



State of Alaska • Department of Health • Division of Senior and Disabilities Services
Home and Community Based Waiver Services • Personal Care Services
Recipient Rights and Responsibilities

Name:

Medicaid Number:

This form explains your rights and responsibilities for services. Contact your care coordinator or service provider if you have any questions.

I have the right to:

- Stop my application anytime.
- Choose help for everyday things from friends or family instead of from a Direct Care Worker (DCW).
- Choose my service providers.
- Choose new service providers, including my care coordinator or service agency at any time.
- Get respect and dignity from people who give me services.
- Have information about me kept private by the state and by my service providers.
- Have fair testing (assessment) that checks my health and my ability to do and understand everyday things.
- Get the results of my assessment.
- Take part in planning my services.
- Ask for a meeting with my providers and/or planning team anytime if my health or abilities change, and I need new or different services.
- Know how much services cost.
- Know how to give a complaint to my service provider.
- Get it in writing from my service provider if they will be changing, ending my services, or discharging me.
- Appeal any decision that affects my services.
- File a grievance. Grievances may be filed by myself or by my authorized representative. A grievance is an expression of dissatisfaction or complaint related to the state's or a provider's performance regarding the following:
 - the person centered planning process;
 - the person-centered support plan;
 - review of the person-centered support plan; or
 - home and community-based settings.

My Initials

I have been told:

- If I am hurt, sick, not safe, and need help right away, I should call 911 or local emergency services.
- There may not be very many choices for help with everyday living, depending on where I live in Alaska.
- My service providers and care coordinator are mandatory reporters. This means they must tell the Division of Senior and Disabilities Services (SDS) about the following:
 - If I experience abuse, neglect, or exploitation.
 - If I am missing.
 - If I did something that hurt myself or others.
 - If a restrictive intervention was not used right.
 - If a restrictive intervention made me need to see a doctor.
 - If I die.
 - If I have an accident or get hurt, and it impacts my health and safety.
 - If I take the wrong medication and need to see a doctor.
 - If something happens and I am visited by law enforcement.

- That Medicaid can cover medical expenses like checkups, dental care, emergency care and travel to appointments. I can read the Medicaid handbook at: <https://health.alaska.gov/media/ux4ds44w/ada-compliant-2025-medicaid-recipient-handbook.pdf>.
- If I have questions about Medicaid coverage, I can call toll free 800.780.9972.
- If I have questions about finding care in my area, I can call Alaska 2-1-1.
- I should tell SDS, my service provider, or my care coordinator about the following:
 - If I experience abuse, neglect, or exploitation.
 - If I know of waste or abuse of Medicaid funds.
 - If I am unhappy with my services, or if my services are not the same as what my plan says.
- I can tell SDS about these things in the following ways:
 - SDS Main Phone Number: 907-269-3666.
 - Adult Protective Services: 1-800-478-9996.
 - Central Intake Phone Number (in-state only): 1-800-478-9996.
 - Online Centralized Reporting: <https://hssakprod.wellsky.com/assessments/?WebIntake=6AFD8667-02D0-445F-95F0-8043108C4357>.
- If needed, Alaska Relay services can be accessed by calling 800-770-8973 or TTY: 711.
- I should tell about child abuse. I can tell Office of Children's Services at 800-478-4444 or ReportChildAbuse@alaska.gov.

My Initials

I understand I must:

- Get a Verification of Diagnosis (VOD) or Qualifying Diagnosis Certificate (QDC) filled out and signed by my licensed medical provider.
- Be ready for and take part in my eligibility assessment on the day and time SDS schedules it.
- Give my care coordinator or service provider all my health and ability testing records so they can give them to SDS according to timelines found in regulations at 7 AAC 130.207.
- Tell my care coordinator or provider agency within 15 days if anything changes about:
 - How I can do everyday things.
 - Where I live.
 - Where I get mail.
 - My phone number.
 - If I get married, separated or divorced.
 - My medical provider.
 - My provider agency.
 - My legal representative.
- Give all and only true information. If I do not, it could mean that I am violating or abusing the Medicaid program on purpose (intentional program violation or abuse).
- Make a backup plan for someone else to help me if my friends, family, or Direct Care Worker cannot.

My Initials

I understand:

“Intentional program violation/abuse” is when a person hides facts or gives false information about their needs on purpose, to get or keep Medicaid benefits. “Program abuse” is when someone uses Medicaid services the wrong way or uses too many services on purpose.

If SDS believes I have violated or abused Medicaid benefits or services on purpose, the Department of Health will investigate according to law. If the department finds that I have violated or abused Medicaid on purpose, the department may:

1. Deny my application per regulation.
2. Recover (make me pay back) Medicaid costs paid on my behalf, as allowed by 7 AAC 100.910.
3. Refer the matter to the Alaska Department of Law for civil or criminal action in a state or federal court.

Care Coordinator/Personal Care Services (PCS) Agency Representative:

I have discussed the Recipient Rights and Responsibilities with the applicant and/or legal representative.

Care Coordinator/PCS Agency Representative Signature

Printed Name

Date

Applicant/Recipient:

I have discussed my rights and responsibilities with my Care Coordinator and/or my Personal Care Services Agency Representative.

My Signature

Printed Name

Date

Legal Representative Signature if applicable

Printed Name

Date

Witness Signature

Printed Name

Relationship

Date