



Date Stamp Here:

ANNUAL APPLICATION for ALI/APDD

CCMC RE-APPLICATIONS Only

Completed by Care Coordinator:

Recipient Name:

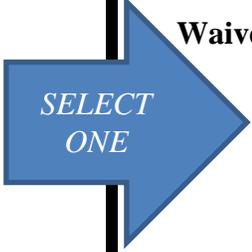
CC Name:

CC Agency Name:

Waiver Type: ALI - Alaskans Living Independently

APDD - Adults with Physical & Developmental Disabilities

CCMC - Children with Complex Medical Conditions



New

Renewal



The ALI/APDD/CCMC Waiver re-application is required annually per 7AAC 130.213

Division of Senior and Disabilities Services Annual Application
ALI (Alaskans Living Independently), APDD (Adults with Physical and Developmental Disabilities) or
Re-Application only: Children with Complex Medical Conditions Waiver

Legal Name (Last, First):	<u>LAST NAME, FIRST NAME</u>		
If Renewal: SDS ID#:	POC Start Date:		POC End Date:

Section I ~ Demographic Information

PROVIDE MEDICAID NUMBER. "PENDING" OR "AWAITING" IS NOT ACCEPTABLE.

POC Type (Select one): ALI APDD CCMC

Medicaid#: DOB: Male Female Married Single Height: _____ Weight: _____

Primary Language: _____

If non-verbal-primary mode of Communication: _____

If a communication barrier exists, please provide an English speaking contact for scheduling:

Contact name: _____ Contact Phone: _____ Relationship: _____

IF THE APPLICANT IS DIFFICULT TO REACH, IDENTIFY A GOOD CONTACT PERSON TO SCHEDULE WITH

Applicant's Physical Address or directions to home in rural areas (No P.O. Boxes)

Address: _____

City: _____ State: _____ Zip: _____

Work-Phone: _____ Home-Phone: _____ Cell-Phone: _____

Email: _____

Mailing address (if different than physical)

Address: _____

City: _____ State: _____ Zip: _____

Applicant's Legal Representative

Does the Name: _____ No

Mailing Address: _____

ONLY COMPLETE IF THE LEGAL REP. IS SIGNING PAGE 5, SIGNING THE RR, ROI, ACC, AND NAME MATCHES THE LEGAL DOCUMENTATION THAT PERMITS THE AGENT TO MAKE "HEALTH CARE DECISIONS"

Work-Phone: _____ Home-Phone: _____ Cell-Phone: _____

E-Mail: _____

Care Coordinator

Name: _____ Cell-Phone: _____ Email: _____

Agency: _____ Work-Phone: _____ Fax#: _____

Address: _____

City: _____ State: _____ Zip: _____

Provider ID#: _____ Provider Group ID#: _____

IF THE APPLICANT'S ADDRESS CHANGES AFTER SUBMISSION, SUBMIT COS FORM.

IF RESIDING IN A FACILITY, PROVIDE BOTH THE CURRENT ADDRESS AND THE ADDRESS THE APPLICANT WILL BE DISCHARGING TO. DON'T FORGET TO SUBMIT WITH THE D/C PLAN WITH THE TENTATIVE DATE.

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Section II ~ Diagnosis & Medical



Primary Diagnosis from the Verification of Diagnosis (VOD):

Secondary Diagnosis(es) from the VOD:

Source(s) for diagnostic information (including the medical professional from the VOD):

Health Summary- Specify and attach appropriate supporting documentation.
Summarize the applicant's health over the **past 12 months.**

Document emergency room visits, hospitalizations, surgeries/ or treatments:

Describe significant changes in the applicant's health or behavior in the last year.

If a renewal application:

Has the applicant received a new primary diagnosis?

Has the applicant been diagnosed with any new health problems, mental health issues, or other problems that might affect his/her functional abilities?

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If Renewal: SDS ID#:	POC Start Date:	

Section III ~ Current Medical Data



Medical and/or Psychiatric Contacts *(Highlight, right-click & insert additional rows as needed)*

Include a fax number for a primary physician as well as a contact phone number for all providers listed.

Full Name	Address	Phone & Fax	Reason for visits and frequency
<u>YOU MUST PROVIDE THE FIRST AND LAST NAME OF THE PROVIDER; THE PROVIDER'S TITLE (DR., ANP, DO, ECT); THE PHONE AND FAX NUMBER; THE REASON FOR THE VISITS AND FREQUENCY.</u>			

Current Medications *(Highlight, right-click & insert additional rows as needed)*

Medication	Dosage	Prescriber	Reason Prescribed	Administered how?
<u>"SEE ATTACHED" IS NOT ACCEPTABLE. YOU MUST LIST ALL CURRENT MEDICATIONS.</u> <i>(Highlight, right-click & insert additional rows as needed)</i>				

Adaptive Medical Equipment (DME/SME)

List all adaptive medical equipment currently in use/available to the applicant regardless of funding source:

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Bath Bench | <input type="checkbox"/> Gait Belt | <input type="checkbox"/> Lift/Hoyer |
| <input type="checkbox"/> Braces/AFOs | <input type="checkbox"/> Grab Bars | <input type="checkbox"/> Stair Glide |
| <input type="checkbox"/> Cane | <input type="checkbox"/> Hand Held Shower | <input type="checkbox"/> Wheelchair |
| <input type="checkbox"/> Commode | <input type="checkbox"/> Hospital Bed | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Elevated Toilet | <input type="checkbox"/> P.E.R.S/Lifeline | |
| <input type="checkbox"/> Other: _____ | | |

List adaptive medical equipment needed:

Environmental Modifications (EMOD's)

List all environmental modifications completed for this applicant regardless of funding source:

List environmental modifications needed:

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If Renewal: SDS ID#:	POC Start Date:	

Statement of Reasonable Expectation of the Need for Long Term Care

I believe that there is reasonable indication the applicant might need services at a level of care provided in a hospital, nursing facility, or ICF/MR in 30 or fewer days unless the applicant receives home and community-based waiver services under 7 AAC 130.211.

I have provided appropriate and contemporaneous documentation that addresses each medical and functional condition and indicates the applicant’s need for home and community based waiver services.

7 AAC 130.217 and 7 AAC 130.240 protect you from conflict of interest by putting definitions around who can serve you as Care Coordinator. Has your Care Coordinator informed you of any employment or family relationship to a certified provider agency (per 7 AAC 130.217 (1)(A) ? *Applicant please initial*

1 **Yes** _____ **No** _____ (there are no known relationships)

**MUST BE
INITIALED**

Section IV ~ Signatures: **INITIAL, SIGNATURES, AND DATES ARE REQUIRED**

By signing below, I certify that the information included in this *application* is true and accurate to the best of my knowledge.

<i>SIGNATURE OF APPLICANT & DATE</i>	<i>SIGNATURE OF LEGAL REP & DATE</i>	2
Recipient Signature	Parent or Legal Representative	Date
<i>SIGNATURE OF CC & DATE</i>		
Care Coordinator	Other Natural Support	Date

Two witnesses are required if recipient signs with an X or a stamp. The Care Coordinator may not serve as a witness.

Witness Printed Name	Signature	Relationship	Date
Witness Printed Name	Signature	Relationship	Date

1 **THERE MUST BE AN INITIAL PRESENT IN THE “CONFLICT OF INTEREST” BOX. IF THERE IS AN “X”, IT IS EXPECTED THAT A WITNESS, NOT THE CC, THAT WILL INITIAL NEXT TO THE APPLICANT’S “X”**

2 **IF LEGAL REP. IS LISTED ON PAGE 2, SIGNING THE RR, ROI, ACC, AND NAME MATCHES THE LEGAL DOCUMENTATION THAT PERMITS THE AGENT TO MAKE “HEALTH CARE DECISIONS”**