

State of Alaska
Department of Health and Social Services
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) 269-3640 to speak with a licensing specialist.

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

2. **Applicant:** The applicant is the individual or legal entity responsible for operation of the proposed assisted living home. If granted, the license will be issued in the name of the applicant.

Name: _____

Title of Applicant
(if applicable): _____

Mailing Address: _____

City _____ State _____ Zip _____

Physical Address: _____

City _____ State _____ Zip _____

Email Address: _____

Phone Number: () _____

Fax Number: () _____

Applicant Date of Birth (MM/DD/YYYY): _____

Driver's License Number, if any: _____ State of Issuance: _____

3. **If the applicant is an association, corporation, or other entity**, 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 _____

Physical Address: _____

City _____ State _____ Zip _____

Email Address: _____

Phone Number: () _____

Fax Number: () _____

4. **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: _____
Mailing Address: _____

City State Zip
Email Address: _____
Phone Number: () _____
Fax Number: () _____

5. **Ownership Interest:** Please provide the following information for each person who has an ownership interest in the proposed Assisted Living Home. Attach additional pages as necessary.

Name: _____
Title: _____
Mailing Address: _____

City State Zip
Physical Address: _____

City State Zip
Email Address: _____
Phone Number: () _____
Fax Number: () _____

Name: _____
Title: _____
Mailing Address: _____

City State Zip
Physical Address: _____

City State Zip
Email Address: _____
Phone Number: () _____
Fax Number: () _____

6. **Owner of Premises:** Please identify the owner of the premises (if the applicant is not the owner) in which the proposed assisted living home will be located.

Name: _____
Title, _____ if _____ applicable: _____
Mailing Address: _____

City State Zip
Physical Address: _____

City State Zip
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 licensure process may require a new application and associated fees. Applications that do not specify a physical location will be returned as incomplete applications*

Street: _____

City State Zip

8. **Facility Phone:** *If licensed, this is the phone number that will be posted on the website listing of licensed facilities. If you do not enter a phone number here, no phone will be listed on the website unless a request is submitted in writing.*

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

Street: _____

City State Zip

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.

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.

_____ 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.

12. **Does the Applicant currently hold, or ever previously held, any other licenses or certifications issued by the Department?** (Example: Child Care License, Foster Care License, Medicaid certification, etc...) If so, please list them below with their expiration dates.

13. **Administrator:** Please provide information regarding the Administrator of the proposed assisted living home.

Name: _____

Title, _____ if _____ applicable: _____

Mailing Address: _____

City _____ State _____ Zip _____

Physical Address: _____

City _____ State _____ Zip _____

Email Address: _____

Phone Number: () _____

Fax Number: () _____

Please list by name and address, any other assisted living home(s) the proposed Administrator is or has been affiliated with:

14. **Resident Manager** (if applicable):

Will the individual identified in question #13 above manage the daily operations of the proposed Assisted Living Home? Yes No

If not, please identify the individual who will serve as the resident manager and manage the daily operations of the proposed Assisted Living Home.

Name: _____

Title, if applicable: _____

Mailing Address: _____

City _____ State _____ Zip _____

Physical Address: _____

City _____ State _____ Zip _____

Email Address: _____

Phone Number: () _____

Fax Number: () _____

Please list by name and address, any other assisted living home(s) the Resident Manager is or has been affiliated with:

15. **Variance (if applicable):** _____

16. **The following, as applicable, are required to be attached to your application.** *If you have previously submitted the below documents, please attach those documents to this application.*

1. Completed Application for License to Operate an Assisted Living Home.

Must be notarized

Must include fee

Provide the legal name and date of birth for each member of the applicant's household and dependents who will be residing in the property where the assisted living home will be located.

2. Administrator/Resident Manager/Designee Qualifications Questionnaire completed by the individual being appointed Administrator. This must include:

Documentation the individual meets the requirements in 7 AAC 75.230

Copy of government issued photo identification

3. Administrator/Resident Manager/Designee Qualifications Questionnaire completed by the individual being appointed Resident Manager (if applicable).

4. Administrator/Resident Manager/Designee Qualifications Questionnaire completed by the individual being appointed Designee.

5. Administrator's Designation form completed by the Administrator

6. 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.

7. Universal Precautions Policy - (see enclosed guide lines and 7 AAC 10.1045 for information on what is required to be included).

8. Incontinence Care Procedures – **only required for six or more resident** (see 7 AAC 10.1055 for information on what is required to be included).

9. Staff Plan and Staff Responsibilities - (see enclosed sample form and 7 AAC 75.080 (b)(11) for information on what is required to be included).

10. 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).

11. Personnel Practices – create policies you will require your staff to comply with. This is similar to an employee handbook.

12. 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.

13. Emergency Evacuation Plan/**Floor Plan** – Will be a clear diagram of each level of the home that identifies walls, doorways and windows. Also create a key that identifies the location of smoke detectors, location of CO2 detectors, location of fire extinguisher, location of Disaster Kit and First Aid Kit, and location of the meeting place outside the home. Include also arrows showing evacuation routes used in an emergency.

14. Restraint Policy – (see 7 AAC 75.295 for information on what is required to be included).

15. List of Services Offered – (see enclosed sample form and 7 AAC 75.080 (b)(8) for information on

what is required to be included).

- 16. Nonprescription Drug Policy – **only required for a home with 3 or more residents** (see 7 AAC 10.1070 (g)(4) for information on what is required to be included).
- 17. Prohibition of Abuse, Neglect, or Exploitation Policy – (see 7 AAC 75.220 for information on what is required to be included).
- 18. Employee Orientation (see 7 AAC 75.210 (a)(3) and 7 AAC 75. 240 (b) for information on what is required to be included).
- 19. Background Checks – When we receive your application, we will contact the Background Checks 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 individuals 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.
- 20. TB Clearance – You will need to submit documentation that each employee and household member in the home is clear of TB.
- 21. Notice of Resident Rights– (see enclosed sample form and AS 47.33.300 for information on what is required to be included).
- 22. Notice of Protection From Retaliation– (see AS 47.33.350 for information on what is required to be included).
- 23. Grievance Procedure – (see enclosed sample form and AS 47.33.340 for information on what is required to be included).
- 24. House Rules – (see enclosed sample form and AS 47.33.060 for information on suggested items to include).
- 25. Residential Service Contract – (see enclosed sample form and AS 47.33.210 for information on what is required to be included).
- 26. Assisted Living Plan & Physician Statement – (see enclosed sample forms and AS 47.33.220 and AS 47.33.230 for information on what is required to be included).
- 27. Plant Notification – **only required if the home has poisonous plants and the Department has approved them to remain in the home.** (see 7 AAC 10.1095 for information on what is required to be included).
- 28. 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).
- 29. 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).
- 30. Change of Use Permit – **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 requirement)
- 31. 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.
- 32. Kitchen/Food Service Inspection – **only required for homes with 13 or more residents.** In the Municipality of Anchorage, contact Food Safety and Sanitation at 343-4200. Outside the Municipality of Anchorage, contact the DEC Food Safety and Sanitation Program at (907) 269-7501.

33. Well Water – **only required if on well water.** You are required to register your well with the Department of Conservation (DEC). Contact Darryl Gillespie at (907) 376-1824.

34. Written permission from property owner and/or Home Owners Association allowing an Assisted Living Home to operate in the property (if applicable).

The regulations/statutes that are cited to provide additional information can be found at <http://dhss.alaska.gov/dhcs/Documents/cl/all/assets/ALHStatutesRegulationsGuide.pdf>

17. Application / modification fees: Please include check or money order with this application.

- Licensure for one or two residents:** \$25.00
- Licensure for three (3) or more residents:** \$25.00 per resident. *(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).*
- Modification of (a) location or other major modification:** \$25.00
- Modification of (b) capacity (# of residents):** \$25.00 per additional resident.
- Modification of both (a) and (b):** \$25.00 plus \$25.00 for each additional resident.

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 and Social Services, or its authorized representatives, upon request.

To permit representatives of the Department of Health and Social Services 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

Return completed applications to:
State of Alaska
DHSS/Division of Health Care Services
Certification & Licensing
4601 Business Park Blvd, Bldg K.
Anchorage, AK 99503

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



Administrator/Resident Manager/Designee Qualification Questionnaire

1. Name of Individual: _____

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

3. Name of Assisted Living Home _____

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

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

6. Physical Address:

Street: _____

_____ AK _____
City State Zip

7. Mailing Address:

Street: _____

_____ AK _____
City State Zip

Character References: Please submit three individuals who are not related by blood or marriage to the person applying to be an Administrator:

Name: _____

Mailing Address: _____

_____ . _____
City State Zip

Phone Number: _____

Name: _____

Mailing Address: _____

_____ _____
City State Zip

Phone Number: _____

Name: _____

Mailing Address: _____

_____ _____
City State Zip

Phone Number: _____

Employment References: Please submit two employment references. The employment references may also serve as part of the three required character references above and may not be related by blood or marriage to the person applying to be an Administrator:

Name: _____

Mailing Address: _____

City State Zip

Phone Number: _____

Name: _____

Mailing Address: _____

City State Zip

Phone Number: _____

Applicants must submit detailed documentation evidencing that they meet at least one of the following criteria:

For Homes serving 1 – 10 Residents:

- a. 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**
- b. Documentation of completion of an approved management or administrator training course 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**
- c. 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**
- d. 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**
- e. 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 Homes serving 11 or more Residents, or if the Administrator is administrator for more than one home where the total capacity of the homes is 11 or more residents:

- a. 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**
- b. 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**
- c. 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**
- d. 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.

Please attach the following relating to the Administrator:

- Copy of government issued ID, such as a driver's license or state ID card, showing date of birth for the Administrator
- Evidence the Administrator is free from active pulmonary tuberculosis (TB), such as a negative TB test or doctor's statement of inactive TB
- If applicable, copies of degrees or transcripts that document a bachelor degree or higher in gerontology, health administration or other health related field.
- If applicable, copy of professional license, nurse aide training certificate or nursing license
- Documentation of Administrator's education and experience. This should be detailed information providing proof of education and experience to include previous employment, specific dates of employment, description of job duties, number of hours worked weekly (full or part time), and employer contact names and phone numbers.

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 Applicant

Date

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



Administrator/Resident Manager/Designee Qualification Questionnaire

1. Name of Individual: _____

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

3. Name of Assisted Living Home _____

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

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

6. Physical Address:

Street: _____

_____ AK _____
City State Zip

7. Mailing Address:

Street: _____

_____ AK _____
City State Zip

Character References: Please submit three individuals who are not related by blood or marriage to the person applying to be an Administrator:

Name: _____

Mailing Address: _____

_____ AK _____
City State Zip

Phone Number: _____

Name: _____

Mailing Address: _____

_____ AK _____
City State Zip

Phone Number: _____

Name: _____

Mailing Address: _____

_____ AK _____
City State Zip

Phone Number: _____

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Name: _____

Mailing Address: _____

City State Zip

Phone Number: _____

Name: _____

Mailing Address: _____

City State Zip

Phone Number: _____

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- d. 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**
- e. 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 Homes serving 11 or more Residents, or if the Administrator is administrator for more than one home where the total capacity of the homes is 11 or more residents:

- a. 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**
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Please attach the following relating to the Administrator:

- Copy of government issued ID, such as a driver's license or state ID card, showing date of birth for the Administrator
- Evidence the Administrator is free from active pulmonary tuberculosis (TB), such as a negative TB test or doctor's statement of inactive TB
- If applicable, copies of degrees or transcripts that document a bachelor degree or higher in gerontology, health administration or other health related field.
- If applicable, copy of professional license, nurse aide training certificate or nursing license
- Documentation of Administrator's education and experience. This should be detailed information providing proof of education and experience to include previous employment, specific dates of employment, description of job duties, number of hours worked weekly (full or part time), and employer contact names and phone numbers.

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.

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Date

State of Alaska
Department of Health and Social Services
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3. Name of Assisted Living Home _____

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6. Physical Address:

Street: _____

_____ AK _____
City State Zip

7. Mailing Address:

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Character References: Please submit three individuals who are not related by blood or marriage to the person applying to be an Administrator:

Name: _____

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_____ AK _____
City State Zip

Phone Number: _____

Name: _____

Mailing Address: _____

_____ AK _____
City State Zip

Phone Number: _____

Name: _____

Mailing Address: _____

_____ AK _____
City State Zip

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City State Zip

Phone Number: _____

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City State Zip

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- a. 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**
- b. Documentation of completion of an approved management or administrator training course 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**
- c. 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**
- d. 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**
- e. 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.

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- a. 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**
- b. 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**
- c. 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**
- d. 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.

Please attach the following relating to the Administrator:

- Copy of government issued ID, such as a driver's license or state ID card, showing date of birth for the Administrator
- Evidence the Administrator is free from active pulmonary tuberculosis (TB), such as a negative TB test or doctor's statement of inactive TB
- If applicable, copies of degrees or transcripts that document a bachelor degree or higher in gerontology, health administration or other health related field.
- If applicable, copy of professional license, nurse aide training certificate or nursing license
- Documentation of Administrator's education and experience. This should be detailed information providing proof of education and experience to include previous employment, specific dates of employment, description of job duties, number of hours worked weekly (full or part time), and employer contact names and phone numbers.

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 Applicant

Date

**State of Alaska
Department of Health & Social Services
Division of Health Care Services
Residential Licensing**

Administrator's Designation

I, _____, designate _____

to act as administrator on my behalf for any period less than 90 days during which I am absent from my assisted living home.

7 AAC 75.210 (A) (2) (B)

An assisted living home shall appoint an administrator who meets the requirements of 7 AAC 75.230 and administrator designee to act on the administrator's behalf for any period during which the administrator is on vacation, is ill, or is otherwise unable to perform regular duties for 24 hours or more; if the administrator designee will be required to manage the daily operation of the home for 90 consecutive days or longer, the designee must have the same qualifications as an administrator under 7 AAC 75.230.

Administrator's Signature

Date

Printed Name of Administrator

Print Name of Assisted Living Home

Printed Name of Designee

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.

Y/N

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;

Y/N

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)

Y/N/NA

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: _____

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: _____

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: _____

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- 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.

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

Position	Monthly Cost
1.	
2.	
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.		
2.		
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.		
2.		
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 financial statements must reflect that the funds in the account belong to the applicant, licensee or owner of 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

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 Home's 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
- Line of Credit/Credit Card

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

Name of the Home: _____

Savings/Assets Total _____

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

Print Name _____

Date _____

Signature _____

Universal Precautions/Standard Precautions Policy

SAMPLE – 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.

STAFFING PLAN: ASSISTED LIVING HOME

State of Alaska

Department of Health & Social Service

Division of Health Care Services

Residential Licensing

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.

Home Name: _____ Physical Location: _____

ONSITE SCHEDULE

NAME - POSITION	DAYS OF WEEK (M - SU)	HOURS (8:00 am- 4:00 pm)
Administrator		
Designee		

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)

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

State of Alaska
Department of Health & Social Services
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 47.33.310, AS 47.33.320, AS 47.33.330, AS 47.33.340, AS 47.33.350

1. **RIGHTS**-Residents of Assisted Living Homes have the right to:
 - a. live in a safe and sanitary environment;
 - b. be treated with consideration and respect for personal dignity, individuality, and the need for privacy, including privacy in
 - (1) medical examination or health-related consultation;
 - (2) the resident's room or portion of a room;
 - (3) bathing and toileting, except for any assistance in those activities that are specified in the resident's assisted living plan; and
 - (4) the maintenance of personal possessions and the right to keep at least one cabinet or drawer locked;
 - c. 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;
 - d. engage in private communications, including
 - (1) receiving and sending unopened correspondence;
 - (2) having access to a telephone, or having a private telephone at the resident's own expense; and
 - (3) visiting with persons of the resident's choice, subject to the visiting hours established by the home;
 - e. close the door of the resident's room at any time, including during visits in the room guests or other residents;
 - f. 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;
 - g. manage the resident's own money;
 - h. participate in the development of the resident's assisted living plan;
 - i. share a room with a spouse if both are residents of the home;

- J. have a reasonable opportunity to exercise and to go outdoors at regular and frequent intervals when weather permits;
- j. exercise civil and religious beliefs;
- k. 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;
- l. self-administer the resident's own medications, unless specifically provided otherwise in the resident's assisted living plan;
- m. receive meals that are consistent with religious or health-related restrictions;
- n. 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;
- o. present to the home grievances and recommendations for change in the policies, procedures, or services of the home;
- p. 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;
- q. 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;
- r. reasonable access to home files relating to the resident, subject to the constitutional right of privacy of other residents of the home;
- s. visits from advocates and representatives of community legal services programs, subject to the resident's consent for the purpose of
 - (1) making personal, social, and legal services available;
 - (2) distributing educational and informational materials to advise a resident or resident's representative of applicable rights; and
 - (3) assisting a resident or resident's representative in asserting legal rights or claims;
- t. immunity from civil liability for the filing a complaint concerning a violation under AS 47.33 or 7 AAC 75 or testifying in an administrative or judicial proceeding arising from a complaint concerning a suspected violation, unless the person acted in bad faith or with malicious purpose.

2. PROHIBITIONS—An Assisted Living Home

- a. may not establish or apply a policy, procedure, or rule that is inconsistent with or contrary to these rights or other legal rights;
- b. may not deprive a resident of the home of the rights, benefit, or privileges guaranteed to the resident by law;
- c. may not enter a resident's room without first obtaining permission, except

- (1) during regular, previously announce, fire, sanitation, or other licensing inspections;
 - (2) when a condition or situation presents an imminent danger;
 - (3) as required by the resident's assisted living plan to provide services specified in the residential services contract; or
 - (4) for other vital health or safety reasons;
- d. may not impose religious beliefs or practices upon a resident or require a resident to attend religious services;
 - e. may not place a resident under physical restraint unless the resident's own actions present an imminent danger to the resident or other; and the home has a written physical restraint procedure that has been approved by the licensing agency. The home shall terminate physical restraint as soon as the resident no longer presents an imminent danger;
 - f. may not place a resident under chemical restraint; this does not prevent a resident from voluntarily taking tranquilizers, or other medication, prescribed by a licensed physician;
 - g. may not 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
 - h. may not restrain, interfere with, coerce, discriminate against, or retaliate against a resident for asserting a right specified by this chapter or by other law;
 - i. may not have an owner, administrator, employee, or agent of the assisted living home 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 or
Resident's Representative

Date _____

Assisted Living Home
Representative

By: _____

Title: _____

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 _____ will hear and attempt to resolve all grievances in a fair and timely manner. (Assisted Living Home)

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.
5. 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 _____ staff to discuss the grievance with such advocates.
(Assisted Living Home)

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 AND SOCIAL SERVICES
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 acknowledges 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)

Health Related Services may include supervision of self-administration of medications; providing intermittent nursing services; arranging for or providing skilled nursing care; providing or arranging for 24 hour a day skilled nursing; and providing care for terminally ill patient, with restrictions see AS 47.33.020 for details

Resident information

Assisted Living Home Information

Name _____

Address _____

Social Security # ____/____/____

Date of Birth ____/____/____

Phone # (____) _____

Contact Person _____

DATE OF THIS PLAN _____

CARE COORDINATOR/CASE MANAGER/PROGRAM SPECIALIST _____

ADDRESS, _____

AGENCY AFFILIATION, (if any) _____

TELEPHONE # _____

ANY PHYSICAL DISABILITIES AND IMPAIRMENTS THAT ARE RELEVANT TO THE SERVICES NEEDED BY THE RESIDENT

RESIDENT'S STRENGTHS/ABILITIES AND LIMITATIONS IN PERFORMING THE ACTIVITIES OF DAILY LIVING

RESIDENT'S PREFERENCE WANTED IN THE FOLLOWING AREAS:

a. roommates _____

b. living environment _____

c. food _____

d. recreational activities _____

e. religious affiliation _____

f. relationships/visitation with friends, family members, and other _____

<u>Assessment Areas</u>	<u>Service Needs</u>	<u>Interventions</u>	<u>Provider</u>	<u>Date</u>
1. Activities of Daily Living				
2. Training for Independent Living				
3. Personal Assistance				
4. Health services				
5. Health (mental/emotional)				

Assessment Areas

Service Needs

Interventions

Provider

Date

6. Legal
Situation

7. Financial
situation
(income)

8. Transport-

9. Day Care
or Day
Activities

Assessment

Service

Interventions

Provider

Date

10/05/2004
AS 47.33.220, AS 47.33.230, & AS 47.33.240

ALH FORM 5B
3 of 5

OTHER FORMS MAY BE USED THAT MEET STATUTORY REQUIREMENTS

Areas

Needs

10. Plan for
Community
Activities

11. Other

Risks

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. _____

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	_____ Date
_____ Care Coordinator/Case Manager/ Program Coordinator	_____ Date
_____ Service Providers (as appropriate)	_____ Date
_____ Assisted Living Home Representative	_____ Date
_____ Licensed Nurse	_____ Date

ATTACHMENT

Physician's statement about the resident

EVALUATION OF ASSISTED LIVING PLAN

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

<u>Date Review Required</u>	<u>Date Completed</u>	<u>Signature of Administrator</u>	<u>*Signature of Resident or representative</u>
--	----------------------------------	--	--

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

**State of Alaska
Department of Health & Social Services
Division of Health Care Services
Residential Licensing**

**Primary Physician's Statement
AS 47.33.230(c)(2)**

Date _____

Residents Name _____

Primary Physician Name _____

1. Medical History _____

2. Physical Examination
(not older than six months from date resident moves into Assisted Living Home)

3. Listing of Resident's Complete Current Medication Regimen _____

4. Statement Of Current Therapy Regimen Necessary To Maintain Or Increase The Resident's Functioning, Mobility, Or Independence _____

Primary Physician's Signature _____

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? 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.