

STATE OF ALASKA  
DEPARTMENT OF HEALTH AND SOCIAL SERVICES  
DIVISION OF ALASKA PIONEER HOMES

APPLICATION FOR PAYMENT ASSISTANCE

Residents of the Pioneer Homes are required, whenever possible, to pay monthly rates and fees, set by regulation in order to partly reimburse the State for the cost of providing care. At the same time, the State wants every resident to have enough money left over after paying for rent and ancillary charges to have at least \$200.00 each month left for personal expenses. The state does not intend

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Hints for the  
**PAYMENT  
ASSISTANCE  
PROGRAM**  
Application Process

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Eligibility is determined by combination of resident's income and resources. Additional consideration is given to resident withal spouse or dependent living in the community.

Any resident approved for the Payment Assistance Program is required to have **Medicare Part A, Part B and Part D or the equivalent medical insurance coverage**. As a condition of receiving Payment Assistance a resident shall also apply for **Medicaid** and any other state or federal program that may reduce the amount of state assistance. *Alaska Regulation 7 AAC 74.040 and Alaska Statute 47.55.020.*

ELIGIBILITY FOR PAYMENT ASSISTANCE WILL NORMALLY BECOME EFFECTIVE THE MONTH FOLLOWING APPROVAL FOR PAYMENT ASSISTANCE.

NAME OF PIONEERS' HOME \_\_\_\_\_

LEVEL OF CARE \_\_\_\_\_

|  |                   |
|--|-------------------|
| Name of Applicant:                     | Social Security # |
| Name of Person Completing Application: |                   |
| Relationship to Applicant:             |                   |
| Mailing Address:                       |                   |
| Phone Number:                          |                   |

As a resident of an Alaskan Pioneer Home this is my application for Payment Assistance. If approved I realize I must have **Medicare Part A, Part B and Part D or the equivalent medical insurance coverage**. I affirm under penalty of perjury that the information on this application is true and complete to the best of my knowledge.

I understand that this information may be verified by the State of Alaska, and I hereby give my permission for that review. By a copy of this application (including a photocopy) I authorize all persons and entities to disclose to the State any information necessary to process my application for Payment Assistance. I acknowledge my obligation to promptly report any future changes in income or resources to the Pioneers' Homes' Revenue Unit.

I acknowledge that I am obligated to pay to the State each month, the calculated Payment Assistance rate, toward the cost of my care.. I understand that my failure to pay this amount owing may result in my eviction from the Pioneers' Homes, and that the State may sue me to recover the sums that I have failed to pay. I also understand that any payment assistance given to me creates an indebtedness to the State, and that, under *Alaska Statute 47.55.080*, the State may, after my death, file a claim against my estate to collect on this indebtedness. I understand, as a resident applying for Payment Assistance I shall also apply for **Medicaid** and any other state or federal programs that may reduce the amount of state assistance under *Alaska Statute 47.55.020(e)*.

\_\_\_\_\_  
 Signature of Applicant *(Attach of a financial Power of Attorney if signed by other than the applicant or other appropriate documentation)*

Provide the **Resident's signature on** the application if possible. If the resident cannot sign the application, it to act on the resident's behalf (POA, guardian, conservator, etc.) **A copy of the authorizing document must be provided with the application.**

ALL applications must have a **second signature.**

\_\_\_\_\_  
 Name of Witness  
*(Print or Type)*

\_\_\_\_\_  
 Signature of Witness

\_\_\_\_\_  
 Date

Name of Applicant

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If you have filed a federal income tax return in any or all of the past three years please enclose a copy of each return with this form.

If you have not filed a tax return for any of the past three years, please indicate the reason:

Most recent year

Year Before

Year Before That

Copies of past 3 years - IRS Tax returns: The resident must provide the three most recent Federal Income Tax returns (joint tax returns for a couple) OR an explanation as to why taxes were not filed

Is spouse living in the community?

Yes

No

If Yes, Name of Spouse:

APPLICANT'S MONTHLY INCOME

SPOUSE'S INCOME

(If under \$2,000.00/mo)

GROSS AMOUNT

GROSS AMOUNT

Social Security (1)

Longevity Bonus

Veteran's Benefits (2)

Pensions/Annuities (1)

Interest or Dividends (1)

(list by account source)

- a.
b.
c.
d.
e.
f.

The Payment Assistance rate is calculated using the resident's GROSS income. Allowable deductions for Federal Income Tax, health insurance premiums, Medicare Part A, Part B and Part D, and spousal allowance if applicable are subtracted from the gross income.
If the spouse is living in the community he/she must also provide income statements and proof of deductions.
Income Documentation must be provided: Provide benefits statements showing gross benefits and, deductions. The Social Security Administration typically provide documents at the end of a year, Depending on the source pension benefits may be renewed at other times during the year.
Sometimes this information can be determined from the prior year's W-4/1099 forms or current bank statements if the payments are electronically deposited.

- (1) Please include a copy of your most r
(2) This item not included in determining

\*\* NOTE: Spousal income information is to be provided if it will create undue hardship for the spouse or

Is spouse a Pioneer Home resident?

Yes

No

Do you have **Medicare Part A**? (Hospital Insurance)

Do you have **Medicaid Part B**? (Medical Insurance)

Do you have **Medicaid Part D**? (Prescription Drug Cov

Are you receiving **Medicaid benefits**?

If Yes, please provide your Medicaid number: \_\_\_\_\_

Do you have supplemental health insurance

If Yes, what is the monthly amount you pay? (1) \_\_\_\_\_

\$

Name of insurance company \_\_\_\_\_

Address of insurance company \_\_\_\_\_

Account number \_\_\_\_\_

Residents who rely on Payment Assistance Program are required to have **Medicare Parts A, Part B and Part D or equivalent medical insurance**. Please provide documentation of the premiums: pension statement, payment stub, or bank statement.  
  
As a condition of receiving Payment Assistance a resident shall also apply for **Medicaid** and other state or federal program the may reduce the amount of state assistance.

Do you have long term care insurance?

Yes

No

If Yes, what is the monthly amount you pay? (1) \_\_\_\_\_

Name of insurance company \_\_\_\_\_

Address of insurance company \_\_\_\_\_

Account number \_\_\_\_\_

If a resident has **Long Term Care Insurance**, please provide documentation of the premium: copy of insurance policy, pension statement, payment stub or bank statement.

Do you receive dividends from corporations established

Yes

No

under the Alaska Native Claims Settlement Act?

If yes, names of the corporations? \_\_\_\_\_

Frequency of distribution? \_\_\_\_\_

Do you receive an Alaska Permanent Fund Dividend

A resident receiving benefits under **Alaska Native Claims Settlement Act** is allowed to keep dividends up to \$2,000 per year. Usually any amount over \$2,000 must be applied toward the accrued indebtedness.  
  
**Alaska Permanent Fund Dividend (PFD)** is an exempt resource.

| <u>RESOURCES</u>          | <u>Value</u> | <u>Description</u><br><u>(Include Location/Account Number)</u>   |  |
|---------------------------|--------------|--|--|
| Cash/Savings/Checking (1) |              | <div style="border: 1px solid black; padding: 5px;"> <p><b>Documentation must be provided for all accounts:</b> Provide statements for the past 3 months for all saving and checking accounts. Provide the most recent statement for burial account, Stock Holdings, Investments, and other financial accounts.</p> </div> |  |
| Stocks/Investments (1)    |              |  |  |
| *Car: Primary             |              |  |  |
| Car(s): Additional        |              |  |  |
| Boat/Plane                |              |  |  |
| Jewelry                   |              |  |  |
| Artwork                   |              |  |  |
| *Home (Inc. Land): Pri    |              |  | <div style="border: 1px solid black; padding: 5px;"> <p><b>Property:</b> A house or property must be sold at fair market value <b>IF</b> it is not occupied by a spouse or a dependent <b>OR</b> if it causes the resident to exceed the resource limit (\$10,000/single or \$98,000/couple). The resident may be allowed to deduct certain expenses from the sale price and the remaining proceeds are applied to the accrued indebtedness. All property sales are considered on a case-by-case basis.</p> </div> |
| Other Real Estate (1)     |              |  |  |
| *Insurance: Life (1)      |              |  |  |
| *Insurance: Burial (1)    |              |  |  |
| Insurance: Other (1)      |              | PROVIDE DOCUMENTATION  |  |
| Commercial Fishing Permit |              |  |  |
| Livestock                 |              |  |  |
| Major Equipment           |              |  |  |
| Other Resources           |              |  |  |

**TOTAL RESOURCES**

| <u>LIABILITIES</u> | <u>Creditor</u> | <u>Monthly Payment</u> | <u>Total Due</u> |
|--------------------|-----------------|------------------------|------------------|
| Mortgage(s)        |                 |                        |                  |
| Real Estate        |                 |                        |                  |
| Auto Loan(s)       |                 |                        |                  |
| Credit Card(s)     |                 |                        |                  |
| Doctor(s)          |                 |                        |                  |
| Pharmacy           |                 |                        |                  |
| Dept. Store(s)     |                 |                        |                  |
| Loan(s)            |                 |                        |                  |
| Other Liabilities  |                 |                        |                  |

**Other Thing to Consider**

**Outstanding liabilities: Credit Card debt** and other liabilities are usually not the responsibility of the Pioneer Home.

**Life Insurance:** Life insurance **with** a cash value is considered a resource. Provide copy of most recent statement.

**Property for Sale:** If property is being actively marketed for sale, we may allow a short-term monthly income deductions : to pay minimal utilities and property tax, etc. The deductions are limited and approved on a case-by-case basis.

**Medical Bills:** If ALL other means of payment have been exhausted, resident can apply for Grant Assistance. Applications for Grant Assistance are reviewed/approved on a case-by-case basis.

**Pharmacy:** On rare occasions, a resident may receive medications from the VA or a private provider. On a case-by-case basis charges may be deducted from the resident's Regular Account and added to the State Subsidy Account. Proof of charges and payments must be provided.

**TOTAL LIABILITIES**

\* = Value not considered a resource or income for the purposes of determining eligibility for payment assistance.  
 (1) Please include a copy of your most recent statement

**STATEMENT OF PROPERTY DISPOSED OF**

Please identify any resource\* which has been given, sold, transferred or otherwise disposed of during the last 36 months. Give details, including account number, name and address of all accounts including checking, savings, or brokerage firm.

| <u>Resource Description</u> | <u>Date of Disposition</u> | <u>Disposition</u> | <u>Value at time of Disposition</u> |
|-----------------------------|----------------------------|--------------------|-------------------------------------|
|-----------------------------|----------------------------|--------------------|-------------------------------------|

**The Payment Assistance Program requires a 36-month look back period.** Residents must disclose ANY resources that were sold, given, transferred or otherwise disposed of in the past 36 months. Any item (property or assets of any kind) sold and used for a residents cost of care may be allowed with documentation. Determination made on a case-by-case basis.

Items that were given away must be reviewed. The gifting of a house may or may not disqualify the resident until the 36 months look back period has passes. It is important that the information is provided and it is evaluated on a case-by-case basis.

**Single Resident:** Residents can have up to \$10,000 in resources, a designated burial account up to \$4,500 (pre-paid burial agreement/insurance), life insurance policies without a cash value, (we do not deduct for premiums), one car, the annual Alaska Permanent Fund Dividend, Veteran's Disability Benefits, and Native Dividends up to \$2,000.

**Resident with spouse living in the community:** Combined resources up to \$98,000, the primary home the spouse resides in, a designated burial account up to \$4,500 each (pre-paid burial agreements/insurance, life insurance policies without a cash value (we still do not deduct for premiums), the portion of the resident's income that would bring the community spouse income up to \$2,000 per month.

**Both spouses in the Pioneer Home:** Each may have the same as a single resident.

Additional information is available in the Payment Assistance handbook.

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

\*Resources include items such as automobiles, boats, jewelry (other than costume jewelry), cash, stocks, bonds, notes, livestock and major equipment.

STATE OF ALASKA - SITKA PIONEERS HOME

Resident Name: Smith, Robert C.  
Resident No.: 1234567

Statement No.: 1956  
Statement Date: 08/01/01

TOTAL DUE: 2,300.00

CREDIT CARD: VISA ( ) MASTER CARD ( )

Card Holder: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Signature: \_\_\_\_\_

PA CALC

Robert C. Smith  
625 Caribou Way  
Juneau, Alaska 99801

RETURN THIS PORTION WITH YOUR PAYMENT

| DATE     | DESCRIPTION |               |
|----------|-------------|---------------|
| 07/05/01 | CREDIT CARD | <b>SAMPLE</b> |

| DATE     | DESCRIPTION                 | QUANTITY | UNIT PRICE | TOTAL PRICE |           |
|----------|-----------------------------|----------|------------|-------------|-----------|
| 08/01/01 | Resident income             | 1.000    | 4,035.44   | 4,035.44    | 4,035.44  |
| 08/01/01 | Anticipated Federal Taxes   | 1.000    | -49.49     | -49.49      |           |
| 08/01/01 | Insurance Premium Allowance | 1.000    | -154.13    | -154.13     |           |
| 08/01/01 | Insurance Premium Allowance | 1.000    | -136.74    | -136.74     |           |
| 08/01/01 | Less Medicare Part B        | 1.000    | -50.00     | -50.00      |           |
| 08/01/01 | Less Personal Allowance     | 1.000    | -100.00    | -100.00     |           |
| 08/01/01 | Less Spouse Allowance       | 1.000    | -1245.08   | -1245.08    |           |
|          |                             |          |            |             | -1,735.44 |

0.00

**The monthly statement for residents on payment assistance reflects the resident's GROSS Income and each Allowable Deduction. This is the amount the resident is required to pay each month.**

0.00

RESIDENT NAME: Robert C. Smith

REMIT PAYMENT TO:

State of Alaska  
Division of AK Longevity Programs  
PO Box 110211  
Juneau, AK 99811-0211

PRIOR MONTH BALANCE: 2,300.00  
TOTAL PAYMENTS: 2,300.00  
TOTAL CURRENT CHARGES: 2,300.00

In-state toll free: 1-888-355-3117

Phone: (907) 465-4401 or (907) 465-4599

TOTAL BALANCE DUE: 2,300.00

STATE OF ALASKA - SITKA PIONEERS HOME

Resident Name: Smith, Helen G.  
Resident No.: 7891011

Statement Date: 07/01/01  
Statement No.: 1910

\*\*\*\*INDEBTEDNESS STATEMENT\*\*\*\*

PAY ASSIST

Helen H. Smith  
625 Caribou Way  
Juneau, Alaska 99801

THE AMOUNT SHOWN ON THIS STATEMENT REFLECTS THE  
RESIDENT'S TOTAL INDEBTEDNESS TO THE STATE OF  
ALASKA AS OF 08/08/01

Juneau AK 99801

| DATE                   | DESCRIPTION | AMOUNT PAID     |
|------------------------|-------------|-----------------|
| 03/27/01               | 2987408     | 30.31           |
| 04/06/01               | ALB04       | 250.00          |
| 04/11/01               | 8579        | 3,406.14        |
| 04/24/01               | 3030286     | 30.31           |
| 05/07/01               | ALB05       | 250.00          |
| 05/09/01               | 8594        | 530.42          |
| 05/21/01               | 3073169     | 30.31           |
| 06/06/01               | ALB06       | 250.00          |
| 06/08/01               | 8611        | 531.42          |
| 06/20/01               | 3115971     | 30.31           |
| <b>TOTAL PAYMENTS:</b> |             | <b>5,338.22</b> |

**Residents on payment assistance will receive an indebtedness statement on a quarterly basis. The statement reflects all full charges and payments for the three-month period and the resident's current indebtedness to the State of Alaska.**

| DATE     | DESCRIPTION             | QUANTITY | UNIT PRICE | TOTAL PRICE |
|----------|-------------------------|----------|------------|-------------|
| 05/01/01 | Room Charge             | 1.000    | 4,920.00   | 4,920.00    |
| 06/01/01 | Room Charge             | 1.000    | 4,920.00   | 4,920.00    |
| 07/01/01 | Room Charge             | 1.000    | 5,685.00   | 5,685.00    |
|          |                         |          |            | 15,525.00   |
| 04/23/01 | Pharmacy Charge         | 1.000    | 158.07     | 158.07      |
| 05/21/01 | Pharmacy Charge         | 1.000    | 143.93     | 143.93      |
| 06/21/01 | Pharmacy Charge         | 1.000    | 151.72     | 151.72      |
|          |                         |          |            | 453.72      |
| 04/18/01 | Insert Pads             | 60.000   | 0.19       | 11.40       |
| 04/18/01 | Washcloths - Disposable | 1.000    | 2.58       | 2.58        |
| 05/21/01 | Insert Pads             | 20.000   | 0.19       | 3.80        |
| 06/01/01 | Insert Pads             | 40.000   | 0.19       | 7.60        |
| 06/07/01 | Insert Pads             | 15.000   | 0.19       | 2.85        |
|          |                         |          |            | 28.23       |
|          |                         |          |            | 0.00        |

SAMPLE

QUESTIONS?

In-state toll free: 1-888-355-3117  
Phone: (907) 465-4401 or 465-4599

State of Alaska, Alaska Longevity Programs  
PO Box 110211  
Juneau, AK 99811-0211

**TOTAL CURRENT CHARGES:** 16,006.95  
**TOTAL PAYMENTS:** 5,338.22  
**TOTAL INDEBTEDNESS:** 19,806.89

STATE OF ALASKA - SITKA PIONEERS HOME

Resident Name: Smith, Robert C. Statement No.: 1956  
 Resident No.: 1234567 Statement Date: 08/01/01

Your Pharmacy Insurance has been billed. TOTAL DUE: 2,300.00

\$37.67

PRIVATE

Robert C. Smith  
 625 Caribou Way  
 Juneau, Alaska 99801

CREDIT CARD: VISA ( ) MASTER CARD ( )

Card Holder: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Sitka AK 99835

RETURN THIS PORTION WITH YOUR PAYMENT

| DATE            | DESCRIPTION                              | AMOUNT PAID |
|-----------------|--|-------------|
| 07/03/01        | LB07 ← Automatic Longevity Bouns Payment | 250.00      |
| 07/13/01        | 10356216 ← Pharmacy Insurance Payment    | 81.92       |
| 07/13/01        | 1306 ← Resident Payment                  | 4,442.57    |
| TOTAL PAYMENTS: |  | 4,774.49    |

| DATE     | DESCRIPTION               | QUANTITY | UNIT PRICE | TOTAL PRICE |
|----------|---------------------------|----------|------------|-------------|
| 08/01/01 | Room Charge               | 1.000    | 4,655.00   | 4,655.00    |
| 07/23/01 | Anticipated Federal Taxes | 1.000    | 108.07     | 108.07      |
| 07/26/01 | Medium Briefs             | 48.000   | 0.32       | 15.36       |
| 07/26/01 | Large Briefs              | 24.000   | 0.46       | 11.04       |
|          |                           |          |            | 26.40       |
|          |                           |          |            | 0.00        |

**SAMPLE**

**Resident statements reflect the coming month's ROOM charges and the prior month's pharmacy and supply charges.**

**Residents with pharmacy insurance are billed the full pharmacy charge, but are responsible only for their co-pay portion. The co-pay amount is noted on a sticker, which is placed on the monthly statement.**

RESIDENT NAME: Robert C. Smith

REMIT PAYMENT TO:

State of Alaska  
 Division of AK Longevity Programs  
 PO Box 110211  
 Juneau, AK 99811-0211

PRIOR MONTH BALANCE: 4,412.42  
 TOTAL PAYMENTS: 4,774.49  
 TOTAL CURRENT CHARGES: 4,789.47

In-state toll free: 1-888-355-3117

Phone: (907) 465-4401 or (907) 465-4599 TOTAL BALANCE DUE: 4,427.40