S—GENERAL RELIEF for ASSISTED LIVING CARE

History and Origin of the DSDS General Relief for Assisted Living Care Program
The DSDS General Relief for Assisted Living Care Program began as part of the Alaska Division of Public Assistance GRA program, which pre-dates statehood and was created during a period when federally-funded assistance programs were not as extensive as they are today. 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.

DSS 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: **Teresa Clark, Adult Protective Services, Division of Senior and Disabilities Services at (907) 269-3666 or e-mail at: teresa.clark2@alaska.gov**

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 presented within this section to 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. These forms are available in an "electronic form-fill" format on the DSDS web site at:

www.hss.state.ak.us/dsds/docs/U-GeneralReliefAssistedLivingCare.doc

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

Teresa Clark
Division of Senior and Disabilities Services
Adult Protective Services
3601 C Street, Suite 310
Anchorage, Alaska 99503-5984
fax: (907) 269-3648
e-mail: teresa.clark2@alaska.gov

Division of Senior and Disabilities Services

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

First Name:
Middle Name:
Last Name:
Date of Birth:
Current Age:
Gender:
Marital Status:
Street Address:
City, State and Zip Code:
Phone 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:

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Anchorage, Alaska 99503-5984 • fax: (907) 269-3648 • e-mail: teresa.clark2@alaska.gov

State of Alaska • Department of Health and Social Services
Division of Senior and Disabilities Services
3601 C Street, Suite 310 • Anchorage, Alaska 99503-5984 • (907) 269-3666(800) 478-6065

AUTHORIZATION FOR RELEASE OF INFORMATION

(for enrollment and eligibility uses)

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 attached to 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 payment, enrollment in a health plan and 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: _____ Date: _____

Signature of Legal Representative*: _____ Date: _____

Witness #1 Signature: _____ Date: _____
Witness #1 Printed Name:
_____
Witness #1 Relationship to Client: _____

Witness #2 Signature: _____ Date: _____
Witness #2 Printed Name:
_____
Witness #2 Relationship to Client: _____

**Documentation of status as legal representative is attached, or has been submitted to DSDS at an earlier date.*
(Two witnesses are required if client signs with an X. The Care Coordinator may not serve as a witness.)

Note: This authorization was revoked on: _____ (See attached revocation.)

RECIPIENT INFORMATION: If the information released pertains to alcohol or drug abuse, the confidentiality of this 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 preceding page of this form, be rescinded, effective _____ (*date*). I understand that any action taken on this authorization prior to the rescinded date is legal and binding. I understand that this authorization to release information is required to ensure payment for health care services, enrollment in a health plan, or eligibility for benefits and that payment, enrollment and eligibility may now be seriously affected or denied altogether when this revocation goes into effect.

Signature of Client: _____ Date: _____

Signature of Legal Representative**: _____ Date: _____

Witness #1 Signature: _____ Date: _____
Witness #1 Printed Name:
_____
Witness #1 Relationship to Client: _____

Witness #2 Signature: _____ Date: _____
Witness #2 Printed Name:
_____
Witness #2 Relationship to Client: _____

***Documentation of status as legal representative is attached, or has been submitted to DSDS at an earlier date.*
(Two witnesses are required if client signs with an X. The Care Coordinator may not serve as a witness.)

** If this revocation section has been completed and signed, please note the date of the revocation on the previous page of this form in the space provided.*

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Division of Senior and Disabilities Services

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

First Name:	Age:
Middle Name:	Gender:
Last Name	Height:
Date of Birth:	Weight:

Medication Prescribed	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 of 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:

PHYSICIAN'S RECOMMENDATION:

Physician's Name (please print):
Phone:

Street Address: City, State and Zip Code:

Physician 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.

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TUBERCULIN CLEARANCE

Authority: AS 47.35.00

Client's Full Name (please print): Birthdate:

Date:

TUBERCULIN TEST (check one)
☐ Positive
☐ Negative

Date:

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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CLIENT ACTIVITY REPORT

Client Information

Client Number Assigned by DSDS:
First Name:
Middle Name:
Last Name:
Social Security Number:
Date of Birth:
Age:
Gender:
Race:

☐ **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 CHOICE 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 (name of previous assisted living home):
To (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 (please print): Care Coordination Agency:

Care Coordinator Signature Date

Send this form to:

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General Relief for Assisted Living Care

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:

Send this form to:

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