



Recipient Rights and Responsibilities

Applicant/Recipient: _____ Medicaid #: _____

Instructions: Initial below each section to indicate your agency representative or care coordinator has discussed the items with you.

I have the right:

- To withdraw from the application process at any time
- To make choices regarding my care
- To be treated with respect and dignity by my services providers
- To confidentiality regarding information about me in state and provider records
- To have information about me maintained as confidential by the state and by my service providers
- To a fair and comprehensive screening of my health and of my functional and cognitive abilities
- To my assessment results after eligibility determination has been made
- To participate in the planning of my eligibility services
- To request, as does any member of my comprehensive planning team, a meeting to amend my information that might effect my authorized service levels and/or plan of care at any time
- To know the fees for services before accepting care from a service provider
- To decline any service included in my plan of care and/or service level authorization
- To change service providers, including my care coordinator or service agency at any time
- To submit a complaint through a grievance procedure established by my service provider
- To written notification from my service provider regarding any change in, termination of, or discharge from services
- To appeal any decision that affects my care

_____ **Applicant/Recipient Initials**

I have been informed that

- The geographic location of my residence may limit my options for services to those made available by the service providers located in my community
- I should report abuse, neglect, self-neglect, and financial exploitation to Adult Protective Services at 800-478-9996 (in state only) or 907-269-3666 or through the centralized reporting system on line at <http://dhss.alaska.gov/dsds/Pages/CentralizedReporting.aspx> or the Alaska Relay System 800-770-8973, or to the Office of Children’s Services at 800-478-4444, ReportChildAbuse@alaska.gov or Fax: 907-269-3939.
- I should report services that are not satisfactory or are not provided as outlined in my Plan of Care and/or authorized PCA service level to the SDS Quality Assurance Unit at 907-269-3666, the Central Intake Unit at 800-478-9996 or on line at <http://dhss.alaska.gov/dsds/Pages/CentralizedReporting.aspx> or through the Alaska Relay System 800-770-8973.
- I should report circumstances that might indicate Medicaid fraud, abuse, or waste to the SDS Quality Assurance Unit at 907-269-3666 or Central Intake at 1-800-478-9996 or on line at <http://dhss.alaska.gov/dsds/Pages/CentralizedReporting.aspx> or through the Alaska Relay System 800-770-8973.

_____ **Applicant/Recipient Initials**

I am responsible for

- Working with my provider agency/care coordinator to submit a complete application packet according to timelines found in regulations at 7 AAC 130.207
- Obtaining a completed Verification of Diagnosis or Qualifying Diagnosis form from my licensed medical provider
- Cooperating with SDS in the scheduling and completion of my eligibility assessment

- Reporting to the provider agency/care coordinator within 15 days any change to my functional condition, residence, mailing address, telephone number, marital status, medical provider, provider agency, or legal representative.
- Providing only true and complete information and understand that to do otherwise could be an intentional program violation or program abuse
- Developing a contingency plan to ensure my health and welfare if PCA or HCB Waiver services are unable to be provided.

_____ **Applicant/Recipient Initials**

If receiving CDPCA services, I am also responsible for:

- Choosing a legal representative who is involved in my day-to-day care to manage and evaluate the PCA service as it occurs in my home for me, if determined that I cannot do so
- Managing my own care. This includes recruiting and scheduling my PCA
- Specifying training requirements for my PCA and assuring that the training has been received
- Developing a back-up plan about how PCA services are provided if the regularly scheduled PCA is unavailable.

_____ **Applicant/Recipient Initials**

Intentional Program Violation/Program Abuse

An “intentional program violation” occurs when an individual intentionally misrepresents, conceals, or withholds a material fact in order to establish or maintain eligibility for Medicaid benefits. “Program abuse” occurs when an individual misuses or overuses Medicaid benefits and causes unnecessary cost to the Medicaid program.

If Senior and Disabilities Services (SDS) has reason to believe that you have committed an intentional program violation or program abuse, the Department of Health and social Services will conduct a full investigation in accordance with state and federal law. If, after a full investigation, the department finds that you have committed an intentional program violation or program abuse, the department may:

1. Deny your application for Medicaid, subject to a hearing under 7 AAC 49
2. Recover Medicaid expenditures made on your behalf in accordance with 7 AAC 100.910
3. Refer the matter to the Alaska Department of Law for civil or criminal action in a state or federal court.

Care Coordinator/PCA Agency Representative

I have discussed the Recipient Rights and Responsibilities with the applicant/recipient and/or legal representative.

Care Coordinator/PCA Agency Representative Signature and Printed Name _____
Date

Applicant/Recipient

I have discussed my rights and responsibilities with my care coordinator/PCA agency representative.

Applicant/Recipient Signature and Printed Name _____
Date

Legal Representative Signature, if applicable, and Printed Name _____
Date

Witness Signature and Printed Name _____
Relationship _____
Date