ARIZONA PIONEERS' HOME

Application for Admission

THE MISSION OF THE ARIZONA PIONEERS' HOME IS TO PROVIDE A HOME FOR ARIZONA PIONEERS AND DISABLED MINERS THAT DELIVERS THE OPTIMAL PHYSICAL, EMOTIONAL, AND SPIRITUAL CARE IN A HOMELIKE AND COMPASSIONATE ENVIRONMENT. QUALITY CARE IS PROVIDED IN A PROFESSIONAL MANNER, PROTECTING DIGNITY AND HONORING THE PERSONAL DIRECTIVES OF EACH RESIDENT, WHILE CONSIDERING THE UNIQUENESS OF EACH INDIVIDUAL

300 S McCormick St. Prescott, AZ 86303

Main: (928) 445-2181 FAX (928) 778-1148

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Welcome!

Hello, and thank you for your interest in the Arizona Pioneers' Home! If you have not already received and/or completed the Qualifying Documents packet, please call our Administrative Services office at 928-277-2721.

You are now reading the Application for Admission. There are five sections, and they include:

1. Medical Record Requests
2. Required Healthcare Provider Documents
3. Healthcare and Financial Directives
4. Additional Required Documents
5. Consumer Report

On the following page is a checklist so you can keep track of what you've accomplished!

If you have any questions, please do not hesitate to call our Administrative Services Office at 928-277-2721

Application Checklist

- Medical Record Requests
  - ☐ Authorization to Disclose HIPAA Protected Health Information
  - ☐ Medical Provider List

- Required Healthcare Provider Documents
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  - ☐ History and Physical
  - ☐ Pre-Admission Eye Examination Form
  - ☐ Pre-Admission Dental Examination Form
  - ☐ TB Test Results

- Healthcare and Financial Directives
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  - ☐ Mental Health Power of Attorney
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  - ☐ DNR or Full Code

- Additional Required Documents
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  - ☐ U.S. Citizenship Form
  - ☐ Primary Care Physician Form
  - ☐ Health Insurance Form
  - ☐ Mortuary Selection Form
  - ☐ Rules Form
  - ☐ Acknowledgements Form
  - ☐ Don't forget front and back copies of:
    - Current Arizona Driver's License or State ID
    - Social Security card
    - Medicare card
    - Veteran's Affairs ID (if applicable)
    - AHCCCS card (if applicable)
    - *Supplemental insurance card AND Medicare Part D prescription card*
    - *Advantage Plan insurance card*

- Consumer Report
  - ☐ Notice of Intent to Obtain a Consumer Report
  - ☐ Disclosure Regarding Background Investigation
  - ☐ Acknowledgement and Authorization for Background Check

1
Medical Record Requests

Before we can offer an Interview, we will need the applicant's most recent two years of medical records. If you turn in the Authorization for Disclosure of Health Information and the Medical Provider List right away, our staff can start requesting medical records that may take some time to receive.

On the Authorization to Disclose HIPAA Protected Health Information form (page 5), please only fill in the applicant's name and date of birth – then fill out the boxes at the bottom of page 6 with the printed name of who is signing, their signature, their relation to the applicant and the date. (Please remember only the applicant and their power of attorney (resident representative) can sign). The rest of the form needs to be blank so the Arizona Pioneers' Home can use it to request medical records for the last two years from multiple doctors as part of your admission process. In addition, staff will then put the blank copy in your chart at the Arizona Pioneers' Home so when our Nursing Department needs records, they will be able to request them as necessary to treat you.

Authorization to Disclose HIPAA Protected Health Information

PATIENT NAME (PLEASE PRINT)	DATE OF BIRTH

I authorize the following individual or organization to make the disclosure of the above-named individual's HIPAA protected health information to the Arizona Pioneers' Home, for the reason listed above.

NAME		PHONE
ADDRESS		
CITY	STATE	ZIP

PURPOSE FOR DISCLOSURE:

- ☐ Admission
- ☐ Coordination of continued care
- ☐ Communication between medical providers regarding treatment

DATE OF REQUEST

The type and amount of information to be used or disclosed is as follows:

- ☐ Complete health records
- ☐ Physical exam
- ☐ Immunization record
- ☐ Lab results/x-ray reports
- ☐ Consultation reports
- ☐ Other (please specify): _____

Send health information to:	
Arizona Pioneers' Home 300 S. McCormick St Prescott, Arizona, 86303	Attention:
	E-mail:
	Fax: 928-778-1148

Authorization to Disclose HIPAA Protected Health Information

PATIENT NAME (PLEASE PRINT)	DATE OF BIRTH

By signing this Authorization, I understand that:

- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

- I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

- I understand that uses and disclosures already made based upon my original permission cannot be taken back.

- I understand that it is possible that information used or disclosed with my permission may be redisclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

- I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

- I may revoke this authorization at any time.

- I understand the Arizona Pioneers' Home cannot evaluate my qualifications for residency without the authority to request my medical records.

I hereby consent to the release of all of my medical records EXCEPT information protected by state/federal law for the following dates of service _____.

This authorization is effective until I am either deemed unqualified for residency of the Arizona Pioneers' Home or until I discharge from the Arizona Pioneers' Home by either death or discharge.

SIGNATURE OF PATIENT OR LEGALLY AUTHORITZED REPRESENTATIVE	DATE
NAME OF PERSON SIGNING (PLEASE PRINT)	RELATIONSHIP TO PATIENT

MEDICAL PROVIDER LIST

Please provide the following information for each provider you have seen in the last two years.
This includes primary care visits, specialists, hospital stays and emergency room visits.

Resident's Name: _____ Date of Birth: _____

Primary Care Physician: _____
Address: _____
Work phone: _____ Fax Number: _____

Dentist: _____
Address: _____
Work phone: _____ Fax Number: _____

Eye Doctor: _____
Address: _____
Work phone: _____ Fax Number: _____

Other: _____Specialty: _____
Address: _____
Work phone: _____ Fax Number: _____

Other: _____Specialty: _____
Address: _____
Work phone: _____ Fax Number: _____

Other: _____Specialty: _____
Address: _____
Work phone: _____ Fax Number: _____

Other: _____Specialty: _____
Address: _____
Work phone: _____ Fax Number: _____

Other: _____Specialty: _____
Address: _____
Work phone: _____ Fax Number: _____

Other: _____Specialty: _____
Address: _____
Work phone: _____ Fax Number: _____

*Please ask for another copy of this page if you have more providers to list.

2
Required Healthcare Provider Documents

TO BE COMPLETED BY THE LICENSED PRIMARY MEDICAL PHYSICIAN

The applicant will need an appointment with his/her licensed primary medical provider, to have the following filled out by the medical provider and returned with the application.

Please note: The 90-Day Determination form and all three pages of the History and Physical form must be filled out by hand, by the medical provider. If the provider writes, "See attached" and attaches medical records, we will have to send you back to the provider to have the form re-done.

Please take the following to your appointment with your primary medical provider.

- ☐ Letter to your licensed primary medical provider (Page 11)
- ☐ 90 Day Determination (Page 12)
- ☐ History & Physical (Pages 13-15)

At this time, you will also need to schedule an eye exam, and a dental exam (even if you have dentures). The following are Arizona Pioneers' Home forms that must be filled out by the medical provider and returned:

- ☐ Pre-Admission Eye Examination (Page 16)
- ☐ Pre-Admission Dental Examination (Page 17)

TB TEST

AUTHORITY: Arizona Administrative Code, R9-10-113

Before admission you are required to provide The Arizona Pioneers' Home evidence of freedom from active tuberculosis. Documentation must be from a licensed health care provider in the form of a tuberculin (TB) test or chest x-ray that is no older than 12 months. The documentation must state "Freedom from active tuberculosis" or words to that effect.

If you do not have TB documentation from the last 12 months, please have a TB test done at your medical providers office and turn the results in with this application.

Dental Expenses

- Costs incurred from dental treatment will be shared 50/50 by the Arizona Pioneers' Home resident and the Arizona Pioneers' Home. However, any pre-existing issues will be the sole responsibility of the resident and the Arizona Pioneers' Home will not share in any of those costs.
- The Arizona Pioneers' Home will pay half of each dental bill, not related to a pre-existing issue, until the $1,000 lifetime maximum is reached. Once the balance has been reached all future costs incurred will be the resident's sole responsibility.

Eye Exams & Glasses

- Costs for eye care:
  - Will be shared 50/50 by the Arizona Pioneers' Home and the resident.
  - Refraction is covered 100% by the Pioneers Home.
  - Frames and lenses are covered up to $150.00, which is the maximum Arizona Pioneers' Home will pay per calendar year.
- The Pioneers' Home will assume responsibility to pay its share for new glasses (frames and lenses), when there is a change in vision or broken, but will not share in the cost when glasses are lost or simply out of style.

Arizona Pioneers' Home

Katie Hobbs
Governor

300 South McCormick Street
Prescott, Arizona 86303
Phone (928) 445-2181 Fax (928) 778-1148

Jessica Sullivan
Superintendent

Dear Primary Medical Provider,

_____ is applying for residency at the Arizona Pioneers' Home. As part of the Application for Admission, there are four (4) pages which need to be filled out by their licensed Primary Medical Provider: the 90 Day Determination form and the History and Physical form.

Our staff requests that the provider takes the time to fill out the History and Physical by hand. We encourage attached medical records to be returned with the completed form. However, we are not allowed to accept the form with attached medical records and the words "See Attached" written in lieu of filling out the form.

Also, the applicant is required to provide the Arizona Pioneers' Home "Evidence of Freedom from Active Tuberculosis". The documentation must be from a licensed health care provider in the form of a tuberculin (TB) test or chest x-ray that is no older than 12 months. The documentation must state "Freedom from Active Tuberculosis" or words to that effect.

If the applicant does not have TB documentation from the last 12 months, we request that your office provide this test and return the results with the 90-Day Determination and the History and Physical.

We understand your time is valuable and we appreciate the time and effort it will take to comply with our request. If you have any questions, please call our Administrative Services office for more information.

Sincerely,

Linda Meyer
Administrative Services
Arizona Pioneers' Home
Desk: 928-277-2721
Fax: 928-778-1148
Linda.Meyer@aph,az,gov

ARIZONA PIONEERS' HOME

90-DAY DETERMINATION: LEVEL OF HEALTH CARE EVALUATION

APPLICANT'S NAME: _____ DOB: _____

The above-named individual is applying for residency at the Arizona Pioneers' Home. ***The Arizona Administrative Code section R9-10-807 requires that they submit documentation of determination of their level of care that is dated within 90 calendar days before they are accepted by an assisted living facility.***

Please make the following determinations regarding the level of care that the above listed applicant currently requires.

1. Level of care currently required - check which **ONE** applies.

   □ **Supervisory care services**: means general supervision, including daily awareness of resident functioning and continuing needs, the ability to intervene in a crisis and assistance in self-administering prescribed medications.

   □ **Personal care services**: means assistance with activities of daily living that can be performed by persons without professional skills or professional training and includes the coordination or provision of intermittent nursing services and the administration of medications and treatments by a nurse who is licensed pursuant to title 32, chapter 15 or as otherwise provided by law.

   □ **Directed care services**: means programs and services, including supervisory and personal care services, that are provided to persons who are incapable of recognizing danger, summoning assistance, expressing need or making basic care decisions.

2. Does the individual require?

   □ Continuous medical or nursing services: skilled or intermediate nursing care
   □ Continuous behavioral health services: behaviors that require skilled attention
   □ Bedrails
   □ Restraints
   □ None of the above

_____ _____

LICENSED MEDICAL PROVIDER'S PRINTED NAME AND CREDENTIALS DATE

_____

LICENSED MEDICAL PROVIDER'S SIGNATURE

APH HISTORY AND PHYSICAL Name: DOB:

Chief Complaint: _____

DIAGNOSES			

PAST SURGICAL HISTORY			

FAMILY HISTORY	
Mother:	
Father:	
Other:	

SPECIALISTS	
Provider Name	*Specialty*

Continent of Bowel: Yes _____ No _____

Continent of Bladder: Yes _____ No _____

Social Hx: Tobacco: *Current?* Yes _____ No _____ *Former?* Yes_____ No _____

Alcohol: _____ Caffeine: _____ Drug use: _____

Marital status: _____ **Advanced directives**: _____ **Code Status**: _____ **Assistive devices**: _____

IMMUNIZATION DATES	Date Rvcd:	Date Rvcd:
Pneumonia Vaccines: PSV23:		
Pneumonia Vaccines: PSV13:		
RSV Vaccine:		
Influenza Vaccine:		
Tetanus Vaccine:		
Shingles Vaccine:		
Negative TB test date:		
OR- TB questionnaire date (for past + PPD):		
COVID Vaccine 1st Dose		
COVID Vaccine 2nd Dose:		
COVID Vaccine Booster(s):		

REVIEW of SYMPTOMS	
General:	
HEENT:	
PULM:	
CARDIAC:	
GI:	
GU:	
Musculoskeletal:	
Neuro:	
Psychological:	
Endocrine:	
Integument:	

APH HISTORY AND PHYSICAL **Name**: **DOB:**

ALLERGIES			

Vital Signs: _____T:_____ P:_____ R:_____ B/P: _____ O2 Sat (RA or LPM?) _____
Current Weight:_____ Weight 1 year ago: ____ Height: _____

PHYSICAL FINDINGS	
Head/Neck:	
Chest/Breast/Lungs:	
Cardio-Vascular:	
Abdomen/Genito-urinary/Rectal:	
Skin:	
Musculoskeletal	
Neuro:	

INVESTIGATION		
LABS:	Radiology:	
	Mammo:	
	Colon Screen:	
	Other:	
	EKG:	

DIAGNOSIS			

PLAN/RECOMMENDATION

Current Medication list

Include ALL meds including over the counter medications, "as needed" medications, and any topical creams/ointments, etc. (if you need more room, please add an additional page)

MEDICATION	DOSE	FREQUENCY	DIAGNOSIS

RESIDENT NAME: _____

DATE OF BIRTH: _____

Printed Name of Physician (Include credentials): _____

Physician Signature: _____ **Date: _____**

ARIZONA PIONEERS' HOME

PRE-ADMISSION EYE EXAMINATION FORM

Patient Name: _____ DOB: _____ Exam Date: _____

To Be Completed by Examining Doctor

Ocular history: ☐ Normal ☐ or positive for _____

Examination	Distance			Near
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? ☐ Yes ☐ No

	Normal	Abnormal	Not Assessed
External exam (lids, lashes, cornea, etc.)			
Internal exam (vitreous, lens, fundus, etc.)			
Pupillary reflex (pupils)			
Binocular Function (stereopsis)			
Accommodation and vergence			
Color vision			
Glaucoma evaluation			
Oculomotor assessment			
Other Diagnosis:			

Diagnosis:	☐ Normal	☐ Myopia	☐ Hyperopia	☐ Astigmatism	☐ Strabismus	☐ Amblyop

Does the patient currently wear prescription glasses?	☐ Yes	☐ No
If YES – Are frames and lenses in good condition?	☐ Yes	☐ No
If YES – Is prescription in the lenses adequate?	☐ Yes	☐ No
If NO – Does patient need prescription glasses?	☐ Yes	☐ No

Physician Comments: _____

_____

_____

Physician Name: _____ Physician Signature: _____

Address/Phone: _____

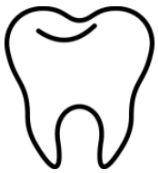
To Be Completed by Resident/Applicant

I understand the above conditions are pre-existing prior to my admission to the Arizona Pioneers' Home. I agree that the Arizona Pioneers' Home is not financially responsible for any procedures to correct these conditions.

Signature of Resident/Resident's Representative _____ Date _____

ARIZONA PIONEERS' HOME

PRE-ADMISSION DENTAL EXAMINATION FORM



Patient Name: _____DOB: _____ Exam Date: _____

To Be Completed by Examining Doctor

The purpose of this form is to identify pre-existing dental conditions for the above applicant which are determined to be imminently in need of treatment.

Tooth #'s Involved	Type of Appliance	Condition	Treatment Plan

Document all dental treatment being recommended at this time (please use back of paper if needed).

Tooth #'s Involved	Describe Problem	Treatment Recommended

Other dental treatment recommendations: _____

_____

Dentist Name: _____Date: _____

Address: _____ Phone: _____

Dentist Signature: _____

To Be Completed by Resident/Applicant

I understand the above conditions are pre-existing prior to my admission to the Arizona Pioneers' Home. I agree that the Arizona Pioneers' Home is not financially responsible for any procedures to correct these conditions.

Signature of Resident/Resident's Representative: _____ *Date:* _____

3
Healthcare and Financial Directives

GREETINGS

This section pertains to all future residents at the Arizona Pioneers' Home; Pioneers and Miners alike. It is the policy of the Arizona Pioneers' Home that all residents must have a Resident Representative and have healthcare and financial directives on file. The policies in their entirety are on the next two pages of this section.

The specific directives the Home requires are:

- Healthcare Power of Attorney
- Mental Health Care Power of Attorney
- Financial Power of Attorney
- Living Will
- Pre-Hospital Medical Care Directive: Either a DNR (Do Not Resuscitate) or a FULL Code

There are two possibilities regarding whether or not you need to fill out the above-mentioned paperwork.

- You took care of this matter in the past and currently have the above documents completed, signed and witnessed (or notarized).
  - If this is the case, please turn in what you have with your Application for Admission. Our staff will review your documents and determine if they are appropriate to fill the requirements of the Home's policy on Resident Representatives and Directives.
  - If they are, you can consider this part of the Application completed.
  - If they are not, please see the instructions for filling out the proper forms.

OR

- You do not have the above documents complete and you need to take care of them before you turn in your Application for Admission to the Arizona Pioneers' Home.
  - Please see the instructions for filling out the proper forms.

If you do not have a trusted family member or friend who is willing and able to be your Resident Representative, you may want to talk to a fiduciary. A fiduciary is for those persons in need of guardianship, conservatorship or administration and for whom there is no person or corporation qualified and willing to act in that capacity. As a guardian the fiduciary ensures that the basic needs of a person are met. These needs include, but are not limited to, personal, medical, psychiatric and housing. There are private and public fiduciaries. Please keep in mind that not every person qualifies to have a fiduciary.

The Yavapai County Public Fiduciary is Kathryn Blair and her contact information is as follows:

Kathryn Blair
Public Fiduciary
Prescott, AZ 86305
Phone: (928) 771-3153
Fax: (928) 771-3152

HEALTHCARE AND FINANCIAL DIRECTIVES PACKET

The Healthcare and Financial Directives Packet is available upon request.

If you have any questions or need the packet, please call our Administrative Services Office at 928-277-2721.

Disclaimer: The staff at the Arizona Pioneers' Home cannot legally advise applicants or residents. Please consult the Attorney General's office or an attorney.

The packet includes the following:

- The Attorney General's Life Care Planning Packet:
  - Healthcare Power of Attorney
  - Living Will
  - Mental Health Care Power of Attorney
  - Pre-Hospital Medical Care Directive: DNR (Do Not Resuscitate)
  - POLST (optional)
- Financial Power of Attorney
- FULL Code (the opposite of a DNR)

Once you have completed your directives, please use the RESIDENT REPRESENTATIVE CONTACT INFORMATION form on the next page to list the individuals that you have assigned as your Resident Representatives.

*Please be sure the information you put on the Resident Representative Contact Information form accurately reflects who is listed on your Healthcare and Financial Directives.

RESIDENT REPRESENTATIVE

Per Arizona Pioneers' Home policy D10-P11, each Resident must have a Resident's representative(s).

POLICY: To establish a Resident representative: a legal guardian, and individual acting on behalf of the Resident, or a surrogate as defined in A.R.S. 36-3201

AUTHORITY: A.R.S. 36-3201, R9-10-810 (C9,10)

PROCEDURE:

1. The Resident's Representative(s) hereby states that he/she is legally empowered to incur and discharge and conduct the personal and legal affairs of the Resident under Court order or other document, as defined in the Residency Agreement.
    a. Has a health care power of attorney established under A.R.S. 36-3221 or a mental health care power of attorney executed under A.R.S. 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or
    b. Is a legal guardian, a copy of the court order establishing guardianship.
    c. Has a financial power of attorney established under A.R.S. 14-5501, a copy of the financial power of attorney; or is a legal guardian, a copy of the court order establishing guardianship.
2. R9-10-810 (C9,10)
    a. To participate or have the Resident's representative participate in the development of, or decisions concerning, the Resident's service plan
    b. To receive assistance from a family member, the Resident's representative, or other individual in understanding, protecting, or exercising the Resident's rights

HEALTHCARE and FINANCIAL DIRECTIVES

Per Arizona Pioneers' Home policy D11-P8, you must have healthcare and financial directives on file.

POLICY: To obtain and ensure documentation of healthcare and financial directives as a part of the permanent record.

AUTHORITY: A.R.S. 36-3221, R9-10-803(G)

PROCEDURE:

1. Documents signed by the Residents consenting for the Resident's representative to act on the Resident's behalf:
    a. Health care power of attorney established under ARS § 36-3221 or a mental health care power of attorney executed under ARS § 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or a legal guardian, a copy of the court order establishing guardianship.
    b. Financial power of attorney established under A.R.S. 14-5501, a copy of the financial power of attorney; or a legal guardian, a copy of the court order establishing guardianship.
    c. Prehospital Medical Care Directive - only ONE of the following two may be chosen
        i. Do Not Resuscitate (DNR) - Must be signed by a physician; OR
        ii. FULL CODE (see policy D5-P34)
    d. Living Will (End of Life Care)
2. These documents will remain in effect unless revoked by the Resident in writing or court ordered revocation occurs. A copy of this policy shall be provided to the Resident before or at the time of acceptance of an individual's acceptance to the Home.

If you already have these documents filled out and signed you may provide them with your application. If you do not, then there are blank copies at the end of this application in EXHIBIT "A", Healthcare and Financial Directives.

***For the Prehospital Medical Care Directive - We require you to have either a DNR on file or a FULL CODE on file. You cannot have both. If you need help choosing, please contact your medical provider for advice. Blank copies of both of these documents are at the end of this application if you need them. Please keep in mind that a DNR requires a doctor's signature. ***

RESIDENT REPRESENTATIVE CONTACT INFORMATION

Name: _____ DOB: _____

1st Healthcare Resident Representative: _____ Relation: _____

Address: _____

Home phone: _____ Cell Phone: _____

Work phone: _____ Fax Number: _____

Email address: _____

2nd Healthcare Resident Representative: _____ Relation: _____

Address: _____

Home phone: _____ Cell Phone: _____

Work phone: _____ Fax Number: _____

Email address: _____

1st Mental Health Resident Representative: _____ Relation: _____

Address: _____

Home phone: _____ Cell Phone: _____

Work phone: _____ Fax Number: _____

Email address: _____

2nd Mental Health Resident Representative: _____ Relation: _____

Address: _____

Home phone: _____ Cell Phone: _____

Work phone: _____ Fax Number: _____

Email address: _____

1st Financial Resident Representative: _____ Relation: _____

Address: _____

Home phone: _____ Cell Phone: _____

Work phone: _____ Fax Number: _____

Email address: _____

2nd Financial Resident Representative: _____ Relation: _____

Address: _____

Home phone: _____ Cell Phone: _____

Work phone: _____ Fax Number: _____

Email address: _____

4
Additional Required Documents

ADMISSION FORM

Please check the box for type of admission desired:

☐ AZ PIONEER: I am 70 years of age or older, have been a Resident of Arizona for 50 or more years and believe I meet all qualifications for admission to the Arizona Pioneers' Home.

☐ AZ DISABLED MINER: I am 60 years of age or older ***and*** believe I meet all qualifications for admission to the Hospital for Disabled Miners at the Arizona Pioneers' Home.

Name of Applicant: _____ Nickname: _____

Mailing Address: _____City: _____ Zip Code: _____

Home Phone w/ area code: _____ Cell: _____

E-mail: _____

County of Residency: _____ Birthdate: _____ Age: _____

Sex: M F Birthplace: _____ Languages: _____

Veteran? Y N Branch: _____ Dates of Service: _____ to _____

Year You Came to Arizona: _____ How Many Years Have You Lived in Arizona? _____

When Would You Be Ready to Enter the Home? _____

Please make copies of the following…front and back.

- ☐ Current Arizona Driver's License or State ID
- ☐ Social Security card
- ☐ Medicare card
- ☐ Veteran's Affairs ID (if applicable)
- ☐ AHCCCS card (if applicable)
- ☐ *Supplemental insurance card AND Medicare Part D prescription card*

  OR

- ☐ *Advantage Plan insurance card*

Signature of Applicant/Applicant's Representative: _____ Date: _____

U.S. CITIZENSHIP VERIFICATION

Resident Name: _____ DOB: _____

1) Photocopy 1 (one) of the forms of citizenship verification listed below:
    a) An Arizona Driver's License issued after 1996 or an Arizona non-operating identification license.
    b) A birth certificate or delayed birth certificate issued in any state, territory or possession of the United States.
    c) A United States certificate of birth abroad.
    d) A United States passport
    e) A foreign passport with a United States visa
    f) An I-94 form with a photograph
    g) A United States citizenship and immigration services employment authorization document and refugee travel document
    h) A United States certificate of naturalization
    i) A United States certificate of citizenship
    j) A Tribal Certificate of Indian blood
    k) A Tribal or Bureau of Indian Affairs affidavit of birth

2) Sign the statement below and attach this instruction sheet to the photocopy being furnished to the Arizona Pioneers' Home.

The document I have presented to verify my United States Citizenship is a true copy.

Printed Name: _____

Signature of Applicant/Applicant's Representative: _____ Date: _____

PRIMARY CARE PHYSICIAN

Name: _____ DOB: _____

I understand it is required that I choose either the Arizona Pioneers' Home staff physician for my primary medical care provider, OR I choose a personal physician outside the Arizona Pioneers' Home.

Initial ***ONE*** below.

_____ I choose the Arizona Pioneers' Home staff physicians. I understand that my insurance claims are filed for me.

OR

_____ I choose my personal physician for my medical care. I understand that either my personal physician, myself or my representative must file my insurance claims and that I am ultimately responsible for all paperwork and payment for all medical expenses I incur.

Physician Name: _____ Phone: _____

Practice Name: _____

Practice Address: _____

Printed Name: _____

Signature of Applicant/Applicant's Representative: _____ Date: _____

HEALTH INSURANCE INFORMATION

Name: _____ DOB: _____

AUTHORITY: Arizona Pioneers' Home policy D2-P6 Insurance Requirements for Residents

I understand that unless I have VA coverage, it is required that I maintain Medicare Parts A & B and I have a supplemental plan that has a separate Medicare Part D plan, **OR** I have an Advantage plan that includes my Medicare Part D (Drug plan) **OR** I have Medicare Parts A & B and AHCCCS coverage. All insurance coverage must be valid in Yavapai County.

I understand I am required to maintain insurance coverage that covers the cost of prescription medication. If my medication is not covered by VA or AHCCCS, I must maintain a Medicare Part D insurance policy while I am a Resident of the Arizona Pioneers' Home. This must be either in a standalone Part D policy or part of an Advantage plan.

1. Please fill in the correct boxes that match the coverage you currently have.

☐ **I have Medicare**		
Medicare #	*Effective Date Part A*	*Effective Date Part B*

☐ **I have a Supplemental Insurance plan**			
Insurance Company Name	*Member ID #*	*Monthly Premium*	*Paid w/ which account?*
		$	
☐ **AND a Medicare Part D plan**			
Insurance Company Name	*Member ID #*	*Monthly Premium*	*Checking or Soc Sec?*
		$	

OR

☐ **I have an Advantage plan (that includes Medicare Part D coverage)**			
Insurance Company Name	*Member ID #*	*Monthly Premium*	*Paid w/ which account?*
		$	

☐ **I have VA coverage**			
Plan #	*Member ID #*	*Monthly Premium*	*Paid w/ which account?*
		$	

☐ **I have AHCCCS coverage and an AHCCCS card**			
Insurance Company Name	*Member ID #*	*Monthly Premium*	*Paid w/ which account?*
		$	

☐ **I have Dental/Vision/Hearing insurance**			
Insurance Company Name	*Member ID #*	*Monthly Premium*	*Paid w/ which account?*
		$	

HEALTH INSURANCE INFORMATION Cont'd

If my current insurance coverage is not deemed to be the most cost effective by the Arizona Pioneers' Home Administration, I understand and agree to cancel the policy and obtain coverage from an insurance provider which is approved by the Arizona Pioneers' Home.

If my current insurance coverage does not cover the deductibles, the Resident or family is responsible to pay any medical costs not covered by insurance.

Residents who do not purchase an approved insurance policy or who let payments lapse and have their coverage canceled by the insurance company will be personally liable for all expenses that would normally be paid out by the insurance company. If this occurs, Residents must contact the Arizona Pioneers' Home Accounting Office and arrange for immediate payment. Residents will be held liable to the State for all insurance premiums paid to an insurance carrier.

I understand that if I use a primary physician other than Arizona Pioneers' Home staff physicians, either my personal physician, myself or my representative must file my insurance claims and that I am ultimately responsible for all paperwork and payment for all medical expenses I incur.

I understand that any insurance checks I receive related to medical insurance, medical services, prescriptions, etc. are to be given to the Arizona Pioneers' Home Business Office for reimbursement of bills paid on my behalf.

I agree to change my mailing address to the Arizona Pioneers' Home with Social Security, and all insurance plans that apply (Advantage plan, Supplement Insurance, Medicare Part D, AHCCCS or VA coverage).

I understand that the Arizona Pioneers' Home will give me a credit on my Payment for Care each month for premiums that I pay for health insurance, but only if they are listed on this form and the Resident Financial Disclosure found on pages 62-63 in this Admissions Application. I must also give the appropriate financial documents listed in Exhibit A of this Application in order to qualify for the credits, which will effectively lower my Payment for Care.

Fluctuations in your health insurance premiums will affect your Payment for Care amount, but will not change your spending allowance.

Signature of Resident/Resident's Representative _____ Date: _____

MORTUARY SELECTION

Name: _____ DOB: _____

In order to honor your preferences at the time of death, the Home would like to include your choice of mortuary in your Arizona Pioneers' Home files.

The mortuaries in the Prescott Area are listed below, or you may specify "other" and write in the mortuary you wish to collect your remains at the time of death.

_____ Ruffner-Wakelin - Prescott, 303 S Cortez, Prescott 928-445-2221

_____ Heritage Memory Mortuary, 131 Grove Ave, Prescott 928-445-1881

_____ Hampton Funeral Home, 240 S Cortez, Prescott 928-778-4400

_____ Sunrise Funeral Home, 8167 E Hwy 69, Prescott Valley 928-772-7475

_____ Ruffner-Wakelin – Bradshaw, 8480 E Valley, Prescott Valley 928-772-2296

_____ Chino Valley Funeral Home, 480 W Palomino, Chino Valley 928-636-8225

_____ Other:

Name _____

Phone _____

Address _____

_____

If representatives from the mortuary selected are unable to schedule a pick-up of your body within 4 hours, the Arizona Pioneers' Home reserves the right to call the next mortuary on our rotation list.

If your remains are being donated and the donation agency refuses your body donation or pick-up is delayed more than 4 hours, the Arizona Pioneers' Home reserves the right to call the next mortuary on our rotation list.

Your Resident Representative WILL be responsible for ALL costs incurred related to your remains.

AUTHORITY: Arizona Pioneers' Home Policy & Procedure D2-P3

Signature of Resident/Resident's Representative _____ Date: _____

RULES

Name: _____ DOB: _____

Please read each item and sign below as accepted:

1. During your time of residency at the Arizona Pioneers' Home, should your condition require care which exceeds the scope of what the Home can provide on a continuing basis, it will be necessary to discharge you. The Arizona Pioneers' Home is not responsible for the arrangements to transfer a Resident to a new facility or for the cost of the alternate facility.
2. Profane or obscene language is forbidden in the buildings or on the grounds.
3. Cleanliness in person, dress and in quarters is mandatory. All Residents will be required to bathe at least once a week.
4. Use of any and all electrical appliances must be approved by the Maintenance department. Quarters will be checked for safety and sanitation.
5. No loud, boisterous or angry discussion on any subject will be allowed.
6. Courtesy for the rights of other Residents and respectful behavior towards employees and the management of the Home must be maintained.
7. Waste or defacement of property and utilities of the Home will not be permitted.
8. All Residents of the Home will be required to adhere to the Standards of Conduct.
9. No Resident of the Home shall be allowed to involve himself/herself in the financial affairs of another Resident.
10. Residents planning for extended leaves of absence require the Administration's approval for coordination. During a person's initial Adjustment Period at the Home, leaves must be approved. The time away from the Home shall not be counted as part of the 60-Day Adjustment Period.
11. Absolutely no smoking or vaping will be permitted in Resident rooms or any areas of the building that have not been designated as smoking areas.
12. Reports of suspected abuse or neglect should be brought immediately to the attention of a nurse, the Resident Advocate, the Director of Nursing, or the Superintendent.
13. The use of intoxicating alcohol on the grounds or in the buildings is prohibited, except when prescribed by a physician.
14. Residents are prohibited to have firearms in their possession, in the buildings or on the grounds.
15. Only prescription and over-the-counter medication prescribed by a Resident's medical provider are allowed and they must be kept in locked storage.
16. During his/her residency at the Home, each Resident shall be expected to carry medical, hospital and drug coverage.

Residents violating any of these rules will be liable to discharge.

Signature of Resident/Resident's Representative: _____ Date: _____

ACKNOWLEDGEMENTS

Name: _____ DOB: _____

Please initial each item as read and accepted:

1. _____(initial) I understand that per A.R.S 41-923 A person admitted to the Arizona Pioneers' Home shall pay to this state, to the extent that he is financially able to do so, the cost incurred by this state for his care. The cost shall be paid monthly to the superintendent and shall not be in excess of the average monthly per capita cost of operating the home based on the average number of persons then residing at the home during the year. A person who neglects or refuses to reimburse this state as required under this subsection shall not be permitted to reside at the home during the continuance of this neglect or refusal to pay. *This is for Pioneers only, and does not apply to qualified miners.*

2. _____ (initial) I understand that unless I have VA coverage, it is required that I maintain Medicare Parts A & B and I have a supplemental plan that has a separate Medicare Part D plan, OR I have an Advantage plan that includes my Medicare Part D (Drug plan) OR I have Medicare Parts A & B and AHCCCS coverage. All insurance coverage must be valid in Yavapai County.

3. _____ (initial) I understand I am required to maintain insurance coverage that covers the cost of prescription medication. If my medication is not covered by VA or AHCCCS, I must maintain a Medicare Part D insurance policy while I am a Resident of the Arizona Pioneers' Home. This must be either in a standalone Part D policy or part of an Advantage plan.

4. _____ (initial) I understand that per the Arizona Administrative Code, assisted living facilities generally and the Arizona Pioneers' Home specifically, institute the following changes:

    a. The Manager of the Arizona Pioneers' Home shall not accept or retain an individual if the primary condition for which the individual needs assisted living services is a behavioral health issue.
    b. The Manager of the Arizona Pioneers' Home shall not accept or retain an individual if the services needed by the individual are not within the assisted living facility's scope of services and a home health agency or hospice service agency is not involved in the care of the individual.

5. _____(Initial) I am aware of the 60-Day Adjustment Period I must pass to become a permanent Resident of the Arizona Pioneers' Home. During this period, I must demonstrate evidence of adjusting to the Home and not in need of nursing care. An evaluation will be completed at the end of 21, 45 and 60 days. *This is for Pioneers only, and does not apply to qualified miners.*

6. _____ (initial) I understand that the Arizona Pioneers' Home nursing staff may, from time to time, need to share my medical history information in an effort to coordinate medical care. I acknowledge this fact and give them liberty to do so.

7. _____ (initial) As a resident of the Arizona Pioneers' Home, I am aware that photos are periodically taken of residents enjoying daily life and activities at the Arizona Pioneers' Home and public outings. These photos may be taken of me directly or with me in the background, and are sometimes posted in the Home for all to enjoy. I realize that my picture may be used from time to time, either in the Home, on the Arizona Pioneers' Home website, any of the Home's social media sites, in print media and Arizona Pioneers' Home marketing material.

8. _____ (initial) I understand that I may be asked to move from one room to another, either temporarily or permanently. If asked, I will move willingly.

9. _____ (initial) I understand that my level of care is determined by my Individual Service Plan and this may reflect a need for additional care services, which are provided in the infirmaries. Additional charges will apply.

Signature of Resident/Resident's Representative: _____ Date: _____

5
Consumer Report

Our staff will review the completed application and the medical records to determine if an Admissions Meeting can be offered. If offered, after the Admissions Meeting, payment for the above referenced consumer report ($65.50 non-refundable) will be due and the report will be run. This consumer report is for Resident screening purposes only and is strictly confidential. Once we receive the report we will be in touch with a decision.

NOTICE TO APPLICANT OF INTENT TO OBTAIN A CONSUMER REPORT

Dear Applicant:

Pursuant to A.R.S. 41-923(A,C) and in connection with your application for residency, we need to procure certain background information concerning you which is contained in a consumer report.

A.R.S. 41-923(A) A person of good character is eligible to be admitted to the Arizona Pioneers' Home.
A.R.S. 41-923(C) The superintendent may admit a person to the home when a full examination and investigation reveal that the person possesses the qualifications prescribed by this section.

Before we may procure a consumer report, you must authorize such procurement in writing. You have the right to decline authorization for us to procure a consumer report. *However, we will not consider you further for residency if you so decline.*

☐ I have read the "Notice to Applicant of Intent to Obtain A Consumer Report" letter above**.**

☐ I understand that I have the right to decline authorization for the Arizona Pioneers' Home to procure a consumer report concerning me.

If you agree to the Consumer Report, please sign and date the following documents:

- Disclosure Regarding Background Investigation
- Acknowledgment and Authorization for Background Check

Applicant agrees to pay a non-refundable application fee of $64.50, payable by personal check.

This consumer report is for Resident screening purposes only, and is strictly confidential. This report contains information compiled from sources believed to be reliable, but the accuracy of which cannot be guaranteed. I hereby hold the Arizona Pioneers' Home and its employees free and harmless of any liability for any damages arising out of any unintentional release or misuse of this information.

Applicant/Applicant's Representative Name (Please Print):

_____

Applicant/Applicant's Representative Signature:

_____

Date: _____

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

The Arizona Pioneers Home ("the Home") may obtain information about you from a third-party consumer reporting agency for purposes of evaluating your application for residency at the Home, subject to the Fair Credit Reporting Act ("FCRA"). Thus, you may be the subject of a "consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living. These reports may contain information regarding your criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks.

You have the right, upon written request made within a reasonable time, to request whether a consumer report has been run about you and to request a copy of your report. These searches will be conducted by CastleBranch Corporation, 1844 Sir Tyler Drive, Wilmington, NC 28405, 888-723-4263, **www.castlebranch.com**.

Applicant/Applicant's Representative Name (Please Print):

_____

Applicant/Applicant's Representative Signature:

_____

Date: _____

ARIZONA PIONEERS' HOME

ACKNOWLEDGMENT AND AUTHORIZATION FOR BACKGROUND CHECK

I acknowledge receipt of the separate document entitled DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT, attached as Exhibit "B", and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by the Arizona Pioneers Home (the "Home") at any time after receipt of this authorization and throughout my application for residency. To this end, I hereby authorize any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by CastleBranch Corporation, 1844 Sir Tyler Drive, Wilmington, NC 28405, 888-723-4263, www.castlebranch.com. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

Applicant/Applicant's Representative Name (Please Print):

_____

Applicant/Applicant's Representative Signature:

_____

Date: _____

A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
  - a person has taken adverse action against you because of information in your credit report;
  - you are the victim of identity theft and place a fraud alert in your file;
  - your file contains inaccurate information as a result of fraud;
  - you are on public assistance;
  - you are unemployed but expect to apply for employment within 60 days.

  In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.consumerfinance.gov/learnmore for additional information.
- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit- worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in Residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures

Consumer reporting agencies must correct or delete inaccurate, incomplete, or

- **unverifiable information.** Inaccurate, incomplete, or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need -- usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.
- **You many limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt out with the nationwide credit bureaus at 1-888-5-OPTOUT (1- 888-567-8688).
- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.consumerfinance.gov/learnmore.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For information about your federal rights, contact:

Para información en español, visite www.consumerfinance.gov/learnmore o escribe a la Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

TYPE OF BUSINESS:	CONTACT:
1.a. Banks, savings associations, and credit unions with total assets of over $10 billion and their affiliates b. Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the CFPB:	a. Consumer Financial Protection Bureau 1700 G Street, N.W. Washington, DC 20552 b. Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 (877) 382-4357
2. To the extent not included in item 1 above: a. National banks, federal savings associations, and federal branches and federal agencies of foreign banks b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and Insured State Branches of Foreign Banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act c. Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations d. Federal Credit Unions	a. Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney Street, Suite 3450 Houston, TX 77010-9050 b. Federal Reserve Consumer Help Center P.O. Box. 1200 Minneapolis, MN 55480 c. FDIC Consumer Response Center 1100 Walnut Street, Box #11 Kansas City, MO 64106 d. National Credit Union Administration Office of Consumer Protection (OCP) Division of Consumer Compliance and Outreach (DCCO) 1775 Duke Street Alexandria, VA 22314
3. Air carriers	Asst. General Counsel for Aviation Enforcement & Proceedings Aviation Consumer Protection Division Department of Transportation 1200 New Jersey Avenue, S.E. Washington, DC 20590
4. Creditors Subject to the Surface Transportation Board	Office of Proceedings, Surface Transportation Board Department of Transportation 395 E Street, S.W. Washington, DC 20423

5. Creditors Subject to the Packers and Stockyards Act, 1921	Nearest Packers and Stockyards Administration area supervisor
6. Small Business Investment Companies	Associate Deputy Administrator for Capital Access United States Small Business Administration 409 Third Street, S.W., 8th Floor Washington, DC 20416
7. Brokers and Dealers	Securities and Exchange Commission 100 F Street, N.E.
	Washington, DC 20549
8. Federal Land Banks, Federal Land Bank Associations, Federal Intermediate Credit Banks, and Production Credit Associations	Farm Credit Administration 1501 Farm Credit Drive McLean, VA 22102-5090
9. Retailers, Finance Companies, and All Other Creditors Not Listed Above	FTC Regional Office for region in which the creditor operates or Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 (877) 382-4357