State of Alaska • Department of Health and Social Service • Senior and Disabilities Services

Remote Allowance for First Aid and CPR Training
Personal Care Assistants

Please complete all fields below. Submissions with missing or inadequate information will be returned.
Completed forms may be e-mailed to DSDSCertification@alaska.gov (preferred) or faxed to (907) 754-3475

Name of Agency ______________________ **Provider #** ______________
Program Administrator ______________________ **Phone** ______________
E-mail ______________________________

Section I: Employee for whom the allowance is being requested (full legal name)

PCA Enrollment #

Last Name	**First Name**	**Middle Initial**	**Hire Date**	**Expiration Dates** CPR	**Expiration Dates** First Aid	**Employee Service Delivery Location(s)**

Is the above employee a Personal Care Assistant whose training will or has expired? Yes No

Is CPR and/or First Aid training periodically available within 100 miles of employee's service location? Yes No

Date of previous CPR/First Aid training (month/year) ______________

The employee must have documentation on file verifying successful completion of training every three years.

Section II: Plan for Compliance with CPR/First Aid Training Requirements

Date training expected to be completed ______________ *Completion date is required; TBD will result in allowance denial*

Name of accepted course ______________ Training location:

For a list of approved courses, see http://dhss.alaska.gov/dsds/Documents/SDSforms/AcceptedCourseCPR-FirstAid.pdf.

Section III: Personal Care Services Employee Assurance

I assure and understand an approved allowance is only valid until the expiration date specified by SDS as indicated below. It is my responsibility to work with my agency for ongoing compliance with CPR/First Aid training requirements including proper documentation of compliance in my agency personnel file.

______________________________ ______________________________
Signature Personal Care Services Employee Date

Section IV: Personal Care Services Certified Agency Assurance

I assure my agency will not submit a claim for reimbursement from Medicaid for personal care services rendered by the employee named on this allowance during a time period the employee is not compliant with CPR/First Aid training requirements or under an approved allowance per 7 AAC 125.090(e). Any false statement, misrepresentation, omission, or concealment in this document may subject my agency and/or me to criminal, civil, or administrative penalties. Under penalty of perjury, I certify that the information I have provided is true, accurate, and complete to the best of my knowledge.

______________________________ ______________________________
Signature Program Administrator PCS Agency Date

This Section for SDS Use Only

Allowance is Approved Denied

SDS Decision Date ______________ Allowance Expiration Date ______________

______________________________ ______________________________
Signature SDS Certification and Compliance Date

Comments

Cert 49-B
Revised 12/23/2019
ADA 2/14/2020