State of Alaska • Department of Health & Social Services
Division of Senior and Disabilities Services
Personal Care Assistance Program and
Community First Choice Personal Care Assistance Program

Shared Agency Service Agreement

When a Recipient is receiving services from two PCA Provider Agencies, it is necessary to complete and submit the information requested in this form. Complete all of the information requested, obtain signatures and upload as specified in your Harmony Guide.

Recipient Name: _____

Effective Date of Shared Services: _____

Information for Primary PCA/CFC-PCA Provider Agency

Name Primary PCA/CFC-PCA Agency: _____

Medicaid Provider number for Primary PCA/CFC-PCA Agency: _____

Total hours per week being provided at Primary PCA/CFC-PCA Agency: _____

Primary PCA/CFC-PCA Agency Modifiers:

Consumer Directed PCA Modifier: _____

Agency Based PCA Modifier: _____

Consumer Directed CFC-PCA Modifier: _____

Agency Based CFC-PCA Modifier: _____

Information for Secondary PCA/CFC-PCA Provider Agency

Name Secondary PCA/CFC-PCA Agency: _____

Medicaid Provider number for Secondary PCA/CFC-PCA Agency: _____

Total hours per week being provided at Secondary PCA/CFC-PCA Agency: _____

Secondary PCA/CFC-PCA Agency Modifiers:

Consumer Directed PCA Modifier: _____

Agency Based PCA Modifier: _____

Consumer Directed CFC-PCA Modifier: _____

Agency Based CFC-PCA Modifier: _____

The above named "Primary PCA Agency" will provide the "Secondary PCA Agency" with copies of the contents of the recipient's file, in accordance with the "Authorization for Release of Information" form. The "Secondary PCA Agency" must submit a completed transfer form to SDS within 15 calendar days of receipt of the recipient's information.

Signatures:

Signature of Client (or legal representative if applicable): _____

Date: _____

Print Client's Name (or legal representative if applicable): _____

Signature of "Primary PCA/CFC-PCA Agency" Representative: _____

Date: _____

Print Name of "Primary PCA/CFC-PCA Agency" Representative: _____

Signature of "Secondary PCA/CFC-PCA Agency" Representative: _____

Date: _____

Print Name of "Secondary PCA/CFC-PCA Agency" Representative: _____

For CFC-PCA Only:

Signature of Care Coordinator: _____

Date: _____

Print Name of Care Coordinator: _____