



Department of Health and Social Services
 Division of Alaska Pioneer Homes
Waitlist Transfer / Change Request

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	MI	Date of Birth						
Preferred Mailing Address			Preferred Contact Phone Number						
City	State	Zip	Preferred Email Address						
Power of Attorney or Alternate Contact <i>(as applicable)</i>									
<p><i>I would like to:</i></p> <p>Transfer to the Active Waitlist**</p> <p>Move to the Inactive Waitlist</p> <p>Change My Home Choices</p>									
<p>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 <u>numerically rank selected home(s) in order of preference.</u> <i>(Only rank those that the applicant is willing to live in)</i></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; text-align: center;">_____ Alaska Veterans & Pioneers Home (Palmer)</td> <td style="width: 33%; text-align: center;">_____ Fairbanks</td> <td style="width: 33%; text-align: center;">_____ Ketchikan</td> </tr> <tr> <td style="text-align: center;">_____ Anchorage</td> <td style="text-align: center;">_____ Juneau</td> <td style="text-align: center;">_____ Sitka</td> </tr> </table>				_____ Alaska Veterans & Pioneers Home (Palmer)	_____ Fairbanks	_____ Ketchikan	_____ Anchorage	_____ Juneau	_____ Sitka
_____ Alaska Veterans & Pioneers Home (Palmer)	_____ Fairbanks	_____ Ketchikan							
_____ Anchorage	_____ Juneau	_____ Sitka							
<p>** Please include the following documents with your active transfer request:</p> <ul style="list-style-type: none"> • Certificate of Need • History & Physical Report • Power of Attorney (as applicable) 		<p>** For veterans transferring to the active waitlist for the Alaska Veterans & Pioneers Home, the additional forms are also needed:</p> <ul style="list-style-type: none"> • 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



**Department of Health and Social Services
Division of Alaska Pioneer Homes
Certificate of Need**

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Juneau, AK 99811-0690
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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 History: _____					

Family History: _____					
Social History: _____					
Alcohol Use: <input type="checkbox"/> Yes <input type="checkbox"/> No Tobacco Use <input type="checkbox"/> Yes <input type="checkbox"/> No Other Drugs <input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Further information: _____ _____ _____
Dysphagia / Swallowing Difficulties?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is applicant in full control of bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is applicant in full control of bowels?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Diet	Food Allergies: (Please provide reaction to each food allergy) _____ _____
	<input type="checkbox"/> Regular <input type="checkbox"/> Soft <input type="checkbox"/> Low Cal <input type="checkbox"/> Salt Restricted
	<input type="checkbox"/> Fluid thickened: consistency: _____
	<input type="checkbox"/> Other: _____
	Special Instructions: _____

Tuberculosis Status: (Note: This section must be completed before 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 _____
Diphtheria/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