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

Personal Care Services Initial Application

See Instructions for Completion of Initial Personal Care Services Initial Application for details on how to complete and submit this form

Participant Name **Medicaid #**

Program type ☐ Agency- based ☐ Consumer-directed

Personal Care Services Agency

Agency/Center name _____ Provider # _____

Agency/Center representative _____

Phone _____ Email address _____

Section I Participant Information

1. Participant profile

Date of birth _____ Gender Identification: ☐ Male ☐ Female ☐ Other

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow

Alaska Resident: ☐ Yes ☐ No

Primary language: _____ Interpreter needed? ☐ Yes ☐ No

If primary language not English, provide the name of English-speaker for communication purposes
Name _____ Phone _____
Relationship to Participant _____

2. Participant address

Physical address _____ City/State/Zip _____
Mailing address _____ City/State/Zip _____
Phone _____ Email address _____

Current location, if not at physical address:
N/A Participant is at current address ☐ **If marked N/A, skip to #3 below**

Name of facility/other location _____
Physical address _____
City/State/Zip _____ Expected date of discharge _____

☐ Acute care facility ☐ Long term care facility ☐ Assisted living home ☐ Other

3. Participant current services	Yes	No
Has the Participant applied for Medicaid Waiver services?	☐	☐
Does the Participant receive chore services as a waiver service?	☐	☐
Has the Participant applied for grant services?	☐	☐

Does the Participant receive chore services through a grant?	☐ yes	☐ no
Is the Participant a U.S. Veteran?	☐ yes	☐ no

4. Participant representative

None/Not applicable ☐ **If marked N/A skip to Section II**

Participant's legal representative _____
Mailing address _____
City/State/Zip _____ Phone _____ Email _____

Does the Participant want SDS documents mailed to the Participant's legal representative? ☐ yes ☐ no

Representative type ***Attach documentation showing representative's authority to act for the Participant***

- ☐ Public Guardian (OPA)
- ☐ Full Guardian
- ☐ Parent
- ☐ Representative Payee
- ☐ Other _____
- ☐ Conservator
- ☐ Power of Attorney
- ☐ Partial Guardian
- ☐ Delegated parental authority

Does a legal representative plan to be physically present to manage personal care services for the Participant? ☐ Yes ☐ No

Does the representative live in the same community as the Participant? ☐ Yes ☐ No

Is the representative involved in the day-to-day care of the Participant, in person or telephonically? ☐ Yes ☐ No

Has the representative designated an individual to act as the representative's designee in accordance with 7 AAC 125.100(c) and Approved Form PCA-10? ☐ Yes ☐ No
If yes complete the representative's designee information below

Full Name representative's designee _____
Mailing address _____
City/State/Zip _____ Phone _____ Email _____

Section II Personal Care Services review

1. Physical condition

A. Primary Physician/health care provider
Full Name Primary Health Care Provider _____
Phone number _____ Fax number _____

B. By observation or report does the Participant have a physical condition that affects the Participant's capacity to perform the activities covered by the personal care services program? ☐ Yes ☐ No

If "No" skip to question number 2. If "Yes" complete the questions below

Describe the condition _____

Describe how the condition affects the Participant's capacity to perform the activities covered by personal care services _____

Describe any risks to health safety, and welfare the Participant would face if physical assistance is not provided _____

Is the Participant's physical condition documented in clinical records? ☐ Yes ☐ No

2. Material change in physical condition

Did the Participant submit an application for personal care services during the previous 365 day period?

☐ Yes ☐ No

If "No" skip to question number 3

Has a material change, as defined in 7 AAC 125.012 (b), occurred following submission of that application?

☐ Yes ☐ No

If "No" skip to question number 3. If "Yes" complete the answer in the text boxes below

Describe the change that happened after the previous application or assessment _____

_____

By observation or report describe how the change affects the Participant's capacity to perform activities covered by personal care services _____

_____

3. Age of Participant

Is the Participant 6 to 18 years of age? ☐ Yes ☐ No

If "Yes" answer the question below, if "No" skip to question 4

Does the Participant need more physical assistance with activities than a same-age individual who does not have a disability? ☐ Yes ☐ No

If "No" skip to question 4

If the need for assistance is due to a disability rather than age, describe how the disability affects the Participant's capacity to perform activities that a same-age individual could perform without assistance

_____

4. Need for physical assistance

List all needs even though natural supports may provide physical assistance with some of the activities listed.

A. By observation or report does the Participant need physical assistance with the activities of daily living (ADLs) specified in 7 AAC 125.030 (a) ☐ Yes ☐ No

If "Yes", check the box and describe what kind of physical assistance is needed to perform the activity and why

☐ bed mobility _____

_____

_____

_____

☐ transferring _____

_____

_____

_____

☐ locomotion _____

_____

_____

_____

☐ dressing _____

_____

_____

_____

☐ eating and drinking _____

_____

_____

_____

☐ toileting

☐ personal hygiene

☐ bathing

B. By observation or report does the Participant need physical assistance with the instrumental activities of daily living (IADLs) specified in 7 AAC 125.030 (b) ☐ Yes ☐ No

If "Yes", check the box and describe what kind of physical assistance is needed to perform the activity and why

☐ light meal preparation

☐ main meal preparation

☐ light, routine housework

☐ laundry

☐ shopping

C. Does the Participant report the need for physical assistance with the other activities specified in 7 AAC 125.030 (d)? ☐ Yes ☐ No

If "Yes", check the box and describe what kind of physical assistance is needed to perform the activity and why

☐ self-administration of medication

☐ maintenance of respiratory equipment

☐ sterile dressing changes and wound care

☐ passive range-of-motion _____

_____

_____

_____

5. Location for delivery of services

A. Does the Participant live in a location where personal care services providers are available to provide services for the Participant? ☐ Yes ☐ No

B. Does the Participant anticipate receiving personal care services from an individual that is qualified and willing to provide physical assistance through the consumer-directed personal care services program? ☐ Yes ☐ No

C. Does the Participant meet the requirements of 7AAC 125.140(a) for the consumer-directed personal care services program? ☐ Yes ☐ No

D. Does the Participant's residence meet the "place of service" requirements of 7 AAC 125.050(a)(1)? ☐ **Yes** ☐ **No**

6.Shared Residence/Natural Supports Do other people live in the same residence as the Participant? ☐ Yes ☐ No

If "No", skip to question 7

If "Yes"; how many people reside in the residence including the Participant? _____

How many are under 18 years old?_____ Do any residents under 18 years old receive Medicaid services?_____

_____

List other residents who are 18 years old and older who live in the same residence as the Participant and answer the questions in the table below.

Resident's Name _____ Age: _____ Relationship to Participant:_____	**Yes**	**No**	***If yes, describe the activity and the physical assistance provided** **Activity** _____
***Does this Resident help the Participant with activities that he/she is unable to perform without physical assistance?**	☐	☐	Assistance Provided _____
Is the help provided by this Resident temporary/intermittent?	☐	☐	
Is this Resident paid to provide this help?	☐	☐	
Has this Resident applied for Home and Community Based Waiver Services?	☐	☐	
Does this Resident receive or has he/she applied for Chore Services?	☐	☐	
Does this Resident receive or has he/she applied for Personal Care Services?	☐	☐	
Does this Resident receive or has he/she applied for Chore services through a grant?	☐	☐	

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Resident's Name _____ Age: _____ Relationship to Participant:_____	Yes	No	*If yes, describe the activity and the physical assistance provided Activity _____
***Does this Resident help the Participant with activities that he/she is unable to perform without physical assistance?**	☐	☐	
Is the help provided by this Resident temporary/intermittent?	☐	☐	Assistance Provided
Is this Resident paid to provide this help?	☐	☐	
Has this Resident applied for Home and Community Based Waiver Services?	☐	☐	
Does this Resident receive or has he/she applied for Chore Services?	☐	☐	
Does this Resident receive or has he/she applied for Personal Care Services?	☐	☐	
Does this Resident receive or has he/she applied for Chore services through a grant?	☐	☐	

Resident's Name _____ Age: _____ Relationship to Participant:_____	Yes	No	*If yes, describe the activity and the physical assistance provided Activity _____
***Does this Resident help the Participant with activities that he/she is unable to perform without physical assistance?**	☐	☐	
Is the help provided by this Resident temporary/intermittent?	☐	☐	Assistance Provided
Is this Resident paid to provide this help?	☐	☐	
Has this Resident applied for Home and Community Based Waiver Services?	☐	☐	
Does this Resident receive or has he/she applied for Chore Services?	☐	☐	
Does this Resident receive or has he/she applied for Personal Care Services?	☐	☐	
Does this Resident receive or has he/she applied for Chore services through a grant?	☐	☐	

Resident's Name _____ Age: _____ Relationship to Participant:_____	Yes	No	*If yes, describe the activity and the physical assistance provided Activity _____
***Does this Resident help the Participant with activities that he/she is unable to perform without physical assistance?**	☐	☐	
Is the help provided by this Resident temporary/intermittent?	☐	☐	Assistance Provided
Is this Resident paid to provide this help?	☐	☐	
Has this Resident applied for Home and Community Based Waiver Services?	☐	☐	
Does this Resident receive or has he/she applied for Chore Services?	☐	☐	
Does this Resident receive or has he/she applied for Personal Care Services?	☐	☐	
Does this Resident receive or has he/she applied for Chore services through a grant?	☐	☐	

7. Individual Supports

Does the Participant have individuals who do not live with them, help with activities that he/she is unable to perform without physical assistance? Yes ☐ No ☐

If "No" skip to question 8. If "Yes" answer the questions in the table below.

Individual's Name _____ Age _____ Relationship to Participant _____	Describe the activity and the physical assistance provided Activity _____
Is the assistance: Paid ☐ Unpaid ☐	Assistance Provided _____
Is the assistance: Temporary ☐ Ongoing ☐	

Individual's Name _____ Age _____ Relationship to Participant _____	Describe the activity and the physical assistance provided Activity _____
Is the assistance: Paid ☐ Unpaid ☐	Assistance Provided _____
Is the assistance: Temporary ☐ Ongoing ☐	

Individual's Name _____ Age _____ Relationship to Participant _____ Is the assistance: Paid ☐ Unpaid ☐ Is the assistance: Temporary ☐ Ongoing ☐	Describe the activity and the physical assistance provided Activity _____ _____ _____ _____ Assistance Provided_____ _____ _____ _____

8. Community Supports

Do community organizations help the Participant with activities that he/she is unable to perform without physical assistance? Yes ☐ No ☐

If No, skip to Section III, if yes answer the questions in the table below

Name of Community Agency _____ Relationship to Participant _____ Name of Agency Contact _____ Is the assistance: Paid ☐ Unpaid ☐ Is the assistance: Temporary ☐ Ongoing ☐	Describe the activity and the physical assistance provided Activity _____ Assistance provided _____ _____ _____

Name of Community Agency _____ Relationship to Participant _____ Name of Agency Contact _____ Is the assistance: Paid ☐ Unpaid ☐ Is the assistance: Temporary ☐ Ongoing ☐	Describe the activity and the physical assistance provided Activity _____ Assistance provided _____ _____ _____

Section III Participant signature page

Participant assurances

I, (Print or type name) _____ *understand that, although I claim that I need physical assistance with the activities specified in this application for Personal Care Services, the decision to authorize personal care services for those activities will be made by Senior and Disabilities Services on the basis of a review of my current clinical documentation and a functional assessment of my capacity to perform the activities. I understand that failure to provide all or any part of the information requested could affect the determination made by Senior and Disabilities Services to authorize services for me.* ***I certify that that the content of this form has been explained to me by the agency/resource center representative in language that I understand; that I agree to the content of this form; and that this is an application for medical assistance program benefits.***

I understand that knowingly making a false statement may subject me to criminal prosecution or civil sanction, including, without limitation, monetary penalties. I understand that knowingly making a false statement may constitute the crimes of perjury (AS 11.56.200), medical assistance fraud (AS 47.05.210) and/or unsworn falsification (AS 11.56.210).

I certify, under penalty of perjury, that the information I have provided herein is true, accurate, and complete to the best of my knowledge.

Participant/Representative signature Date

_____ _____

Print or type Participant/Representative name

_____

Witness

If the Participant signs with a mark, the signature of a witness who is Not the Participant's care coordinator, personal care assistant or representative of the personal care services agency is required.

Witness signature Date

_____ _____

Print or type Witness name

_____

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Section IV Agency signature page

Agency Name _____ Provider # _____

Agency Assurances

I certify that I have screened the Participant's need for physical assistance with activities covered by the Personal Care Services regulations. I understand that the decision to authorize Personal Care Services will be made by Senior and Disabilities Services on the basis of a review of the Participant's current clinical documentation and a functional assessment of capacity to perform the activities indicated in this request.

I, (Agency representative print or type name) _____ *understand that knowingly making a false statement may subject me or the named agency or resource center to criminal prosecution or civil sanction, including, without limitation, monetary penalties. I understand that knowingly making a false statement may constitute the crimes of perjury (AS 11.56.200), medical assistance fraud (AS 47.05.210) and/or unsworn falsification (AS 11.56.210). My initials are my certification, under penalty of perjury, that the following statements are true to the best of my knowledge.*

Initials	Sworn Statement
_____	*I represent the named agency/resource center; by signing this application, I am acting within the scope of my employment.*
_____	*I have read the Participant's answers to the question on this application, and believe the answers to be true, accurate and complete to the best of my knowledge.*
_____	*I believe the Participant needs physical assistance with the personal care services activities specified in this application.*
_____	*If I learn that the Participant does not need personal care services, I will Notify Senior & Disabilities Services immediately.*
_____	*I have included clinical records as supportive of the Participant's claim of a functional limitation and need for physical assistance with ADLs, IADLs and other covered services specified in this application.*

As required, I have attached the following:

- ☐ *Release of Information form*
- ☐ *Verification of Diagnosis form*
- ☐ *clinical records that are not older than one year prior to the date of this application and that support the Participant's diagnosis and need for physical assistance*
- ☐ (*if applicable*) *documentation showing representative's authority to act for the Participant*

Agency representative signature Date

_____ _____