NFLOC-04 Application Instructions

The NFLOC-04 Application is posted on the Senior and Disabilities Services (SDS) Approved Forms website and is to be completed by a Care Coordinator.

To use the NFLOC-04 Application 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. Please use the latest version. You can download it free at https://get.adobe.com/reader/ . Please complete the form by entering a response for each item listed unless directed to skip that item. There are features included on the form to assist you such as: free text boxes, date selectors, radio buttons, check boxes and dropdown lists. You will need to save the form to your computer. To do this go to the File menu, click Save As, type in a file a name, choose a file destination on your computer and then click Save. Documents with file names that include special characters cannot be opened in Harmony when using the Chrome browser. SDS requests that all Harmony users do not use the following special characters when naming files that will be uploaded in Harmony as Note attachments: comma (,) and semi column (;).

This is an SDS Approved Form so please do not make any changes to the form. If extra pages are needed to respond to any of the questions beyond the space allowed within the form, then you have the option to submit extra pages by creating a separate Word document with the title "Additional Information for NFLOC-04 Application"**.** You can include extra pages after page 7 of the NFLOC-04 Application 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 page 6 as necessary for signatures. Page 6 is where the Applicant or the applicant's legal representative signs, dates and prints name. Page 6 is where the Care Coordinator signs and dates. Two witnesses are needed if the Applicant signs with an X or stamp. Both witnesses must print name, sign, date and provide their relationship to the Applicant. *Note – ensure printer settings are set to grayscale if you wish to avoid printing in color.

The completed form contains Protected Health Information (PHI) and must be submitted through the SDS secure **Harmony Data System**. Please refer to the T24 Care Coordinator Guide for SDS Harmony Data System for the correct steps to submit the application.

NFLOC-04 – Application Page 1 Coversheet

Information requested	What to enter	Example
(Top of Page) Header: Recipient Name	Enter Recipient's first and last name Recipient name entered here will autofill 1a. Recipient Name and header on each subsequent page	John Smith
(Top of Page) Header: Medicaid ID	Enter applicant's Medicaid Number Medicaid numbers are ten digits and begin with either **06** or **20**.	0600000000
Select one:	Select one radio button for either: **Initial Application** or **Renewal Application**	⊙Initial Application
1.a. Recipient Name	Enter Recipient's first and last name (if this did not autofill from header)	John Smith
1.b. Care Coordinator Name	Enter Care Coordinator's first and last name	Jane Doe
1.c. Care Coordination Agency Name	Enter Care Coordination Agency's name	Doe and Friends Care Coordination
1.d. Application Date	Enter the date the application is being completed (if this did not autofill from header)	5/20/2021
1.e. Medicaid ID	Enter applicant's Medicaid Number Medicaid numbers are ten digits and begin with either **06** or **20**.	0600000000
2. Select Program	Select radio button next to one of the following: Alaskans Living Independently (ALI) Adults with Physical and Developmental Disabilities (APDD) Children with Complex Medical Conditions (CCMC)	⊙Alaskans Living Independently (ALI)
3. Checklist	Checkmark each item that applies If checking *Person-Centered Intake Completed in Harmony for Initial Applicants Only*, please also provide the Date of PCI	☑ Uni-07 Recipient Rights and Responsibilities

NFLOC-04 – Application Page 2

Section I – Demographic Information

Information requested	What to enter	Example
4. Gender	Select from dropdown list	Male
5. DOB	Enter applicant's date of birth (DOB) using 00/00/000 format	11/23/1940
6. Preferred Pronouns	Select from dropdown list	He/him/his/himself
7. Marital Status	Select from dropdown list	Singe/Never Married
8. Primary Language	Select from dropdown list	English
9. Interpreter needed	Select from dropdown list: **Yes** indicates an SDS contracted interpreter is needed for the assessment. **No** indicates that no SDS contracted interpreter is needed for the assessment.	⊙Yes
10. If non-verbal, primary mode of communication	Enter communication information for non-verbal applicants	Responds with nods
11.a. Who should be contacted for the purpose of scheduling an assessment?	Select from dropdown list	Legal Representative
11.b. Contact Phone Number for scheduling	Enter telephone number for scheduling	907-555-5555
11.c. Phone Type	Select from dropdown list	Legal Representative Mobile
11.d. If you selected "other" for 11.a. please indicate: ***(Please ensure this person is listed on the ROI)***	Enter first and last name Select Relationship to applicant from dropdown list If person listed is not the Applicant, Legal Representative, or Care Coordinator, please ensure that they are listed on the ROI.	Anne Smith - Wife
12 a. Physical Address: **Street**	Enter the number and street where the applicant resides *This is where the applicant is physically located at the time the application is submitted to SDS. Fill in Facility/Other Location address if applicant is currently at that location.	18679 Main Street

Information requested	What to enter	Example
12 a. Physical Address: **City**	Enter City name	Anchorage
12 a. Physical Address: **State**	Select from dropdown list	AK
12 a. Physical Address: **Zip**	Enter Zip code	99501
12.b. Is this address a facility? (Hospital, Long Term Care facility, DOC, IMD):	Select one radio button for either: **Yes** or **No** If **Yes** = respond to a., b., and c.	⊙Yes
12.b. Is this address a facility? **Yes: a. Facility Type**	a. Select from dropdown list	Facility Type: Hospital
12.b. Is this address a facility? **Yes: b. Enter name of facility**	b. Enter name of facility	Facility Name: Providence Medical Center
12.b. Is this address a facility? **Yes: c. Expected Date of Discharge**	c. Use date selector to select the expected date of discharge. If exact expected date of discharge is unknown, please provide estimated date of discharge. If the applicant is admitted to a facility, do not leave blank.	Expected Date of Discharge: 12/31/2021
13. Is this address an assisted living home?	Select one radio button for either: **Yes** or **No** If **Yes** = Enter ALH name and ***Skip to 15*** If **No** = *continue to 14*	⊙Yes ALH Name: Alaska Assisted Living
14. For applicants residing in private residences (non-ALH) only: Do any other household members receive Medicaid waiver or personal care services (PCS)? **(If applicant lives in ALH, skip to #15)**	Select one radio button for either: **Yes** or **No**	⊙Yes
15.a. Where should SDS documents and notices be mailed?	Select from dropdown list: Applicant mailing address Legal Representative mailing address	Legal Representative mailing address
15.b. Name	Enter the name of the person that you selected for 15.a.	Anne Smith
15.c. Mailing Address: **Street**	Enter the mailing address number and street	PO Box 123
15.c. Mailing Address: **City**	Enter City name	Anchorage
15.c. Mailing Address: **State**	Select from dropdown list	AK

Information requested	What to enter	Example
15.c. Mailing Address: **Zip**	Enter Zip code	99501
16a. Participant has a legal representative:	Select one radio button for either **Yes** or **No** If **Yes** = respond to 16.b. – 16.e. If **No** = move to question 17	Yes
16.b. Name	Enter the name of the applicant's legal representative	Anne Smith
16.c. Legal Relationship	Select from dropdown list	Power of Attorney
16.d. Contact Phone Number for Legal Representative	Enter the phone number of the legal representative	907-269-6666
16.e. Phone Type	Select from dropdown list	Legal Representative Mobile

NFLOC- Application Page 3

SECTION II – Diagnosis & Medical Information

Information requested	What to enter	Example
17. Document emergency room visits, hospitalizations, surgeries and/or treatments over the past 12months: **If none check NA**	If none, select N/A checkbox	☑ N/A
17. Document emergency room visits, hospitalizations, surgeries and/or treatments over the past 12months: **Date of Event**	Use date selector to select the date of the event	4/1/2021
17. Document emergency room visits, hospitalizations, surgeries and/or treatments over the past 12months: **Visit Type- Check All that Apply**	Check each item that applies	☑ER Visit ☑Hospitalization
17. Document emergency room visits, hospitalizations, surgeries and/or treatments over the past 12months: **Brief Description of Event SDS Assessor Should Be Aware Of**	Enter description of event If additional space is needed, see page 7 SECTION V– ADDITIONAL NOTES AND DOCUMENTATION	Applicant taken to Alaska Hospital ER due to…

Information requested	What to enter	Example
17. Document emergency room visits, hospitalizations, surgeries and/or treatments over the past 12months: **Identify Attached Supporting Documentation or Medical Records that will be submitted with the Application**	Identify the specific medical records or supporting documentation for this event that will be submitted along with the application. If no supporting documentation exists for this event, put NA.	Alaska Hospital ER Discharge Summary Dated 04/01/2022
17. Document emergency room visits, hospitalizations, surgeries and/or treatments over the past 12months: **Was a CIR submitted for this event? Yes/No**	Select one radio button for either: **Yes** or **No** If you are not sure if a CIR was submitted, select: **No**	⊙Yes
18. Is the applicant currently receiving physical therapy, occupational therapy, speech therapy and/or nursing care?	Select one radio button for either: **Yes** or **No** If **Yes** = respond to each column of Therapy table If **No** = ***Skip to 19***	⊙Yes
18. **Therapy Type:** Physical Therapy, Occupational Therapy, Speech Therapy, Nursing Care: Frequency	Select from dropdown list.	4 days/week
18. **Therapy Type:** Physical Therapy, Occupational Therapy, Speech Therapy, Nursing Care: Identify Attached Supporting Documentation	Enter a reference to the documentation that supports this therapy	PT Note dated 5/1/2021

NFLOC – Application Page 4

SECTION II – Diagnosis & Medical Information Continued

Information Requested	What to enter	Example
19. Describe significant changes in the applicant's life, health and/or behavior in the last year	Enter description of significant changes in the last year. If additional space is needed, see page 7 SECTION V – ADDITIONAL NOTES AND DOCUMENTATION	Applicant had a stroke 2 months ago…

Information Requested	What to enter	Example
20. Is there other information about the applicant's health the SDS assessor should be aware of?	Enter description of significant changes in the last year. If additional space is needed, see page 7 SECTION V – ADDITIONAL NOTES AND DOCUMENTATION	Applicant has had to relocate

NFLOC – Application Page 5

SECTION II – Diagnosis & Medical Information Continued

Information requested	**What to enter**	**Example**
21. Medical Providers	**For each provider, please complete all fields. Put N/A if field is not applicable:**	N/A
22. Current Medications: **Medication Name**	Enter medication name	Metformin
22. Current Medications: **Dosage**	Enter dosage amount	500 mg
22. Current Medications: **Route of Administration** (dropdown)	Select from dropdown list	PO (by mouth/oral)
22. Current Medications: **Frequency** (dropdown)	Select from dropdown list	Daily
22. Current Medications: **Status**	Select from dropdown list	Current
23. a. Additional Information: has the recipient been approved for waiver for the past 2 or more consecutive years?	Select one radio button for either: **Yes** or **No**	⊙Yes
23.b. Additional Information: Does the recipient want to undergo an assessment instead of a comprehensive file review (if he/she qualifies for the file review)?	Select one radio button for either: **Yes** or **No** **Yes** = the applicant would like to undergo an assessment instead of a file review **No** = the applicant would like to have a comprehensive file review instead of an assessment (if they qualify)	No

23.c. Additional Information: Are there material changes in health or functional status within the past year? If yes, please provide explanation in the space provided in Questions 19 and 20.	Select one radio button for either: **Yes** or **No** Per 7 AAC 130.211(c), a material change is defined as an alteration in the applicant's health, behavior, or functional capacity of sufficient significance that the department is likely to reach a different decision regarding the applicant's need for home and community-based waiver services.	No

NFLOC – Application Page 6

SECTION III - Statement of Reasonable Expectation of the Need for Long Term Care:

Information requested	What to enter	Example
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.	Checkmark statement	☑
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.	Checkmark statement	☑
25. Conflict of Interest - Applicant Acknowledgement	Select one radio button next to the statement that applies	⊙Yes, my care coordinator has informed me that …

SECTION IV – Signatures

Information requested	What to enter	Example
Applicant or Legal Representative Signature	Applicant or Legal Representative signs here – only one signature requested	*Anne Smith*

Information requested	What to enter	Example
Date	Enter the date signed by the Applicant or Legal Representative	5/19/2021
Printed Name of Signer (Applicant or legal representative)	Enter first and last name of person who signed	Anne Smith
Care Coordinator signature	Care Coordinator signs here	*Jane Doe*
Date	Enter the date signed by the Care Coordinator	5/20/2021
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**	First witness signs here	*Deb Crane*
Two witnesses are required if recipient signs with an X or a stamp. The care coordinator may not serve as a witness: **Date**	Enter the date signed by first witness	5/20/2021
Two witnesses are required if recipient signs with an X or a stamp. The care coordinator may not serve as a witness: **Witness #1 Printed Name**	Enter first and last name of first witness	Deb Crane
Two witnesses are required if recipient signs with an X or a stamp. The care coordinator may not serve as a witness**: Relationship**	Enter relationship	Friend
Two witnesses are required if recipient signs with an X or a stamp. The care coordinator may not serve as a witness: **Witness #2 Signature**	Second witness signs here	*Rob Stowe*
Two witnesses are required if recipient signs with an X or a stamp. The care coordinator may not serve as a witness: **Date**	Enter the date signed by first witness	5/20/2021
Two witnesses are required if recipient signs with an X or a stamp. The care coordinator may not serve as a witness: **Witness # 2 Printed Name**	Enter first and last name of second witness	Rob Stowe

Information requested	What to enter	Example
Two witnesses are required if recipient signs with an X or a stamp. The care coordinator may not serve as a witness**: Relationship**	Enter relationship	Friend

NFLOC – Application Page 7

SECTION V- Additional Notes and Documentation

Information requested	What to enter	Example
Below provide any additional information that SDS staff should be aware of that was not otherwise documented within the application.	Enter additional information as needed. If extra pages are needed to respond to any of the questions beyond the space allowed within the form, then you have the option to submit extra pages by creating a separate Word document with the title "Additional Information for UNI-04 Application". You can include extra pages after page 7 of the UNI-04 Application form.	Additional medications…