Arizona Pioneers' Home

Doug Ducey
Governor

300 South McCormick Street
Prescott, Arizona 86303

Ted Ihrman
Superintendent

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

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

If You Are Pursuing Admission Immediately (or within a few months):

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.

If You Are NOT Pursuing Immediate Admission, But Sometime In the Future:

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.

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300 S McCormick St., Prescott, AZ 86303
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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 ______________________

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APPLICATION FOR ADMISSION – FRIENDS STATEMENT (SEE ARS 41-923)

TO THE SUPERINTENDENT, ARIZONA PIONEERS HOME:

IN MAKING APPLICATION TO THE ARIZONA PIONEERS' HOME, I DO RESPECTFULLY SHOW THAT I HAVE BEEN A CITIZEN OF THE UNITED STATES FOR (5) YEARS PRIOR TO THE DATE OF APPLICATION; HAVE BEEN A RESIDENT OF ARIZONA FOR NOT LESS THAN FIFTY (50) YEARS PRECEDING THE DATE OF THIS APPLICATION; AND HAVE REACHED THE AGE OF SEVENTY (70) OR MORE YEARS; AT THE TIME OF ADMISSION TO THE HOME, DO NOT REQUIRE HOSPITAL CARE, SKILLED NURSING, OR INTERMEDIATE NURSING CARE.

I HAVE LISTED ON THE BACK SIDE OF THIS DOCUMENT THE PLACES IN ARIZONA WHICH I HAVE RESIDED TO MEET THE 50 YEARS OF AZ STATE RESIDENCY. THEREFORE, I RESPECTFULLY REQUEST THAT I BE ENTITLED TO BECOME A RESIDENT OF THE ARIZONA PIONEERS' HOME IF IT APPEARS THAT I POSSESS ALL THE QUALIFICATION LISTED ABOVE.

______________________________ ______________________________

PRINTED NAME OF APPLICANT

____

____

______________________________ ______________________________

SIGNATURE OF APPLICANT ADDRESS OF APPLICANT

> FRIENDS STATEMENT <

I, ______________________ (APPLICANTS' FRIEND), BEING DULY SWORN, DEPOSE AND SAY THAT I KNOW

______________________ (APPLICANT), AND THAT HE/SHE TRUTHFULLY MEETS THE ABOVE QUALIFICATION.

__________________________ FRIENDS' SIGNATURE

SUBSCRIBED AND SWORN TO BEFORE ME THIS ________ DAY OF ______________, 20_________

(SEAL) ______________________________

NOTARY PUBLIC

==

~ SUPERINTENDENT – ARIZONA PIONEERS' HOME ~

AFTER FULL EXAMINATION AND INVESTIGATION OF THE MATTERS SET FORTH IN THE APPLICATION OF ______________________ ______________________, IT APPEARS TO ME THAT HE/SHE POSSESSES ALL THE QUALIFICATIONS PROVIDED BY ARIZONA REVISED STATUE 41-923, ENTITLING HIM/HER TO BECOME A RESIDENT OF THE ARIZONA PIONEERS' HOME AND TO RECEIVE THE BENEFITS PROVIDED THEREIN.

SUPERINTENDENT SIGNATURE ______________________________ DATE ______________

THE ARIZONA PIONEERS' HOME IS AN EQUAL OPPORTUNITY, AFFIRMATIVE ACTION AGENCY. ALL QUALIFIED MEN AND WOMEN ARE ENCOURAGED TO PARTICIPATE.

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APPLICATION FOR ADMISSION – FRIENDS STATEMENT - CONTINUED

Year From	Year To	AZ City	During these years did you:
			☐ file taxes? ☐ own/rent property? ☐ Attended school/worked? ☐ paid utilities? ☐ Had an AZ state DL or ID ☐ Other
			☐ file taxes? ☐ own/rent property? ☐ Attended school/worked? ☐ paid utilities? ☐ Had an AZ state DL or ID ☐ Other
			☐ file taxes? ☐ own/rent property? ☐ Attended school/worked? ☐ paid utilities? ☐ Had an AZ state DL or ID ☐ Other
			☐ file taxes? ☐ own/rent property? ☐ Attended school/worked? ☐ paid utilities? ☐ Had an AZ state DL or ID ☐ Other
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			☐ file taxes? ☐ own/rent property? ☐ Attended school/worked? ☐ paid utilities? ☐ Had an AZ state DL or ID ☐ Other

Please attach a separate sheet if additional space is needed or if any explanation of circumstances is necessary.

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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 one year. 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.

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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 ____________

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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.

____
Signature of Resident

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.