State of Alaska • Department of Health and Social Services • Senior and Disabilities Services

Application for Personal Care Services

Instructions: *Provide all information requested in Sections I and II. If an item is not applicable, enter NA in the fill-in box. (The application will be considered to be incomplete if any fill-in box is blank, and will not be processed.) Complete form online, obtain signatures and submit form and all required documents to*

Senior and Disabilities Services, 550 W. Eighth Avenue, Anchorage, AK 99501

Section I Recipient Information

Medicaid recipient name _____ **Medicaid #** _____

Application type and program *(Check appropriate type and program.)*

☐ Initial ☐ Agency-based program
☐ Reauthorization ☐ Consumer-directed program

Personal Care Services Agency

Agency/Center name _____ Provider # _____
Agency/Center representative _____
Telephone/cell _____ Email address _____

Recipient address

Physical address _____ City/State/Zip _____
Mailing address _____ City/State/Zip _____
Telephone/cell _____ Email address _____
Current location, if not at physical address
☐ Acute care facility ☐ Long term care facility ☐ Assisted living home ☐ Other
Name of facility _____
Physical address _____ City/State/Zip _____
Expected date of discharge _____

Recipient profile

Date of birth _____ Gender ☐ M ☐ F
Marital status _____ Alaska resident ☐ Yes ☐ No
Primary language _____ Interpreter needed ☐ Yes ☐ No
If primary language not English, provide the name of English-speaker for communication purposes
Name _____ Telephone/cell _____
Relationship to recipient _____

Has the recipient applied for home and community-based waiver services? ☐ Yes ☐ No
Does the recipient receive chore services as a waiver service? ☐ Yes ☐ No
Has the recipient applied for grant services? ☐ Yes ☐ No
Does the recipient receive chore services through a grant? ☐ Yes ☐ No
Is the recipient a U.S.Veteran? ☐ Yes ☐ No

Recipient representative

Name _____
Mailing address _____ City/State/Zip _____
Telephone/cell _____ Email address _____

Representative type (*Attach documentation showing representative's authority to act for the recipient*)

☐ None/not applicable ☐ Partial Guardian
☐ Public Guardian (OPA) ☐ Conservator
☐ Parent ☐ Power of Attorney
☐ Delegated Parental Authority ☐ Representative Payee
☐ Full Guardian ☐ Unknown

☐ Other _____

Medicaid recipient name _____ **Medicaid #** _____

Section II Personal Care Services review

1. Physical condition

Does the recipient have a physical condition that affects the recipient's capacity to perform the activities covered by the personal care services program? ☐ Yes ☐ No

If yes, describe the condition _____

describe how the condition affects the recipient's capacity to perform the activities covered by personal care services _____

describe any risks to health safety, and welfare the recipient would face if physical assistance is not provided_____

Is the recipient's physical condition documented in clinical records? ☐ Yes ☐ No

2. Material change in physical condition

Did the recipient submit an application for personal care services during the previous 365 day period? ☐ Yes ☐ No

Has a material change, as defined in 7 AAC 125.012 (b), occurred following submission of that application? ☐ Yes ☐ No

If a material change occurred,

describe the change that happened after the previous application or assessment _____

describe how the change affects the recipient's capacity to perform activities _____

3. Age of applicant

Is the recipient 6 to 18 years of age? ☐ Yes ☐ No

Does the recipient need more physical assistance with activities than a same-age individual who does not have a disability? ☐ Yes ☐ No

If the need for assistance is due to a disability rather than age, describe how the disability affects the recipient's capacity to perform activities that a same-age individual could perform without assistance _____

4. Need for physical assistance

Does the recipient need physical assistance with the activities of daily living (ADLs) specified in 7 AAC 125.030 (a) ☐ Yes ☐ No

If yes, check the box and describe the physical assistance needed by the recipient to perform the activity in the space provided

- ☐ body mobility _____
- ☐ transferring _____
- ☐ locomotion _____
- ☐ dressing _____
- ☐ eating and drinking _____
- ☐ toileting _____
- ☐ bathing _____

Does the recipient need physical assistance with the instrumental activities of daily living (IADLs) specified in 7 AAC 125.030 (b) ☐ Yes ☐ No

If yes, check the box and describe the physical assistance needed by the recipient to perform the activity in the space provided

- ☐ light meal preparation _____
- ☐ main meal preparation _____
- ☐ light, routine housework _____
- ☐ laundering _____

☐ shopping to perform activity ____

Medicaid recipient name _____ **Medicaid #** _____

Does the recipient need physical assistance with the other activities specified in 7 AAC 125.030 (d)/ ☐ Yes ☐ No

If yes, check the box and describe the physical assistance needed by the recipient to perform the activity in the space provided

- ☐ self-administration of medication _____
- ☐ administration of medication_____
- ☐ diabetic testing set-up _____
- ☐ maintenance of respiratory equipment _____
- ☐ sterile dressing changes and wound care _____
- ☐ passive range-of-motion _____

5. Location for delivery of services

Does the recipient live in a location where personal care services providers are available to provide services for the recipient? ☐ Yes ☐ No

Does the recipient anticipate receiving personal care services from an individual that is qualified and willing to provide physical assistance through the consumer-directed personal care services program? ☐ Yes ☐ No

If yes, does the recipient meet the requirements of 7AAC 125.140 for the consumer-directed personal care services program? ☐ Yes ☐ No

Describe the location where personal care services will be provided, if approved: _____

Does the recipient's residence meet the place of service requirements of 7 AAC 125.050? ☐ Yes ☐ No

5. Natural supports

Does a representative plan to manage personal care services for the recipient? ☐ Yes ☐ No

Does the representative live in the same community as the recipient? ☐ Yes ☐ No

Is the representative involved in the day-to-day care of the recipient? ☐ Yes ☐ No

Do other people live in the same residence as the recipient? ☐ Yes ☐ No

If yes, list others who live in the same residence as the recipient on the table below by defining their relationships to the recipient (for example: mother, father, sister, brother, aunt, uncle, cousin, niece, nephew, grandmother, grandfather, friend, roommate tenant); include the age of each person:

Resident's relationship to the recipient	Age of resident

Do the other residents in the recipient's home help the recipient with activities that he/she is unable to perform without physical assistance? ☐ Yes ☐ No

If yes, describe the resident by relationship and age, and describe the activity and the physical assistance provided by the resident in the table below:

Relationship to recipient	Age of resident
Activity	Physical assistance provided
Relationship to recipient	Age of resident
Activity	Physical assistance provided
Relationship to recipient	Age of resident

Activity	Physical assistance provided

Medicaid recipient name _____ **Medicaid #** _____

Do individuals who do not live in the same residence help the recipient with activities that he/she is unable to perform without physical assistance? ☐ Yes ☐ No

If yes, describe the resident by relationship and age, and describe the activity and the physical assistance provided by the resident in the table below:

Relationship to recipient	Age of resident
Activity	Physical assistance provided
Relationship to recipient	Age of resident
Activity	Physical assistance provided
Relationship to recipient	Age of resident
Activity	Physical assistance provided
Relationship to recipient	Age of resident
Activity	Physical assistance provided

Do community organizations help the recipient with activities that he/she is unable to perform without physical assistance? ☐ Yes ☐ No

If yes, specify the organization and the activity and the physical assistance provided by the organization in the table below:

Name of organization	
Activity	Physical assistance provided
Name of organization	
Activity	Physical assistance provided
Name of organization	
Activity	Physical assistance provided
Name of organization	
Activity	Physical assistance provided

6. <u>Shared residence</u>

Do home and community-based waiver recipients live in same residence? ☐ Yes ☐ No

Have others living in the same residence applied for home and community-based waiver services? ☐ Yes ☐ No

Do other home and community-based waiver recipients living in same residence receive chore services? ☐ Yes ☐ No

Have other home and community-based waiver recipients living in the same residence applied for to receive chores services? ☐ Yes ☐ No

Do other Medicaid recipients living in the same residence receive personal care services? ☐ Yes ☐ No

Have others living in the same residence applied to receive personal care services? ☐ Yes ☐ No

Do others living in the residence receive chore services through a grant program? ☐ Yes ☐ No

Have others living in the same residence applied to receive chore services through a grant program? ☐ Yes ☐ No

Application for Personal Care Services

Section III Signature page

Medicaid recipient name _____ Medicaid # _____

Recipient assurances

I, (Print name) _____ *understand that, although I claim that I need physical assistance with the activities specified in this application for Personal Care Services, the decision to authorize personal care services for those activities will be made by Senior and Disabilities Services on the basis of a review of my current clinical documentation and a functional assessment of my capacity to perform the activities. I understand that failure to provide all or any part of the information requested could affect the determination made by Senior and Disabilities Services to authorize services for me.*

I certify that that the content of this form has been explained to me by the agency/resource center representative in language that I understand; that I agree to the content of this form; and that this is an application for medical assistance program benefits.

I understand that knowingly making a false statement may subject me to criminal prosecution or civil sanction, including, without limitation, monetary penalties. I understand that knowingly making a false statement may constitute the crimes of perjury (AS 11.56.200), medical assistance fraud (AS 47.05.210) and/or unsworn falsification (AS 11.56.210).

I certify, under penalty of perjury, that the information I have provided herein is true, accurate, and complete to the best of my knowledge.

_____ _____

Recipient/Representative signature Date

Witnesses

If the recipient signs with a mark, the signature of a witness who is not the recipient's care coordinator, personal care assistant or representative of the personal care services agency is required.

_____ _____

Witness signature Date

_____ _____

Witness printed name Date

Application for Personal Care Services

Section III Signature page

Medicaid recipient name _____ Medicaid # _____

Agency/Resource Center name _____ Provider # _____

Agency Assurances

I certify that I have screened the recipient's need for physical assistance with activities covered by the Personal Care Services regulations. I understand that the decision to authorize Personal Care Services will be made by Senior and Disabilities Services on the basis of a review of the recipient's current clinical documentation and a functional assessment of capacity to perform the activities indicated in this request.

I, (Agency representative print name) _____ *understand that knowingly making a false statement may subject me or the named agency or resource center to criminal prosecution or civil sanction, including, without limitation, monetary penalties. I understand that knowingly making a false statement may constitute the crimes of perjury (AS 11.56.200), medical assistance fraud (AS 47.05.210) and/or unsworn falsification (AS 11.56.210).*

My initials are my certification, under penalty of perjury, that the following statements are true to the best of my knowledge.

Initials	Sworn statement
	I represent the named agency/resource center; by signing this application, I am acting within the scope of my employment.
	I have read the recipient's answers to the questions on this application, and believe the answers to be true, accurate, and complete to the best of my knowledge.
	I believe the recipient needs physical assistance with the personal care services activities specified in this application.
	If I learn that the recipient does not need personal care services, I will notify Senior and Disabilities Services immediately.
	I have identified the following clinical records as supportive of the recipient's claim of a functional limitation and need for physical assistance with the ADLs, IADLs, and other covered services specified in this application; list records reviewed:

As required, I have attached the following:

- ☐ *Release of Information form*
- ☐ *Verification of Diagnosis form*
- ☐ *clinical records that are not older than one year prior to the date of this application and that support the recipient's diagnosis and need for physical assistance*
- ☐ (*if applicable*) *documentation showing representative's authority to act for the recipient*

_____ _____

Agency representative signature Date