

GENERAL RELIEF for ASSISTED LIVING CARE

General Relief for Assisted Living Care Program

General Relief Assistance provides for the most basic needs of many Alaskans without the personal resources to meet an emergent need and ineligible for assistance from other programs. GRA is designed to meet the immediate, basic needs of Alaskans facing extreme financial crisis. The GRA program is 100% state-funded and designed to be used as a last resort for financially eligible individuals and families who have exhausted all other possible resources.

Senior and Disabilities Services General Relief for Assisted Living Care Program

The Division of Senior and Disabilities Services' Adult Protective Services (APS) unit administers state General Relief funds to provide assisted living care to adults needing protective services, under the authority granted by AS 47.24.017. The General Relief for Assisted Living Care program is designed to assist those APS clients who lack adaptive behavior to the degree that they cannot manage to live independently. The program provides non-medical residential care and financial assistance to needy adults who require the protective oversight of an assisted living home. The overall objective of the program is to enable these adults to obtain the level of care they could receive in their own home from friends or relatives and to live in the least restrictive setting possible.

For specific questions about this program, contact: **Lynn Thurston, Program Manager, Christina Anaruk-Senior Services Tech., or Joshua Welsh- Senior Services Tech., Division of Senior and Disabilities, General Relief Program at (907) 269-3666**

Assisted Living Care Defined

Assisted living care is a range of care which includes more than room and board, but which does not include continuous nursing or medical care. It encompasses twenty-four hour supportive and protective services in the activities of normal daily living and is provided in a residential environment which encourages independent living to the extent possible for each resident ([7 AAC 47.310](#)).

Eligibility Criteria

The Division of Senior and Disabilities Services purchases assisted living care for APS clients who meet the medical, social, and financial eligibility criteria outlined in [7 AAC 47.330 through 7 AAC 360](#). A resident of the state is eligible for General Relief for assisted living care if the individual:

- 1) is 18 years of age or older;
- 2) has been assessed for eligibility by a care coordinator or other person approved by the Department of Health and Social Services;
- 3) has a disability that is attributable to mental retardation, cerebral palsy, epilepsy, autism or another condition closely related to mental retardation that significantly impairs intellectual functioning and adaptive behavior;
- 4) has a hearing, speech, visual, orthopedic, or other major health impairment that significantly impedes participation in the social, economic, educational, recreational, and other activities generally available to the individual's non-impaired peers in the community; or
- 5) has a significant deficit in adaptive behavior in the area of self-care, communication of needs, mobility, or independent living, which may be the result of the aging process, an emotional health disturbance, or alcohol or drug dependence;

- 6) without assisted living care is subject to, or at risk of, abuse, neglect, or exploitation by others;
- 7) does not have income that exceeds the limits permitted in [7 AAC 47.350](#);
- 8) does not have resources that exceed the amount permitted by [7 AAC 47.350](#);
- 9) has applied for the cash assistance programs as required by [7 AAC 47.370\(a\)](#);
- 10) has applied for and exhausted the use of alternative resources;
- 11) has a total monthly countable income which does not exceed the income limit which applies to the individual under the financial eligibility criteria of the APA program;
- 12) has a total monthly countable income which does not exceed 300 percent of the maximum individual SSI (Social Security Income) monthly income limit in effect on the date of application for assistance.

Program Forms

Care coordinators must use the forms provided by APS on the [Senior and Disabilities Services, General Relief Program](http://www.hss.state.ak.us/dsds/aps.htm) (<http://www.hss.state.ak.us/dsds/aps.htm>) website apply for General Relief for Assisted Living Care on behalf of their clients. Each applicable form must be filled out completely. If there is no information available under a certain question on these forms, please indicate “n/a” for not applicable or not available.

Completed General Relief for Assisted Living Care forms should be sent to:

Lynn Thurston
Division of Senior and Disabilities Services
General Relief Program Manager
550 W. 8th Ave.
Anchorage, Alaska 99501
Phone: (907) 269-3666 or (800) 478-9996 Fax:
(907) 269-3648

•Lynn Thurston •Division of Senior and Disabilities Services •General Relief Program •
•550 W 8th Ave Anchorage, Alaska 99501•Fax: (907) 269-3648•

General Relief for Assisted Living Care

Application Form

To facilitate processing of the General Relief for Assisted Living Care application, please note:

- Processing may require additional paperwork to be completed according to the individual's situation.
- The TB test or chest x-ray must be current within a year.
- The physician's statement and adult care application must be current within the month of application.
- If the physician's statement indicates "nursing care" is needed—this will preclude the applicant from entering an assisted living home until the applicant's condition has improved, and the applicant no longer needs "nursing care."
- If all paperwork is approved, DSDS will issue a credit/calculation sheet to the care coordinator and assisted living home. This credit/calculation sheet determines what amount (above the applicant's income/resources) is needed to pay for assisted living care. The credit/calculation sheet will indicate the general relief rate, client's contribution (if any), and contribution by General Relief per day to the assisted living facility.
- DSDS staff determine the date the client is approved for assisted living care.

Client Information

Last Name: _____ First Name: _____ Middle Initial: _____
Date of Birth: _____ Gender: Male Female
Street Address: _____ Apartment: _____
City: _____ State: _____ Zip: _____
Marital Status: _____ Race: _____ Phone Numbers: _____
Social Security Number: _____ Native Corporation: _____

Medical and Social Information

- Documentation need for assisted living care. (Describe disability, impairment or deficit.):

- Reason for recommending assisted living care rather than board and room, independent living, etc.:

- Specific services needed (e.g, provide transportation, make appointments, obtain prescriptions):

- Type/amount of supervision needed (e.g., assist adult in keeping appointments, remind to take medication, supervise spending money, etc.):

- Goals for the placement:

• Expected duration of placement:

• Other agencies providing service to the client, type of service being provided, and contact person:

• Name of family/friend (if any), address and phone. Extent of involvement:

• Name of guardian (if any) address and phone:

Placement history:

• Significant information about behavior (adult's routines, likes, dislikes, strengths which need to be supported, problem areas):

• Plans for follow-up after placement (referring agency's involvement, other agencies' responsibilities):

Applicants Monthly Income: \$ _____

Source of Income: Social Security Public Assistance VA Other
Describe

• Other significant information:

Send this form to:

Lynn Thurston • Division of Senior and Disabilities Services • General Relief Program

550 W. 8th Avenue, Alaska 99501 • Fax: (907)-269-3648



State of Alaska
 Department of Health and Social Services
 Division of Senior & Disabilities Services
 550 West 8th Ave • Anchorage, Alaska 99501
 (907) 269-3666 • 1-800-478-9996

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____

Record # or Other ID: _____ Date of Birth: _____

Other Names under which records might be filed: _____

Person/Organization Releasing Information: _____

Person/Organization Receiving Information: _____

Description of Information To Be Released: *(If substance abuse information is to be released from a federally assisted substance abuse treatment center, then this information must be included in the description)*

The purpose of the release of this information is: _____

I hereby authorize the use or disclosure of my health care and/or other information as described above. I understand that this authorization is voluntary. I understand that my records *may* contain sensitive information. I understand that I may revoke this authorization at any time by signing the revocation section on the back of this release, or by notifying the individual(s) or organization releasing this information in writing, but if I do, it won't have any affect on actions taken on this authorization before my revocation was received. I understand that the individual(s) or organization releasing this information *may* condition my treatment, payment, enrollment in a health plan (if applicable) or eligibility for benefits on whether I provide this authorization. I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization.

This authorization expires on the following date or event: _____

 Signature of Client or Personal Representative
 (Or Witness if signature is by mark)

 Date

 Printed Name of Personal Representative or Witness

 Description of Personal Representative's Authority

NOTE: This authorization was revoked on: _____ *(see reverse or attached revocation statement)*
 Date

RECIPIENT INFORMATION: If the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by federal law (CFR 42 Part 2) prohibiting you from making any further disclosure of this information without the specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42 Part 2. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

REVOCATION SECTION

I do hereby request that this authorization to release the information of: _____
(Printed Name of Client)

described on the reverse side of this form, be rescinded, effective _____. I understand that any
(Date)

action taken on this authorization prior to the rescinded date is legal and binding.

Signature of Client or Personal Representative
(Or Witness if signature is by mark)

Date

Printed Name of Personal Representative or Witness

Description of Personal Representative's Authority

Signature of Staff

* This Revocation Section must appear on the reverse side of DHSS Authorization for Release of Information 06-5870 (03/03) and is invalid if used separately. If a separate form is required, use DHSS Revocation of Authorization for Release of Information 06-5872 (03/03). If this revocation section has been completed and signed, please note the date of the revocation on the reverse side of this form in the space provided.

General Relief for Assisted Living Care

Physician's Report

Instructions: The Physician's Report is necessary in determining eligibility and must be submitted with the Application Form. The physician's statement must be signed by a physician; not a nurse or psychologist. The signature may not be signed "by" someone else for the physician.

Resident Information

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Gender: Male Female

Current Age: _____ Height: _____ Weight: _____

Medication Prescribed

Medication	Dosage	Instructions

Medication - Resident Will Require

NO ASSISTANCE

REMINDER TO TAKE MEDICATION

READING OF REGIMEN ON LABEL

SUPERVISION AS TO LABELED DOSAGE

Diet

Regular Low Calorie Soft Salt Free Other:

Food Allergies None OR:

Assistance Required

TYPE	Frequency of Assistance					Extent of Assistance		
	Independent	Occasional	Often	Always		Minimum	Moderate	Maximum
Bathing								
Dressing								
Grooming								
Oral Hygiene								
Toileting								
Eating								
Moving About								
In/Out Bed								

Mobility/Activity (check one):

Walker Cane Crutches Wheelchair No Restrictions Other Restrictions (please specify):

Medical History & Current Medical Problems

(please list and describe)

Mental Status (check one):

Clear Disoriented Occasionally Disoriented

Comments:

Behavior

DID DID NOT Manifest behavior which was assaultive, combative, suicidal or otherwise dangerous to self or others.

Comments:

Other Significant Information

EXTENT OF MENTAL OR PHYSICAL IMPAIRMENT, E.G., INCONTINENCE – SPECIFIC ASSISTANCE OR SUPERVISION NEEDED ETC. :

Physician's Diagnosis: (Include ICD codes)

Physician's Recommendation:

Physician's Name: _____

Street Address: _____ Phone Numbers: _____

City: _____ State: _____ Zip: _____

Physician's Signature: _____ Date: _____

Assisted Living Care Defined

An assisted living home provides housing and food service to its residents and, offers or obtains for its resident's assistance with the activities of daily living and/or personal assistance.

Send this form to:

*Lynn Thurston • Division of Senior and Disabilities Services • General Relief Program • 550 W. 8th Ave.
Anchorage, Alaska 99501 • fax: (907) 269-3648*

General Relief for Assisted Living Care

TUBERCULIN CLEARANCE

Authority: AS 47.35.00

Client's Full Name (please print): _____

Birth date: _____

Today's Date: _____

TUBERCULIN TEST (check one)

Positive

Negative

Date of Test: _____

CHEST X-RAY (check one)

Satisfactory

Not Satisfactory

Name of Health Official: _____

Name of Clinic/Facility: _____

Signature of Health Official: _____ Date: _____

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General Relief for Assisted Living Care

CLIENT ACTIVITY REPORT

Client Information

Client Number Assigned by SDS: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Gender: Male Female

Current Age: _____ Race: _____ Social Security Number: _____

Client Eligibility

- Credit sheet for initial determination is needed.
- Credit sheet for income change is needed.
- Approval is needed for emergency general relief assistance.
- Application for Public Assistance and other benefits made.
- Client is applying for/or is currently on the Medicaid waiver program.

Begin General Relief Assistance

Effective Date: _____

Name of Assisted Living Home: _____

Client Transfer

Client receiving general relief has changed assisted living homes and continues to need General Relief assistance.

Effective Date: _____

From of Assisted Living Home: _____
(name of previous assisted living home)

To of Assisted Living Home: _____
(name of new assisted living home):

Terminate General Relief Assistance for Assisted Living Care

Effective Date: _____

Name of Assisted Living Home: _____

Reason for termination (check one): Moved Private Pay Deceased
Other (please specify):

Name of Care Coordinator _____

Care Coordination Agency: _____

Care Coordinator Signature _____ Date _____

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ASSISTED LIVING CARE CONTRACT

Instructions: The Assisted Living Care contract specifies that the client's Personal Needs Allowance (PNA) is \$100 monthly.

I agree to stay at the Assisted Living Home with the understanding that I am responsible for payment to the facility of income available to me, minus \$100.00 a month for spending allowance.

The money that is paid by the State to cover my cost of care will be reimbursed when retroactive and other sources of payment become available to me. This amount paid will not be more than the amount the State has paid while in assisted living facility.

The money will be forwarded to the Division of Senior and Disabilities Services.

Client Signature _____ Date _____

Witness Signature _____ Date _____

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