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

Appointment for Care Coordination/Targeted Case Management Services

Recipient

Name:
Case Number:
Plan of Care Start Date:
Former Care Coordinator:
Former Care Coordination Agency:

Care Coordinator

Name:
IP Number:
Telephone Number:
Care Coordination Agency:
Provider Number:

I am a certified care coordinator authorized by the State of Alaska to assist you to obtain services funded by the Medicaid Home and Community Based Waiver Services program. If you are determined eligible and continue to meet eligibility requirements, you will qualify for services through the Select One program.

As your care coordinator, I agree to:

- Assist with your initial application for and renewals of Medicaid eligibility, but it is your responsibility to complete the forms and submit them to the Division of Public Assistance with all required documentation.
- Explain your program rights and responsibilities, and to give you a copy of the *SDS Recipient Rights and Responsibilities* and the *Notice of Adverse Action & Fair Hearing Rights*.
- Inform you of any employment or family relationship I have to a certified provider agency (7 AAC 130.217 and 7 AAC 130.240).
- Assist you and/or your legal representative to develop a Support Plan to meet your needs, to revise this plan when your needs change or are not being met, and to submit timely, on your behalf, all documents required by SDS.
- Submit a signed amendment to SDS within 10 days if your changing needs require a change of providers or an increase or decrease of services.
- Maintain case notes (available to you upon request) documenting visits, contacts, and other matters regarding your services.
- Evaluate whether your Support Plan is meeting your needs and whether the services approved have been provided, (unless waived by SDS) through 2 contacts per month one of which must be face to face..
- Contact providers of services to monitor if services are being provided to meet your needs.
- Contact your providers when services are not provided to your satisfaction or in accordance with your Support Plan.
- Provide you with contact information for another care coordinator for assistance whenever I will be unavailable for over 72 hours.
- Provide contact information as to where you can reach me, with the understanding that I cannot be available to you at all times and that you should call 911 when emergency care is needed.
- Provide you with 30 days notice, inform SDS, and help you to find another care coordinator if I exercise my right to terminate my services to you.
- Cooperate in the transfer of care coordination services to include transfer of documents if you exercise your right to change care coordinators at any time or for any reason.
- If this is a transfer of care coordination a payment agreement has been developed.
- Report abuse, neglect, self-neglect, and financial exploitation to Adult Protective Services at 1-800-478-9996, or to the Office of Children's Services at 1-800-478-4444.
- Report circumstances which might indicate Medicaid fraud, abuse or waste to the SDS Quality Assurance Unit at 1-800-478-9996.
- I understand that my Care Coordination responsibilities end when the approved Support Plan, Amendments, and all case notes for the past 12 months are sent to the new CC, and SDS is provided with a copy of this form

Signature of New Care Coordinator _____ Effective Date of Appointment

Signature of Applicant/Recipient or Legal Representative _____ Date

Signature of Transferring Care Coordinator _____ Date