Date Stamp Here:

NEW APPLICATION and RENEWAL APPLICATION ALI/APDD/CCMC/CFC

DRAFT

Completed by Care Coordinator:

Recipient Name:______________________

CC Name:___________________________

CC Agency Name: ____________________

Waiver Type (choose one):

☐ **ALI - Alaskans Living Independently**
☐ **APDD - Adults with Physical & Developmental Disabilities**
☐ **CCMC - Children with Complex Medical Conditions**

Community First Choice (choose one):

☐ **CFC – Community First Choice**
☐ **Waiver and CFC – Waiver and Community First Choice**

☐**New Application**

Note: If you do not qualify for Waiver or CFC services would you like to be considered for State Plan Personal Care Services? ☐**Yes** ☐**No**

If yes, please state your preferred Personal Care Services Agency

____

☐ **Renewal Application**

Note: Re- application is required for the ALI/APDD/CCMC Waivers and the CFC Program annually per 7AAC 130.213 and7 AAC 127.030

Legal Name (Last, First):

If Renewal: SDS ID#: **POC Start Date:** **POC End Date:**

Section I ~ Demographic Information

POC Type (Select one): ALI ☐ APDD ☐ CCMC ☐ CFC only ☐ Waiver and CFC ☐

Medicaid#: **DOB:**

Male ☐ Female ☐ Married ☐ Single ☐ Height:______Weight:______

Primary Language:

If non-verbal-primary mode of Communication:

If a communication barrier exists, please provide an English speaking contact for scheduling:

Contact name:________________Contact Phone:________ Relationship:__________

Applicant's Physical Address or directions to home in rural areas (No P.O. Boxes)

Address:
City: **State:** **Zip:**

Work-Phone: **Home-Phone:** **Cell-Phone:**
Email:

Mailing address (if different than physical)

Address:
City: **State:** **Zip:**

Applicant's Legal Representative

Does the applicant want SDS documents mailed to the Power of Attorney (POA)? **Yes ☐ No ☐**
Name: **Role/Relationship: Guardian ☐ POA ☐**

Mailing Address:
City: **State:** **Zip:**

Work-Phone: **Home-Phone:** **Cell-Phone:**
E-Mail:

Care Coordinator

Name: **Cell-Phone:** **Email:**

Agency: **Work-Phone:** **Fax#:**

Address:
City: **State:** **Zip:**

Provider ID#: **Provider Group ID#:**

Legal Name (Last, First):

If Renewal: SDS ID#: **POC Start Date:** **POC End Date:**

Section II ~ Diagnosis & Medical

Primary Diagnosis from the Verification of Diagnosis (VOD):

Secondary Diagnosis(es) from the VOD:

Source(s) for diagnostic information (including the medical professional from the VOD):

Health Summary- **Specify and attach appropriate supporting documentation.**
Summarize the applicant's health over the past 12 months.

Document emergency room visits, hospitalizations, surgeries/ or treatments:

Describe significant changes in the applicant's health or behavior in the last year.

If a renewal application:
Has the applicant received a new primary diagnosis?

Has the applicant been diagnosed with any new health problems, mental health issues, or other problems that might affect his/her functional abilities?

Legal Name (Last, First):

If Renewal: SDS ID#: **POC Start Date:** **POC End Date:**

Section III ~ Current Medical Data

Medical and/or Psychiatric Contacts *(Highlight, right-click & insert additional rows as needed)*

Include a fax number for a primary physician as well as a contact phone number for all providers listed.

Full Name	Address	Phone & Fax	Reason for visits and frequency

Current Medications *(Highlight, right-click & insert additional rows as needed)*

Medication	Dosage	Prescriber	Reason Prescribed	Administered how?

Legal Name (Last, First):

If Renewal: SDS ID#: **POC Start Date:** **POC End Date:**

Adaptive Medical Equipment (DME/SME)

List all adaptive medical equipment currently in use/available to the applicant regardless of funding source:

☐ Bath Bench	☐ Gait Belt	☐ Lift/Hoyer
☐ Braces/AFOs	☐ Grab Bars	☐ Stair Glide
☐ Cane	☐ Hand Held Shower	☐ Wheelchair
☐ Commode	☐ Hospital Bed	☐ Walker
☐ Elevated Toilet	☐ P.E.R.S/Lifeline	
☐ Other:_____________		

List adaptive medical equipment needed:

Environmental Modifications (EMOD's)

List all environmental modifications completed for this applicant regardless of funding source:

List environmental modifications needed:

Legal Name (Last, First):

If Renewal: SDS ID#: **POC Start Date:** **POC End Date:**

Statement of Reasonable Expectation of the Need for Long Term Care

I believe that there is reasonable indication the applicant might need services at a level of care provided in a hospital, nursing facility, or ICF/MR in 30 or fewer days unless the applicant receives home and community-based waiver services under 7 AAC 130.211 or Community First Choice PCS under 127.010.

I have provided appropriate and contemporaneous documentation that addresses each medical and functional condition and indicates the applicant's need for home and community based waiver services.

7 AAC 130.217 and 7 AAC 130.240 protect you from conflict of interest by putting definitions around who can serve you as Care Coordinator. Has your Care Coordinator informed you of any employment or family relationship to a certified provider agency (per 7 AAC 130.217 (1)(A) ? ***Applicant please initial***

Yes __________ **No** ___________(there are no known relationships)

Section IV ~ Signatures:

By signing below, I certify that the information included in this ***application*** is true and accurate to the best of my knowledge.

Recipient Signature	Date	Parent or Legal Representative	Date
Care Coordinator	Date	Other Natural Support	Date

Two witnesses are required if recipient signs with an X or a stamp. The Care Coordinator may not serve as a witness.

Witness Printed Name	Signature	Relationship	Date
Witness Printed Name	Signature	Relationship	Date