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

NFLOC-04 APPLICATION FOR ALI/APDD/CCMC

Select one: **Initial Application** **Renewal Application**

1. Applicant Information:

1.a. Recipient Name:

1.b. Care Coordinator Name:

1.c. Care Coordinator Agency Name:

1.d. Application Date:

1.e. Medicaid ID:

2. Select Program:

Alaskans Living Independently (ALI)

Adults with Physical and Developmental Disabilities (APDD)

Children with Complex Medical Conditions (CCMC)

If applying or renewing application for Community First Choice (CFC), also complete CFC-06 Community First Choice Application – NOTE: Children under 6 years are not eligible for Personal Care Services. Applicants intending to live and recipients living in assisted living homes (ALHs) cannot receive CFC services (whether Personal Care Services, Personal Emergency Response Systems, or Chore services

3. Checklist

Please refer to Application Requirements Care Coordinator Checklist for specific details regarding application requirements.

Person-Centered Intake Completed in Harmony for Initial Applicants Only:

Date of PCI:

For APDD Initial Applications Only

Attach the SDS Developmental Disabilities Determination Approval Letter

Uni-07 Recipient Rights & Responsibilities

Attach to Application Note

Uni-09 Verification of Diagnosis

Attach to Application Note

Medical Documentation within the last 12 months

Attach to Application Note

Legal Representative documents, if applicable

Attach to Application Note

Recipient Name: Medicaid ID:

SECTION I-DEMOGRAPHIC INFORMATION

4. Gender: **5. DOB:**

6. Preferred Pronouns: **7. Marital Status:**

8. Primary Language: **9. Interpreter needed:**

10. If non-verbal, primary mode of communication:

11. Assessment Scheduling

11.a. Who should be contacted for the purpose of scheduling an assessment?

11.b. Contact Phone Number for scheduling:

11.c. Phone Type:

11.d. If you selected "other" for 11a. please indicate: **(Please ensure this person is listed on the ROI)**

First and last name:
Relationship to applicant:

12. Applicant Address:

12.a. Physical Address:

Street:

City: State: Zip:

12.b. Is this address a facility? (Hospital, Long Term Care facility, DOC, IMD): Yes No

a. Facility Type:
b. Facility Name:
c. Expected Date of Discharge:

13. Is this address an assisted living home? Yes No

ALH name:

14. For applicants residing in private residences (non-ALH) only: Do any other household members receive Medicaid waiver or personal care services (PCS)? Yes No (If applicant lives in ALH, skip to #15)

15. Where should SDS documents and notices be mailed?

15.a.

15.b. Name: ***(Must match name on legal representative document)***

15.c. Mailing Address where SDS documents and notices will be sent:

Street:

City: State: Zip:

16. Applicant's Legal Representative (if applicable):

16.a. Participant has a legal representative: Yes No

16.b. Name:

16.c. Legal Relationship:

16.d. Contact Phone Number for Legal Representative:

16.e. Phone Type:

Recipient Name: Medicaid ID:

SECTION II – DIAGNOSIS & MEDICAL INFORMATION

17. Document emergency room visits, hospitalizations, surgeries and/or treatments over the past 12 months. If none check NA here:

(If description exceeds available space, add additional information in Section V as necessary)

Date of Event	Visit Type Check All That Apply	Brief Description of Event SDS Assessor Should Be Aware of	Identify Attached Supporting Documentation or Medical Records that will be submitted with the Application	Was a CIR submitted for this event? Yes/No
	ER Visit Hospitalization Surgery Treatment			Yes No
	ER Visit Hospitalization Surgery Treatment			Yes No
	ER Visit Hospitalization Surgery Treatment			Yes No
	ER Visit Hospitalization Surgery Treatment			Yes No
	ER Visit Hospitalization Surgery Treatment			Yes No
	ER Visit Hospitalization Surgery Treatment			Yes No

18. Is the applicant currently receiving physical therapy, occupational therapy, speech therapy and/or nursing care?

Yes No *(If no, skip to #19)*

Therapy Type	Frequency per Week	Identify Attached Supporting Documentation
Physical Therapy		
Occupational Therapy		
Speech Therapy		
Nursing Care		

Recipient Name: Medicaid ID:

19. Describe significant changes in the applicant's life, health and/or behavior in the last year: ***(If description exceeds available space, add additional information in Section V as necessary)***

20. Is there other information about the applicant's health the SDS assessor should be aware of? ***(If description exceeds available space, add additional information in Section V as necessary)***

SECTION III – Medical Providers and Medication

21. Medical Providers: ***(For each medical provider listed, please complete all fields. Put N/A if field is not applicable. If you need additional space, please add the information in Section V)***

21.a. Provider Name:
Phone Number: Fax Number:
Provider Specialty: Number of visits last 12 months:

21.b. Provider Name:
Phone Number: Fax Number:
Provider Specialty: Number of visits last 12 months:

21.c. Provider Name:
Phone Number: Fax Number:
Provider Specialty: Number of visits last 12 months:

Recipient Name: Medicaid ID:

21.d. Provider Name:
Phone Number: Fax Number:
Provider Specialty: Number of visits last 12 months:

21.e. Provider Name:
Phone Number: Fax Number:
Provider Specialty: Number of visits last 12 months:

21.f. Provider Name:
Phone Number: Fax Number:
Provider Specialty: Number of visits last 12 months:

21.g. Provider Name:
Phone Number: Fax Number:
Provider Specialty: Number of visits last 12 months:

22. Current Medications: ***(Put NA if the applicant is not taking any medications. If number of medications exceeds available space, add additional information in Section V as necessary.)***

Medication Name	Dosage	Route of Administration	Frequency	Status

23. Additional Information:

23.a. Has the recipient been approved for waiver for the past 2 or more consecutive years?

Yes **No**

23.b. Does the recipient want to undergo an assessment instead of a comprehensive file review (if he/she qualifies for the file review)?

Yes **No**

23.c. Are there material changes in health or functional status within the past year? If yes, please provide an explanation in space provided in Questions 19 & 20.

Yes No

Recipient Name: Medicaid ID:

24. Statements of/Documentation of Reasonable Expectation of the Need for Long Term Care

Both statements must be checked for a complete application

24.a. **Yes** I believe there is a reasonable indication that the applicant might need services at a level of care provided in a hospital, nursing facility, IMD, or ICF/IID in 30 or fewer days unless the applicant receives home and community-based waiver services under 7 AAC 130 or Community First Choice services under 127.

24.b. **Yes** 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.

25. Conflict of Interest – Applicant Acknowledgement

7 AAC 127.020, 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 the care coordinator's employment by or family relationship to a certified provider agency?**

Yes, my care coordinator has informed me of possible conflicts, and I wish to proceed.

Or

Yes, my care coordinator has informed me that they have no conflicts, and I wish to proceed.

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.

Applicant or Legal Representative Signature (only one signature requested) Date

Printed Name of Signer (Applicant or legal representative)

Care Coordinator Signature Date

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

Witness #1 Signature Date

Witness #1 Printed Name Relationship

Witness #2 Signature Date

Witness #2 Printed Name Relationship

SECTION V – ADDITIONAL NOTES AND DOCUMENTATION

Provide any additional information carried over from any section which did not provide sufficient room and/or add any additional information that SDS staff should be aware of that was not otherwise documented within the application.