IKAYUQTI
Email: assisted.living@unkira.org
PO BOX 270
Unalakleet Alaska 99684
(907) 625-1656

Ikayuqti was designed and constructed specifically as a home for elders who are in need of assisted living care. In addition to providing care, it is a great opportunity for elders to remain in a village where they can continue to enjoy their subsistence food and cultural practices.

We at **Ikayuqti** understand how hard it can be to find an adequate home away from home and are grateful that you have considered **Ikayuqti** in your search. Thanks again, the steps and information to get into **Ikayuqti** are listed below.

Steps to get in Ikayuqti

1: Contact the administrator at IKAYUQTI, (907) 625-1656

2: Complete the IKAYUQTI Resident Application Packet.

3: If you have a care coordinator, let him/her know you want to apply for IKAYUQTI and she/he will begin the process of applying for State General Relief (GR) for Assisted Living Care and Medicaid, if appropriate.

4: You will need to have a medical provider complete the physician's report and TB Clearance which is a part of the State GR application packet

5: The IKAYUQTI Administrator will then meet with the Care Coordinator and/or the caregivers to determine if IKAYUQTI can safely and adequately meet the applicant's level of care.

6: The Care Coordinator will then submit the application for State GR, if necessary. If that is approved a move-in date can be set. If State GR is not necessary or an option, the Administrator will work with the family to set a possible move in date.

Paying for care is one of the major concerns elders and families have. In Alaska, assisted living home residents are required to pay all but $100 of their monthly income, then the remaining balance of the cost of care is provided through State GR or Medicaid, **for those who qualify**.

For those who are over resource or do not qualify for State GR or Medicaid, they will need to pay from their resources according to their level of care. **Level I care costs $7792 per month, Level II costs $8292 per month and Level III costs $8792 per month***. Basically, if someone has a regular monthly income of over $1,750.00 per month and/or money in the bank exceeding $2,000.00, they will not qualify for State GR or Medicaid. Resident will have to pay out of their own resources until they become eligible to reapply for State GR and/or Medicaid.

If the resident is outside of Unalakleet, travel costs are the responsibility of the applicant. If the resident is on Medicaid, that can be an option. If the applicant is a tribal member, often times, they will help with the air fare as well. We will meet the applicant at the airport in Unalakleet if necessary.

Elders can bring personal items that will fit into their personal units and are acceptable under the IKAYUQTI policies and procedures. Each unit at IKAYUQTI comes with wall jacks for a telephone and cable TV; however, it is the resident's responsibility to provide the service for these. Residents are allowed to bring their own food and snacks; however, we provide three nutritious meals plus snacks per day.

It is good to bring family pictures, personal items etc. to put around the living space to make it feel more like your very own home unless it is a safety issue. The units are furnished with a bed, nightstands, table and chairs as well as linens and towels. If necessary, we do have hospital beds and electronic recliners available.

We encourage family and friends to come and visit as much as possible; the coffee and tea pots are always on. It is good to take the elder out for visits to family events, community events and out for holidays. IKAYUQTI has a van that is used to provide transportation for the residents so we get them to church, potlatches, ball games and other community activities. Family members are encouraged to call anytime to check on the elder.

When possible, family members are encouraged to take the elder to medical appointments if they are in Unalakleet; however, IKAYUQTI staff is available to do that as well. If a resident has an appointment outside of Unalakleet, IKAYUQTI does not provide escorts; that is the responsibility of the family. IKAYUQTI staff will notify the next of kin in the event of an emergency.

Feel free to call the IKAYUQTI Administrator at 625-1656 (cell), email assisted.living@unkira.org with any questions. Our fax number is 624-3621.

Thank you again for considering IKAYUQTI where "We honor our elders by providing safe and compassionate care and support in a culturally sensitive home."

*Subject to change annually per DHSS Chart of Waiver Service rates

IKAYUQTI

Resident Application

Name_____ Date_____
First Middle Last

Date of Birth_____/_____/_____ Social Security Number_____-_____-_____

Current Address_____

City_____ State____ Zip_____

Home Phone_____ Cell Phone_____

❑ Male ❑ Female Requested Move-In Date_____

Physical Limitations:

_____

_____

_____

Special Requirements:

_____

_____

_____

Health Insurance_____

Identification Number_____ Phone_____

Secondary Insurance
Identification Number_____ Phone_____

Primary Physician_____ Phone_____

Physicians Address _____ City_____
State_____ Zip_____

Power of Attorney (If Applicable) _____

Relationship_____ Phone_____

Address_____City_____
State_____ Zip_____

Please attach copy of Power of Attorney Documentation

Primary Contact_____

Relationship_____ Phone_____

Address_____

City_____ State_____ Zip_____

Care Coordinator/Case Manager/Program Specialist:

_____

Address and Telephone: _____

Agency Affiliation (if any) _____

Signature(s) of Applicant or Applicants Representative

Resident_____ Date_____

Spouse_____ Date_____

Representative_____ Date_____

IKAYUQTI
PHYSICIANS STATEMENT AND RECOMMENDATION

Resident Information

First Name: _____ Age: _____
Middle Name: _____ Gender: _____
Last Name: _____ Height: _____
Date of Birth: _____ Weight: _____

Medication Prescribed **Dosage**
Instructions

Medication - Resident Will Require

☐ NO ASSISTANCE ☐ REMINDER TO TAKE MEDICATION
☐ READING OF REGIMEN ON LABEL ☐ SUPERVISION AS TO LABELED DOSAGE

Diet

☐ Regular ☐ Low Calorie ☐ Soft ☐ Salt Free ☐ Other: Food Allergies ☐ None or:

Assistance Required

TYPE	FREQUENCY OF ASSISTANCE					EXTENT OF ASSISTANCE		
	INDEPENDENT	OCCASIONAL	OFTEN	ALWAYS		MINIMUM	MODERATE	MAXIMUM
Bathing	☐	☐	☐	☐		☐	☐	☐
Dressing	☐	☐	☐	☐		☐	☐	☐
Grooming	☐	☐	☐	☐		☐	☐	☐
Oral Hygiene	☐	☐	☐	☐		☐	☐	☐
Toileting	☐	☐	☐	☐		☐	☐	☐
Eating	☐	☐	☐	☐		☐	☐	☐
Moving About	☐	☐	☐	☐		☐	☐	☐
In/Out of Bed	☐	☐	☐	☐		☐	☐	☐

Mobility/Activity (check one)**:**

☐ Walker ☐ Cane ☐ Crutches ☐ Wheelchair ☐ No Restrictions ☐ Other Restrictions (please specify):

MEDICAL HISTORY & CURRENT MEDICAL PROBLEMS (please list and describe):

MENTAL STATUS (check one): ☐ Clear ☐ Disoriented ☐ Occasionally Disoriented
Comments:

Behavior

☐ DID ☐ DID NOT
Manifest behavior which was assaultive, combative, suicidal or otherwise dangerous to self or others.

Comments:

OTHER SIGNIFICANT INFORMATION

EXTENT OF MENTAL OR PHYSICAL IMPAIRMENT, E.G., INCONTINENCE – SPECIFIC ASSISTANCE OR SUPERVISION NEEDED ETC.:

PHYSICIAN'S RECOMMENDATION:

_____

Physician's Name (please print) Phone

_____

Physician Signature Date

Confidential Financial Statement

Applicant's Name_____

Assets

Value of Real Estate $_____
Stocks $_____
Bonds $_____
Savings $_____
Checking $_____
CDs $_____
Other (Please Describe): _____ $_____

Total Assets $_____

Liabilities

Mortgage on Home: $_____
Mortgage(s)on other Real Estate: $_____
Other Debts or Liabilities (Itemized):
1._____ $_____
2._____ $_____

Total Liabilities $_____

Monthly Income

Social Security $_____
Pension $_____
Retirement Annuity $_____
Investments (Interest and Retirement Annuity) $_____
Investments (Interest and Dividends) $_____

Total Monthly Income $_____

I hereby acknowledge that the above information is accurate to the best of my knowledge. I understand that this information will be kept confidential and will be relied upon to evaluate the resident's ability to pay for services rendered. The monthly income and assets listed are available to the resident or responsible party/guarantor to pay for the resident's care.

Resident_____ Date_____

Responsible Party_____ Date_____

IKAYUQTI
Resident Interview Questions

Does the applicant have an advanced health care directive?_____

Does the applicant have a comfort one order?_____

What is the funding source? Medicaid_____GR_____Private_____Other_____

Is there a diagnosis for mental health? If so, what?_____

Does the applicant have any criminal history? If so, describe_____
_____

Does the applicant have any history or aggressive behaviors (biting, hitting, scratching, etc.)? If so, describe_____
_____

Does the applicant require any of the following:

_____Injectable medications
_____Catheter
_____Colostomy bag

Does the applicant have any open wounds?_____

Is the applicant on any controlled substances (medications); if so, what and is it scheduled or a PRN?_____

What is the applicant's mobility?_____
_____

Does the applicant need assistance with?

_____Toileting
_____Personal Hygiene
_____Feeding
_____Walking
_____Dressing
_____Transportation

Do they need any restraints? Describe_____
_____

Is the applicant a wandering risk?_____
_____

How does he/she sleep at night_____
_____

Does the applicant require a special diet?_____
_____

Is the applicant incontinent?_____

Is the applicant affiliated with a Tribe? If so, what?_____

Is the applicant on Medicaid?_____

Please list any allergies the applicant may have
_____
_____
_____
_____