State of Alaska ● Department of Health ● Senior and Disabilities Services

Application for Personal Care Services and CFC-Personal Care Services When Traveling

Recipient Name _____ Agency Name & PCG# _____

Legal Representative Name _____ Agency Staff Name _____

Recipient Medicaid number _____ Agency Contact Phone # _____

Date of Application _____ Agency Fax # _____

The Division may pay for a recipient's approved services for up to 30 days annually while the recipient is away from their community, for medical necessity, an educational opportunity not available in the state or for a vacation. Additional time may be granted for medical necessity or if the department determines that the benefits to the recipient of an educational opportunity justify a longer temporary absence.

The Division must authorize the travel before it begins; the services must be necessary to maintain the recipient's current level of functioning; the recipient may not be able to meet their needs by any means other than being accompanied by a personal care assistant or a CFC personal care assistant and the services to be provided during the recipient's temporary absence must be the same as those provided when the recipient is at home. 7 AAC 125.050(c); 7AAC 127.075(c). The Division will not pay for transportation, room or board for a personal care assistant to travel with a recipient. 7 AAC 125.050(e); 7 AAC 127.075(e)

To Be Completed by Recipient or Legal Representative

Purpose of Travel

☐ Medical Necessity **attach documentation** of medical necessity from a licensed physician that is qualified to practice under AS 08.64 or 7 AAC 105.200(c)

☐ Educational opportunity not available in recipient's community or in the state (**attach documentation** that the educational opportunity will further the recipient's capacity for vocational or professional employment)

☐ Vacation

Dates of Travel

Start date _____ End date _____

Travel Destination

City _____ State _____ U.S. Territory (If applicable) _____

Has the recipient submitted and had authorized, a *Personal Care Services or a CFC-Personal Care Services When Traveling Application* this calendar year?

◯ Yes ◯ No

If Yes state dates of travel this calendar year _____

Is the recipient requesting the same services the recipient currently receives? ◯ Yes ◯ No

If No, please describe why _____ If no services are needed while traveling this request may be "Approved as submitted" and Service Authorization may be adjusted to remove units for dates of travel.

State why Personal Care Services are necessary to maintain the recipient's current level of function:

The following field is mandatory. State why the recipient's need for assistance with ADLs, IADLs and other covered services during the travel period can be met only by a personal care assistant

Does the recipient anticipate a temporary absence for more than 30 days? ◯ Yes ◯ No

If No proceed to signatures If Yes, answer the following:

Purpose of Extended Travel

☐ Medical Necessity **-attach documentation** of medical necessity for a temporary absence of more than 30 days from a licensed physician that is qualified to practice under AS 08.64 or 7 AAC 105.200(c)

☐ Educational opportunity not available in recipient's community or in the state **-attach documentation** that the educational opportunity is of sufficient benefit to the recipient to justify a temporary absence of more than 30 days

Signatures

I certify, under penalty of perjury, that the information provided herein is true, accurate, and correct to the best of my knowledge. I understand my responsibilities regarding 7 AAC 125.050(c)(d) or 7AAC 127.075(c)(d) *above.*

Recipient Signature Date _____

Legal Representative Name _____

Legal Representative Signature Date _____

Provider Agency Staff Name _____

Provider Agency Staff Signature Date _____

Care Coordinator Name
*CFC-PCS only _____

Care Coordinator Signature Date _____

DSDS Staff Only Below this Line

◯ Approved as Submitted

◯ Returned to Submitter See Attachments

All other determinations – see- PCS Services When Traveling Determination letter

SDS Staff Name _____

SDS Staff Signature _____ Date