THE RENAISSANCE

COMPLEX-PLACEMENT ASSISTED LIVING

WASILLA, ALASKA

The bridge between institutional care and ordinary assisted living.

We take the referrals other homes decline.

LICENSED ALH #102100 · TWO CLINICIANS · TWO RESIDENTS · 1:1 & 2:1 ACUITY · ALI + PRIVATE PAY

WHO FITS

- Dementia with behavioral complexity
- Serious mental illness needing structure and supervision
- Developmental disabilities with complex behavioral needs
- Residents needing dedicated 1:1 or 2:1 staffing
- Hospital or API discharges with no safe placement

Not for skilled-nursing or locked-facility needs.

WHY PLACE HERE

- Two mental-health clinicians in the home
- Documented 1:1 and 2:1 acuity, awake 24/7
- Continuity, not churn: two residents, one steady team
- HCBS settings rights fully protected

FUNDING

- Alaska Medicaid ALI, with the acuity add-on
- Private pay, clear terms
- Behavioral-health and APDD pathways on request

THE PROCESS

I — Refer
Needs, funding, and timeline

II — Review
Same-week fit and safety review

III — Placement
Intake, care plan, acuity documents

Now accepting referrals across Wasilla, Palmer, and the Mat-Su Valley.

FULL REFERRAL & INTAKE FORM ATTACHED · PAGES 2 TO 8

REFER A CLIENT

hello@renaissance-alf.com · (907) 310-1560

The Renaissance Assisted Living LLC · Licensed ALH, State of Alaska #102100 · Wasilla, Mat-Su Valley

REFERRAL & INTAKE FORM

Complete every section that applies. Write "unknown" rather than leaving a required item blank.

RETURN COMPLETED FORM

hello@renaissance-alf.com · (907) 310-1560 · Send by encrypted email · Same-week fit and safety review

Privacy notice. This form contains protected health information. A health care provider may share it with The Renaissance for treatment and care coordination under HIPAA (45 CFR 164.506). Records of substance use disorder treatment protected by 42 CFR Part 2 may only be shared with the written consent in Section M.

A. REFERRAL SOURCE

Date of referral | Referring agency or facility | Referrer name and title

Phone | Email | Fax (if secure) | Best time to reach

Referral type ☐ Hospital ☐ Alaska Psychiatric Institute ☐ Tribal health ☐ SDS care coordinator ☐ Behavioral health agency ☐ Guardian or family ☐ Self Other

Person is now at ☐ Hospital ☐ API ☐ Own or family home ☐ Another ALH ☐ Nursing facility ☐ Correctional facility ☐ Shelter or unhoused Other

Facility, unit, or address | Anticipated discharge date | Desired move-in date

Urgency ☐ Urgent, within 72 hours ☐ Within 2 weeks ☐ Planned, 30 days or more

B. PROSPECTIVE RESIDENT

AS 47.33.070(a)(1)

Full legal name | Preferred name | Date of birth | Age

Sex | Gender identity / pronouns (optional) | Social Security # (optional) | Marital status

Current address | Phone

Primary language | Years in Alaska | Veteran, branch and dates | Race / ethnicity (optional)

Interpreter needed ☐ Yes ☐ No Language

Communication needs ☐ None ☐ Hearing loss ☐ Vision loss ☐ Sign language ☐ Speech device / AAC ☐ Limited reading

Alaska Native or American Indian ☐ Yes ☐ No ☐ Prefer not to say Tribe or corporation

Religious or spiritual preference | Tribal health or IHS beneficiary number (if any)

C. CONTACTS & LEGAL REPRESENTATIVE

AS 47.33.070(a)(2), (3)

CLOSEST RELATIVE

Name | Relationship | Phone | Email

Mailing address

EMERGENCY CONTACT, IF DIFFERENT

Name | Relationship | Phone | Alternate phone

LEGAL REPRESENTATIVE

Decision maker ☐ Self, no representative ☐ Full guardian ☐ Limited guardian ☐ Conservator ☐ Power of attorney ☐ Health care agent (AS 13.52) ☐ Representative payee

Representative name | Agency or relationship | Phone | Email

Mailing address | Court case or document number

Actions the representative is authorized to take for the resident (attach letters of guardianship or POA)

CARE COORDINATOR OR CASE MANAGER

Name | Agency | Phone | Email

D. FUNDING & ELIGIBILITY

7 AAC 130 · AS 47.33.210

Payment source ☐ Medicaid ALI waiver ☐ Medicaid APDD waiver ☐ Medicaid IDD waiver ☐ Medicaid State Plan only ☐ Medicare ☐ Private pay ☐ Long-term care insurance ☐ VA ☐ Tribal / IHS Other

Medicaid status ☐ Active ☐ Application pending ☐ Not yet applied ☐ Not eligible

Medicaid ID # | Medicare # | Other insurance and policy #

Level of care assessment (CAT, interRAI, or ICAP) ☐ Completed ☐ Scheduled ☐ Not started Date

Waiver support plan / plan of care ☐ Approved ☐ Submitted to SDS ☐ Not started Date

Income sources ☐ SSI ☐ SSDI ☐ Social Security retirement ☐ Adult Public Assistance ☐ Pension ☐ VA benefits ☐ Employment ☐ None

Other

Approximate monthly income | Representative payee and phone | Private pay responsible party

Room and board is billed separately from waiver services. Rates, advance payments, and refund terms are stated in the Residential Services Contract (AS 47.33.030, 47.33.210).

E. PRIVATE PAY & FINANCIAL RESPONSIBILITY

AS 47.33.030, .090, .210

Private pay applies ☐ Full private pay ☐ Private pay until Medicaid begins ☐ Room and board only (waiver pays services) ☐ Not applicable

RESPONSIBLE PARTY (PERSON OR ENTITY PAYING)

Responsible party is ☐ Resident ☐ Legal representative ☐ Family member ☐ Trust Other

Name | Relationship | Phone | Email

Mailing address | Alternate contact and phone

RATE AND PAYMENT TERMS (PRELIMINARY)

Quoted monthly rate | Acuity add-on (1:1 / 2:1) | Rate quoted by | Date quoted

Security deposit amount | Due at move-in (deposit + first period) | Payment due day of month | Billing email

Payment method ☐ Check ☐ ACH / bank transfer ☐ Money order ☐ LTC insurance direct pay ☐ Trust disbursement

Other

Long-term care insurance company | Policy # | Daily benefit and elimination period

If private funds run low ☐ Will apply for Medicaid ☐ Medicaid application started ☐ Not expected to need Medicaid

Expected date

Advance payments are limited to a security deposit and rent for the next rental period, held as required by AS 47.33.030. Rates may increase only after 30 days written notice (AS 47.33.090).

Financial acknowledgment. I understand the quoted rate is preliminary and will be confirmed after the pre-admission evaluation. Final rates, deposits, refunds, and termination terms are set in the Residential Services Contract signed at admission (AS 47.33.210). By signing, I state that I intend to pay, or arrange payment of, the agreed charges for the resident.

Responsible party signature | Printed name | Date

F. HEALTH & MEDICAL

AS 47.33.230(b)(2), (c)

Primary care provider | Clinic | Phone

Psychiatric provider | Clinic | Phone

Preferred pharmacy | Preferred hospital | Other specialists

Medical diagnoses

Behavioral health diagnoses

Developmental, intellectual, cognitive, or dementia diagnoses (include type and stage)

Medication allergies | Food or environmental allergies

CURRENT MEDICATIONS (OR ATTACH CURRENT LIST / MAR)

MEDICATION	DOSE	FREQUENCY	ROUTE	REASON / PRESCRIBER

Medication help ☐ Self-administers ☐ Needs reminders or supervision ☐ Needs administration by delegated staff ☐ Injectables ☐ PRN psychotropic orders ☐ Refuses at times

Health-related needs ☐ None ☐ Diabetes / insulin ☐ Oxygen ☐ Wound care ☐ Catheter ☐ Ostomy ☐ Feeding tube ☐ Dialysis ☐ Seizures ☐ CPAP / BiPAP ☐ Hospice Other

The Renaissance does not provide ongoing 24-hour skilled nursing. Intermittent nursing and delegation are provided through a licensed registered nurse (AS 47.33.020).

Special diet or texture | Height | Weight | Date of last history & physical

Hospitalizations and ER visits in the past 12 months (dates, facility, reason)

TB screening ☐ Negative ☐ Positive ☐ Not done Date and type

Infection requiring precautions ☐ No ☐ Yes Describe

On file ☐ Advance directive (AS 13.52) ☐ POLST ☐ DNR ☐ Living will ☐ Mental health treatment declaration ☐ None

G. ACTIVITIES OF DAILY LIVING

AS 47.33.230(b)(1), (4)

ACTIVITY	INDEPENDENT	CUEING	LIMITED HELP	EXTENSIVE HELP	TOTAL HELP	NOTES
Bathing	☐	☐	☐	☐	☐	
Dressing	☐	☐	☐	☐	☐	
Grooming and hygiene	☐	☐	☐	☐	☐	
Toileting	☐	☐	☐	☐	☐	
Bladder continence	☐	☐	☐	☐	☐	
Bowel continence	☐	☐	☐	☐	☐	
Transfers	☐	☐	☐	☐	☐	
Walking / mobility	☐	☐	☐	☐	☐	
Eating	☐	☐	☐	☐	☐	
Taking medications	☐	☐	☐	☐	☐	
Managing money	☐	☐	☐	☐	☐	
Preparing meals	☐	☐	☐	☐	☐	
Laundry and housekeeping	☐	☐	☐	☐	☐	
Transportation	☐	☐	☐	☐	☐	
Phone and communication	☐	☐	☐	☐	☐	

Mobility aids ☐ None ☐ Cane ☐ Walker ☐ Wheelchair ☐ Hospital bed ☐ Mechanical lift Other

Falls in past 6 months ☐ None ☐ One ☐ Two or more

Two-person transfer ☐ No ☐ Yes

Can leave the home in an emergency ☐ Independently ☐ With verbal cues ☐ With physical help ☐ Unable

H. COGNITION, SUPERVISION & ACUITY

Oriented to ☐ Person ☐ Place ☐ Time ☐ Situation

Memory ☐ Intact ☐ Mild impairment ☐ Moderate ☐ Severe

Wandering or exit seeking ☐ None ☐ Occasional ☐ Frequent

Elopement history ☐ No ☐ Yes Most recent date

Night needs ☐ Sleeps through ☐ Wakes 1 to 2 times ☐ Up often ☐ Needs awake overnight monitoring

Supervision needed ☐ General ☐ 1:1 part of day ☐ 1:1 around the clock ☐ 2:1 part of day ☐ 2:1 around the clock

Staffing ratio in current setting

Hours per day of 1:1 or 2:1 needed

Tasks or times needing 1:1 or 2:1

I. BEHAVIORAL HEALTH & SAFETY

7 AAC 75.295

BEHAVIOR	NEVER	PAST YEAR	PAST 30 DAYS	MOST RECENT DATE AND DETAILS
Physical aggression toward others	☐	☐	☐	
Verbal aggression or threats	☐	☐	☐	
Self-harm	☐	☐	☐	
Suicidal thoughts or attempt	☐	☐	☐	
Property destruction	☐	☐	☐	

Sexually inappropriate behavior	☐	☐	☐	
Fire setting	☐	☐	☐	
Elopement or running away	☐	☐	☐	
Psychosis (hallucinations, delusions)	☐	☐	☐	
Alcohol or substance use	☐	☐	☐	
Refusing medications or care	☐	☐	☐	
Hoarding or food seeking	☐	☐	☐	
Vulnerable to exploitation	☐	☐	☐	
Other	☐	☐	☐	

Known triggers

What works (calming strategies, strengths, de-escalation that helps)

Psychiatric hospitalizations, crisis episodes, and API stays in the past 2 years (dates, facility)

Behavior support or safety plan ☐ Attached ☐ In progress ☐ None

Past restraint or seclusion ☐ None ☐ Physical restraint ☐ Emergency medication ☐ Seclusion Most recent

Current behavioral health services (therapy, ACT, case management)

Provider and phone

Tobacco or vaping ☐ None ☐ Tobacco ☐ Vape ☐ Wants support to quit

J. LEGAL STATUS

Civil commitment or court-ordered treatment (AS 47.30)	☐ Yes ☐ No	Details	
On probation or parole	☐ Yes ☐ No	Officer and phone	
Pending charges or upcoming court dates	☐ Yes ☐ No	Details	
Required to register as a sex offender	☐ Yes ☐ No	Details	
Protective or no-contact orders	☐ Yes ☐ No	Details	
Owns firearms or other weapons	☐ Yes ☐ No	Where stored now	
Open Adult Protective Services report	☐ Yes ☐ No	Details	

These answers support safety planning. No single answer automatically excludes a referral.

K. PERSON-CENTERED PREFERENCES

AS 47.33.230(b)(3) · 42 CFR 441.301(c)

In the person's own words, what do they want from this move and from daily life?

Daily routine, wake and sleep times

Food preferences and cultural foods

Religious or cultural practices

Hobbies, interests, and activities

Important relationships and visitors

Work, school, or day program

Pets or animals (allergies, fears, wishes)

Community activities and transportation needs

Person has been told about this referral and agrees to consider The Renaissance (AS 47.33.200) ☐ Yes ☐ No ☐ Representative consents

Other settings offered (HCBS choice of setting) ☐ Own home with supports ☐ Family home ☐ Other assisted living home ☐ Non-disability-specific setting ☐ None

HCBS rights modifications that may be needed ☐ None expected ☐ Access to food ☐ Visitors ☐ Door locks / privacy ☐ Personal funds

Other

Any modification of HCBS settings rights must be tied to a specific assessed need, tried with less restrictive methods first, and documented in the person-centered plan with the person's informed consent (42 CFR 441.301(c)(4)(vi)(F)).

L. DOCUMENTS TO ATTACH

- ☐ Face sheet
- ☐ History & physical within 6 months / physician statement
- ☐ Psychiatric evaluation or recent notes
- ☐ Behavior support or safety plan
- ☐ Advance directive, POLST, MH declaration
- ☐ Level of care assessment and support plan
- ☐ Photo ID and insurance cards
- ☐ Signed releases of information
- ☐ Private pay rate quote or signed acknowledgment
- ☐ Medication list or current MAR
- ☐ Hospital or API discharge summary
- ☐ Guardianship, POA, or court orders
- ☐ Medicaid eligibility notice
- ☐ TB screening result
- ☐ Recent labs

M. AUTHORIZATION TO RELEASE INFORMATION

45 CFR 164.508 · 42 CFR Part 2

I authorize the referring agency and the providers named in this form to share with The Renaissance Assisted Living LLC the health, behavioral health, functional, legal, and benefit information described in this form. The purpose is to decide whether The Renaissance can safely meet my needs and to plan my care. I understand that my treatment, payment, enrollment, and eligibility for benefits do not depend on signing. I may revoke this authorization in writing at any time, except for actions already taken. Information shared under HIPAA may be redisclosed and lose federal protection. Substance use disorder records protected by 42 CFR Part 2 are included only if the box below is checked, and they may not be redisclosed without my consent.

☐ I consent to release of substance use disorder treatment records (42 CFR Part 2) Program name

This authorization expires on (date or event, default one year from signing)

Resident signature

Date

Legal representative signature

Authority (guardian, POA, agent)

Date

Referrer certification. The information in this form is accurate and complete to the best of my knowledge.

Referrer signature

Printed name and agency

Date

N. FOR RENAISSANCE USE ONLY

Date received

Received by

Pre-admission evaluation date

Interview with person / rep. date

Decision ☐ Accepted ☐ Declined ☐ Waitlisted ☐ More information needed

Reason, conditions, and next steps

Administrator signature

Date

Planned admission date

The Renaissance complies with federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, or religion. Language assistance and reasonable accommodations are free on request.