Arizona Pioneers' Home

Doug Ducey
Governor

300 South McCormick Street
Prescott, Arizona 86303

(928)445-2181 - FAX (928)778-1148
pioneershome.az.gov

Ted Ihrman
Superintendent

Dear Prospective Resident:

To initiate an application for admission to the Arizona Pioneers' Home, the following items will need to be completed and returned.

- Application for Admission
- Friend's Statement (verifying you meet the criteria for admission)
- U.S. Citizenship Verification (verifying eligibility per AZ statutes)
- Authorization to Release Medical Information
- Pre-Admission Questionnaire

<u>If You Are Pursuing Admission Immediately (or within a few months):</u>

1. Return the forms *with* current medical records (the last 6 office visits including any specialist labs, x-rays, etc.). A current medication list must be submitted that includes over-the-counter items being taken.
2. Upon return of completed forms, the Home will review and determine initial eligibility. If you are approved to proceed toward admission, there will be additional paperwork required and possibly additional interview(s), prior to final acceptance for residency and establishing a date for admission.

<u>If You Are NOT Pursuing Immediate Admission, But Sometime In the Future:</u>

1. Return the forms *without* current medical records. We will wait for those until the time you wish to actively pursue admission.
2. Your name will be added to a waiting list. At any time you can call to activate your application at which time we will discuss requirements to proceed with the admission process.

Please contact Dale Sams or Lisa Watts, Admission Coordinators, if you have any questions.

Arizona Pioneers' Home

300 S McCormick St., Prescott, AZ 86303
(928) 445-2181 Fax: (928) 778-1148

APPLICATION FOR ADMISSION

Please check the box for type of admission desired:

☐ AZ PIONEER: I am 70 years of age or older and have been a resident of Arizona for 50 or more years.

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

Name of Applicant: _____

Mailing Address: _____

_____

County of Residency: _____ Phone: (include area code)_____

Birthdate: _____ Age: _____ Birthplace: _____

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

When Would You Be Ready to Enter the Home? _____

Marital Status: M ___ W ___ D ___ S ____ Dates: Married-_____ Divorced- _____ Widowed-_____

Names of Current/Past Spouse (#1 being current or most recent):

1. _____ 2. _____

3. _____ 4. _____

Veteran?: Branch:_____ Dates of Service: _____ to _____ V.A. File _____

List Your Major Occupation and Longest Term Employer:

Occupation: _____

Employer: _____

Employer Address/Phone: _____

Level of Education: _____

Father's Name: _____ Birthplace: _____

Mother's Name: _____ Birthplace: _____

Applicant Signature _____ Date _____

For APH Use Only –

Date Rec'd_____ by _____

Arizona Pioneers' Home

300 S McCormick St., Prescott, AZ 86303
(928) 445-2181 Fax: (928) 778-1148

DISABLED MINER – AFFIDAVIT OF MINING EMPLOYMENT

ARS 41-942. Qualifications for admission to hospital; definitions

A. A person, under the order of the governor, shall be admitted to the hospital for miners with disabilities who:
   1. Has been a resident while in the occupation of mining in this state.
   2. Is a citizen or legal resident of the United States.
   3. Has reached the age of sixty years or more, and is financially unable to support himself, or has suffered incapacitating injuries arising from and in the course of mining.

B. Based on available space and funding, the governor may approve a person for admission to the hospital for miners with disabilities who has not yet reached the age of sixty years but otherwise qualifies for admission under subsection A.

Date: _____

Name: _____
Last First Middle Initial

Address: _____
Street City Zip

Telephone: _____ Message Phone: _____

Date of Birth: _____ Place of Birth: _____

References: (List names and addresses of friends or relatives who can verify that you have been in the occupation of mining and have lived in Arizona as required by State law.)

Name: _____ Relationship: _____

FULL Addr/Phone: _____

Name: _____ Relationship: _____

FULL Addr/Phone: _____

List any other information that will substantiate and verify you worked in the occupation of mining:

_____

_____

_____

_____

DISABLED MINER – AFFIDAVIT OF MINING EMPLOYMENT (CONTINUED)

In making application to the Arizona Hospital for Disabled Miners, an applicant must provide information about working in the occupation of mining, showing that they meet the State requirements for admission. Please provide the following:

Mining Employment History

Dates	Company	Job Title	City
Dates	Company	Job Title	City
Dates	Company	Job Title	City
Dates	Company	Job Title	City

Total Number of years worked in the mining industry: _____

Certification

I certify that, to the best of my knowledge, I meet the qualifications for admission to the Arizona Hospital for Disabled Miners at the Arizona Pioneers' Home. (Check appropriate box)

- ❑ I have been a resident of the State of Arizona while in the occupation of mining.
- ❑ I physically participated in mining activities to develop or extract materials from a mine, or I performed executive, administrative, support or clerical functions for the owner or operator of a mine in which there was significant environmental exposure to mining activities, that could be detrimental to a person's health.
- ❑ I am a citizen or legal resident of the United States.
- ❑ I have reached the age of sixty (60) or more years.
- ❑ I am under sixty (60) years of age and request exception based on ARS 41-492-B.
- ❑ I have suffered an incapacitating injury (or illness) arising from the occupation of mining.
- ❑ I am financially unable to support myself.

By submitting this affidavit I certify and swear that I meet the above qualifications and am submitting this application so that I may become a resident of the Arizona Miners Hospital if it appears that I possess all of the qualifications.

_____ _____

Signature Date

Subscribed and sworn to before me this _____ day of _____ A.D., 20_____.

My commission expires _____ Notary Public: _____

Arizona Pioneers' Home

300 S McCormick St., Prescott, AZ 86303
(928) 445-2181 Fax: (928) 778-1148

ACTIVITIES OF DAILY LIVING

Name: _____ Date: _____

Tell us about your ambulation (how you walk):

Do you require any special equipment to perform your daily activities?

Do you have any visual problems that affect your daily living?

Does your hearing affect your daily living?

Does anyone provide assistance to you in daily living? Explain in reference to:

Taking medications _____

Housework _____

Shopping _____

Meals _____

Bathing _____

Dressing _____

Going to the bathroom _____

Do you have incontinence of bowel and/or bladder? Explain.

Are you receiving any regularly scheduled medical treatments? Explain.

To assist in determining compatibility with a roommate, please tell us:

Do you use any tobacco products? Yes_____ No _____
Explain Quantity and Frequency _____

Do you drink alcohol? Yes_____ No _____
Explain Quantity and Frequency _____

(Please continue on the back if needed)

ARIZONA PIONEERS' HOME

Authorization for Disclosure of Health Information

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

1. *I authorize the use or disclosure of the above named individual's health information as described below.*
2. *The following individual or organization is authorized to make the disclosure:*

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).
   - _____ Complete health records
   - _____ Lab results/X-ray reports
   - _____ Physical exam
   - _____ Consultation reports
   - _____ Immunization record
   - _____ Other (please specify): _____

4. 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.

5. *This information may be disclosed to and used by the following individual or organization.*

ARIZONA PIONEERS' HOME
ATTN: _____
300 S. McCORMICK ST.
PRESCOTT, AZ 86303

For the purpose of: _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.

7. If I fail to specify an expiration date, event or condition, this authorization will expire in <u>one year</u>. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact:

   _____,

   Privacy Officer for _____.

_____ _____

Signature of patient or legal representative | Signature of witness

Date: _____ Date: _____

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC – 3701.243) and federal law 42 CFR, part II.

Arizona Pioneers' Home

300 S McCormick St., Prescott, AZ 86303
(928) 445-2181 Fax: (928) 778-1148

US CITIZENSHIP VERIFICATION

1. PHOTOCOPY 1 (ONE) OF THE FORMS OF CITIZENSHIP VERIFICATION LISTED BELOW:
   - AN ARIZONA DRIVER'S LICENSE ISSUED AFTER 1996 OR AN ARIZONA NON-OPERATING IDENTIFICATION LICENSE.
   - A BIRTH CERTIFICATE OR DELAYED BIRTH CERTIFICATE ISSUED IN ANY STATE, TERRITORY OR POSSESSION OF THE UNITED STATES.
   - A UNITED STATES CERTIFICATE OF BIRTH ABROAD.
   - A UNITED STATES PASSPORT
   - A FOREIGN PASSPORT WITH A UNITED STATES VISA
   - AN I-94 FORM WITH A PHOTOGRAPH
   - A UNITED STATES CITIZENSHIP AND IMMIGRATION SERVICES EMPLOYMENT AUTHORIZATION DOCUMENT AND REFUGEE TRAVEL DOCUMENT
   - A UNITED STATES CERTIFICATE OF NATURALIZATION
   - A UNITED STATES CERTIFICATE OF CITIZENSHIP
   - A TRIBAL CERTIFICATE OF INDIAN BLOOD
   - A TRIBAL OR BUREAU OF INDIAN AFFAIRS AFFIDAVIT OF BIRTH

2. SIGN THE STATEMENT BELOW AND ATTACH THIS INSTRUCTION SHE 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.

SIGNED _____

PRINTED NAME _____ DATE _____

Arizona Pioneers' Home

300 S McCormick St., Prescott, AZ 86303
(928) 445-2181 Fax: (928) 778-1148

DEFINING INDEPENDENCE

As a **NEW RESIDENT** admitted as a "Pioneer" you must complete a 60-day trial period (called adjustment period) in which you must remain independent in order to become a permanent resident of the Pioneers' Home. In order to ensure understanding, we have developed the following so that you may understand what the Home considers independence/independent and what you need to be able to demonstrate to complete the trial period successfully. It is not all inclusive but covers most of what nursing will evaluate you on. *Note: If due to illness or injury you temporarily require additional care such as APH infirmary, hospital, or rehabilitation facility, once your independent abilities are regained, your 60-day period may be extended by the number of days you were in the infirmary or out of APH.*

As a **1st and 3rd FLOOR PERMANENT RESIDENT**, MINER OR PIONEER, you must maintain your independence in order to remain on what is considered an independent floor of the Home. The following criteria shall also be considered in determining if you should move to the 2nd floor for infirmary care.

1) Able to demonstrate continence or ability to manage bowel and bladder incontinence independently. Able to change and dispose of soiled briefs or pads in a sanitary manner by placing in a sealed bag and placing in garbage container. Ability to clean self, clothes and linens if incontinent and/or use a urinal and disposing of urine in the toilet and rinse in designated station only. Room must remain odor free.
2) Able to bathe or shower independently and safely twice weekly and shampoo own hair at least once weekly. Ability to enter into shower stall or tub, turn water to a safe temperature and exit shower stall or tub without assistance from any other person. Able to dress in clean clothes after bathing/showering.
3) Ability to ambulate independently and safely (with or without walker and/or cane) from designated room to lobby, dining room, or North Infirmary. Able to ambulate safely outside of building to doctor appointments, work the elevator without assistance and navigate stairs in case of an emergency.
4) Ability to locate important/significant areas of the facility - meaning your assigned room, nurse's station, lobby, restrooms and dining room without verbal or physical cues within two weeks of admission. Able to evacuate facility during an emergency with minimum verbal or physical cues.
5) Able to maintain room cleanliness by keeping items picked up off of the floor, making bed daily, washing linens weekly or as needed when incontinent, take garbage out to larger cans in the hallway, place incontinence pads and briefs tied up in smaller bags into the larger cans. . Small items must be moved out of the way in order for housekeeping to clean the floors each week
6) Ability to care for your physical needs without assistance from others. Able to bathe, toilet, transfer, ambulate, feed, groom and dress yourself without assistance from others. Must attend at least two of the three daily meals each day in dining room.
7) Able to manage day to day activities both physically and cognitively without excessive verbal cues.

I have received the foregoing and have had an opportunity to ask questions.

DO NOT sign until you have had time to ask questions. You will be asked to sign this later during the admission process to indicate your understanding of the Home's requirements. Thank you.

Signature of Resident