Homer Senior Citizens, Inc.

3935 Svedlund Street
Homer, Alaska 99603
(907) 235-7655 Fax: (907) 235-3739

Greetings!

Attached please find additional information from the application for Homer Senior Citizens, Inc.'s (HSC) assisted living facility, The Terrace.

Please complete, sign, date, and return. Incomplete applications will not be put on the waitlist.

Step One: To begin the process for determining eligibility for yourself or a family member, please completely fill out and return the following forms as soon as possible.

1. Rental Application
2. Services Contact Information
3. Consent for Release of Medical Records
4. **Medical History (to be completed by a Physician)**
5. **HIPAA/Privacy Disclosure**
6. **State background check completed, signed and returned** with $20 **check made out to Sate of Alaska**
7. Enclose Nurse assessment fee of $75 Please make check out to Homer Senior Citizens
8. Copy of ID and/or birth certificate
9. Copy of insurance card(s)
10. Copy of POA and/or Guardianship
11. Copy of Comfort One/Advance Directive/Living Will
12. Copy of Vaccination documentation – COVID-19
13. Admission Criteria Policy
14. Confidentiality of Information Policy
15. House rules
16. Resident Fund Account
17. Wait List Policy

Step Two: After the application packet is returned, you will be contacted for scheduling an assessment by our RN Manager.

Step Three: Once determined to be eligible for residency at The Terrace, a rental and service packet will be prepared for you. ***All paperwork and initial fees must be completed prior to residency.***

Thank you for your interest in The Terrace.

Rosalyn Rose Administrative Assistant- Housing

HSC Fee Details

Board of Director Approved Fees/Charges Approved 7-19-2023

Terrace Assisted Living Rent and Service Fees	Last Increase	Current Rate
Terrace Services Day Rate Aligns withState of Alaska Medicaid Waiver Rates	7/20/2023	$204.12
Terrace Respite Day Rate Aligns withState of Alaska Medicaid Waiver Rates	7/20/2023	$416.43
Terrace ALF 1 Bdrm	15-Feb-23	$805
Terrace ALF 1 Bdrm - Furnished	15-Feb-23	$895
Meals ($3.76 per meal)	18-Feb	$450
Terrace Community Nursing per Hour	7/21/2021	$24.25
Late Fee per day for Rent/Services after the 1st of the following month	18-Feb	$10
Application Fee/Nurse Assessment	7/20/2022	$75
Emergency Call Pendant Replacement	18-Feb	$160
Emergency Call Pendant Failure to Return	18-Feb	$160
Additional Housekeeping (More than 1 time per week)	18-Feb	$40
Additional Laundry (More than 1 time per week)	18-Feb	$40
Transportation One Way Aligns withState of Alaska Medicaid Waiver Rates	7/20/2023	$21.00
Escort Personal Activities and Appointments (one way) Medicaid Waiver Rate	7/20/2023	$21.00
Wander Band Activation	2010	$100
Wander Band Replacement	2018	$150
Fall Pad Activation	2018	$135
Emergency Call Pendant (Not Receiving Full Assistance) Monthly Rate		$40
Air Tag Activation Proposed to Board of Directors November 15, 2023	2023	$20
Air Tag Replacement Proposed to Board of Directors November 15, 2023	2023	$25
Medication Management (Not Receiving Full Assistance) hourly rate -- Resident must be signed up with local pharmacist for bubble packs. This rate includes prescription changes and additions to packs.	7/20/2022	$50
Special Services, (i.e., moving furniture, hanging pictures, hanging personal curtains, etc.) Minimum 1 hour fee	7/20/2022	$25
Hourly Cleaning Fee		$35
Room Relocation (If not medically necessary)	2017	$250
Key (card or door) Fee	2017	$25
Meal Delivery per meal (not to exceed $150 monthly) Non-Medical	18-Feb	$10
Special Meal Prep per meal (not to exceed $150 monthly) Non-Medical	18-Feb	$10

Update: The attached Rat(harts contain corrected watermarks. (FAQ remains unchanged, as does the message below.

September 16, 2022

SDS E-Alert: Increase in Payment Rates for Home and Community-Based 1915(c) Waiver and State Plan Services

The Division of Senior and Disabilities Services (SDS) has received approval from the Centers for Medicare and Medicaid Services (CMS) for its latest Appendix K amendment, which raises payment rates to providers of home and community-based waiver services by 10% from the FY 22 rate, per the recent legislative appropriation, with a July 1, 2022, retroactive effective date.

The Department of Health has approved extending the 10% rate increase to Title XIX state plan HCBS services (personal care (PCS), 1915(k) Community First Choice (CFC), and long-term services and supports targeted case management services (LTSS-TCM)) while it awaits final approval from CMS on the corresponding state plan amendment. This increase will also be retroactive to July 1, 2022.

The department implemented a temporary 3.9% increase effective July 1, 2022 based on existing regulations allowing for inflationary adjustments as a way to expedite a portion of the SFY23 legislative appropriate to providers. Now that the department has approved the total 10% increase to service rates, the 3.9% temporary inflation increase is transitioning to being part of the total 10% legislative budget increase to rates, retroactive to July 1, 2022. The total 10% increase is in alignment with the department's final approved budget and regulatory framework.

These rates are effective in the Medicaid Management and Information System (MMIS). Please pay attention to Remittance Advice messages issued by Health Care Services for more information on claims submission and processing regarding these new rates. A Frequently Asked Questions document (attached) addresses many of the questions received from providers recently.

As a reminder, the MMIS calculates claim reimbursement using the lowest of rule, per 7AAC 145.020, "...the department will pay a provider for a covered service at the lowest of the (1) specific payment rate established in 7 AAC 105 – 7 AAC 160; (2) provider's billed charges; or (3) provider's lowest charge ...".

The Rate charts that are retroactively effective to July 1, 2022 will soon be posted on the SDS Rates webpage.

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Rental Application

Date of Application___________**Applicant's name** ___________________________

Address: ____

City, State, Zip: ____

Phone Number: ______________________**SSN:** ___________________________

Applicant's Representative/POA: __________________**Phone:** _____________

Address: ____

City, State, Zip: ____

Applicant's Date of Birth: _________________________**Marital Status:** ________

Federal HOME Program – Homer Senior Citizens, Inc. is required to provide under the Federal HOME Program not less than eight (8) units restricted to occupancy for very-low income families (families whose income does not exceed 50% of the area median income) as determined by HUD, adjusted for family size. Applicants who wish to be considered for the restricted (low-income) rental units based on their income check the appropriate box. Do you want to be considered for a HOME unit? Yes ☐ No ☐

If you have checked yes above, your annual income will be compared to the appropriate HUD income units to determine if the household is eligible for restricted (low-income) units under the HOME Program.

If you have checked yes above, are you aware if you are accepted for residence in a HOME unit at The Terrace that it is not mandatory for you to receive any services from our staff? Yes ☐ No ☐

Other resources may be found at: http://www.ahfc.us/senior-support/

Signature ________________________________**Date** ________________

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Services Contact Information

Applicant's Care Coordinator (if applicable): ______________________________

Care Coordinator's Phone Number: ____________ **Fax Number:** ____________

Address: ____

City, State, Zip: ____

Applicant's Physician (if applicable): ______________________________

Physician's Phone Number: ____________________________________

The Applicant or their Representative acknowledges by their signature on this document that:

- ☐ **They have read and understand the attached document entitled "Requirements for Residency".**
- ☐ **They agree to the release of medical records as contained on the attached "Consent for Release of Medical Records."**

Signature: _________________________________ **Date:** ____________

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Consent for Release of Medical Records

Name: ______________________________ **SSN:** ________________

To: ____

Phone: _________________________ **Fax:** ______________________

I hereby request and authorize you to release all information you have pertaining to me as specified below:

INFORMATION:

- ☐ Hospital Records & Discharge Summary
- ☐ Psychological Evaluations
- ☐ Medical Records
- ☐ Psychiatric Evaluations
- ☐ Recent Treatment Plans or Assisted Living Plans (IHP.IPP.IEP. etc.)
- ☐ CHOICE Medicaid Records

Furthermore, I give my permission for RN, Office Manager, Administrative Assistant or Executive Director of Homer Senior Citizens, Inc. Assisted Living Facility or Adult Day Services to pass medical information about me to:

- ☐ Family Members: ______________________________
- ☐ Medical staff in the community involved in my care: ______________________
- ☐ Home Health Nurses: ______________________________
- ☐ Exclusions: ______________________________

____

RESIDENT/PARTICIPANT/REPRESENTATIVE'S SIGNATURE DATE

This consent is subject to revocation in writing at any time. This consent is valid for one year from the date noted herein, unless revoked earlier.

This transmission is intended only for the use of the individual or entity to whom it is addressed and contains information that is protected. If the reader of this message is not the intended recipient, you are hereby notified that any disclosure, distribution or copying of this information is prohibited. If you have received this transmission in error, please notify us immediately by telephone (call collect at the number provided above) and return the original documents to us at the address given above via the US Postal Service. Thank you for your cooperation.

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MEDICAL HISTORY

(MUST BE COMPLETED BY A PHYSICIAN. PLEASE RETURN TO FAX 907-235-0818)

Name: ____________________ **Sex:** M F **Date of Birth:** ____________

Physician Name: ____________ **Clinic:** ________ **Phone** ____________

Diagnoses/Medical conditions:

☐ Seizures	☐ Cancer	☐ CVA	☐ TB
☐ Glaucoma	☐ Lung Condition	☐ Heart	☐ Parkinson's
☐ Cataracts	☐ Diabetes	☐ Bladder	☐ Multiple Sclerosis
☐ High BP	☐ Anemia	☐ Alzheimer's	☐ Prostate
☐ Arthritis	☐ Cerebral Palsy	☐ Osteoporosis	☐ Allergies
☐ Kidney Disease	☐ Incontinent Bowel	☐ Dementia	☐ Arteriosclerosis

Other: ____

Allergies: ____

Mental Condition – describe: ______________________________

Weight____________
Height____________

DNR Request or Comfort One ____________
Please provide copy.

Medications, dosage and time. Include PRN and OTC: (use the back for more space)

____________ ____________ ____________
____________ ____________ ____________
____________ ____________ ____________

TB Test, Chest X-ray or PPD (within the past year): Date Administered:______ Results ________

Diet: ☐ **Regular Diet** ☐ **Modified Diet (explain)** ______________________
____

Physical Limitations ☐ **No** ☐ **Yes Explain:** ______________________
____

PRN Orders: ____
____

Please identify any concerns: ______________________________
____

I certify that this patient does not have a communicable disease in a transferable stage.

Physician Signature ______________________________ **Date** ____________

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Privacy Policy HIPAA Health Care Disclosure Statement

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Typically, your medical information record contains your symptoms, test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical records, serves as a:

- basis for planning your care and treatment.
- means of communication among the many health professionals who contribute to your care.
- legal document describing the care you received; or are receiving.
- means by which you or a third-party payer can verify that services billed are provided.
- a tool in educating health professionals.
- a source of information for public health officials charged with improving the health of the nation.
- a source of data for facility planning and marketing; and
- a tool with which we can assess and continually work to improve the care and services we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy and request a correction if you find an error in its accuracy.
- better understand who, what, when, where, and why others may access your health information.
- make more informed decisions when authorizing disclosure to others.

Although your health record is the physical property of Homer Senior Citizens, Inc. (The Terrace Assisted Living Facility and Adult Day Services) the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522.
- obtain a paper copy of the notice of information practices upon request.
- inspect and copy your health records as provided for in 45 CFR 164.524:
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528.
- request communications of your health information by alternative means or at alternative locations.
- revoke your authorization to use or disclose health information except to the extent that action has already been taken.

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Homer Senior Citizens, Inc. is required to:

- maintain the privacy of your health information.
- provide you with notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- abide by the terms of this notice.
- notify you if we are unable to agree to a requested restriction.
- accommodate reasonable requests you may have to communicate health information by alternatives means or at alternative locations.

Due to the nature of our operations, you should be aware that all care providers and other healthcare practitioners of Homer Senior Citizens, Inc. have access to all our residents' and participants medical information/records.

If this is an issue for you or creates a problem, please discuss it with our care providers, healthcare practitioner, care coordinator or family member, the Terrace Assisted Living Manager (R.N.), or the Adult Day Services Program Manager. It does not mean we will be able to change our mode of operation but a discussion with any of the mentioned care providers could help alleviate any concerns you might have.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. You will be notified by mail at the last address you have provided.

We do not and will not use or disclose your health information without your authorization, except for core health care activities of "treatment", "Payment", and "Health Care Operations" as defined in the Privacy Rule of 45CFR 164:506 or as otherwise described in this notice.

If you believe your privacy rights have been violated, you may file a complaint with the Homer Senior Citizens, Inc. Executive Director, or with the Secretary of Health and Human Services. Generally, a complaint to HHS should be filed within 180 days of the incident you believe violated your rights. Contact Health and Human Services, 200 Independence Ave, SW, Wash, DC 20201, telephone 202/619-0257 or toll free: 877-696-6775.

Applicant Name: ______________________ **Signature:** ______________________

Name of Signer if other than applicant: ______________________

Relationship to Resident/Participant ______________________ **Date:** __________

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REQUIRED BACKGROUND CHECK

Prior to acceptance into The Terrace Assisted Living Facility, each applicant is required to submit a background check through Alaska State Public Safety by contacting the Alaska State Troopers in Anchor Point. This facility has the discretion to deny admission to any person who is currently engaging in or has engaged in during a reasonable time prior to applying for admission, any of the following:

- Drug-related criminal activity.
- Violent criminal activity.
- Other criminal activity that would threaten the health, safety, or right to peaceful enjoyment of the premises by other residents; or
- Other criminal activity that would threaten the health or safety of Homer Senior Citizens, Inc., or any employee, contractor, subcontractor, or agent of Homer Senior Citizens, Inc who is involved in the housing operations.

Homer Senior Citizens Inc has the discretion to determine a period prior to an admission decision during which the applicant must not have engaged in criminal activity that the facility will consider when deciding of eligibility.

In addition, Homer Senior Citizens Inc has the discretion to reconsider an applicant who was previously denied admission due to criminal activity. HSC may admit the person if they are not currently engaged in, and has not been engaged in, the criminal activity described above, during a reasonable period as determined by HSC. HSC must have sufficient evidence submitted by the applicant which includes (1) a certification that states that she or he is not currently engaged in such criminal activity and has not engaged in such criminal activity during the specified period and (2) supporting information from such sources as a probation officer, a landlord, neighbors, social service agency workers or criminal records that were verified by Homer Senior Citizens

Certification that Background Check has been Requested and Submitted

Name of Applicant ______________________________ DOB ____________________

Signature ____________________________________ Date ____________________

STATE OF ALASKA
DEPARTMENT OF PUBLIC SAFETY
REQUEST FOR CRIMINAL JUSTICE INFORMATION
From the Alaska Criminal History Record Repository
Original forms must be submitted to:
Criminal Records and Identification Bureau
5700 E. Tudor Road, Anchorage, AK 99507
Telephone: (907) 269-5767 Fax: (907) 269-5091
Include fee: $20 single copy, $5 each additional copy
Check or money order must be made payable to "State of Alaska"

Type of information being requested (from the record subject): (Choose ONE)

☐ 1. Criminal Justice Information available only to the SUBJECT
- This report includes all criminal charges and dispositions, including any sealed record.
- If the record subject has a sealed record this box MUST be checked ☐

☐ 2. Criminal Justice Information available to ANY PERSON for ANY PURPOSE
- This report includes current/open criminal charges and charges that resulted in conviction, excluding sealed records.

☒ 3. Criminal Justice Information available to an INTERESTED PERSON
- This report includes all criminal charges and dispositions, excluding sealed records

A check or money order payable to the State of Alaska in the amount of $20 must accompany this request. Additional copies, if requested at the time of this request, may be obtained for an additional $5 per copy. State agencies with a Reimbursable Services Agreement (RSA) in place may fax the appropriate forms. All other requests must be submitted via U.S. Postal Service or in person.

Subject Name: ______________________

Maiden/Alias name(s): ______________________

Mailing Address: ______________________

City/State/Zip: ______________________

Alaska Drivers License #: ______________________

Date of Birth: ______________ Sex: ☐ Male ☐ Female Soc Sec No. ______________

Telephone: ______________ Msg: ______________

MAILING ADDRESS TO SEND REPORT:

Name: ______________________

Title: Homer Senior Citizens, Inc.

Mailing Address: 3935 Svedlund
Homer, Alaska 99603

City/State/Zip: ______________________

☒ If you would like the record faxed to you, provide a Fax Number: 907-235-3739

Unsworn Falsification Statement (Your request will not be processed if you do not sign this statement.)
I certify under penalty of unsworn falsification (AS 11.56.210) that the information I am supplying on and with this form is true and correct.

Record Subject's Signature ______________________ Date ______________

Criminal Records and Identification Bureau Use Only	
☐ Fee Payment Type ______	☐ Report Sent to Subject ______
☐ Fee Waiver/Authorization ______	☐ Report Sent to Requester ______
☐ OCA Number ______	☐ R&I Staff Initials ______

Authority:

AS 11.56.210 – Unsworn Falsification

AS 12.62.160 – Release and Use of Criminal Justice Information; fees

AS 12.62.900 – Definitions

13 AAC 68 Article 4 – Dissemination of Criminal Justice Information

13 AAC 68.905 – Definitions

DPS Form 11/16/03

Revised 2/24/04

Revised 4/20/04

Revised 11/18/04

Revised 1/13/05

Revised 6/13/05

Homer Senior Citizens, Inc.

Admission Criteria Policy

Highlights	Policy Statement
	Our facility will admit only those residents whose medical and nursing care needs can be met.

Policy Interpretation and Implementation

Objectives

1. The objectives of our admissions policies are to

   - provide uniform criteria for admitting residents to the facility
   - admit residents who can be cared for adequately by the facility
   - address concerns of residents and families during the admission process
   - review with the resident, and/or his/her representative, the facility's policies and procedures relating to resident rights, resident care, financial obligations, visiting hours, etc. and
   - assure that the facility receives appropriate medical and financial records prior to or upon the resident's admission.

Physician's Admission Orders

2. Prior to, or at the time of admission, a resident admitted from the community must provide the following medical data to HSC to assure that immediate care of the resident can be implemented.

   - current medical findings
   - admitting diagnosis and prognosis
   - physician's orders for immediate care
   - medication orders, including (as necessary) a medical condition or problem associated with each medication
   - physician's certification that the resident is free from communicable, infectious, or contagious diseases (Note: A negative TB skin test report that is current within 1 year prior to admission must be provided to HSC.)
   - type of diet (e.g., regular, mechanical, etc.)
   - routine care orders to maintain or improve the resident's function
   - advance directives (as applicable) others as necessary or appropriate
   - documentation of COVID-19 vaccination
     - or, documentation of physician recommendation against the vaccine due to specific allergy or other medical condition that the individual may have for which vaccination may cause a severe allergic reaction.

Examples of Conditions Capable of Facility Treatment

Examples of Nursing/ Medical Needs HSC will be able to meet

3. Residents will be admitted to this facility if their nursing and medical needs can be met adequately by the facility. Examples of conditions that can be treated adequately in this facility include:

   - Diabetes
   - Dementia
   - two or more level of assistance with ADL's
   - beginning stages of Alzheimer's

Approval for Admission

Approved by Board of Directors December 17, 2014
Revised and Approved by Board of Directors April 19, 2017
Revised and Approved by Board of Directors – January 17, 2018
Approved by Board of Directors – November 20, 2019
Approved by Board of Directors – January 20, 2021
Proposed to Board of Directors – November 15, 2023

Applicability

Responsibility

Review Process

Apartment Dwelling

4. Examples of nursing/medical needs that can be met adequately include:

   - one and two-person transfer
   - post-operative
   - incontinence

5. The acceptance of residents with certain conditions or needs may require authorization or approval by the Assisted Living Manager and/or the Administrator. Variances will be authorized by the Board.

6. **All deposits, fees for services, and Rent must be paid at time of Admission.**

7. Our admission policies apply to all residents admitted to the facility regardless of race, color, creed, national origin, age, gender, religion, handicap, ancestry, marital or veteran status, and/or payment source.

8. The Administrator shall ensure that the resident and the facility follow applicable admission policies.

9. RN Manager ensures Resident/Participant quarterly reviews are completed. Should Resident/Participant improve/decline in health, residents, care coordinator, and/or family representative will participate in a case conference to reevaluate care.

10. Permanently sharing an apartment is very confining due to size. Sharing the apartment with another person shall be restricted to married couples or immediate family.

11. All mattresses and pillows must have plastic zippered dust mite, bed bug and spill proof zippered microfiber mattress protectors.

12. All furniture must be inspected by HSC Maintenance staff prior to moving into the facility.

13. New admissions **may only occur on Tuesday or Wednesday** of the week between the hours of 10:00 a.m. and 2:00 p.m.. The Administrator, the Terrace Manager and the Resident Manager will meet with the resident, the care coordinator, the family or POA within two hours of moving in on the day of admission. This meeting will include a review of the House Rules, Resident Rights, how to contact staff, and welcome them to the facility. A temporary plan of care will be issued to staff after the meeting. This will serve as the plan of care until the formal plan is reviewed after 7 days of admission.

Approved by Board of Directors December 17, 2014
Revised and Approved by Board of Directors April 19, 2017
Revised and Approved by Board of Directors – January 17, 2018
Approved by Board of Directors – November 20, 2019
Approved by Board of Directors – January 20, 2021
Proposed to Board of Directors – November 15, 2023

Homer Senior Citizens, Inc.

Confidentiality of Information Policy

Highlights	Policy Statement
	HSC shall treat all resident/participant information confidentially.
	Policy Interpretation and Implementation
Confidentiality of Information	1. The facility will safeguard all resident/participant records, whether medical, financial, or social in nature, to protect the confidentiality of the information.
Access to Medical Records	2. Access to resident/participant medical records will be limited to the staff and consultants providing services to the resident/participant. (Note: Representatives of state and federal regulatory agencies have access to resident/participant information without the resident/participant's consent.)
Access to Financial Data	3. Only those personnel concerned with the fiscal affairs of the resident/participant will have access to financial data.
Release of Information	4. Release of resident/participant information, including video, audio, or computer stored information, will be handled in a manner to protect resident/participant rights.
Request to Release Information	5. Resident/participant s may initiate a request to release information contained in their records and charts to anyone they wish. Such requests will be honored only upon the receipt of a written, signed, and dated request from the resident/participant or representative (sponsor).
Transfer of Resident/participant to Another Facility	6. Should the resident/participant be transferred to another facility, medical information pertaining to the resident/participant's plan of care, diagnosis, etc. may be released to such facility in accordance with current transfer/discharge regulations with the resident/participant's written permission.

Signature: ____________________ **Date:** ________

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Resident Fund Account

Please choose either Option A or Option B

Option A

I acknowledge there is a shopping program offered through the Activities Program at The Terrace. I authorize Homer Senior Citizens, Inc. to manage my shopping funds directly. I understand that I will assign funds for shopping purposes to the Senior Center, and that I can maintain a maximum monthly balance of $200; private pay resident's balance is left up to the resident. These funds will be put into an interest bearing financial institutional account. I understand that I **will** receive the following monthly:

- Monthly Statement
  - Beginning Balance
  - Interest Earned
  - Expenses (along with the receipts)
  - Balance Remaining

I will provide The Terrace with a shopping list of items I wish to purchase. I will receive and sign the receipt once I have reconciled items purchased.

______Initial indicating initial deposit has been made.

Signature/POA Date

Witness Date

Option B

I acknowledge that there is a shopping program offered through the Activities Program at The Terrace.

I do not authorize Homer Senior Citizens, Inc. to manage my shopping funds directly.

Signature/POA Date

Witness Date

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LIST OF ITEMS YOU WILL NEED TO BRING TO THE TERRACE

Item		Item	
Paper towels		Liquid hand soap	
Toilet paper		Denture soak	
Facial tissues		Denture adhesive	
Garbage bags		Toothpaste / mouthwash	
Dish soap		2 sets of twin sheets	
Dish sponge / cloths		Blankets	
Dish towels		Pillows	
Laundry soap		Laundry basket	
Dryer sheets		Garbage can(s)	
Shampoo / conditioner		Hangers	
Bar soap / gel		Clothing	
Shower curtain		Personal items (ie., photos, books)	
Bath towels		Cleaning supplies	

SUGGESTED FURNITURE:

Item		Item	
Twin Bed		Assorted dishes/glasses/silverware	
2 comfortable chairs		TV (cable provided)	
Small Table a& chairs		Nightstand	
Dresser		Bookshelf	

RESIDENT NAME: ______________________ **DATE:** ____________

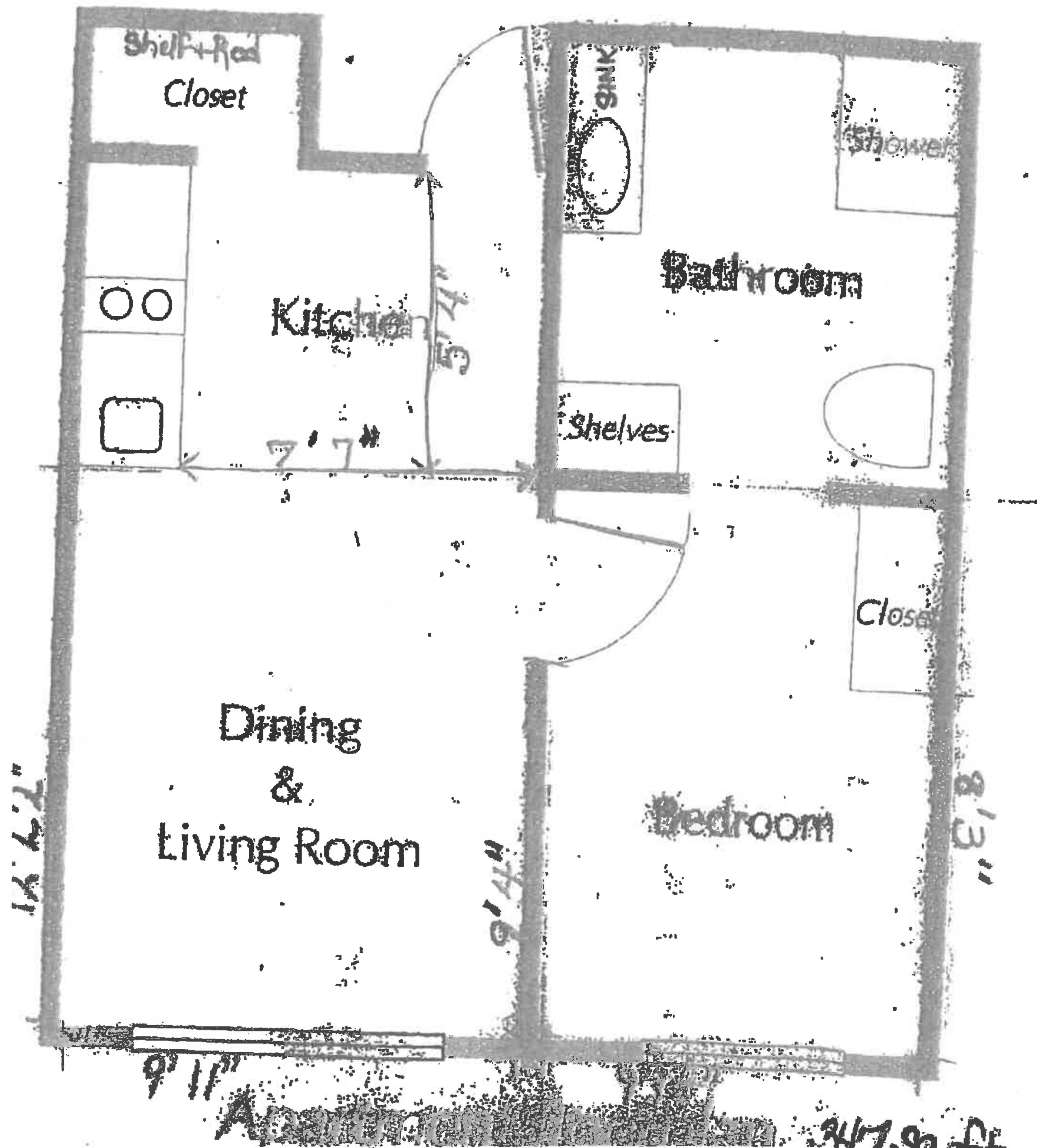
APARTMENT #: ____________

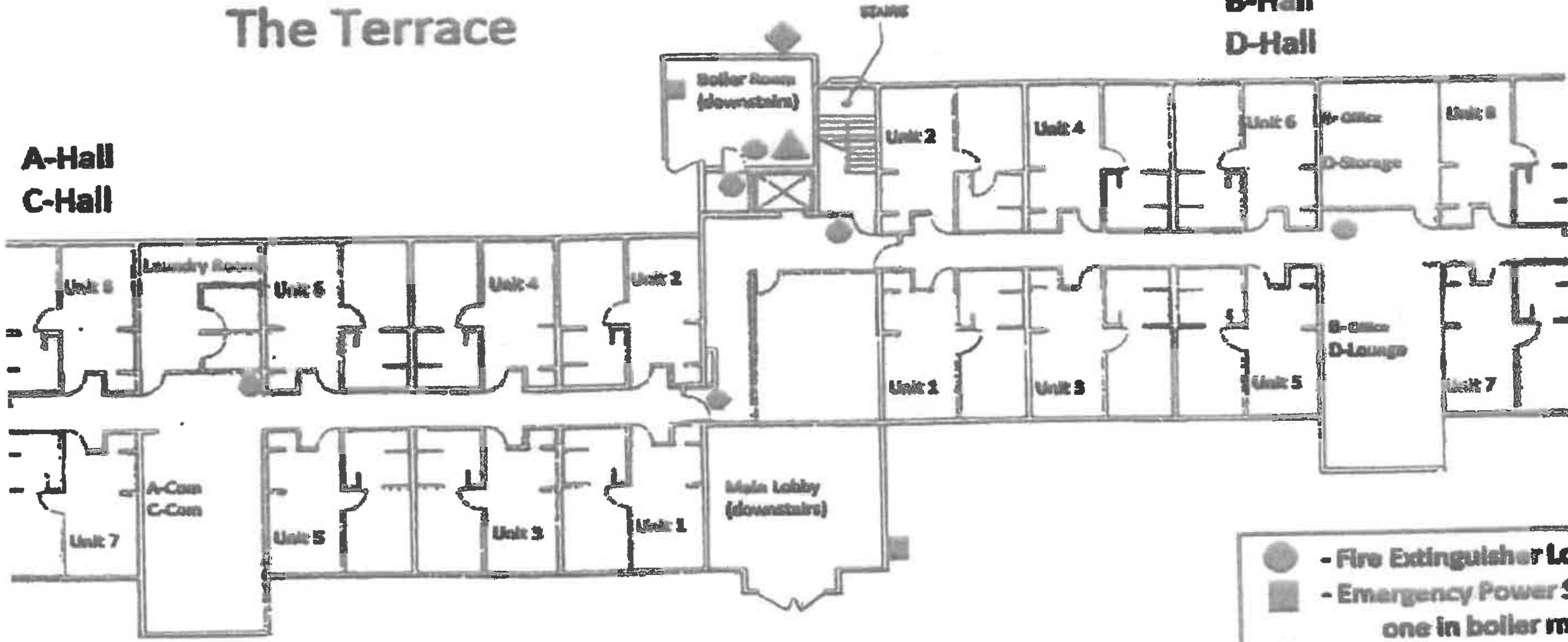
SIGNATURE: ______________________ **DATE:** ____________

Rosalyn Rose - Administrative

Assistant/Housing

Terrace




The Terrace
A-Hall
C-Hall
B-Hall
D-Hall
Boiler Room
(downstairs)
STAIRS
Laundry Room
A-Com
C-Com
Main Lobby
(downstairs)
Unit 1
Unit 2
Unit 3
Unit 4
Unit 5
Unit 6
Unit 7
Unit 8
B-Office
D-Storage
B-Office
D-Lounge
- Fire Extinguisher Lo
- Emergency Power S
one in boiler rm
- Main Water Shutof
-Natural Gas Shutoff

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Locating a Care Coordinator

The first step in applying for the Medicaid waiver (it helps pay for services for those with limited resources) is to be screened by Independent Living Center staff to see if you might qualify. To schedule a screening call (907)235-7911.

After you have passed the screening, you can begin working with a care coordinator.

A care coordinator is the person who works directly with a senior and the family to identify areas of need and to help with filing the paperwork needed to apply for a Medicaid waiver.

Several care coordinators located on the Kenai Peninsula are listed below. This is intended as an information service, not a referral. A more extensive list is included with this packet

Agency	Contact	Phone
• AK Hippie Chic Services	Lee Anne Crafton	907 690-4469
• AKCC	Mary Helman	907 260-1177
• The Agency	Sheryl Baechler	907 235-7084
• Care Coordination	Sean Jones	907 399-3346
Alliance of Homer	Katrina Johnson	907 299-9067
• Care Coordination	Laurie Deakins	907 299-5544
Resource	Julia Lutz	907 299-4540
• Ninilchik Point of Care Coordination	Kathy Wallace	907 252-2508

Other Resources

Resource	Phone
Homer Senior Citizens, Inc.	235-7655
Friendship Center Adult Day Services	235-4556
Hospice of Homer	235-6899
Food Pantry	235-1968
Anchor Point Senior Citizens	235-7786
Handle of Homer Thoughtful Therapies	235-6226
South Peninsula Hospital Home Health Services	235-0369
Independent Living Center	235-7911
Consumer Direct Home Health Services	226-1157
Kenai Peninsula Housing Initiative	235-4357

ALI= Alaskans Living Independently, APDD= Adults with Physical and Developmental Disabilities,
IDD= Intellectual and Developmental Disabilities, CCMC= Children with Complex Medical Conditions

WAIVER SERVICES

Alaska's four Medicaid waivers support the independence of Alaskans who experience physical or developmental disabilities by providing services in their homes and in the community rather than in an institution such as a nursing home. Each waiver covers a different set of services. Which services are available depend on a person's age and where s/he lives.

Services approved for each waiver are marked with a ✔; FT=full time; ALH=assisted living home.

Service	ALI	IDD	APDD	CCMC
*** Care coordination: All waivers require a care coordinator. Your care coordinator will work with you to identify which services you need, and make sure that you get them.	***	***	***	***
[illegible]				
Family habilitation: Help to get, keep or improve self-help and social skills; live FT in the licensed home of a paid caregiver.		✔	✔	✔
[illegible]				
Supported living: Help for ages 18+ to get, keep or improve self-help and social skills; must live FT in your own residence.		✔	✔	✔
[illegible]				
Specialized private duty nursing services: Nursing services for ages 21+ by a licensed nurse, specific to your needs.	✔	✔	✔	
[illegible]				
Adult day services: Group adult day care provided by an organization.	✔		✔	
[illegible]				
Supported employment: Training, support, and supervision to get job skills and to help find and keep a job.		✔	✔	✔
[illegible]				
Environmental modifications: Health- and safety-related home modifications to your own residence.	✔	✔	✔	✔
[illegible]				
Meals: For 18+; Ready to eat meals delivered to your own residence (other than an ALH) or served in a group setting.	✔	✔	✔	✔
[illegible]				
Nursing oversight: A registered nurse who ensures that care of a medical nature is delivered safely.		✔		✔
[illegible]				