STATE OF ALASKA
DIVISION OF ALASKA PIONEER HOMES

APPLICATION FOR PAYMENT ASSISTANCE

Residents of the Pioneer Homes are required to pay monthly rates and fees set by regulation, to reimburse the state for the cost of providing care. After paying monthly rent and ancillary charges residents should have at least $200.00 left over each month to cover personal expenses. The State does not intend for any residents to leave the Pioneer Homes due to inability to pay.

To determine if a resident is eligible for the Payment Assistance Program, please read the booklet titled "Payment Assistance". If you have any questions regarding the Payment Assistance Program or the application process, please call the Pioneer Homes' Revenue Unit at (907) 465-4401. If you believe a resident is eligible, complete the enclosed four-page form and return it to:

State of Alaska
Department of Health & Social Services
Division of Alaska Pioneer Homes
PO Box 110690
Juneau, AK 99811-0690.

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

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

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

ALASKA PIONEER HOME	APPLICATION FOR PAYMENT ASSISTANCE

NAME OF PIONEER HOME _____

NAME OF APPLICANT _____

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

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

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

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

_____ _____

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

Date

_____ _____ _____

Name of Witness
(Print or Type)

Signature of Witness

Date

ALL APPLICATIONS REQUIRE A WITNESS SIGNATURE

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PIONEER HOME - APPLICATION FOR PAYMENT ASSISTANCE

Name of Applicant _____ Page 1

Before an applicant can be considered for the Payment Assistance Program he or she must have proof of Medicaid status. This must include one or more of the following documentation:

Copy of recent Medicaid or Medicaid Waiver application. Date of application _____.

Copy of recent Medicaid or Medicaid Waiver denial letter. Date of letter _____.

In addition please submit copies of the 3 most current years Federal Income Tax documentation. If not required to file Federal Income Taxes please indicate the reason. _____.

Current year _____ Year before _____ Year before _____

Is spouse living in the community? Yes _____ No _____

If Yes, Name of Spouse: _____ _____

APPLICANT'S GROSS MONTHLY INCOME (Income before any deductions are made)	GROSS AMOUNT	SPOUSE'S INCOME (Before deductions are made) GROSS AMOUNT
Social Security **(1)**		
Veteran's Benefits **(1)**		
Pensions/Annuities **(1)**		
Interest or Dividends **(1)**		
(list by account source)		
a.		
b.		
c.		
d.		
Other Income (describe) **(1)**		

(1) Please include a copy of your most recent check stub or statement

****NOTE:** Spousal income information is required to calculate anticipated federal tax liabilities and to determine if the spouse or dependent qualifies for the spousal allowance of up to $2,000 per month.

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PIONEERS' HOME - APPLICATION FOR PAYMENT ASSISTANCE

Name of Applicant	Page 2

Is spouse a Pioneer Home resident? Yes ☐ No ☐

Do you have **Medicare Part A ?** (Hospital Insurance) Yes ☐ No ☐

Do you have **Medicare Part B?** (Medical Insurance) Yes ☐ No ☐

Do you have **Medicare Part D?** (Prescription Drug Coverage) Yes ☐ No ☐

Are you currently receiving **Medicaid** benefits? Yes ☐ No ☐

If Yes, please provide your Medicaid number: _____

Do you have supplemental **health insurance** coverage? Yes ☐ No ☐

If Yes, what is the monthly amount you pay? $ _____

(Please include a copy of your most recent premium statement)

Name of insurance company _____

Address of insurance company _____

Phone number _____

Account number _____

Do you have **Long Term Care Insurance**? Yes ☐ No ☐

If Yes, what is the monthly amount you pay? $ _____

(Please include a copy of your most recent premium statement)

Name of insurance company _____

Address of insurance company _____

Phone number _____

Account number _____

Do you receive dividends and/or own shares from corporations established under the **Alaska Native Claims Settlement Act**? Yes ☐ No ☐

If yes, names of the corporations? _____ _____

Frequency of distribution? _____ _____

Do you receive an **Alaska Permanent Fund Dividend**? Yes ☐ No ☐

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PIONEER HOME - APPLICATION FOR PAYMENT ASSISTANCE

Name of Applicant

RESOURCES	Value	Description (Include Location/Account Number)
Cash/Savings/Checking (2)		
(Statements for past 3 mos.)		
Stocks/Investments **(1)**		
*Car: Primary		
Car(s): Additional		
Boat/Plane		
Jewelry/Artwork		
*Home (Incl.Land): Primary **(1)**		
	Is Home occupied by spouse or dependent?	
Other Real Estate **(1)**		
*Insurance: Life **(1)**		
*Insurance: Burial **(1)**		
Insurance: Other **(1)**		
Commercial Fishing Permit		
Livestock/Major Equipment		
Other Resources		

TOTAL RESOURCES

LIABILITIES	Creditor	Monthly Payment	Total Due
Mortgage(s)			
Real Estate			
Auto Loan(s)			
Credit Card(s)			
Doctor(s)			
Pharmacy			
Loan(s)			
Other Liabilities			

TOTAL LIABILITIES

* = Value not considered a resource or income for the purposes of determining eligibility for Payment Assistance.

(1) Include a copy of your most recent statement

(2) Include the Past 3 months of Bank Statements

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Name of Applicant Page 4

STATEMENT OF PROPERTY DISPOSED OF

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

Resource Description	Date of Disposition	Disposition	Value at time of Disposition

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

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