



4140 Folker Street
Anchorage, AK 99508
Tel: (907) 261-4140
Fax: (907) 261-4160

Application Packet

Thank you for your interest in Providence Horizon House. This application packet is an information-gathering tool that will help us assess the potential resident's service needs and if we are able to meet those needs. The application consists of 8 pages including this cover page. Incomplete applications will delay the process.

Acceptance into PHH is determined by:

- The current residents' needs.
- The ability of PHH to meet the applicant's needs.
- The availability of an apartment.

If your need for moving in is urgent, continue to follow-up on all other options, as our application review process may not satisfy your immediate needs. If you need community resource information, we are happy to assist.

Please consider the following before proceeding:

- To reside at PHH, one must be at least 55 years old.
- This is a non-smoking campus.
- PHH is a large apartment building with congregate dining. Meals are served in a large dining room. There are no assigned seating arrangements.
- Staff is available 24 hours, 7 days a week to assist residents with personal needs. Skilled nursing is not provided.
- Transportation and coordinator to and from medical appointments is not provided.
- Family and friends are encouraged to participate in the PHH community.
- Pet visits are welcomed at PHH, but may not reside with the resident.
- Ensure your income is sufficient to meet PHH daily rate.
- CHOICE recipients are responsible for room and board at PHH.

All completed applications are kept for future apartment availability. If you have any questions about this packet or the intake process, please contact us at (907) 261-4140.

Sincerely,

Jamie Benard
Director



Horizon House

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Anchorage, AK 99508

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Application

Please complete all areas of this application. Please be as thorough and accurate as possible when filling out this application. An incomplete application will delay the process.

First Name _____ MI _____ Last Name _____

Address _____ City _____ State _____ Zip Code _____

Phone (include area code) _____ Message Phone (include area code): _____

Male Female Marital Status: Married Divorced Single Widow Widower

DOB ____/____/____ Age _____ SSN ____/____/____ Religion _____
(MM) (DD) (YYYY)

Medicare # _____ Medicaid # _____

Personal Insurance Carrier: _____ Policy/Group # _____

Average Monthly Income _____ Other Resources _____

Are you on the Medicaid CHOICE Waiver Program? Yes No

Who is your Care Coordinator? _____ Phone # _____

How did you hear about us? ___ Web Site ___ Radio ___ Family/Friends ___ Newspaper
___ Other (explain) _____

If someone other than the applicant has completed this application, please complete the area below.

Name _____ Relationship _____

Contact Phone Numbers (Work) _____ (Home) _____ (Other) _____

Emergency Contacts *(indicate who is POA)* **A minimum of two contacts is required.**

Name	Address (include zip code)	Telephone(include area code)	Relationship
		(H)	
		(W)	
		(C.)	
		(H)	
		(W)	
		(C.)	

Physician(s)	Phone (include area code)	Fax (include area code)

Medical Diagnosis/Past Surgeries *(type statement accepted - include year if possible)*

Medication(s) *(name ,dosage, and frequency OR attach a list)*

Date of last PPD/Results

Allergies *(medication OR food)* _____

Name of Pharmacy _____

Who delivers supplies (i.e., Oxygen, Incontinence Supplies, Medical Equipment, etc. _____

Advance Directives *Are you able to provide us with a copy?* Yes No

If yes, check appropriate box. **Living Will** **Comfort One** **Durable POA**

Hospital Preference _____ Have funeral arrangements been made? Yes No

If, yes, Name of Funeral Home: _____

Social History

Applicant's Name: _____

Please address the following items in the space provided below. Use the back of this page if more space is needed.

Place of Birth (*City & State*) _____ Education Level _____

No. years in Alaska _____ Place of longest residence _____

Past Occupation(s) _____

Marital Status: Married _____ Divorced _____ Single _____ Widow _____ Widower _____

No. of Marriages _____ Number of children/names _____

Number of siblings/names _____

Reason for seeking Assisted Living _____

Present living situation _____

Issues of discussion that might create anxiety, depression, fear, anger, etc.: _____

Interests and hobbies: _____

Aspirations and goals: _____

Strengths and weakness: _____

SERVICE INFORMATION

Applicant's Name _____

Please check appropriate box:

A. Bathing

- No Assistance
- Prompting and/or supervision
- Partial assistance and/or supervision
- Complete assistance/guidance

Comments: _____

B. Communication

- No difficulties (able to use cord appropriately)
- Minimal difficulties (i.e., cognitively intact aphasia)
- Frequent difficulties
- Unable to verbalize needs

Comments: _____

C. Dressing

- No assistance
- Prompting and/or supervision
- Partial assistance and/or supervision
- Complete assistance/guidance

Comments: _____

D. Incontinence

- Continent
- Minimal assistance/prompting guidance
- Frequent incontinence
- Completely incontinent

Comments: _____

E. Mobility

- No assistance
- Minimal assistance/prompting guidance
- Partial assistance/constant observation and guidance

Comment: _____

F. Cognitive Functioning

- Alert to time and place
- Occasional disorientation to time/place
- Disoriented most of the time/place with defect of memory/loss of personal history
- Disoriented most of the time with deficit

memory loss/inability to follow through on tasks (i.e., dressing, feeding, holding cup, etc.)

Comment: _____

G. Behaviors

- Never combative/no wandering or disruptive behavior/No history of such behavior
- Occasionally combative/occasional wandering or disruptive behavior/history of such behavior
- Frequently combative/frequently wandering/unpredictable behavior/History of Mental Illness
- Night Wandering
- Combative or disruptive behavior during care/Requires occasional meds for behavior/unpredictable behavior changes/wandering
- Above behavior with night wandering

Comments: _____

H. Sensory Loss

- No loss
- Limited vision loss/limited hearing
- Moderate vision loss/moderate hearing

Comments: _____

I. Eating

- No assistance
- Occasional assistance/Reminders to go the dining room
- Frequent assistance/Assist to dining room
- Must be fed

Comments: _____

PRIMARY PHYSICIAN'S REPORT

RESIDENT INFORMATION

Name: _____ DOB _____

Date: PPD _____/Results_____ Flu Shot _____ Pneumovax _____

ALLERGY _____

OTC MEDICATION THIS INDIVIDUAL MAY TAKE AS NEEDED

(Please initial all that apply)

Medication	Initials	Medication	Initials
Acetaminophen	_____	OTC NSAIDs	_____
Antacids	_____	Stool Softeners	_____
Antidiarrheals	_____	Other:	_____
Antihistamines	_____		_____
Aspirin	_____		_____
Cough Syrup (Plain)	_____		_____
Decongestants	_____		_____
Laxatives	_____		_____
	_____		_____

Physician's Signature **Date**

Print Physician's Name **Telephone Number**

Name of Person Preparing Form (if other than Physician)

FINANCIAL INFORMATION

CURRENTLY MONTHLY INCOME

Social Security \$ _____

Supplemental Security \$ _____

Retirement (Pensions, IRA, CSA, etc.) \$ _____

AK Longevity Bonus \$ _____

Other _____ \$ _____

Source of Retirement and/ or other Income: _____

ASSETS

Name of Bank _____

Address _____

Checking Account Number _____ Amt In Checking \$ _____

Checking Account Number _____ Amt in Checking \$ _____

Savings Account Number _____ Amt in Savings \$ _____

Savings Account Number _____ Amt in Savings \$ _____

Stocks/Bonds/Certificates of Deposit:

Name _____ Company _____

Number of Shares _____ Value \$ _____

Name _____ Company _____

Number of Shares _____ Value \$ _____

Name _____ Company _____

Number of Shares _____ Value \$ _____

Real Estate - Legal Description

1. Lot and Block Value \$ _____ Mortgage Amt \$ _____

2. Lot and Block Value \$ _____ Mortgage Amt \$ _____

Life Insurance

Company _____ Policy Number _____ Amount

\$ _____ Cash Value \$ _____

Vehicle (Include ATVs, Boats, etc)

Owner _____ Make/Model _____

() Own () Loan Amount \$ _____

Owner _____ Make/Model _____

() Own () Loan Amount \$ _____