Print Form

Division of Senior and Disabilities Personal Care Assistance Program
Consumer/Representative Authorized Services Plan Signature Form

Legal Name (Last, First): **Medicaid:**

CCAN#: **Service Plan Start Date:** **Service Plan End Date:**

I, _____, have received a copy of my Personal Care Assessment Tool (PCAT) including my Authorized Services Plan for Personal Care Services and have reviewed the Authorized Services Plan with my designated provider agency. I acknowledge the receipt of the appeal rights in regards to Personal Care Services.

I have participated in, and understand, the Authorized Services Plan done on my behalf by the Division or its designee.

_____	_____	_____
Consumer/Representative Name	Consumer/Representative Signature	Date