

Instruction for Completion of PCA-08A Personal Care Services Renewal Application

The *PCA-08A Personal Care Services Renewal Application* is completed for Medicaid recipients who have a physical condition that limits their ability to perform activities of daily living (ADLs) and/or instrumental activities of daily living (IADLs) and are seeking to renew their enrollment in a Medicaid program that pays for a personal care assistant.

***Note: To use the form you must have the most current version of Adobe Acrobat Reader.** Adobe Acrobat Reader is a free, safe application that allows you to fill out portable data file (.pdf) forms. SDS always uses the newest version. You can download it free at <https://get.adobe.com/reader/>. You will be able to open the form, see the fields, and type in the fields. You will need to save the document to your computer after you fill it out. Choose “file”, “save as”, then give your file a name and save it to your computer. Make note of where you saved it.

Do not make any changes; it is an SDS Approved Form. If a bar code is applied for use in your agency’s system, be sure it does not obscure any printing on the form.

Print pages 4 and 5, the signature pages. The Participant or the Participant’s representative must place an original signature on page 4. The agency representative must place handwritten initials and a signature on page 5. Once signed pages 4 and 5 may be scanned and submitted by DSM with the rest of the application or the complete application may be printed and submitted by Fax.

The completed form contains private health information (PHI) and must be sent over a secure system. **Use the Direct Secure Messaging (DSM) system** to attach it to an email to SDS. To learn how to get and use Direct Secure Messaging, view our training video here: <https://youtu.be/6Sf3GdV71JM>. DSM is the preferred mode of transmission for this form; an alternate mode of transmission is by Fax; please see the Fax number listed below.

Submit a RENEWAL application with original initials and signatures, to Senior & Disabilities Services via secure Email to DSDS.PCAMailbox@direct.dhss.akhie.com or *Fax: 907-269-8164

*** Note: When SDS begins using Harmony’s automated system to accept applications SDS will no longer accept applications by Fax**

PCA-08A Personal Care Services Renewal Application is posted on the SDS “Approved Forms” website. The form may be completed by entering the requested information into fillable boxes or a blank copy of the form may be printed and handwritten. The signatures pages (pages 4 and 5) *must* be printed so that handwritten initials and original signatures are entered; the entire application may be submitted by secure Email or if necessary, by Fax.

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Information Requested	What to enter	Example
Medicaid Participant Name	Fill in the participant's full name *Note Participant name and Medicaid # will pre-fill into the headers on each page; Participant name will pre-fill into the Participant's name text box on page 7	Efrin Jose Gonzales Efrin J. Gonzales
Medicaid #	Copy the participant's Medicaid # from their most recent Medicaid identification care	1231231234
Program type	Selection the program that the Participant is reapplying for; agency based or consumer directed	<input checked="" type="checkbox"/> Consumer Directed
Personal Care Services Agency		
Agency/Center name	Enter the business name of your agency	ABC Personal Care Services
Agency/Center Representative	Enter the name and title of the person completing the application	Jeremy Jones Intake Worker
Phone	Enter the phone number for your agency	907-555-1212
E-mail address	Enter the e-mail address for your agency	ABCpca@gci.net
*Note Agency name and Provider # will pre-fill into their respective text boxes on page 5		
Section I Participant Information		
Information Requested	What to enter	Example
1. Participant profile		
Date of birth	Enter participant's date of birth using 00/00/000 format	11/23/1940
Gender identification	Select one of the three options based on what the Participant tells you	<input checked="" type="checkbox"/> Male
Marital status	Select one of the five options based on what the Participant tells you	<input checked="" type="checkbox"/> Divorced
Alaska resident	Enter residency status; select either "yes" or "no" based on what the Participant tells you	<input checked="" type="checkbox"/> Yes
Primary language	Enter the language in which the Participant tells you that he/she is fluent	Spanish
Interpreter needed	Select "yes" if the Participant is requesting an interpreter and "no" if an interpreter is not needed/requested	<input checked="" type="checkbox"/> Yes
<i>If primary language is not English, provide the name of English speaker for communication purposes</i>		
Name	Enter the full name, first, middle, last of the person that Participant indicates will help with communications	Jose Morales
Phone	Enter telephone number and indicate "landline" or "cell phone"	907-555-3434 cell phone
Relationship to Participant	Enter the relationship to Participant, based on what the Participant tells you	Cousin

2. Participant address		
Physical address	Enter the number and street where the Participant resides *This is where the Participant is physically located at the time the application is submitted to SDS *Fill in Facility/Other Location address if Participant is currently residing at that location	18679 Main Street
City/State/Zip	Enter City, State, Zip Code for the Participant's physical address	Juneau, AK 99801
Name facility/other location	Complete this text box if applicable . Enter the name of the facility or if Participant is not in a facility describe the "other" location	Sister's house
Expected date of discharge	If this is a facility, hospital, or Assisted Living Home: enter the date on which discharge is expected. If a date is not known, provide estimated discharge timeframe as documented on medical records	01/01/2022
<i>Type of Facility</i>		
Acute care facility Long term care facility Assisted living home Other	Select and enter the most applicable choice that describes the current physical location of the Participant. These are "forced choice" check boxes; you may select only one. If you select "other" provide a description of the location in the text box that appears after the work "other"	Other Private residence; sister's home
Mailing address	Enter number and street (or PO Box) if different from physical address; enter "same as above" if the mailing address is the same as the physical address	PO Box 8976
City/State/Zip	Enter City, State, Zip Code if mailing address is different from physical address; enter "same as above" if the mailing address is the same as the physical address	Juneau, AK 99004
Cell phone	Enter Participant's cell phone number, if no cell phone enter "none" or "N/A"	none
Land line	Enter Participant's land line number, if no land line enter "none" or "N/A"	907-555-2424
Current location if not at physical address	Select this check box if the Participant is not currently residing at their physical address and complete the current location information text boxes. This is a "forced choice" check box; you must select either this check box or the one immediately under it, i.e. "N/A Participant is at current address"	<input checked="" type="checkbox"/> Current location, if not at physical address
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3. Participant current services		
Has the Participant applied for HCBW services?	Select "yes" if the Participant tells you they have applied for waiver services or if they are currently receiving waiver services; answer "no" if the Participant has not applied and/or is not receiving waiver services.	<input checked="" type="checkbox"/> Yes
Does the Participant receive chore services as a waiver service?	Based upon what the Participant tells you, respond "yes" or "no". Note the response can only be "yes" if the response to "Has the Participant applied for HCBW services?" is yes	<input checked="" type="checkbox"/> Yes

Has the Participant applied for grant services?	Select “yes” if the Participant tells you they have applied for grant services or if they are currently receiving grant services; answer “no” if the Participant has not applied and/or is not receiving grant services.	<input checked="" type="checkbox"/> No
Does the Participant receive Chore services through a grant?	Based upon what the Participant tells you, respond “yes” or “no”. Note the response can only be “yes” if the response to “Has the Participant applied for grant services?” is “yes”	<input checked="" type="checkbox"/> No
Is the Participant a U.S. Veteran?	Based upon what the Participant tells you, respond “yes” or “no”	<input checked="" type="checkbox"/> Yes
4. Participant representative		
Participant representative?	Respond “yes” or “no” to this question depending upon what the Participant tells you. Note if the response is “yes” you must attach documentation showing the representative’s authority to act for the Participant and complete the contact information for the Participant’s legal representative in the text boxes following this question. If the response is “no” skip to Section II	<input checked="" type="checkbox"/> Yes
<i>Select the status of the representative and attach documentation showing representative’s authority to act for the Participant</i>		
Public Guardian Full Guardian Parent Representative Payee Conservator Power of Attorney Partial Guardian Delegated parental authority Other	Select and enter the applicable choice that describes the status of the Participant. These are “forced choice” check boxes; you may select only one. If you select “other” provide a description of the location in the text box that appears after the work “other”	<input checked="" type="checkbox"/> Other Participant states he wants his daughter to help with his decision making; he has signed a statement to that effect.
Full Name Participant’s representative	Enter the full name, first, middle, last of the Participant’s representative	Dolores Maria Hernandez
Mailing address	Enter number and street (or P.O. Box) for the Participant	183656 Douglas Highway
City/State/Zip	Enter City, State, Zip Code	Douglas, AK 99824
Phone	Enter the contact phone number for the Participant’s representative	907-555-4545
Email	Enter the Email address for the Participant’s representative	DMH@gci.net
Does the Participant want SDS documents mailed to the Participant’s legal representative?	Enter “yes” or “no” depending upon what the Participant tells you	<input checked="" type="checkbox"/> Yes
Does a legal representative plan to be physically present to manage personal care services for the Participant?	Enter “yes” or “no” depending upon what the Participant tells you	<input checked="" type="checkbox"/> Yes

Is the representative involved in the day-to-day care of the Participant, in person or telephonically?	Enter “yes” or “no” depending upon what the Participant tells you	<input checked="" type="checkbox"/> Yes
Has the legal representative designated an individual to act as the representative” designee in accordance with 7 AAC 125.100(c) and Approved Form PCA-10?	Enter “yes” or “no” depending upon what the Participant tells you	<input checked="" type="checkbox"/> Yes

If yes complete the representative’s designee information below

Full Name of representative’s designee	Enter the full name, first, middle, last of the representative’s designee	James C. Jones
Mailing address	Enter number and street (or P.O. Box) for the representative’s designee	1565 Brenden Avenue
City/State/Zip	Enter City, State, Zip Code	Juneau, AK 99081
Phone	Enter the contact number for the representative’s designee	907-555-3989
Email	Enter the Email address for the representative’s designee	jamescj@gci.net

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Section II Personal Care Services Review

1. Physical condition

Name Health Care Provider/Clinic	Enter the full name of the Participant’s primary health care provider or the full name of the clinic where the Participant in enrolled and receives their primary health care services	Excellent Health Care Clinic
Phone number	Enter the contact phone number for the Participant’s Primary Health care provider	907-555-6767
Fax number	Enter the fax number for the Participant’s Primary Health care provider	907-555-8990

Read and explain to the Participant the following declaration so that you are comfortable that the Participant is knowingly making the declaration: “I (Participant) declare that I have a chronic or permanent physical condition that is stable and predictable and that I have not experienced any changes during the previous service plan year that would affect my current service level authorization. I continue to need hands on help for the activities I have checked from the following list.”

For each of the ADLs/IADLs and other activities listed below ask the Participant if they are continuing to need physical assistance to accomplish the activity and record their “yes” or “no” answer

Bed mobility	Personal Hygiene	Light Meal Preparation
Transferring	Bathing	Main Meal Preparation
Locomotion	Light/Routine Housework	Administration of Medication
Dressing	Shopping	Minor Maintenance of Respiratory Equipment
Eating/Drinking	Laundry	Dressing Changes and Wound Care
Toileting	Passive Range of Motion Exercises	

Participant request for continuing services		
Per 7 AAC 125.012(d), I am requesting a renewal of my Personal Care services at the current level without a reassessment.	If the Participant is requesting continuing services at the same level and has documented their eligibility to proceed without a reassessment, per 7 AAC 125.012(d), which reads: <i>“the department may reauthorize personal care services without a reassessment under 7 AAC 125.020, if the recipient documents in the application submitted in accordance with this section that the recipient (1) has a chronic or permanent physical condition that is stable and predictable; and(2) has experienced no changes that would affect the recipient's current service level authorization”</i>), then select the “Yes” response. If the Participant is seeking a change in the service level authorization, then select the “No” response and refer to PCA-03 Personal Care Services Amendment to Service Plan.	☒ Yes

***Note: It is necessary to review the Participant assurances on page 4 very carefully with the Participant. The Renewal Application will be reviewed by SDS staff and SDS may schedule a reassessment if the Renewal Application does not adequately justify the need for ongoing services, if the Participant has failed to report changes in the preceding service year or for quality assurance purposes or if the Participant has failed to report changes in their condition during the previous year. The Participant is required to acknowledge that even though they are requesting continuing services without a reassessment, the department reserves the right to conduct an assessment as determined necessary by SDS staff (7 AAC 125.020)**

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Section IV Participant signature page

*Participant assurances--Assist the Participant to carefully read and review this signature page; you should be comfortable that the Participant knows and understands the contents of the assurances and what they are signing. The Participant’s name will pre-fill at the top of the page and in the “name” text box. Complete the fillable text boxes, be sure to print or type the name of the person who is signing the Participant assurances, i.e. if the Participant has a representative the representative’s name should be entered in the text box under the signature line. Print the page so that the Participant and the witness, if applicable, can place a handwritten signature on this page of the application. The signed page can be scanned and submitted by DSM with the rest of the application (preferred method) or the complete application may be printed and submitted by Fax. *Note some of the form will print in color. Set your printer to gray scale if you do not want to print in color.*

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Section V Agency signature page

*Agency Assurances--Carefully read and review the Agency signature page. Complete the fillable text boxes and the check boxes which indicate the forms and documents that are attached. Print the page so that the agency representative can place a handwritten signature on this page of the application. The signed page can be scanned and submitted by DSM with the rest of the application (preferred method) or the complete application may be printed and submitted by Fax. *Note some of the form will print in color. Set your printer to gray scale if you do not want to print in color.*