively bill the resident for the additional amount owed. If income or resources are discovered to be available to the resident on an ongoing basis above the allowed amounts, the client may no longer be eligible for the General Relief Program.

| **INCOME** | | | |
|---|---|---|---|
| **Source of Income** | **Name of Income Source** | **Estimated Monthly Amount** | **Comments** |
| Social Security/SSDI | | | |
| Supplemental Security Income (SSI) | | | |
| Public Assistance | | | |
| Veteran's Benefits | | | |
| Senior Benefits | | | |
| Native Dividends | | | |
| Other (Dividends/Interest) | | | |
| Pension | | | |
| Other Income | | | |
| Other Income | | | |
| Other Income | | | |
| Total | | | |

| **RESOURCES** | | | |
|---|---|---|---|
| **Resource** | **Name of Bank Resource Details** | **Estimated Value** | **Comments** |
| Checking Account Balance | | | |
| Savings Account Balance | | | |
| Burial Fund | | | |
| Second Home | | | |
| Land (non-tribal) | | | |
| Second Vehicle | | | |
| RV | | | |
| 4-wheelers/motorcycles | | | |
| Stocks, Bonds, Investments | | | |
| Whole Life Insurance | | | |
| Expected settlement windfall or back pay | | | |
| Other Resource | | | |
| Total | | | |

## Physician's Report

**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

Applicant First Name _____ Applicant Last Name _____

Date of Birth: _____ Height: _____ Weight: _____

### Medical History and Current Medical Problems

Primary Diagnosis (please add ICD-10 code): _____

Secondary Diagnosis (please add ICD-10 code): _____

Chronic Conditions (include behavioral health): _____

| Medication Prescribed | Dosage | Condition Medication Prescribed to Treat | Instructions/Comments |
|---|---|---|---|
| | | | |
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### Applicant requires the following assistance with medication; check all that apply

☐ No Assistance ☐ Reading Label ☐ Reminder to take

☐ Supervision ☐ Administration of Meds

### Assistive Devices, Technology, Equipment or Special Diet Used

| Impairment | No | Yes | If Yes, give description |
|---|---|---|---|
| Hearing impaired? | ☐ | ☐ | |
| Vision impaired? | ☐ | ☐ | |
| Mobility impaired? | ☐ | ☐ | |
| Special Diet needed? | ☐ | ☐ | |
| Medical Equipment or devices used? | ☐ | ☐ | |

| Functional Assistance Required | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Activity of Daily Living** | **Frequency of Assistance** | | | | **Extent of Assistance** | | |
| | Independent | Occasional | Often | Always | Minimum | Moderate | Maximum |
| Bathing | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Dressing | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Grooming | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Toileting | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Eating | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Transferring | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| Safety | | | |
|---|---|---|---|
| **Condition** | **No** | **Yes** | **If Yes, Describe** |
| Allergies? | ○ | ○ | |
| Disoriented? | ○ | ○ | |
| Memory Problems? | ○ | ○ | |
| Using drugs or alcohol? | ○ | ○ | |
| At risk of causing harm to self or others? | ○ | ○ | |

**Please describe any additional information of significance**

**Recommendation for Care**

_____ Date: _____

Physician/PA/ANP Signature

Printed Name: _____ License #: _____

Phone #: _____ Fax #: _____

Mailing Address/city/state/zip: _____

## General Relief Contract

| Applicant First Name | Applicant Last Name |
|---|---|

**Applicant/ Legal Decision Maker initial each item and sign below**

_____ I am applying for the General Relief (GR) Assisted Living Home Care Benefit because I need Assisted Living Home Care and have no other way to pay for this service.

_____ A waitlist to receive benefits may be in effect, depending on authorized funding and the number of people using the program.

_____If I am on the waitlist for benefits and my name is pulled off of the waitlist to receive benefits, the General Relief Program will attempt to contact me, any named legal decision maker, the person who helped me fill out the application for GR, and the two additional people listed on the General Relief Application to notify me of my approval to begin receiving benefits. If the GR Program does not hear back from me, my legal decision maker, service provider or named contacts within 20 days, my application will be closed.

_____The General Relief benefit can be used at any Assisted Living Home that has a current provider agreement with the SDS General Relief program. The General Relief program cannot pay a home that is not licensed and a current SDS General Relief provider and cannot back date a provider agreement.

_____If I move in to an Assisted Living Home before I am approved for General Relief benefits, I am responsible for full payment to the home up to the date I am approved for benefits. General Relief does not back-date the approval date.

_____It is my responsibility to find an Assisted Living Home that can meet my care needs. An Assisted Living Home has the choice to enter into a contract or not with me based on the ability to care for my needs and the existing responsibility to care for other residents in the Assisted Living Home.

_____I am responsible to make payment of my client share of the daily rate to the contracted Assisted Living Home. The General Relief program will create a Calculation Sheet that shows how much I pay and how much the State of Alaska pays. If my income or resources change, I must contact General Relief to make adjustments to how much I pay.

_____The money that is paid by the State of Alaska to cover my cost of care will be reimbursed by me when retroactive and other sources of eligible income or resources become available to me. This amount will not be more than the amount the State has paid for my cost of care. This money will be paid to the "Division of Senior and Disabilities Services" and remitted to the General Relief Program. Call 269-3666 to find out amount.

_____If approved, benefits will last 1-6 months dependent on need. If benefits are still needed after that time period, I must complete a renewal packet and turn it in to the GR program 15 days prior to the benefit ending date on my approval letter or benefits will be terminated.

_____If I terminate my General Relief benefits or allow my benefits to lapse, I will have to reapply to receive benefits again and may be placed on a waitlist if one is in effect.

_____The funding source is State of Alaska General Funds. The availability of this program is based on annual legislative appropriations. There is a chance each fiscal year that this program could be discontinued.

_____The General Relief Program only provides payment assistance for Assisted Living Home Services as described on the front of this packet. It does not provide case management or monitoring of the care provided.

_____If I am being abused, neglected or exploited by anyone, including ALH staff, or I feel that I cannot manage my own care contracts, benefits, or bills, I should report this to Central Intake right away by calling 269-3666. I cannot be evicted for reporting.

_____To file a complaint about the quality of care, environment or services provided by my ALH, I can call the Long Term Care Ombudsman's Office at 334-4480 or Central Intake at 269-3666. I cannot be evicted for filing a complaint.

Applicant First Name | Applicant Last Name

Applicant Signature | Date

Legal Decision Maker (LDM) First Name | LDM Last Name

LDM Signature | Date

Type of Legal Decision Maker:

◯ Guardian ◯ Conservator ◯ Power of Attorney

◯ Other:_____

***** Note: Attach proof of Guardianship/Conservator/POA status***

**SIGNATURES**

By signing below, I certify that the information included in this Application is true and accurate to the best of my knowledge. Misrepresentation or providing false information may be criminally prosecuted as an unsworn falsification under AS 11.56.210

Signature of Applicant Date_____

Signature of Referrer Contact from page 3 (if applicable) Date_____