Department of Family and Community Services
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 $300.00 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 907-465-5732. If you believe a resident is eligible, complete the enclosed four-page form and return it to:

State of Alaska
Department of Family & Community Services
Division of Alaska Pioneer Homes
PO Box 112670
Juneau, AK 99811-2670

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.

Throughout this document, helpful hints are shown in the Comments section. The comments offer additional guidance and clarification to assist in accurately completing the form. Please review them carefully to ensure all sections are filled out correctly.

APPLICATION FOR PAYMENT ASSISTANCE

Name of Pioneer Home: _____

Name of Applicant: _____

Social Security #: _____ Level of Care: _____

AUTHORIZED PERSON INFORMATION

Name of Person Completing Application (if not self): _____

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 Date

(Attach copy of a financial Power of Attorney or other authorizing document if signed by individual other than the applicant)

_____ _____ _____

Name of Witness Signature of Witness Date

APPLICATION FOR PAYMENT ASSISTANCE

Applicant Name:

DOCUMENTS

Any current Pioneer Home resident may apply to the Payment Assistance Program. For those residents who are Level IV and V, proof of Medicaid status must be included. Acceptable evidentiary documentation includes one, or both, of the following:

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

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

Please submit copies of the **3 most current years' Federal Income Tax documentation**. If you have not filed a tax return for any or all of the past three years, please state the reason for each:

_____

APPLICANT'S GROSS MONTHLY INCOME

Please list all below amounts in **gross income** (income before any deductions made) and provide most recent statement or pay stub for each(*).

Social Security* _____

Veteran's Benefits* _____

Pensions/Annuities* _____

Interest or Dividends* _____

Other Income - describe*:

_____ _____

_____ _____

_____ _____

COMMUNITY SPOUSE GROSS MONTHLY INCOME

Does applicant have spouse living independently in the community (not in a care facility)? ◯ Yes ◯ No

If Yes, name of spouse: _____

For a community spouse, please list all below amounts in **gross income** (income before any deductions made) and provide most recent statement or pay stub for each(*).

Social Security* _____

Veteran's Benefits* _____

Pensions/Annuities* _____

Interest or Dividends* _____

Other Income - describe*:

_____ _____

_____ _____

APPLICATION FOR PAYMENT ASSISTANCE

Applicant Name:

Is the applicant's spouse a Pioneer Home resident? ○ Yes ○ No

Does applicant have **Medicare Part A** (hospital insurance): ○ Yes ○ No

Does applicant have **Medicare Part B** (medical insurance): ○ Yes ○ No

Does applicant have **Medicare Part D** (prescription drug coverage): ○ Yes ○ No

Is applicant currently receiving **Medicaid** benefits? ○ Yes ○ No

If Yes, please provide their Medicaid number: _____

Does applicant have supplemental health insurance coverage? ○ Yes ○ No

If Yes, what is the monthly amount they pay? _____

Please include a copy of your most recent premium statement

Name of insurance company: _____

Address of insurance company: _____

Phone number: _____

Account number: _____

Does applicant have **Long Term Care Insurance**? ○ Yes ○ No

If Yes, what is the monthly amount they pay? _____

Please include a copy of your most recent premium statement

Name of insurance company: _____

Address of insurance company: _____

Phone number: _____

Account number: _____

Did applicant receive dividends and/or own shares from corporations established under the **Alaska Native Claims Settlement Act**? ○ Yes ○ No

If yes, please provide corporation name(s) & frequency of distribution:

_____ _____

_____ _____

Did applicant receive an **Alaska Permanent Fund Dividend**? ○ Yes ○ No

Applicant Name:

RESOURCES

As relevant to the applicant, for each of the resources listed in the table below, please provide a corresponding value and description (please include any locations or account numbers as applicable).

Resources	Value	Description (include location/account number)
Cash/Savings/Checking *Copy 3 months of bank statements*		
Stocks/Investments *Copy most recent statement*		
Car: Primary*		
Car(s): Additional		
Boat/Plane		
Jewelry/Artwork		
Home (including Land): Primary* *Copy most recent statement*		
Other Real Estate *Copy most recent statement*		
Insurance: Life* *Copy most recent statement*		
Insurance: Burial* *Copy most recent statement*		
Insurance: Other* *Copy most recent statement*		
Commercial Fishing Permit		
Livestock/Major Equipment		
Other Resources		

** Value of these items not considered a resource or income for the purposes of determining eligibility for Payment Assistance Program*

Is Primary Home occupied by spouse or dependent? ◯ Yes ◯ No

Total Resource Value: _____

Applicant Name:

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).*

Resources Description	Date of Disposition	Disposal Method	Value at time of Disposal

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