



State of Alaska • Department of Health and Social Services
 Senior and Disabilities Services
Community First Choice Amendment to Service Plan

Recipient name: _____ Medicaid #: _____

Care Coordinator name: _____ Provider Billing ID #: _____

Contact telephone #: _____ Care Coordinator FAX #: _____

Care Coordinator Email: _____

Basis for this amendment request

The recipient has experienced a material change(s) in his/her (check all that apply)

- medical condition or functional capacity
- physical living environment
- unpaid supports, caregivers, or services
- paid supports, caregivers, or services
- state plan services (CFC)

Description of change(s)

Date(s) of the change(s): _____ Describe the change(s) in the text box below:

Requested adjustments to the Service Level Authorization for Personal Care Services or other CFC Services: Specify the activity, and the frequency, scope, and length of time for each activity, to be adjusted because of the change in the recipient's condition.

Activity	Frequency <i>Times per day</i>	Scope <i>Times per week</i>	Length <i>How long needed</i>

For each activity listed, describe how the requested adjustments to frequency, scope, and length are necessary because of the material change(s).

[Empty rectangular box for activity descriptions]

Required documentation

Attach documentation that supports the specific adjustments to the Service Level Authorization as required by *Personal Care Services Policy and Procedures 10-13*.

For Community First Choice Amendments, Attach UNI-14B CFC Cost Overview Sheet for requests including Personal Emergency Response System and Skills Building.

Recipient Assurances

I acknowledge the change described in this request for amendment of my Personal Care Services, and the impact of that change on my life. I have participated in the planning of my care, and agree that the adjustments in activities are related to the described change and are appropriate for my care. I request amendment of my Service Level Authorization as indicated in the activities table and/or Community First Choice Cost overview sheet. I understand that this is an application for Medicaid benefits, and that any misrepresentation, omission, or concealment of a material fact may subject me to civil monetary penalties, fines, or criminal prosecution. I certify that the information I have provided is true, accurate, and complete to the best of my knowledge.

<i>Recipient/Legal representative signature</i>	<i>Date</i>
If the recipient signs with an “X”, the signature of a witness who is not the recipient’s care coordinator, personal care assistant, or representative of the personal care services agency is required.	

Witness signature	Date
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Witness printed name	Date
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Care Coordinator Assurances

I certify that the adjustments indicated in the activities table are necessary because of the described material change in the named recipient’s condition and the impact of that change on the recipient’s life. I understand that this is an application for Medicaid benefits, and that any misrepresentation, omission, or concealment of a material fact may subject me to civil monetary penalties, fines, or criminal prosecution. I certify that the information I have provided is true, accurate, and complete to the best of my knowledge.

Care Coordinator signature	Date
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Agency Representative signature	Date
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Agency Representative printed name	Date
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