Department of Health and Social Services
Division of Alaska Pioneer Homes

Waitlist Transfer / Change Request

P.O. Box 110690
Juneau, AK 99811-0690
Ph: 907.465.4416/888.355.3117
Fax: 907.465.4108

Last Name, First Name, MI	Date of Birth
Preferred Mailing Address	Preferred Contact Phone Number
	Preferred Email Address

Primary Point of Contact:
☐ Applicant
☐ Power of Attorney (Name/Ph#): _____
☐ Other (Name/Relationship/Ph#): _____

I would like to:

☐ **Transfer to the Active Waitlist****
☐ **Move to Inactive Waitlist**
☐ **Update Home Choices**

Pioneer Home Waitlist Preference (as applicable):
If you are transferring from the Inactive to the Active Waitlist or would like to update your current home choices, please numerically rank selected home(s) in order of preference. Only rank those that applicant is willing to live in.

_____ Alaska Veterans & Pioneers Home (Palmer) **non-veterans accepted*	_____ Fairbanks	_____ Ketchikan
_____ Anchorage	_____ Juneau	_____ Sitka

**** Please include the following documents with your active transfer request:**

- Certificate of Need
- History & Physical Report
- Power of Attorney (as applicable)

***** For veterans transferring to the active waitlist for the Alaska Veterans & Pioneers Home, the additional forms are also needed:**

- VA Addendum
- VA 10-10 EZ
- Copy of DD214

You may update your Pioneer Home choices at any time in writing, either through an email or letter. However, should you decline a room offer, you will be transferred to the Inactive Waitlist for 180 days. It is your responsibility to submit a new Waitlist Transfer/Change Request form after the 180 days in order to be reinstated to the active waitlist. Your original application date is the date that will be used to determine order of admission into any of the Alaska Pioneer Homes. Should you choose to move out of a Pioneer Home once you have become a resident, a new waitlist application must be submitted.

_____
Signature of Applicant or Power of Attorney Date

_____
Printed Name of Applicant or Power of Attorney

REV 2021/08

Office Use Only:

Date Received/Initials

Department of Health and Social Services
Division of Alaska Pioneer Homes

Certificate of Need

P.O. Box 110690
Juneau, AK 99811-0690
Toll Free: 888.355.3117
Main: 907.465.4416
Fax: 907.465.4108

Applying to the Active waiting list for the Alaska Pioneer Home means that you are prepared to enter a home within 30 days of having an offer of admission made to you.

To be placed on the Active waiting list you must report your physical needs or other cause which prevents you from maintaining a household without regular assistance in shopping housekeeping, meal preparation, dressing or personal hygiene.

This Certificate, along with a History & Physical Medical Examination report must be on file to be placed on the Active waiting list

Please check the box which best describes your situation in each area listed below:

Type	I Need Assistance					Extent of Assistance		
	Never	Occasionally	Often	Always		Limited	Moderate	Substantial
Bathing								
Dressing								
Grooming								
Brushing Teeth								
Toileting								
Eating								
Moving About								
In/Out of Bed								
Taking Medications								
shopping								
Housekeeping								
Meal Preparation								
Remembering								
Feeling Safe								
Other								

DO YOU USE: ☐ Walker ☐ Cane ☐ Crutches ☐ Wheelchair ☐ Other

Please describe any other assistance you require (i.e. assistive devices or services)

Please describe any other assistance you require (i.e. assistive devices or services) :

Your signature below certifies that the information contained in this document is true and complete to the best of your knowledge.

Signature _____ Printed Name _____ Date _____

Department of Health and Social Services
Division of Alaska Pioneer Homes
History and Physical Report

P.O. Box 110690
Juneau, AK 99811-0690
Toll Free: 888.355.3117
Main: 907.465.4416
Fax: 907.465.4108

Last Name	First Name	Middle Initial	Telephone Number

Mailing	City	State	Zip	Date of Exam

DOB:	Age	Height	Weight

Medical History: _____

_____

_____

Surgical Hisory: _____

_____

_____

Family History: _____

Social History: _____

Alcohol Use: ☐ Yes ☐ No

Tobacco Use ☐ Yes ☐ No

Other Drugs ☐ Yes ☐ No

Further Information: _____

_____

_____

Physical Examination

Blood Pressure	Temperature	Pulse	Respiration	O2 Stats

A. General appearance, nutrition, debility, hygiene etc: _____

B. Head and Neck _____

C. Nose & Throat _____

D. Dental _____

E. Lungs _____

F. Heart

Vessels: _____

Pulses: _____

G. Abdomen

liver: _____

Rectum: _____

Hernias: _____

History & Physical Examination Report

Applicant's Last Name	First Name	M.I.	Date of Exam
_____	_____	_____	_____

H. Male Genitourinary

Genitalia: _____

Prostate: _____

I. Female Pelvic: _____

J. Breast: _____

K. Lymph: _____

L. Endocrine: _____

M. Musculoskeletal: _____

Back: _____

Extremities: _____

N. Skin:

O. Psychiatric:

Orientation: ☐ Clear ☐ Occasionally Disoriented ☐ Disoriented

Mood: _____

Intellect: _____

Short-Term Memory: _____

Cooperation: _____

P. Behavior:

☐ Appropriate ☐ Inappropriate, Aggressive ☐ Inappropriate, Assaultive

☐ Inappropriate, Passive ☐ Wandering - Requires Wandering Safeguards

☐ Inappropriate, suicidal, or otherwise dangerous to self or others

Describe: (Please attach additional information if needed)_____

Q. Neurological

Cranial Nerves: _____

Motor Reflexes: _____

Sensory: _____

Coordination: _____

Vision: _____

Hearing: _____

Additional Information:

History & Physical Examination Report

Applicant's Last Name _____ First Name _____ M.I. _____ Date of Exam _____

Assessment of Capabilities for Activities of Daily Living

Daily Living

Type	Frequency of Assistance				Extent of Assistance		
	Independent	Occasional	Often	Always	Min	Mod	Max
Bathing							
Dressing							
Grooming							
Oral Hygiene							
Toileting							
Eating							
Ambulation							
In/Out of Bed							
Taking Medications							
Walk up & down stairs							

Uses: ☐ Walker ☐ Cane ☐ Crutches ☐ Wheelchair ☐ Other_____

Activity restrictions?	☐ Yes	☐ No
Dysphagia / Swallowing Difficulties?	☐ Yes	☐ No
Is applicant in full control of bladder?	☐ Yes	☐ No
Is applicant in full control of bowels?	☐ Yes	☐ No

Further information:

_____

_____

_____

Diet

Food Allergies: (Please provide reaction to each food allergy)_____

_____

☐ Regular ☐ Soft ☐ Low Cal ☐ Salt Restricted

☐ Fluid thickened: consistency: _____

☐ Other: _____

Special Instructions: _____

Tuberculosis Status: (Note: This section must be completed <u>before</u> admission)

Date of Last PPD:_____ Results of Last PPD:_____ ____mm

If history of positive PPD, please note past PPD & treatment:

CXR: _____

Medication Tx: _____

Immunizations

Immunizations: (Date of Administration)

Flu Vaccine _____ Pneumovax_____

Diptheria/Tetanus _____ Has applicant received complete Dip/Tet series? _____

Hepatitis A _____ Hepatitis B _____

Zostavax _____

History & Physical Examination Report

Applicant's Last Name	First Name	M.I.	Date of Exam

Drug Allergies

Please provide reaction to each allergy: _____

_____

_____

Medications

Medication	Dosage	Route	Frequency	Diagnosis	ICD10 Code

(Please attach additional information as needed)

Diagnoses

Primary Diagnosis:	ICD10 Code	Onset date
Secondary Diagnoses:	ICD10 Code	Onset date

(Please attach additional information as needed)

Lab Work

Lab work pertinent to Current Diagnoses: _____

_____

Prognosis

_____

_____

I certify I examined _____ on _____

_____ _____

Physician's Signature National Provider Identifier #

_____ _____

Physician's Typed or Printed Name Street Address

_____ _____ _____ _____

Telephone City State Zip Code