Department of Family & Community Services
Division of Alaska Pioneer Homes

Waitlist Transfer / Change Request

Form used only for applicants already on waitlist

P.O. Box 112670
Juneau, AK 99811
Ph: 907-465-4416/888-355-3117
Fax: 907-465-4108

Applicant's Last Name, First Name, Middle Initial	Date of Birth

Primary Point of Contact:
- ☐ Applicant
- ☐ Power of Attorney (Name/Ph#): _____
- ☐ Other (Name/Relationship/Ph#): _____

Primary Point of Contact Mailing Address	Primary Point of Contact Phone Number
	Primary Point of Contact Email Address

I would like to:

☐ **Transfer to the Active Waitlist**** ☐ **Move to Inactive Waitlist** ☐ **Update Home Choices**

Pioneer Home Waitlist Preference (as applicable):
If you are transferring from the Inactive to the Active Waitlist or would like to update your current home choices, please numerically rank selected home(s) in order of preference. *Only rank those that applicant is willing to live in.*

_____ Alaska Veterans & Pioneers Home (Palmer) **non-veterans accepted*	_____ Fairbanks	_____ Ketchikan
_____ Anchorage	_____ Juneau	_____ Sitka

**** Please include the following documents with your *active transfer* request:**

- *Certificate of Need*
- *History & Physical Report*
- *Power of Attorney (as applicable)*

***** For veterans transferring to the *active waitlist* for the Alaska Veterans & Pioneers Home, the additional forms are also needed:**

- VA Addendum
- VA 10-10 EZ
- Copy of DD214

You may update your Pioneer Home choices at any time in writing, either through an email or letter. However, should you decline a room offer, you will be transferred to the Inactive Waitlist for 180 days. It is your responsibility to submit a new Waitlist Transfer/Change Request form after the 180 days in order to be reinstated to the active waitlist. Your original application date is the date that will be used to determine order of admission into any Pioneer Home. Should you choose to move out of a Pioneer Home once you have become a resident, a new waitlist application must be submitted.

_____

Signature of Applicant or Power of Attorney Date

_____

Printed Name of Applicant or Power of Attorney

Office Use Only:

Date Received/Initials

REV 08/2023

Department of Family and Community Services
Division of Alaska Pioneer Homes

Certificate of Need

For Active Applications or Active Transfers Only

P.O. Box 112670
Juneau, AK 99811
Toll Free: 888.355.3117
Fax: 907.465.4108

As part of the active waitlist application/active transfer request, you must report your physical needs or other cause which prevents you from maintaining a household without regular assistance in shopping, housekeeping, meal preparation, dressing or personal hygiene.

For *each* "Activity of Daily Living" listed below, please check the box that best describes your situation:

Bathing Assistance:
- ☐ Never
- ☐ Occasionally
- ☐ Often
- ☐ Always

Dressing Assistance:
- ☐ Never
- ☐ Occasionally
- ☐ Often
- ☐ Always

Grooming Assistance:
- ☐ Never
- ☐ Occasionally
- ☐ Often
- ☐ Always

Brushing Teeth Assistance:
- ☐ Never
- ☐ Occasionally
- ☐ Often
- ☐ Always

Toileting Assistance:
- ☐ Never
- ☐ Occasionally
- ☐ Often
- ☐ Always

Eating Assistance:
- ☐ Never
- ☐ Occasionally
- ☐ Often
- ☐ Always

Moving About Assistance:
- ☐ Never
- ☐ Occasionally
- ☐ Often
- ☐ Always

In/Out of Bed Assistance:
- ☐ Never
- ☐ Occasionally
- ☐ Often
- ☐ Always

Taking Medication Assistance:
- ☐ Never
- ☐ Occasionally
- ☐ Often
- ☐ Always

Shopping Assistance:
- ☐ Never
- ☐ Occasionally
- ☐ Often
- ☐ Always

Housekeeping Assistance:
- ☐ Never
- ☐ Occasionally
- ☐ Often
- ☐ Always

In Home Meal Prep Assist:
- ☐ Never
- ☐ Occasionally
- ☐ Often
- ☐ Always

Memory Assistance:
- ☐ Never
- ☐ Occasionally
- ☐ Often
- ☐ Always

Feeling Safe Assistance:
- ☐ Never
- ☐ Occasionally
- ☐ Often
- ☐ Always

Do You Use?
- ☐ Walker
- ☐ Cane
- ☐ Wheelchair

Please describe any other assistance you require (i.e. assistive devices or services) :

_____

_____

_____

_____

Your signature below certifies that the information contained in this document is true and complete to the best of your knowledge.

_____ _____ _____

Signature Printed Name Date

Name of Waitlist Applicant: _____

Department of Family & Community Services
Division of Alaska Pioneer Homes
History and Physical Report
For Active Applications & Active Transfers Only

P.O. Box 112670
Juneau, AK 99811
Ph: 888-355-3117/907-465-4416
Fax: 907-465-4108

Last Name	First Name	Middle Initial	Telephone Number

Mailing Address	City	State	Zip	*Date of Exam*

Date of Birth	Age	Height	Weight

Medical History:

Surgical History:

Family History:

Social History:

Alcohol Use: ☐ Yes ☐ No Tobacco Use: ☐ Yes ☐ No Other Drugs: ☐ Yes ☐ No	Further Information:

Physical Examination

Blood Pressure	Temperature	Pulse	Respiration	O2 Stats

A. General appearance, nutrition, debility, hygiene, etc: _____

B. Head and Neck: _____

C. Nose & Throat: _____

D. Dental: _____

E. Lungs: _____

F. Heart
Vessels: _____
Pulses: _____

G. Abdomen
Liver: _____
Rectum: _____
Hernias: _____

Applicant's Last Name _____ First Name _____ M.I. _____ Date of Exam _____

H. Male Genitourinary

Genitalia: _____

Prostrate: _____

I. Female Pelvic: _____

J. Breast: _____

K. Lymph: _____

L. Endocrine: _____

M. Musculoskeletal: _____

Back: _____

Extremities: _____

N. Skin: _____

O. Psychiatric:

Orientation: ☐ Clear ☐ Occasionally Disoriented ☐ Disoriented

Mood: _____

Intellect: _____

Short-Term Memory: _____

Cooperation: _____

P. Behavior:

☐ Appropriate ☐ Inappropriate, Aggressive ☐ Inappropriate, Assaultive ☐ Inappropriate, Passive

☐ Inappropriate, Suicidal, or otherwise dangerous to self or others ☐ Wandering-Requires safeguards

Describe behavior(s) & provide additional information as needed: _____

_____

_____

_____

Q. Neurological

Cranial Nerves: _____

Motor Reflexes: _____

Sensory: _____

Coordination: _____

Vision: _____

Hearing: _____

Applicant's Last Name _____ First Name _____ M.I. _____ Date of Exam _____

Activities of Daily Living

Frequency of Assistance Needed for ADLs

ADL	Never	Occasional	Often	Always
Bathing				
Dressing				
Grooming				
Oral Hygiene				
Toileting				
Eating				
Ambulation				
In/Out of Bed				
Taking Medication				
Walking up/ down stairs				

Extent of Assistance Needed for ADLs

ADL	None	Minimum	Moderate	Max
Bathing				
Dressing				
Grooming				
Oral Hygiene				
Toileting				
Eating				
Ambulation				
In/Out of Bed				
Taking Medication				
Walk up and/or down stairs				

Uses: ☐ Walker ☐ Cane ☐ Crutches ☐ Wheelchair ☐ Other: _____

Activity restrictions? ☐ Yes ☐ No

Dysphagia/Swallowing difficulties? ☐ Yes ☐ No

Is applicant in full control of bladder? ☐ Yes ☐ No

Is applicant in full control of bowels? ☐ Yes ☐ No

Further Information:

Diet

Food Allergies: (Please provide reaction to each food allergy) _____

_____

☐ Regular ☐ Soft ☐ Low-Cal ☐ Low Fat/Low Cholesterol ☐ Salt Restricted ☐ Diabetic

☐ Fluid thickened: Consistency - _____ ☐ Other: _____

Special Instructions: _____

Tuberculosis Status

Note: This section must be completed before admission

Date of Last PPD: _____ Results of Last PPD: _____ _____ mm

If history of positive PPD - CXR: _____ Medication Tx: _____

Immunizations

Date of Administration for the Following Immunizations:

Flu Vaccine: _____ Pneumovax: _____

Diphtheria/Tetanus: _____ Has applicant received complete Dip/Tet series? _____

Hepatitis A: _____ Hepatitis B: _____

Zostavax: _____ COVID-19 Vaccine: _____

Applicant's Last Name _____ First Name _____ M.I. _____ Date of Exam _____

Drug Allergies

Please provide reaction to each allergy:

Medications

Medication	Dosage	Route	Frequency	Diagnosis	ICD10 Code

Please attach additional medication information as needed

Diagnoses

Primary Diagnosis:	ICD10 Code	Onset Date

Please attach additional diagnoses information as needed

Lab Work

Lab work pertinent to current diagnoses:

Prognosis & Therapy Needs (if indicated)

I certify that I examined _____ on _____.

_____ _____

Healthcare Practitioner's signature National Provider Identifier #

_____ _____

Healthcare Practitioner's typed or printed name Street Address

_____ _____ _____ _____

Telephone City State Zip Code