State of Alaska • Department of Health and Social Services • Senior and Disabilities Services

Senior and Disabilities Services Program Recipient Rights

Recipient:
CCAN: Medicaid Number:
Care Plan Start Date: End Date:

Instructions: The recipient/legal representative should write initials beside each item as it is discussed.

_____ I have the right to make choices regarding my care.

_____ I have the right to be treated with respect and dignity by my service providers.

_____ I have the right to confidentiality regarding information about me in state and provider records.

_____ I have the right to withdraw from the application for services process at any time.

_____ I have the right to a fair and comprehensive assessment of my health, and of my functional, psychological, and cognitive abilities.

_____ I have the right to participate in the planning of my care and to a copy of my care plan.

_____ I have the right to request, as does any member of my comprehensive planning team, a meeting to amend my care plan any time.

_____ I have the right to know the fees for services before accepting care from a service provider.

_____ I have the right to refuse any service included in my care plan.

_____ I have the right to change service providers, including my care coordinator, at any time.

_____ I have the right to submit a complaint through a grievance procedure established by my service provider.

_____ I have the right to written notification from my service provider regarding any change in, termination of, or discharge from service.

_____ I have the right to appeal any decision that affects my care.

_____ 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 have been informed that I should report abuse, neglect, self-neglect, and financial exploitation to Adult Protective Services, 1-800-478-9996, or to the Office of Children's Services, 1-800-478-4444.

_____ I have been informed that I should report services which are not satisfactory or are not provided as outlined in my care plan to the SDS Quality Assurance Unit, 1-800-478-9996.

_____ I have been informed that I should report circumstances which might indicate Medicaid fraud, abuse or waste by my service provider to the SDS Quality Assurance Unit, 1-800-478-9996.

_____ I have received a copy of the Notice of Adverse Actions, Hearings, and Appeals.

I have explained the SDS Program Recipient Rights to the recipient and/or legal representative

_____

Care coordinator/PCA agency representative Date

My care coordinator/PCA agency representative has explained my rights.

_____

Recipient Signature Date Legal Representative Date

_____

Witness Signature Printed Name Relationship Date