

**STATE OF ALASKA
DIVISION OF 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 \$200.00 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) 465-4401. If you believe a resident is eligible, complete the enclosed four-page form and return it to:

State of Alaska
Department of Health & Social Services
Division of Alaska Pioneer Homes
PO Box 110690
Juneau, AK 99811-0690.

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.

ALASKA PIONEER HOME**APPLICATION FOR PAYMENT ASSISTANCE**

NAME OF PIONEER HOME _____

NAME OF APPLICANT _____

Social Security #:	Level of Care:
Name of Person Completing Application:	
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, as a resident applying for Payment Assistance I shall also 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 (*Attach copy of a financial Power of Attorney or other authorizing documentation if signed by other than the applicant*)

Date

Name of Witness
(*Print or Type*)

Signature of Witness

Date

ALL APPLICATIONS REQUIRE A WITNESS SIGNATURE

PIONEER HOME - APPLICATION FOR PAYMENT ASSISTANCE

Name of Applicant _____	Page 1
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If you have filed a Federal Income Tax return in any or all of the past three years please enclose a copy of each return with this form.

If you have not filed a tax return for any of the past three years, please indicate the reason:

Most recent year _____

Year Before _____

Year Before That _____

Is spouse living in the community? Yes _____ No _____

If Yes, Name of Spouse: _____

APPLICANT'S GROSS MONTHLY INCOME

(Income before any deductions are made)

GROSS AMOUNT

Social Security (1)	
Veteran's Benefits (1)	
Pensions/Annuities (1)	
Interest or Dividends (1)	
(list by account source)	
a. _____	
b. _____	
c. _____	
d. _____	
Other Income (describe) (1)	

SPOUSE'S INCOME

(Before deductions are made)

GROSS AMOUNT

(1) Please include a copy of your most recent check stub or statement

****NOTE:** Spousal income information is required to calculate anticipated federal tax liabilities and to determine if the spouse or dependent qualifies for the spousal allowance of up to \$2,000 per month.

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Name of Applicant _____	Page 2
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Is spouse a Pioneer Home resident?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have Medicare Part A ? (Hospital Insurance)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have Medicare Part B ? (Medical Insurance)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have Medicare Part D ? (Prescription Drug Coverage)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you receiving Medicaid benefits?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If Yes, please provide your Medicaid number: _____

Do you have supplemental health insurance coverage?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If Yes, what is the monthly amount you pay?	\$ _____	

(Please include a copy of your most recent premium statement)

Name of insurance company _____
Address of insurance company _____
Phone number _____
Account number _____

Do you have Long Term Care Insurance ?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If Yes, what is the monthly amount you pay?	\$ _____	

(Please include a copy of your most recent premium statement)

Name of insurance company _____
Address of insurance company _____
Phone number _____
Account number _____

Do you receive dividends and/or own shares from corporations established under the Alaska Native Claims Settlement Act ?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, names of the corporations?	_____	
Frequency of distribution?	_____	

Do you receive an Alaska Permanent Fund Dividend ?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Name of Applicant	Page 3
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RESOURCES	<u>Value</u>	<u>Description (Include Location/Account Number)</u>
Cash/Savings/Checking (1)	_____	_____
Stocks/Investments (1)	_____	_____
*Car: Primary	_____	_____
Car(s): Additional	_____	_____
Boat/Plane	_____	_____
Jewelry/Artwork	_____	_____
*Home (Incl.Land): Primary (1)	_____	_____
	Is Home occupied by spouse or dependent? _____	
Other Real Estate (1)	_____	_____
*Insurance: Life (1)	_____	_____
*Insurance: Burial (1)	_____	_____
Insurance: Other (1)	_____	_____
Commercial Fishing Permit	_____	_____
Livestock/Major Equipment	_____	_____
Other Resources	_____	_____

TOTAL RESOURCES

LIABILITIES	<u>Creditor</u>	<u>Monthly Payment</u>	<u>Total Due</u>
Mortgage(s)	_____	_____	_____
Real Estate	_____	_____	_____
Auto Loan(s)	_____	_____	_____
Credit Card(s)	_____	_____	_____
Doctor(s)	_____	_____	_____
Pharmacy	_____	_____	_____
Dept. Store(s)	_____	_____	_____
Loan(s)	_____	_____	_____
Other Liabilities	_____	_____	_____

TOTAL LIABILITIES

* = Value not considered a resource or income for the purposes of determining eligibility for Payment Assistance.

(1) Please include a copy of your most recent statement

Resources & Liabilities
(Rev. 07/25/11)

