Applicant Name: _____ Medicaid ID: _____

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

CFC-06 APPLICATION FOR COMMUNITY FIRST CHOICE (CFC)

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).

Select *one* ☐ **Initial Application** **or** ☐ **Renewal Application**

1. Applicant Information:

1a. Applicant Name: _____

1b. Care Coordinator Name: _____

1c. Care Coordination Agency Name: _____

1d. Application Date: _____

2. Community First Choice (CFC) Information

2a. Select the level of care applicant is pursuing or has already met:

☐ Nursing Facility (for Alaskans Living Independently (ALI), Adults with Physical and Developmental Disabilities (APDD) or Children with Complex Medical Conditions (CCMC) Waiver)

☐ Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

☐ Other level of care based on referral from an institution for mental diseases (IMD)
Only available for participants ages 65+ or under age 22

2b. Is the applicant considering Personal Care Services (PCS)?

☐ No, not considering PCS. Only considering Personal Emergency Response System (PERS) and/or Chore services. No CAT Required. *Skip to 3.*

☐ Yes, considering Personal Care Services (PCS) – Consumer Assessment Tool (CAT) Required. *If yes answer 2c. Please note applicants that do not have a PCS Agency at the time of the CAT will experience a delay in services. The PCS Agency will need to submit a CFC inquiry through Harmony before they can be added as a provider for the recipient. Recipients without a PCS Agency will be placed in a suspend status and will be sent a 30 day notice to select an agency or closure will occur.*

2c. *If you answered yes to 2b:* **If the applicant does not meet level of care for CFC, does the applicant want to be considered for automatic enrollment into State Plan Personal Care Services?**

☐ **Yes**, applicant wants to be automatically enrolled in PCS in the event of a CFC level of care denial

☐ **No**

Applicant Name:_____ Medicaid ID:_____

3. 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 Signature

Choose an item
Relationship

Witness Printed Name

Date

Witness Signature

Choose an item
Relationship

Witness Printed Name

Date