State of Alaska Department of Health and Social Services Senior and Disabilities Services  
Community First Choice Program  
REQUIREMENTS FOR A COMPLETE INITIAL APPLICATION CFC PROGRAM ONLY

☐ ADRC Person Centered Intake (PCI) Completion Form
  ❖ The applicant should have received this one page form from the ADRC after Options Counseling; if not, have the applicant complete a Release of Information allowing the care coordinator to receive the applicant’s ADRC Person Centered Intake Completion form from the ADRC used by the applicant.

☐ Uni-04 Application for ALI/APDD/CCMC Waivers and Community First Choice Option
  ❖ Select CFC-Community First Choice (only); page 1  
  ❖ Indicate the applicant’s preferred Personal Care Services Agency; page 1  
  ❖ Must be dated and signed by Applicant  
  ❖ Must include all 6 pages  
  ❖ Complete every line and every page; use “n/a” if the information does not apply  
  ❖ Medicaid number must be present on the application  
  ❖ List the full name, contact information and reason and frequency of visits for each doctor or health provider listed  
  ❖ Complete every block under current medications including reason prescribed (can’t be unknown)  
  ❖ If there is a parent or legal representative, they must sign where designated (not on recipient line)

☐ FOR DD DIAGNOSES ONLY –Documentation of DD determination
  ❖ Attach the SDS Developmental Disabilities Determination approval Letter

☐ FOR MENTAL HEALTH DIAGNOSES ONLY –Documentation of Level of Care
  ❖ Criteria under 7 AAC 127.025(d)(e)

☐ Uni-05 Appointment for Care Coordination Services
  ❖ Care coordinator and applicant or representative must sign and date  
  ❖ Select “Community First Choice-only” in the drop down prompt at the top of the page

☐ Uni-07 Recipient Rights & Responsibilities
  ❖ Applicant or legal representative must initial every line by hand; do not use check marks  
  ❖ Applicant or legal representative must sign and date  
  ❖ Care coordinator and/or PCS agency and/or PCS agency representative must sign and date  
  ❖ Witness signature is optional

☐ Uni-09 Verification of Diagnosis
  ❖ The provider must include the license number and state where licensed on the form  
  ❖ The form must have an accurate ICD-10 code  
  ❖ The form must be signed and dated by the provider within 6 months of submission to SDS  
  ❖ Electronic signatures are not acceptable  
  ❖ The provider name, telephone, facsimile number and license number must be included in either handwritten or typewritten format.

☐ Medical Information
  ❖ Medical documents related to any visits or consultations with medical professionals within the 12 months preceding the date of submission of the application; including the 3 most recent visits to clinics or emergency rooms or the information the applicant considers the most relevant to the application  
  ❖ Medical documents that are related to the long term care need  
  ❖ Records of residential stays, if applicable including a nursing facility, hospital, psychiatric institution or
assisted living home.

- Records of therapies provided by a qualified therapist for any of the following: physical, speech/language, occupational or respiratory
- Records of psychiatric or mental health counseling or treatments provided by a qualified therapist or physician, nurse practitioner or physician assistant.
- Special treatments received such as IV medications, parenteral nutrition, testing, home health services or hospice services
- Outpatient treatments such as chemotherapy, radiation or dialysis

[ ] Uni-16 Release of Information ---Care Coordinators and Medical Provider(s) to DSDS
- Must be signed and dated by recipient or legal representative
- Must be dated within 12 months of submission
- Note: The general language in the “Person/Organization Releasing Information” paragraph covers all health care providers.

[ ] Legal Representative documents, if applicable
- The documentation must include language that gives the representative authority to make medical decisions on behalf of the Recipient and must not be expired
- Electronic signatures are not acceptable

[ ] Proof of Medicaid Eligibility and Identity
- Must document active coverage with current Denali Card or Medicaid number or a print out from DPA or a print out from Enterprise showing active coverage