

DEPARTMENT OF HEALTH AND SOCIAL SERVICES



Personal Care Assistance Agency Certification Application Packet

**7 AAC 125.010-395 MEDICAL ASSISTANCE
Personal Care Assistants**



**2005
Second Edition**



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

Certification Application Packet

Agency-Based Personal Care Assistant Agency
And
Consumer-Directed Personal Care Assistant Agency

Name of Agency: _____

Instructions: Identify the agency as one of the following and submit the materials listed.

- Agency-Based PCA Agency (ABPCA)
 1. Signed and dated ABPCA agency assurances and agreement.
 2. Required attachments.

- Consumer-Directed PCA Agency (CDPCA)
 1. Signed and dated CDPCA agency assurances and agreement.
 2. Required attachments.

- Agency-Based PCA Agency and Consumer-Directed PCA Agency
 1. Signed and dated ABPCA agency assurances and agreement.
 2. Signed and dated CDPCA agency assurances and agreement.
 3. One set of required attachments.

- Agency with multiple office locations.
 1. Signed and dated ABPCA and/or CDPCA agency assurances and agreement for each location, and required personnel attachments for the administrator, PCA Manager or supervising registered nurse for each location (if personnel are different in the various locations).
 2. One set of required attachments, and attachments for personnel as indicated.

Certification Overview

1. The Division of Senior and Disabilities Services (DSDS) will certify an agency, as a personal care services provider authorized to enroll with the Medicaid fiscal intermediary, after review of the Certification Application Packet and approval of the required documentation and agreement by the agency to meet all standards and requirements for participation.
2. Because the Certification Application Packet has been adopted by reference, 7 AAC 125.060 the requirements in this packet are personal care services regulations
3. Agencies operating multiple, staffed office locations where recipient records are maintained must submit an agreement and the specified additional materials for each office location.
4. A packet containing all required attachments and agency agreements must be submitted as a unit with each attachment labeled, tabbed or indexed in the order designated. Packets not so configured will be returned.
5. When indicated, DSDS will notify the agency of missing documents and/or the need for revised materials which must be provided by the date specified in the notice. If, after review of the additional materials, they are determined to be inadequate for certification purposes, or certification cannot be accomplished within 30 days after the initial notification of the need for additional materials because of an agency failure to provide them in a timely manner, the entire packet will be returned to the agency. A revised application may be submitted at any time.
6. After review and approval of the packet materials, DSDS will mail a Provider Certification form indicating the personal care services which the agency has been approved to provide. This form must accompany the Medicaid fiscal intermediary enrollment form. The date the certification application packet is complete will be the beginning date of the certification period.

Required Attachments: The following documents must be submitted for review.

- 1. Current State of Alaska business license in the name of the agency to be certified.
- 2. Insurance policy certificate indicating workers' compensation, general liability, and automobile liability coverage for personal care assistants, and naming the Division of Senior and Disabilities Services, PCA Provider Certification (550 West 8th Ave., Anchorage, Alaska 99501) as a certificate holder.
- 3. Description of the fiscal and accounting process which incorporates the requirements of 7 AAC 105.230 and which is used to insure correct billing.

- 4. Bank statement or audit report indicating capacity to meet at least three months of operating expenses.
- 5. Organization chart showing lines of authority, position titles, and names of people in the positions.
- 6. Positions descriptions for the PCA program administrator, supervising registered nurse, and personal care assistants, which incorporate age, education, and experience requirements.
- 7. Documentation of attendance by the administrator at PCA Agency orientation provided by the Division of Senior and Disabilities Services.
- 8. Documentation, including a current resume, a copy of a diploma or transcript for the required education, and verification of previous employment, demonstrating that at least one full-time supervisor (who must be a registered nurse for an agency-based program) meets the following requirements:
 - a) One year of experience in a full-time, salaried position utilizing the knowledge and skills gained through the education and/or experience listed in (b) to provide services to individuals in a human services delivery setting; and one year of experience (which may be concurrent) in a full-time, salaried position utilizing the knowledge and skills gained through the education and/or experience listed in (b) to supervise two or more people providing services to individuals in a human services delivery setting.
 - b) In addition to the experience specified in (a), education and experience as follows:
 - 1) Bachelor of Arts or Bachelor of Science degree in nursing, social work, rehabilitation, developmental disabilities, psychology, or another closely-related human services field, from an accredited college or university;
or
 - 2) Associate of Arts or Associate of Science degree in nursing, social work, rehabilitation, developmental disabilities, psychology, or another closely-related human services field, from an accredited college or university, and two years of experience in a full-time, salaried position utilizing the skills and knowledge gained through this education to provide services to individuals in a human services delivery setting;
or
 - 3) Documentation of training, equivalent to that specified in 7 AAC 125.160(b) within the 5 year period immediately preceding application to work in a PCA program, and four years of experience in a full-time, salaried position utilizing the skills and knowledge gained from this training to provide services to individuals in a human services delivery setting.

- 9. Policy on confidentiality, including HIPAA, and the agency Notice of Privacy Practices provided to recipients
- 10. Procedure for evaluation of personal care assistants.
- 11. Personal Care Assistant Handbook or orientation materials addressing agency code of ethics, non-discrimination policy; safety and health policies; personal care assistant rights, including a grievance procedure; performance measures; etc.
- 12. Personal care assistant training standards and schedules, including required training and information regarding continuing-education opportunities and resources.
- 13. Procedure for development of backup and contingency plans for recipients.
- 14. Procedure for recipients to file grievances, and for maintenance of a complaint file including tracking each complaint, investigation, and resolution.
- 15. Policy on termination of recipient services.
- 16. Policy and materials informing recipients about living wills and limited powers of attorney for health care.
- 17. Procedure for an annual assessment and written report which includes the following elements for each certified agency-based program and consumer-directed program.
 - a) Evaluation of recipient satisfaction with services based on the distribution and collection of recipient satisfaction survey forms which allow for a range of answers.
 - b) Evaluation of whether the services delivered met the assessed needs of the recipient.
 - c) Evaluation of the adequacy of personal care assistant training provided by the agency or by the recipient.
 - d) Evaluation of quality assurance and quality improvement activities necessitated by problem areas brought to light by the assessment or recipient grievance process.

Agency-Based Personal Care Services

Agency Name _____

Agency Billing Number/Numbers _____

Owner/Administrator _____

PCA Program Manager _____

Supervising Registered Nurse _____

Mailing Address _____

Physical Address _____

Communities served _____

Telephone number _____ FAX number _____

Cell number _____ Email _____

Person completing packet _____

Telephone number _____ Email _____

General Assurances. The agency agrees to:

1. Provide services in accordance with an approved service plan, 7 AAC 125.010(b), in the recipient's personal residence, 7 AAC 125.050(a);
2. Determine that personal care assistants are qualified, 7 AAC 125.090(a); and submit requests for criminal history record information, 7 AAC 125.090(c);
3. Verify that personal care assistants meet their responsibilities for maintaining records, 7 AAC 125.120(a);
4. Follow reporting requirements regarding child protection, 7 AAC 125.120(f), and adult protection, 7 AAC 125.100;
5. Employ an administrator who has attended mandatory division orientation, 7 AAC 125.150(d) and (e);
6. Employ a supervising registered nurse to perform specified duties regarding services every six months or every 12 months where a waiver is in effect, 7 AAC 125.170(a)(2);

7. Delineate agency responsibility for personal care services when the personal care assistant is unavailable, and for working with the recipient to develop a contingency plan, 7 AAC 125.020(b)(6);
8. Provide for confidentiality of records in accordance with applicable federal and state laws, including HIPAA/Health Insurance Portability and Accountability Act of 1996.

Agency Agreement

Your signature indicates that the agency agrees to fulfill all the standards and requirements pertaining to the personal care services program, 7 AAC 125.010-125.199; to meet all administrative standards and requirements for participation in the Medicaid program, 7 AAC 105.200-290, 7 AAC 105.600-610, 7 AAC 145.005-025, and 7 AAC 105.400-105.490; and to accept this agreement as notice that failure to do so can be cause for decertification and disenrollment, 7 AAC 125.080, and for Medicaid sanctions, 7 AAC 105.400, including recoupment of payment for services, 7 AAC 105.410.

Your signature indicates the State of Alaska, its officers, agents and employees, shall be indemnified, held harmless, and defended from all liability, including costs and expenses, for all actions and claims resulting from injuries or damages sustained by any person or property arising directly or indirectly as a result of any error, omission, or negligent act of your agency, agency subcontractors or anyone directly or indirectly employed by the agency in the delivery of personal care assistant services.

As authorizing agent, I affirm that I have read and will fulfill all the standards and requirements for participation in the personal care services program and in the Medicaid program; that all staff meet the required levels of experience, education and training to provide personal care services; and that the information in this application is true and correct.

Name of Agency

Signature of Authorized Agent	Position Title
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Printed Name	Date
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Consumer-Directed Personal Care Services

Agency Name _____

Agency Billing Number/Numbers _____

Owner/Administrator _____

Program Manager _____

Mailing Address _____

Physical Address _____

Communities served _____

Telephone number _____ FAX number _____

Cell number _____ Email _____

Person completing packet _____

Telephone number _____ Email _____

General Assurances. The agency agrees to:

1. Provide services in accordance with an approved service plan, 7 AAC 125.010(b), in the recipient's personal residence, 7 AAC 125.050(a);
2. Determine that personal care assistants are qualified, 7 AAC 125.090(a); and submit requests for criminal history record information, 7 AAC 125.090(c);
3. Verify that personal care assistants meet their responsibilities for maintaining records, 7 AAC 125.120(a);
4. Follow reporting requirements regarding child protection, 7 AAC 125.120(f); and adult protection, 7 AAC 125.100;
5. Employ an administrator who has attended mandatory division orientation, 7 AAC 125.130(c) and (d);
6. Delineate agency responsibility for personal care services when the personal care assistant is unavailable, and for working with the recipient to develop a contingency plan, 7 AAC 125.020(c);

7. Provide for confidentiality in accordance with applicable federal and state laws, including HIPAA/Health Insurance Portability and Accountability Act of 1996;
8. Negotiate contracts for services with recipients, 7 AAC 125.140(a)(6);
9. Review recipient needs annually, 7 AAC 125.130(a); and
10. Collect and verify personal care assistant timesheets and submit claims for services to the Medicaid fiscal intermediary, 7 AAC 125.130(b).

Agency Agreement

Your signature indicates that the agency agrees to fulfill all the standards and requirements pertaining to the personal care services program, 7 AAC 43.125.010-125.199; to meet all administrative standards and requirements for participation in the Medicaid program, 7 AAC 105.200-290, 7 AAC 105.600-610, 7 AAC 145.005-025, and 7 AAC 105.400-105.490; and to accept this agreement as notice that failure to do so can be cause for decertification and disenrollment, 7 AAC 125.080, and for Medicaid sanctions, 7 AAC 105.410, including recoupment of payment for services, 7 AAC 105.410.

Your signature indicates the State of Alaska, its officers, agents and employees, shall be indemnified, held harmless, and defended from all liability, including costs and expenses, for all actions and claims resulting from injuries or damages sustained by any person or property arising directly or indirectly as a result of any error, omission, or negligent act of your agency, agency subcontractors or anyone directly or indirectly employed by the agency in the delivery of personal care assistant services.

As authorizing agent, I affirm that I have read and will fulfill all the standards and requirements for participation in the personal care services program and in the Medicaid program; that all staff meet the required levels of experience, education and training to provide personal care services; and that the information in this application is true and correct.

Name of Agency

Signature of Authorized Agent Position Title

Printed Name Date