



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 State 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



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www.homerseniors.org





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July 24, 2024

Dear Terrace Residents/Friendship Center Participants/POA's/Guardian's/Care Coordinators:

The Department of Health and Human Services have increased their Medicaid Payment rates effective July 1, 2024, to reflect for Inflation and Legislative Adjustments. The Homer Senior Citizens, Inc. (HSC) Board of Directors approved this rate increase on July 17, 2024. This notice will serve as your 30-day notice for a rate increase as required by Alaska State Statute 7AAC 75.29(d). The following will be the new rates charged for assisted living services, respite services, transportation and escort services, and adult day services.

Terrace Assisted Living Daily Rate	\$218.61
Terrace Respite Daily Rate	\$445.99
Transportation One-way	\$22.49
Escort Personal Activities and Appointments (one-way)	\$22.49
ADS Services (4 hours)	\$115.83
ADS 15-minute increments	\$8.07

The effective date for the rate increase is August 23, 2024, for Medicaid Waiver, Private Pay and Insurance.

If you have any questions regarding your invoice, please contact Connie Ball, at 907-235-4552 accounting@homerseniors.com.

If you have any other questions, please let me know.

Thank you,

Connie Ball
Interim Executive Director

cc: Homer Senior Citizens, Inc. Board of Directors
State of Alaska Assisted Living Licensing
State of Alaska Adult Day Services Program Manager



Update: The attached Rate charts contain corrected watermarks. The 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 appropriation 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:** _____





Homer Senior Citizens, Inc.

3935 Svedlund Street
Homer, Alaska 99803
(907) 235-7855 Fax: (907) 235-3739

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 907-235-0016)

Name: _____ Sex: M F Date of Birth: _____

Physician Name: _____ Clinic: _____ Phone: _____

Diagnoses/Medical conditions:

- | | | | |
|---|--|---------------------------------------|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Cancer | <input type="checkbox"/> CVA | <input type="checkbox"/> TB |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Lung Condition | <input type="checkbox"/> Heart | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bladder | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> High BP | <input type="checkbox"/> Anemia | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Incontinent Bowel | <input type="checkbox"/> Dementia | <input type="checkbox"/> 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 Anchorage. 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 _____



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STATE OF ALASKA
DEPARTMENT OF PUBLIC SAFETY
REQUEST FOR CRIMINAL JUSTICE INFORMATION

From the Alaska Criminal History Record Repository

Original form must be submitted to:
Criminal Records and Identification Bureau
6700 E. Tudor Road, Anchorage, AK 99507

Telephone: (907) 269-5767 Fax: (907) 269-5081

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 original 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/Alas name(s): _____
Mailing Address: _____
City/State/Zip: _____
Alaska Driver License #: _____
Date of Birth: _____ Sex: Male Female Soc Sec No. _____
Telephone: _____ Map: _____

MAILING ADDRESS TO SEND REPORT:

Name: _____
Title: Homer Senior Citizens, Inc.
3995 Svalbard
Mailing Address: 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 11.41.210) that the information I am supplying on and with this form is true and correct.

Record Subject's Signature: _____ Date: _____

Request for Criminal Justice Information
Page 2

Criminal Records and Identification Bureau Use Only	
<input type="checkbox"/> Fee Payment Type _____	<input type="checkbox"/> Report Sent to Subject _____
<input type="checkbox"/> Fee Waiver/Authorization _____	<input type="checkbox"/> Report Sent to Requester _____
<input type="checkbox"/> OCA Number _____	<input type="checkbox"/> R&I Staff Initials _____

Authority:

AR 11.06.210 - Unwarn Felatation

AR 12.02.920 - Release and Use of Criminal Justice Information; type

AR 12.02.906 - Definitions

18 AAC 95.0304 - Dissemination of Criminal Justice Information

18 AAC 95.006 - Definitions

DPS Form 1616/00

Revised 2/9/04

Revised 4/20/04

Revised 11/18/04

Revised 1/13/06

Revised 6/13/06



Admission Criteria Policy

Highlights	Policy Statement
	<p>Our facility will admit only those residents whose medical and nursing care needs can be met.</p>
	<p align="center">Policy Interpretation and Implementation</p>
Objectives	<p>1. The objectives of our admissions policies are to</p> <ul style="list-style-type: none"> • 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	<p>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.</p> <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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	<p>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:</p> <ul style="list-style-type: none"> • 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



Homer Senior Citizens, Inc.

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
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Homer Senior Citizens, Inc.

Confidentiality of Information Policy

Highlights	Policy Statement
Confidentiality of Information	HSC shall treat all resident/participant information confidentially.
Access to Medical Records	Policy Interpretation and Implementation
Access to Financial Data	1. The facility will safeguard all resident/participant records, whether medical, financial, or social in nature, to protect the confidentiality of the information.
Release of Information	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.)
Request to Release Information	3. Only those personnel concerned with the fiscal affairs of the resident/participant will have access to financial data.
Transfer of Resident/participant to Another Facility	4. Release of resident/participant information, including video, audio, or computer stored information, will be handled in a manner to protect resident/participant rights.
	5. Resident/participant 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).
	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

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 (la., photos, books)
Bath towels	Cleaning supplies

SUGGESTED FURNITURE:

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

RESIDENT NAME: _____ **DATE:** _____

APARTMENT #: _____

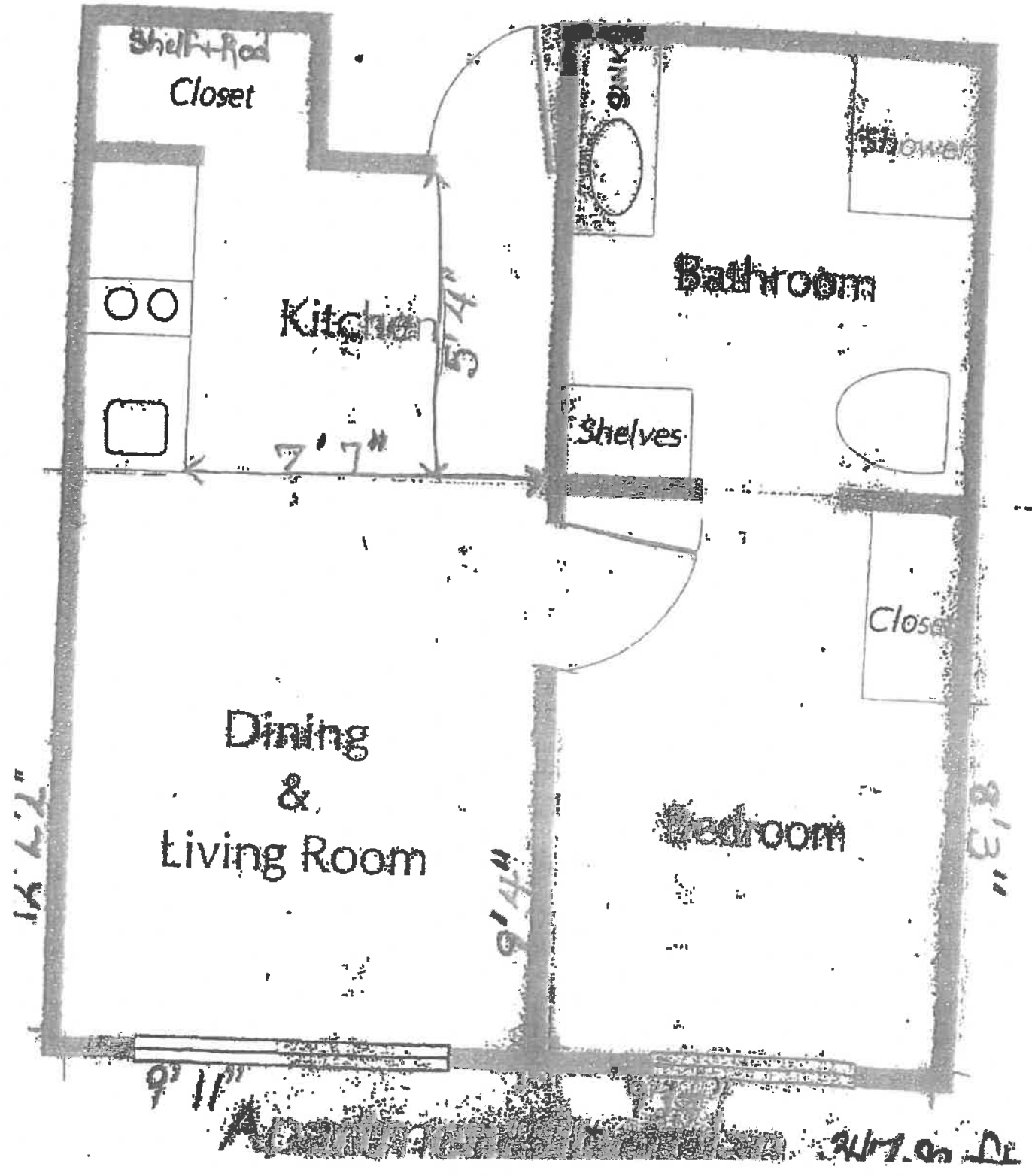
SIGNATURE: _____ **DATE:** _____

Rosalyn Rose - Administrative

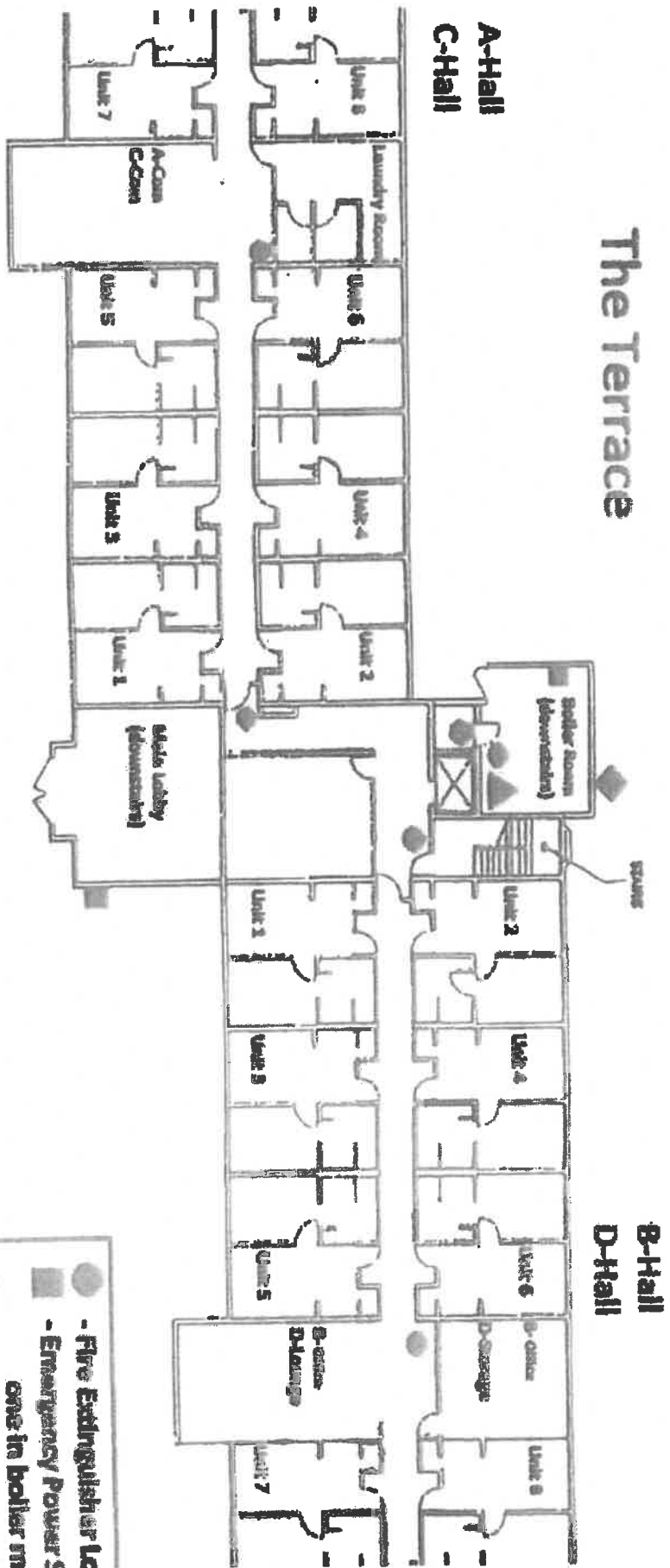
Assistant/Housing



Terrace



The Terrace



- - Fire Extinguisher Location
- - Emergency Power Source
- ▲ - Natural Gas Shutoff
- ◆ - Natural Gas Shutoff

HOMER AREA CARE COORDINATOR LIST

AGENCY NAME	CONTACT	PHONE	EMAIL	ADDRESS
AK Care Coordination Services, LLC	Tara Johnson	907-262-0430 907-252-4661	tarajohnson@akcarecoordinationsservices.onmicrosoft.com	35477 Kenai Spur Highway Suite 217 Kenai, AK 99611
Abacus Care Coordination	Robert Croley	907-351-6910	bob@abacuscarecoordination.com	624 International Airport Rd. Anchorage, AK 99518
Abacus Care Coordination	Amy Smith	907-202-4448	Amy.Smith@abacuscarecoordination.com	Homer and Wasilla
Alaska Community Care	Mary Heiman	907-398-8431	Akcc.mheiman@gmail.com	P.O. Box 2294 Soldotna AK 99669
Alaskan's Caring for Alaskan's Care Coordination Services	Andrea Miller	907-394-4275	aca.carecoordination@gmail.com	51045 Polaris Way Kenai, AK 99611
Kachemak Care Coordination	Katrina White	907-299-9087	katrinawhite5522@gmail.com	Homer, AK 99063
Care Coordination Alliance of Homer	Sean Jones	907-399-3346	ccaoh@outlook.com	Homer, AK 99063
Care Coordination Resource	Laurie Deakins	907-299-5544	lauriedeakins@outlook.com	126 W. Pioneer Avenue Suite 2 P.O. Box 407 Homer, AK 99603
Care Coordination of Alaska	Steven Smith	907-301-0072 Fax 833-409-2220	steve@ccsofalaska.com admin@ccsofalaska.directak.net	ALL,APDD,CCMC,IDD,JSW

HOMER AREA CARE COORDINATOR LIST

Care Solutions and Coordination, LLC	Janelle Weller	907-395-7687	caresolutionsandcoordination@gmail.com	P.O. Box 1601, Kenai, AK 99611
Clarity Care Coordination	Irene Pipkin	907-262-0423		30612 Peanuts Court Soldotna, AK 99669
J-Care Coordination, LLC	Jan Justice	907-262-7001	jjusticecc@outlook.com	585 Trollius Ave Soldotna, AK 99669
Nettie's Care Coordination	Annette Brookshire	907-776-5242	netties@acsalaska.net	51768 Stanga Street Nikiski, AK 99635
Quality Care Coordination	Lane Beauchamps	907-252-5142	laneb@gci.net	Soldotna, AK
Compassionate Care Coordination & Planning	Deb Rafferty	907-252-1938	drafferty.cccp@gmail.com	Kenai, AK
The Agency for Care Coordination	Sheryl Baechler	907-435-7887	theagency@gmail.com	Homer, AK 99063
Starburst Care Coordination	Hollyn Smith	907-399-3633	starburstcare@gmail.com	60530 East End Road Homer, AK 99603
We Care Coordination	Gisselle De La Cruz	907-884-0289	wecarecoordination@gmail.com	P.O. Box 200574 Anchorage, AK 99520
Ninilchik Point of Care Coordination	Kathleen Wallace	907-567-3990	npolodging@gmail.com	Ninilchik AK 99639
Val's Care Coordination, LLC	Valerie Flake	907-398-8835 Fax: 866-496-9997	valerieflake@gmail.com	

HOMER AREA CARE COORDINATOR LIST

ALJ- Adults 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 she lives.

Services approved for each waiver are marked with a ✓. FT=full time; ALJ=assisted living waiver.

Self 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.

Family habilitation: Help to get, keep or improve self-help and social skills; live FT in the licensed home of a paid caregiver.

Supported living: Help for ages 18+ to get, keep or improve self-help and social skills; live FT in your own residence.

Specialized private duty nursing services: Nursing services for ages 21+ by a licensed nurse, specific to your needs.

Adult day services: Group adult day care provided by an organization.

Supported employment: Training, support, and supervision to get job skills and to help find and keep a job.

Environmental modifications: Health- and safety-related home modifications to your own residence.

Meals For 18+: Ready to eat meals delivered to your own residence (other than an ALJ) or served in a group setting.

Nursing oversight: A registered nurse who ensures that care of a medical nurse is delivered safely.

	ALJ	IDD	APDD	CCMC
Self Care coordination	✓	✓	✓	✓
Family habilitation	✓	✓	✓	✓
Supported living	✓	✓	✓	✓
Specialized private duty nursing services	✓	✓	✓	✓
Adult day services	✓	✓	✓	✓
Supported employment	✓	✓	✓	✓
Environmental modifications	✓	✓	✓	✓
Meals For 18+	✓	✓	✓	✓
Specialized nursing	✓	✓	✓	✓
Nursing oversight	✓	✓	✓	✓