Instruction for PCA-08
Personal Care Services Initial Application

The Application for Personal Care services 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 enroll 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 extra pages are needed to respond to questions 6, 7 and/or 8 follow the instructions under those sections for submitting extra pages. 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 7 and 8, the signature pages. The Participant or the participant's representative must place an original signature on page 7. The agency representative must place handwritten initials and a signature on page 8. Once signed pages 7 and 8 may be scanned and submitted by DSM with the rest of the application or the complete application may be printed and submitted by Fax. *Note some of the form will print in color depending upon your printer settings. Set your printer to gray scale if you wish to avoid printing in color.

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.

The Application is to be completed by a representative of a Personal Care Agency

When completed, submit an INITIAL application with original initials and signatures, to Senior & Disability Services via secure Email DSDS.PCSInitialApplication@direct.dhss.akhie.com. 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-08 *Application for Personal Care Services* is posted on the SDS "Approved Forms" website. The application may be completed by entering the requested information into fillable boxes or a blank copy of the application may be printed and hand-written. The signatures pages (pages 7 and 8) *must* be printed so that hand-written initials and original signatures are entered; the entire application may be submitted by secure Email or if necessary, by Fax. ***Every set of check boxes must have a response; do not submit an incomplete application.***

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	Efren Jose Gonzales Efren J. Gonzales
Medicaid #	Copy the participant's Medicaid # from their most recent Medicaid identification care	1231231234
Personal Care Services agency		
Information requested	**What to enter**	**Example**
Program type	Selection the program that the participant is applying for; agency based or consumer directed	☒Consumer Directed
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 *Note this may be different from the agency representative who signs the attestations on page 8	Jeremy 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 8		
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	☒Male
Marital status	Select one of the five options based on what the participant tells you	☒Widow
Primary language	Enter the language in which the participant is fluent	Spanish
Interpreter needed	Select "yes" if the participant is requesting an interpreter and "no" if an interpreter is not needed/requested	☒Yes
If primary language is not English, provide the name of English speaker for communication purposes		
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
Type of Facility		
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"	970-555-2424

Page 2

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.	☒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	☒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.	☒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"	☒No
Is the Participant a U.S. Veteran?	Based upon what the Participant tells you, respond "yes" or "no"	☒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 representative in the text boxes following this question. If the response is "no" skip to Section II	☒Yes
Select the status of the representative and attach documentation showing representative's authority to act for the Participant		
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. Select only one. If you select "other" provide a description of the status of the Representative in the text box that appears after the work "other"	☒ 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 PO 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	☒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	☒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	☒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	☒Yes
If marked "yes" complete the representative's designee information below		
Full Name 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 PO 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
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
By observation or report does the Participant have a physical condition that affects the Participant's capacity to perform the activities covered by the personal care services program?	Some questions you might ask the Participant to make a determination about how to answer this question are: What are your medical conditions or diagnoses; what causes your physical limitation(s); what has your doctor (health care professional) told you about your medical condition; has your doctor recommended that you have assistance to take care of yourself. Ask enough questions and follow-up questions so that you can make an informed decision about the Participant's medical condition. Combine your own observations (if you are having an in person interview) with what the Participant tells you to answer the question "yes" or "no"	☒Yes
Is the Participant's physical condition documented in clinical records?	Answer this question "Yes" or "No" depending upon what the Participant tells you. If the answer is "No" you will not be able to submit a complete application. If the answer is "Yes", medical records and a current VOD and ROI must be submitted with the complete application	☒Yes

Page 3		
2. Material change in physical condition *USE THIS SECTION ONLY IF PARTICIPANT IS SUBMITTING A SECOND APPLICATION WITHIN A 365 DAY PERIOD		
Did the Participant submit an application for personal care services during the previous 365-day period?	If this is the Participant's first application in the previous 365 days, then the answer is "No" and you can skip to question #3.	☒Yes
If "No" skip to question number 3		
Has a material change, as defined in 7 AAC 125.012(c) occurred following submission of that application?	Review the regulation excerpt below and discuss with the Participant what they describe as their material change in circumstances. Determine if what they describe is consistent with the definition in the regulation. Together with the Participant, if you conclude that there has been a material change in circumstances, the record the answer as "Yes" and complete the next 2 questions. If you and the Participant conclude that the answer is "No", then record the answer and let the Participant know that they do not meet the criteria to submit a second application with the 365-day time period.	☒Yes
If "No" the applicant does not meet the criteria to apply—If "Yes" complete the answer tin the text boxes below*		
If the Participant has had an application denied anytime within the previous 365 day period they must meet the "material change in circumstance" definition noted in 7 AAC 125.012(c) as follows: " (c) A recipient determined not to qualify for personal care services on the basis of the recipient's application or after an assessment, may reapply in the same 365-day period only if a material change in the recipient's physical condition occurred after that determination. In this subsection, "material change" means an alteration in the physical condition of sufficient significance that the department is likely to reach a different decision regarding the recipient's need for physical assistance with ADLs, IADLs, and other covered activities."		
Describe the change that happened after the previous application or assessment	Based on what the Participants tells you describe what happened to cause a significant change in the Participant's physical condition. Limit your answer to the space allowed; be specific and concise. It is necessary that medical records support what the Participant tells you.	Participant had a stroke 2 months ago
By observation or report describe how the change affects the Participant's capacity to perform activities covered by personal care services	Based on what the Participant tells you describe what happened to cause a significant change in the Participant's physical condition. Limit your answer to the space allowed; be specific and concise. It is necessary that medical records support what the Participant tells you.	Participant has left sided paralysis; does have the use of his left arm, hand, or leg.
3. Age of Participant		
Is the Participant 6 to 18 years of age?	Ask the Participant's age and respond "Yes" if participant is between ages 6-18 and "No" if the Participant is under 6 years of age or over 18 years of age.	☒No
If "Yes" answer the question below, if "No" skip to question 4		

Does the Participant need more physical assistance with activities than a same-age individual who does not have a disability?	Ask the Participant's parent or primary care giver if in their opinion the Participant needs more physical assistance with activities than a same-age individual without a disability. Discuss with the parent or primary care giver why they feel that the Participant needs more assistance than an individual of the same age without a disability. Based on the information you receive and the discussion that you have with the primary care giver, answer the question either "Yes" or "No"	☒Yes
4. Need physical assistance with: TO BE ANSWERED BY THE APPLICANT/PARTICIPANT		
Bed mobility	Ask the participant if he/she needs hands on help from another person to move in bed. "yes" or "no" answer	☒Yes
Transferring	Ask the participant if he/she needs hands on help from another person to stand up from the bed to a chair. "yes" or "no" answer	☒Yes
Locomotion	Ask the participant if he/she needs hands on help from another person to walk or use a wheelchair. "yes" or "no" answer	☒Yes
Dressing	Ask the participant if he/she needs hands on help from another person to get dressed. "yes" or "no" answer. "yes" or "no" answer	☒Yes
Eating and drinking	Ask the participant if he/she needs hands on help from another person to eat and drink. "yes" or "no" answer	☒No
Toileting	Ask the participant if he/she needs hands on help from another person to go to the bathroom. "yes" or "no" answer	☒Yes
Personal hygiene	Ask the participant if he/she needs hands on help from another person to wash their face and comb their hair and trim their nails. "yes" or "no" answer	☒Yes
Bathing	Ask the participant if he/she needs hands on help from another person to bathe or shower. "yes" or "no" answer	☒Yes
Light meal preparation	Ask the participant if he/she needs hands on help from another person to prepare a snack or a light meal. "yes" or "no" answer	☒No
Main meal preparation	Ask the participant if he/she needs hands on help from another person to prepare the main meal of the day. "yes" or "no" answer	☒Yes
Housework	Ask the participant if he/she needs hands on help from another person to make their bed, dust the furniture, sweep or vacuum the floors. "yes" or "no" answer	☒Yes
Shopping	Ask the participant if he/she needs hands on help from another person to shop for groceries and medications. "yes" or "no" answer	☒Yes
Page 4		
Laundry	Ask the participant if he/she needs hands on help from another person to do the laundry. "yes" or "no" answer	☒Yes
Taking medications	Ask the participant if he/she needs hands on help from another person to take medications. "yes" or "no" answer	☒No
Maintenance of respiratory equipment	Ask the participant if he/she needs hands on help from another person to take care of their respiratory equipment. "yes" or "no" answer	☒No

Dressing changes or wound care	Ask the participant if he/she needs hands on help from another person to change a dressing or take care of a wound. “yes” or “no” answer	☒No
Passive range of motion exercises	Ask the participant if their doctor has recommended passive range of motion exercises. “yes” or “no” answer	☒Yes
5. Location for delivery of services		
A. By observation and report does the Participant live in a location where personal care services providers are available to provide services for the Participant?	If this is an application for agency-based PCS and your agency has personnel available to provide services for this Participant, respond with a “yes” answer, (if services are not currently available respond with a “no” answer). If this is an application for consumer –based PCS, based on what the Participant tells you, provide a “yes” or “no” answer.	☒Yes
B. By observation and report does the Participant 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?	If this is an application for agency-based PCS, respond with a “no” answer. If this is an application for consumer –based PCS, based on what the Participant tells you, provide a “yes” or “no” answer.	☒Yes
*C. Does the Participant meet the requirements of 7 AAC 125.140 for the consumer-directed personal care services program?	Review and discuss the criteria in the regulation with the Participant and based on your discussion with the Participant respond with a “yes” or “no” answer.	☒Yes

*5C refers to 7AAC 125.140(a) which reads:

“To qualify for personal care services through a consumer-directed program, a recipient or a recipient's representative identified in accordance with (e)(2) of this section must

(1) demonstrate cognitive capacity for decision-making;

(2) understand the impact of, and assume responsibility for, managing and training the recipient's personal care assistants;

(3) designate a personal care services agency that administers a consumer directed program to fulfill the `responsibilities of 7 AAC 125.130 on behalf of the recipient

(4) cooperate with the department in reviews of the recipient's service level authorization;

(5) cooperate with the department and with other state and federal oversight agencies during compliance reviews, investigations, or audits; and

(6) negotiate a contract for the recipient's personal care services with the personal care services agency that will administer those services through a consumer-directed program.

**D. By observation and report does the Participant's residence meet the "place of service" requirements of 7 AAC 125.050?	Review and discuss the criteria in the regulation with the Participant and based on your discussion with the Participant respond with a "yes" or "no" answer.	☒Yes
*5D refers to 7 AAC 125.050(a)(1) which reads: (a) The department will pay for personal care services for a recipient only if provided (1) in the recipient's residence if that residence is (A) the dwelling that the recipient considers to be the recipient's established or principal home and to which, when absent, the recipient intends to return; and (B) real property or personal property that is fixed or mobile and that is located on land or water, if the living conditions are appropriate for the needs of the recipient, including adequate arrangements for hand washing and waste disposal;		
6. Shared Residence/Natural Supports		
Do other people live in the same residence as the Participant?	Ask the Participant and based on his/her response answer the question "yes" or "no"	☒Yes
If "No" skip to question 7		
If yes; how many people reside in the residence including the Participant?	Ask the Participant and based on his/her response record the total number of persons residing in the residence including the Participant	Two
How many are under 18 years old?	Ask the Participant and based on his/her response record the total number of persons if any residing in the residence that are under 18 years old	None
Do any residents under 18 years old receive Medicaid services?	If there are residents under the age of 18 receiving Medicaid services respond with the answer "yes". If there are residents under the age of 18 not receiving Medicaid services, or if there are no residents under the age of 18 respond with the answer "no"	☒No
List other resident who are 18 years old and older who live in the same residence as the Participant and answer the questions in the table below; **list each person 18 years of age and older in the text box "Resident's Name". Answer each or the following questions specific to that individual resident. There are 4 text boxes to individually list 4 residents; *if more than 4 adults live in the household with the Participant, create a Word document titled *"Additional Information for #6 Shared Residence/Natural Supports"* and complete an answer for each of the questions that pertain to each additional resident; scan it and attach it when submitting the Application Form.**		
Resident's Name, Age, Relationship to Participant	Record the resident's name, age, and relationship to the Participant in the text boxes.	Mary Louise Sampson, age 75 Sister
Does this Resident help the Participant with activities that he/she is unable to perform without hands on assistance?	Depending upon what the Participant or his/her representative tells you answer the question with a "yes' or "no" answer.	☒Yes

Is the help provided by the Resident temporary?	Depending upon what the Participant or his/her representative tells you answer the question with a "yes" or "no" answer. If the resident is available, it is important to ask them as well.	☒Yes
Is this Resident paid to provide this help?	Depending upon what the Participant or his/her representative tells you answer the question with a "yes" or "no" answer. If the resident is available, it is important to ask them as well.	☒No
Has this Resident applied for Home and Community Based Waiver Services?	Depending upon what the Participant or his/her representative tells you answer the question with a "yes" or "no" answer. If the resident is available, it is important to ask them as well.	☒No
Does this Resident receive or has he/she applied for Chore Services?	Depending upon what the Participant or his/her representative tells you answer the question with a "yes" or "no" answer. If the resident is available, it is important to ask them as well.	☒No
Does this Resident receive or has he/she applied for Personal Care Services?	Depending upon what the Participant or his/her representative tells you answer the question with a "yes" or "no" answer. If the resident is available, it is important to ask them as well.	☒No
Does this Resident receive or has he/she applied for Chore services through a grant?	Depending upon what the Participant or his/her representative tells you answer the question with a "yes" or "no" answer. If the resident is available, it is important to ask them as well.	☒No
Page 5		
7. Individual Supports		
Do individuals who do not live with the Participant, help with activities that he/she is unable to perform without hands on assistance?	Depending upon what the Participant or his/her representative tells you answer the question with a "yes" or "no" answer.	☒Yes
If the answer is "No" skip to question 8. If the answer is "Yes answer the questions for each individual listed below; list each individual who helps the Participant in a separate text box and answer each of the questions specific to the individual who is helping the Participant. There are 3 boxes with questions following to list 3 individuals; **if more than 3 individuals help the Participant, create a Word document titled "Additional Information for #7 Individual Supports" and complete the text box information for each additional individual, scan it and attach it when submitting the Application Form.**		
Individual's Name, Age, Relationship to Participant	Record the individual's name, age, and relationship to the Participant in the text boxes.	Dolores Maria Hernandez, age 45, daughter
Is the assistance Paid; Unpaid	Depending upon what the Participant or his/her representative tells you answer the question "Paid" or "Unpaid"	☒Unpaid
Is the assistance Temporary or Ongoing?	Depending upon what the Participant or his/her representative tells you answer the question "Temporary" or "Ongoing"	☒Ongoing
Page 6		
8. Community Supports		

Do community organizations help the Participant with activities that he/she is unable to perform without physical assistance?	Depending upon what the Participant or his/her representative tells you answer the question with a "yes' or "no" answer.	☒Yes
If the answer is "No" skip to Section III. If the answer is "Yes" list each community agency that helps the Participant in a separate text box and answer each of the questions specific to the community agency who is helping the Participant. There are 2 text boxes to individually list 2 community supports; **if more than 2 community organizations help the Participant, create a Word document titled "Additional Information for #8 Community Supports" and list the text box information for each additional community organization, scan it and attach it when submitting the Application Form.**		
Name of Community Agency; Relationship to Participant	Record the name of the community agency and the Participant's relationship to the agency in the text boxes	Saint Benedict's Catholic Church; parishioner
Name of Agency Contact	Record the name of the agency contact	Father Brown
Is the assistance Paid; Unpaid	Depending upon what the Participant or his/her representative tells you answer the question "Paid" or "Unpaid"	☒Unpaid
Is the assistance Temporary or Ongoing?	Depending upon what the Participant or his/her representative tells you answer the question "Temporary" or "Ongoing"	☒Ongoing
Page 7		
Section III 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 that 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.**		
Page 8		
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.**		