



STATE OF ALASKA

Department of Health and Social Services
 Senior and Disabilities Services

PCA Program – Change of Information (Amendment to Service Plan)

Recipient Name:		Agency Contact Name:	
Recipient Medicaid #:		Agency Contact Phone #:	
Agency Name & PCG #:		Agency Fax #:	

Recipient request a change in services between Chore and IADLs:

Recipient Chooses Chore Services

Recipient Chooses IADLs

Effective Date if choosing IADLs will be the date of PCA review

Care Coordinator notified of consumer choice: Date: _____ via: Phone **Fax** **Email**

Recipient has experienced a material change in functional/medical condition:

Explain in detail the changes that have occurred in the recipient's functional/medical condition that requires either an addition or reduction of services. **All increases in service(s) must include documentation from a qualified medical professional that documents changes in the recipient's condition (7 AAC 125.199).** Examples include hospital discharge summaries, physical therapy evaluation and/or discharge summary, or a qualified medical professional's office visit progress note(s).

Explain:

Recipient has a Prescribed Task Form (attached)

Explain in detail the rationale regarding the recipient's functional/medical condition that requires a Prescribed Task Form. The Prescribed Task form must be completed and signed by a physician, physician assistant, or an advanced nurse practitioner (7 AAC 125.030).

Explain:



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The recipient’s living situation has changed:

Explain the change in the recipient’s living condition or supports (changes must be reported within 15 days of change) that may increase or decrease recipients service level authorization. Examples include marital status, improvement or decline in physical living environment.

Explain:

Please read the following statements and **initial** each to indicate you have read and understand each statement:

_____ I have participated in the planning of my own care and agree with the above Service Plan amendment.

_____ I agree to the release of any documentation requested by SDS or its agents including the PCA agency to support this request.

By my signature below, I understand and affirm that I have met and must continuously comply with the changes in personal care service level authorization and reporting changes requirements in 7 AAC 125.026 and 7 AAC 125.028.

Recipient or Legal Representative Signature: _____ Date: _____

Witness signature: _____ Date: _____

Witness printed name: _____ Date: _____

Witness relationship to client: _____

Witness is required if recipient signs with an "X". Witness may not be Care Coordinator, PCA or PCA agency representative.

Agency Representative signature: _____ Date: _____