



Department of Health and Social Services
Division of Alaska Pioneer Homes
Waitlist Transfer / Change Request

P.O. Box 110690
Juneau, AK 99811-0690
Ph: 907.465.4416/888.355.3117
Fax: 907.465.4108

Last Name, First Name, MI		Date of Birth	
Preferred Mailing Address		Preferred Contact Phone Number	
		Preferred Email Address	
☐ Applicant Primary Point of Contact: ☐ Power of Attorney (Name/Ph#): _____ ☐ Other (Name/Relationship/Ph#): _____			
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. <u>Only rank those that applicant is willing to live in.</u> _____ 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 of the Alaska Pioneer Homes. 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



Department of Health and Social Services
Division of Alaska Pioneer Homes
Certificate of Need

P.O. Box 110690
Juneau, AK 99811-0690
Toll Free: 888.355.3117
Main: 907.465.4416
Fax: 907.465.4108

Applying to the Active waiting list for the Alaska Pioneer Home means that you are prepared to enter a home within 30 days of having an offer of admission made to you.

To be placed on the Active waiting list 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.

This Certificate, along with a History & Physical Medical Examination report must be on file to be placed on the Active waiting list

Please check the box which best describes your situation in each area listed below:

Type	I Need Assistance					Extent of Assistance		
	Never	Occasionally	Often	Always		Limited	Moderate	Substantial
Bathing								
Dressing								
Grooming								
Brushing Teeth								
Toileting								
Eating								
Moving About								
In/Out of Bed								
Taking Medications								
shopping								
Housekeeping								
Meal Preparation								
Remembering								
Feeling Safe								
Other								

DO YOU USE:

Walker Cane Crutches Wheelchair Other

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

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

HISTORY AND PHYSICAL REPORT

PO Box 112670, Juneau, AK 99811 | Ph: 888-355-3117 / 907-465-4416 | Fax: 907-465-4108



For Active Applications & Active Transfers Only

_____ Last Name	_____ First Name	_____ Middle Initial	_____ Telephone Number
_____ Mailing Address	_____ City	_____ State	_____ Zip
_____ Date of Birth	_____ Age	_____ Height	_____ Weight

Medical History:

Surgical History:

Allergies (provide reactions to each):

Family History:

Applicant's Last Name

First Name

M.I.

Date of Exam

Social History:

Alcohol Use: ☐ Yes ☐ No Further Information:

Tobacco Use: ☐ Yes ☐ No

Other Drugs: ☐ Yes ☐ No

Physical Examination

Blood Pressure

Temperature

Pulse

Respiration

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

B. Head and Neck: _____

C. Nose and Throat: _____

D. Dental: _____

E. Lungs: _____

F. Cardiovascular: _____

G. Abdomen: _____

H. Genitourinary: _____

I. Lymph: _____

J. Endocrine: _____

K. Musculoskeletal: _____

L. Skin/Wound Care: _____

M. Psychiatric

Orientation: ☐ A + O x 3 ☐ Occasionally Disoriented ☐ Disoriented

Mood: _____

Cognition: _____

Short-Term
Memory: _____

Applicant's Last Name

First Name

M.I.

Date of Exam

N. Behavior: (Check all that apply)

- ☐ Appropriate ☐ Inappropriate, Aggressive ☐ Inappropriate, Assaultive ☐ Inappropriate, Passive
- ☐ Inappropriate, suicidal, or otherwise dangerous to self or others ☐ At risk of causing harm to self or others ☐ Wandering, Requires safeguards

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

O. Neurological

Cranial Nerves: _____

Motor Reflexes: _____

Sensory: _____

Coordination: _____

Vision: _____

Impairment/Devices: ☐ Yes ☐ No

Hearing: _____

Impairment/Devices: ☐ Yes ☐ No

Diet

- ☐ Regular ☐ Soft ☐ Low-Cal ☐ Low Fat/Low Cholesterol ☐ Salt Restricted ☐ Diabetic
- ☐ Fluid thickened: Consistency - _____ ☐ Other: _____

Special Instructions:

Applicant's Last Name

First Name

M.I.

Date of Exam

Activities of Daily Living

	Frequency of Assistance Needed				Extent of Assistance Needed			
	Never	Occasional	Often	Always	None	Minimum	Moderate	Always
Bathing								
Dressing								
Grooming								
Oral Hygiene								
Toileting								
Eating								
Ambulation								
In/Out of Bed								
Taking Medication								
Walking Up / Down Stairs								

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

Activity restrictions? ☐ Yes ☐ No

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

Dysphagia/Swallowing difficulties? ☐ Yes ☐ No

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

Further information:

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: _____

COVID-19: _____

RSV: _____

Shingles: _____

Pneumonia: _____

HPV: _____

Tdap: _____

Hepatitis A: _____

Hepatitis B: _____

Meningitis: _____

MMR: _____

Other: _____

Medications

Name	Dosage	Route	Frequency	Diagnosis	ICD10 Code

Please attach additional medication information as needed.

Diagnoses

Primary Diagnosis:	Onset Date	ICD10 Code
Secondary Diagnoses:		

Please attach additional diagnoses information as needed.

Applicant's Last Name

First Name

M.I.

Date of Exam

Code Status

☐ Hospice (End of Life Care) Further information:

☐ DNR

☐ Comfort One

Lab Work

Lab work pertinent to current diagnoses:

Prognosis

Rehabilitation/Therapy Needs

Is a therapy regimen necessary to maintain or increase patient function, mobility, or independence? ☐ Yes ☐ No

Describe:

Certification

I certify that I examined _____ on _____
First Name Applicant's Last Name Date of Exam

Healthcare Practitioner's signature

National Provider Identifier #

Mailing Address

Healthcare Practitioner's printed name

Phone

City

State

Zip