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

Personal Care Services Initial Application

See Instructions for Completion of Personal Care Services Initial Application on how to complete and submit this form

Participant Name: _____ **Medicaid #:**_____

Program Type: ☐ Agency-Based ☐ Consumer-Directed

Personal Care Services Agency

Agency/Center Name: _____ Provider #: _____

Agency/Center Representative: _____

Phone: _____ E-mail: _____

Section I Participant Information

1.) **Participant Profile**

Date of Birth: _____

Gender Identification: ☐ Male ☐ Female ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Primary Language: _____ Interpreter needed? ☐ Yes ☐ No

If primary language is not English, provide the name of English-speaker for communication purposes.

Name: _____ Phone: _____

Relationship to Participant: _____

2.) **Participant Address**

Physical Address:_____ City/State/Zip:_____

☐ *If this is a Facility/Other Location:*

Name of Facility/Other Location: _____

Expected Date of Discharge: _____

☐ Acute Care Facility ☐ Long Term Care Facility ☐ Assisted Living Home ☐ Other: _____

Mailing Address: _____ City/State/Zip: _____

Cell Phone: _____ Landline Phone: _____

Participant Name: _____ Medicaid #: _____

3.) **Participant Current Services**

	Yes	No
Has the Participant applied for HCBW services?	☐	☐
Does the Participant receive chore services as a waiver service?	☐	☐
Has the Participant applied for grant services?	☐	☐
Does the Participant receive chore services through a grant?	☐	☐
Is the Participant a U.S. Veteran?	☐	☐

4.) Participant Representative

Does Participant have a legal Representative? ☐ Yes ☐ No

**If marked "Yes" complete representative information below; if marked "No" skip to Section II*

Representative Type (*Attach Documentation*)

- ☐ Public Guardian (OPA)
- ☐ Parent
- ☐ Power of Attorney
- ☐ Representative Payee
- ☐ Other _____
- ☐ Full Guardian
- ☐ Conservator
- ☐ Partial Guardian
- ☐ Delegated Parental Authority

Representative's Full Name: _____
Mailing Address 2: _____
City/State/Zip: _____ Phone: _____
E-mail: _____

Does the Participant want SDS documents mailed to the Participant's legal representative?

☐ Yes ☐ No

Does the legal representative plan to be physically present to manage personal care services for the Participant?

☐ Yes ☐ No

Is the legal representative involved in the day-to-day care of the Participant, in person or telephonically?

☐ Yes ☐ No

Has the legal representative designated an individual to act as the representative's designee in accordance with 7 AAC 125.100(c) and Approved Form PCA-10?

☐ Yes ☐ No

**If marked "Yes" complete the representative's designee information below; if marked "No" skip to Section II*

Representative's Designee's Full Name: _____
Mailing Address: _____
City/State/ Zip: _____ Phone: _____
Email: _____

Participant Name: _____ Medicaid #: _____

Section II Personal Care Services Review

1.) **Physical Condition**

Full Name of Primary Health Care Provider / Primary Health Care Clinic: _____
Phone: _____ Fax: _____

By observation or report does the Participant have a physical condition that affects the Participant's capacity to perform the activities covered by the personal care services program?

☐ Yes ☐ No

Is the Participant's physical condition documented in clinical records?

☐ Yes ☐ No

2.) **Material Change in Physical Condition** (*Use this section only if Participant is submitting a second application / re-application within a 365 day period*)

Did the Participant submit an application for personal care services during the previous 365 day period?

☐ Yes ☐ No **If marked "No" skip to #3*

Has a material change, as defined in 7 AAC 125.012 (b), occurred following submission of that application?

☐ Yes ☐ No

**If marked "No" the applicant does not meet the criteria to apply; if marked "Yes" complete questions below.*

Describe the change that happened after the previous application or assessment _____

By observation or report describe how the change affects the Participant's capacity to perform activities covered by personal care services

3.) **Age of Participant**

Is the Participant under 6 years of age?

☐ Yes ☐ No *If the answer is "yes" the Participant does not qualify for PCA services per 7 AAC 125.010(8)(A)*

Is the Participant 6 to 18 years of age?

☐ ☐ *If the answer is "no" skip to question 4; if the answer is "yes" answer the question below; 7 AAC 125.010(8)(B)(i)(ii)*

Does the Participant need more physical assistance with activities than a same-age individual who does not have a disability? ☐ Yes ☐ No

4.) **Need Physical Assistance With?**

By observation or report does the Participant need physical assistance with the activities of daily living, instrumental activities of daily living, and other covered services specified in 7 AAC 125.030 (a-b)

**Check "Yes" or "No" to indicate where help is needed to perform the activity (must be answered by the participant).*

Participant Name: _____ Medicaid #: _____

Activities	YES	NO	Activities	YES	NO
Bed Mobility	☐	☐	Light Meal Preparation	☐	☐
Transferring	☐	☐	Main Meal Preparation	☐	☐
Locomotion	☐	☐	Light/Routine Housework	☐	☐
Dressing Eating/	☐	☐	Shopping	☐	☐
Drinking	☐	☐	Laundry	☐	☐
Toileting	☐	☐	Administering of Medication	☐	☐
Personal Hygiene	☐	☐	Minor Maintenance of Respiratory Equipment	☐	☐
Bathing	☐	☐	Dressing Changes and Wound Care	☐	☐
Escort	☐	☐	Passive Range of Motion Exercises	☐	☐

5.) **Location for Delivery of Services**

By observation and report does the Participant live in a location where personal care services providers are available to provide services for the Participant?

☐ Yes ☐ No

By observation and report does the Participant anticipate receiving personal care services from an individual that is qualified and willing to provide physical assistance through the consumer-directed personal care services program?

☐ Yes ☐ No

Does the Participant meet the requirements of 7AAC 125.140 for the consumer-directed personal care services program?

☐ Yes ☐ No

By observation and report does the Participant's residence meet the "place of service" requirements of 7 AAC125.050?

☐ Yes ☐ No

**See Instructions for PCS-08 Personal Care Services Initial application for full text of regulations*

6.) **Shared Residence/Natural Supports**

Do other people live in the same residence as the Participant? ☐ Yes ☐ No

**If "No", skip to Question 7*

If "Yes"; how many people reside in the residence including the Participant? _____

How many are under 18 years old? _____ Do any residents under 18 years old receive Medicaid services? _____

List other residents who are *18 years old and older* who live in the same residence as the Participant and answer the questions in the table below:

Resident's Name: _____

Age: _____ Relationship to Participant: _____

	YES	NO
***Does this Resident help the Participant with activities that he/she is unable to perform without physical assistance?** *(* If "No", skip remaining questions.)*	☐	☐
Is the help provided by this Resident temporary/intermittent?	☐	☐
Is this Resident paid to provide this help?	☐	☐
Has this Resident applied for Home and Community Based Waiver Services?	☐	☐
Does this Resident receive or has he/she applied for Chore Services?	☐	☐
Does this Resident receive or has he/she applied for Chore services through a grant?	☐	☐

Resident's Name: _____
Age: _____ Relationship to Participant: _____

	YES	NO
***Does this Resident help the Participant with activities that he/she is unable to perform without physical assistance?** *(* If "No", skip remaining questions.)*	☐	☐
Is the help provided by this Resident temporary/intermittent?	☐	☐
Is this Resident paid to provide this help?	☐	☐
Has this Resident applied for Home and Community Based Waiver Services?	☐	☐
Does this Resident receive or has he/she applied for Chore Services?	☐	☐
Does this Resident receive or has he/she applied for Chore services through a grant?	☐	☐

Resident's Name: _____
Age: _____ Relationship to Participant: _____

	YES	NO
***Does this Resident help the Participant with activities that he/she is unable to perform without physical assistance?** *(* If "No", skip remaining questions.)*	☐	☐
Is the help provided by this Resident temporary/intermittent?	☐	☐
Is this Resident paid to provide this help?	☐	☐
Has this Resident applied for Home and Community Based Waiver Services?	☐	☐
Does this Resident receive or has he/she applied for Chore Services?	☐	☐
Does this Resident receive or has he/she applied for Chore services through a grant?	☐	☐

Resident's Name:
Age: Relationship to Participant:

	YES	NO
***Does this Resident help the Participant with activities that he/she is unable to perform without physical assistance?** *(* If "No", skip remaining questions.)*	☐	☐
Is the help provided by this Resident temporary/intermittent?	☐	☐
Is this Resident paid to provide this help?	☐	☐
Has this Resident applied for Home and Community Based Waiver Services?	☐	☐
Does this Resident receive or has he/she applied for Chore Services?	☐	☐
Does this Resident receive or has he/she applied for Chore services through a grant?	☐	☐

7.) **Individual Supports**

Do individuals who do not live with the Participant help with activities that he/she is unable to perform without physical assistance? ☐ Yes ☐ No

**If "No" skip to Question 8. If "Yes" answer the questions in the table below.*

Individual's Name:
Age: Relationship to Participant:
Is the assistance: ☐ Paid ☐ Unpaid
Is the assistance: ☐ Temporary ☐ Ongoing

Individual's Name:
Age: Relationship to Participant:
Is the assistance: ☐ Paid ☐ Unpaid
Is the assistance: ☐ Temporary ☐ Ongoing

Individual's Name: _____
Age: _____ Relationship to Participant: _____
Is the assistance: _____ ☐ Paid ☐ Unpaid
Is the assistance: _____ ☐ Temporary ☐ Ongoing

Individual's Name: _____
Age: _____ Relationship to Participant: _____
Is the assistance: _____ ☐ Paid ☐ Unpaid
Is the assistance: _____ ☐ Temporary ☐ Ongoing

8.) **Community Supports**

Do community organizations help the Participant with activities that he/she is unable to perform without physical assistance? ☐ Yes ☐ No

**If "No", skip to Section III. If "Yes" answer the questions in the table below.*

Name of Community Agency: _____
Name of Agency Contact: _____
Relationship to Participant: _____
Is the assistance: _____ ☐ Paid ☐ Unpaid
Is the assistance: _____ ☐ Temporary ☐ Ongoing

Name of Community Agency: _____
Name of Agency Contact: _____
Relationship to Participant: _____
Is the assistance: _____ ☐ Paid ☐ Unpaid
Is the assistance: _____ ☐ Temporary ☐ Ongoing

Participant Name: _____ Medicaid #: _____

Section III Participant Signature Page

Participant Assurances

I, (print / type Participant name) *understand that, although I claim that I need physical assistance with the activities specified in this application for Personal Care Services, the decision to authorize personal care services for those activities will be made by Senior and Disabilities Services on the basis of a review of my current clinical documentation and a functional assessment of my capacity to perform the activities. I understand that failure to provide all or any part of the information requested could affect the determination made by Senior and Disabilities Services to authorize services for me.* ***I certify that I have reviewed and signed SOA approved form Uni-07 Recipient Rights and Responsibilities and that the content of this form SOA PCA-08 Personal Care Services Initial Application has been explained to me by the agency/resource center representative in language that I understand; that I agree to the content of this form; and that this is an application for medical assistance program benefits.***

I understand that knowingly making a false statement may subject me to criminal prosecution or civil sanction, including, without limitation, monetary penalties. I understand that knowingly making a false statement may constitute the crimes of perjury (AS 11.56.200), medical assistance fraud (AS 47.05.210) and/or unsworn falsification (AS 11.56.210).

I certify, under penalty of perjury, that the information I have provided herein is true, accurate, and complete to the best of my knowledge.

Participant/Representative Signature: Date: _____

Print or Type Participant/Representative Name:

Witness

If the Participant signs with a mark, the signature of a witness who is NOT the Participant's care coordinator, personal care assistant or representative of the personal care services agency is required.

Witness Signature: Date: _____

Print / Type Witness Name:

_____

Participant Name: _____ Medicaid #: _____

Section IV Agency Signature Page

Agency Name_____ Provider # _____

Agency Assurances

I certify that I have screened the Participant's need for physical assistance with activities covered by the Personal Care Services regulations. I understand that the decision to authorize Personal Care Services will be made by Senior and Disabilities Services on the basis of a review of the Participant's current clinical documentation and a functional assessment of capacity to perform the activities indicated in this request.

I, (print / type Agency Representative name) _____*understand that knowingly making a false statement may subject me or the named agency or resource center to criminal prosecution or civil sanction, including, without limitation, monetary penalties. I understand that knowingly making a false statement may constitute the crimes of perjury (AS 11.56.200), medical assistance fraud (AS 47.05.210) and/or unsworn falsification (AS 11.56.210). My initials are my certification, under penalty of perjury, that the following statements are true to the best of my knowledge.*

Initials	Sworn Statement
☐	*I represent the named agency/resource center; by signing this application, I am acting within the scope of my employment.*
☐	*I have read the Participant's answers to the question on this application, and believe the answers to be true, accurate and complete to the best of my knowledge.*
☐	*I believe the Participant needs physical assistance with the personal care services activities specified in this application.*
☐	*If I learn that the Participant does not need personal care services, I will notify Senior & Disabilities Services immediately.*
☐	*I have included clinical records as supportive of the Participant's claim of a functional limitation and need for physical assistance with ADLs, IADLs and other covered services specified in this application.*

As required, I have attached the following:

- ☐ *Release of Information Form*
- ☐ *Verification of Diagnosis Form*
- ☐ *Clinical records that are not older than one year prior to the date of this application and that support the Participant's diagnosis and need for physical assistance*
- ☐ *Documentation showing representative's authority to act for the Participant (if applicable). The documentation must include language that gives the representative authority to make medical decisions on behalf of the Participant and must not be expired.*
- ☐ *PCA-02 Request for Passive Range of Motion (if applicable)*

Agency Representative Signature: Date: _____