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

Request for Waiver of In-Person Review of Services

Participant Name: _____ Medicaid Number: _____

Participant Address:

_____

Program Administrator: _____

Phone Number: _____

PSA Agency: _____

I hereby request a waiver of the requirement that the in-person review under 7 AAC 125.130 (a)(l)* occur every six months, because all of the factors listed below are true:

1) the recipient's residence is in a remote community or location;

2) my agency performs in accordance with (a)(l) of this section a review of the recipient's services at least once in a 12-month period;

3) instead of the omitted six-month review the agency conducts, at the time the six-month review would occur, a telephonic or electronic meeting with the recipient and the recipient's personal care assistant for the review of services will occur; **and**

4) waiving one of the six-month reviews will not compromise the health, safety, or welfare of the recipient.

* 7 AAC 125.130(a)(1) states that a personal care services agency that administers a consumer-directed program will review the recipient's services at least once every six months, including interviewing the recipient at the recipient's residence to evaluate whether services were provided as authorized and that those services meet the recipient's continuing needs; interviewing the recipient's PCS to evaluate the service records and timesheets; documenting the recipient's record if needed; and amending the recipient's service level authorization as needed.

_____ _____

Signature of Program Administrator Date

_____ _____

Signature of Recipient or Legal Representative Date

For SDS Use only

☐ Request approved - effective date _____ Expiration Date: _____

☐ Request denied - date notice sent: _____

Reason for denial:

_____

SDS Staff Name: _____

_____