

STATE OF ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES SENIOR AND DISABILITIES SERVICES POLICY & PROCEDURE MANUAL	SECTION: Waivers	Number: 3-7	Page: 1
	SUBJECT: Initial Application for Services/Yearly Reapplication		
	APPROVED:		DATE:
	Effective		

Purpose

To define what SDS considers a “complete” application

To emphasize and explain the importance of timeliness and completeness in the submission of an initial and a renewal application for ALI, APDD, CCMC and IDD Waiver services.

Policy

Each applicant requesting services from the ALI, APDD, CCMC and the IDD Home and Community Based Waiver Programs must submit an initial application. The initial application is usually submitted by a Care Coordinator selected by the applicant. Prior to processing an initial application for the ALI/APDD Waivers, the applicant (if not already screen by the ADRC program), must be referred to and undergo the prescreening and options counseling process conducted by the “ADRC Pre-Screen and Options Counseling Program”. The processing of an initial complete application prompts the scheduling of an assessment to determine eligibility based on level of care. The applicant must meet the criteria in AAC 130.215 “Level-of-care determination”, as a prerequisite for eligibility for the Waiver program for which they have applied. The completion of an initial application in a timely and thorough manner is required before the applicant can be scheduled for an assessment to determine their eligibility based on a level of care determination. All forms requiring a signature must be signed by hand; no electronic signatures are acceptable.

All recipients of ALI, APDD and CCMC Waiver Services must apply through their Care Coordinator, each year to renew their Waiver services. Recipients of these Waiver services must also receive a yearly assessment to determine their ongoing eligibility based on a level of care determination. Care Coordinators are required to submit a complete and timely reapplication form each year as a prerequisite to submitting a Renewal Plan of Care. The yearly reapplication is also required prior to scheduling the annual level of care assessment. The timeliness of this yearly reapplication is crucial to securing a timely assessment date and thus the determination of ongoing eligibility based on level of care.

All recipients of the IDD Waiver must also have an annual determination of level of care; the procedure used to determine level of care is based upon the individual circumstances of the recipient.

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Authority

AS 47.05.010 [Duties of the Department]; AS 47.07.010 [Purpose]; AS 47.07.030 [Medical Services to Be Provided]; AS 47.07.045 [Home and Community Based Services]; AS 47.80.900 (7) [Definitions]. 7AAC 130.205 Recipient enrollment and eligibility; 7AAC 130.207 Application for home and community-based waiver services; 7AAC 130.211 Screening; 7AAC 130.213 Assessment and Reassessment; 7AAC 130.215: Level of Care Determination

Definitions

“Applicant” means an individual who is seeking to enroll in one of the Home and Community-Based Waiver Services programs

“Care Coordinator/Care Coordinator Agency” means a provider that is acting on behalf of applicants, participants and/or recipients to complete Initial Applications and/or Reapplications for Waiver Services

“Complete application” means all completed documents required by SDS to determine eligibility and enroll an applicant in Waiver Services or to request a yearly assessment to renew the waiver of a participant/recipient.

“Home and Community-Based Waiver Services programs” means the Intellectual and Developmental Disabilities, the Children with Complex Medical Conditions, the Alaskans Living Independently and the Adults with Physical and Developmental Disabilities Waiver programs.

“Participant” means an individual who receives services, funded by Medicaid, through one of the Home and Community-Based Waiver Services programs.

“Provider” means a Care Coordinator or a Care Coordinator Agency that has entered into a Medicaid provider agreement and complies with the standards for certification as set out in SDS Policy and Procedure 12-1

“Recipient” means an individual who is enrolled in one of the Home and Community-Based Waiver Services programs

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“Representative” means a parent, guardian, or other individual with authority to act on behalf of an applicant/participant/recipient

“Timely application” means a complete application or reapplication submitted within the guidelines set out in the Program Eligibility and Enrollment Policy and Procedure for the Waiver service for which the applicant is applying or the participant/recipient is reapplying.

Responsibilities

1. **SDS** is responsible for
 - a. monitoring Care Coordinator compliance with the standards for a complete Initial Application for Services, including due dates and required forms, documents and signatures
 - b. monitoring Care Coordinator compliance with the standards for a timely and complete application including medical documentation as required by the specific Waiver, for *yearly assessment for level of care and renewal of services, submitted no sooner than 120 days and no later than 90 days prior to end of preceding Level of Care assessment
 - c. Sending a closure/disenrollment notice via DSM to the Care Coordinator and via certified mail to the recipient and/or legal representative when the Care Coordinator has not submitted a renewal application within the time frame noted in paragraph b above
 - d. contacting the care coordinator one time informally about insufficient or incomplete applications with request to respond within 5 days; place in “pending” status for 5 days or until the information is received and the application is processed
 - e. giving notice by certified mail to the Recipient and/or Recipient’s legal representative, with a copy via DSM to the Care Coordinator or Care Coordinator Agency, when SDS does not receive a timely response to inquiries regarding insufficient applications; notice requires response within 30 days.
 - f. monitoring remediation progress regarding the notice of non-compliance
 - g. managing provider non-compliance
 - h. following the insufficient process until compliance is met or applicant is dis enrolled
 - i. Providing a screening letter to ALI/APDD applicants once the initial application is processed as complete; date on letter reflects the date the application is reviewed and determined to be complete

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- j. Note: IDD Waiver requires a yearly determination of level of care individualized to the specific circumstances of the recipient.
2. **Care Coordinator** is responsible for
- a. submitting a timely and complete initial application for services
 - b. submitting a timely and complete renewal application for *yearly assessment for level of care and renewal of services, no sooner than 120 days and no later than 90 days before the end of the current Level of Care assessment date
 - c. responding promptly to the informal request regarding insufficient application within 5 days and/or formal notice of non-compliance within 15 days
 - d. Note: IDD Waiver requires a yearly determination of level of care individualized to the specific circumstances of the recipient.
3. **Applicant/recipient or representative** is responsible for
- a. submitting forms necessary for eligibility determination as requested by the Care Coordinator
 - b. releasing all confidential information that is necessary for application or reapplication as requested by the Care Coordinator
 - c. Obtaining Medicaid; providing proof of active coverage and providing a form of identification
 - d. Applicants for APDD waiver must show proof of DD eligibility

Procedures

Intellectual and Developmental Disabilities Waiver

***SEE**

Attachment A: Check List for Documents Required for IDD Interim Application Packet.
Attachment B: Check List for Documents Required for IDD Initial Application
Attachment C: Check List for Documents Required for IDD Renewal Application

Children with Complex Medical Conditions

***SEE**

Attachment D: Check List for Documents Required for CCMC Initial Screening Packet
Attachment E: Check List for Documents Required for CCMC Renewal Application

Alaskans Living Independently

****SEE***

Attachment F: Check List for Documents Required for ALI/APDD Initial Application
Attachment G: Check List for Documents Required for ALI/APDD Renewal Application

Adults with Physical and Developmental Disabilities

****SEE***

Attachment F: Check List for Documents Required for ALI/APDD Initial Application
Attachment G: Check List for Documents Required for ALI/APDD Renewal Application



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Check List for Documents Required for SDS Waiver Policy 3-7
IDD INTERIM APPLICATION PACKET
Attachment A

For applicants below age 3:

- IDD-10 “Interim ICF/IID Level of Care Information”**
 - Complete every blank
 - Use N/A if the information requested is not applicable to the individual recipient
- IDD-13 “Qualifying Diagnosis Certification Form”**
 - This form must have been completed with the previous 12-month period
- Supportive evaluation/documentation from health care providers who determined the qualifying diagnosis and/or signed the IDD-13 form.**
 - Documents must relate to and support the completed IDD-13, within last 12 months
 - Use HSS-06-5870 “Release of Information” form to obtain records
- Uni-05 P Appointment of Care Coordination Services” form**
 - Care coordinator and recipient must sign and date
 - Select “Intellectual and Developmental Disabilities” in the drop down prompt at the top of the page
- Current guardianship adoption or custody paperwork if applicable**

For applicants older than 3:

- IDD-10 “Interim ICF/IID Level of Care Information”**
 - Complete every blank
 - Use N/A if the information requested is not applicable to the individual recipient
- IDD-13 “Qualifying Diagnosis Certification Form”**
 - This form must have been completed with the previous 12-month period
- Supportive evaluation/documentation from health care providers who determined the qualifying diagnosis and/or signed the IDD-13 form.**
 - This is required only if there has been a change in the Qualifying Diagnosis from previous Level of Care.
 - The supportive documentation for the new Qualifying Diagnosis and ICD 10 code must have been completed within the previous 36-month period
- Uni-05 Appointment of Care Coordination Services” form**
 - Care coordinator and recipient must sign and date
 - Select “Intellectual and Developmental Disabilities” in the drop down prompt at the top of the page
- Current guardianship adoption or custody paperwork if applicable**



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IDD INITIAL APPLICATION PACKET
Attachment B

Information to be read prior to completing the Initial Application Packet: When an individual is drawn from the DRRR, a “Waitlist Selection Letter” is sent. The individual is directed to select a care coordinator and notify the department of the care coordinator selected via the return of a postcard provided by the division. Upon notice to the department of care coordination, an ICAP Packet request is generated. *Once the request has been sent a care coordinator has 60 days to submit the requested documentation for a complete ICAP packet.* *Note: In order for an individual to qualify for services from the IDD unit a participant must be diagnosed with one of the qualifying diseases as follows: Intellectual Disability, Seizure Disorder, Cerebral palsy, Autism, Other Intellectual Disability. Specific types of evaluations and documentation are required dependent on which diagnosis is experienced by the individual. In order for the IDD unit to serve a participant under the diagnosis of Autism a comprehensive diagnostic evaluation is required, this evaluation must be completed with 36 months of the date of submission. The evaluation must include cognitive and adaptive testing. For the diagnosis of autism the evaluation must be completed by a Neurologist, a clinical level psychologist (Ph.D.), or a developmental pediatrician

CHECK LIST OF FORMS FOR COMPLETE ICAP PACKET

- IDD-03 ICAP Assessment Information and Consent**
- Check all applicable boxes
 - 3 appropriate respondents must be identified
 - The initials of the participant or their legal representative must be included on page 2.
 - The participant or their legal representative must sign on page 2
- HSS-06-5870 Release of Information (ROI)**
- Complete a Release of Information form for each ICAP respondent and agency.
 - The ROI must contain language that releases information from the respondent to SDS
 - The ROI must be signed by the recipient and/or legal representative
 - Do not have the recipient sign the “revocation” option on the second page unless consent is actually being revoked.
 - Be sure to include both pages of the ROI
 - Each ROI must be dated within 12 months of submission
- Uni-05 Appointment for Care Coordination Services**
- Must be signed and dated by Care Coordinator and Recipient
 - Legal representative, if designated, must sign and date

- Uni-07 Recipient Rights & Responsibilities**
 - Applicant must initial every line; Applicant must sign and date
 - Care coordinator must sign and date
 - Legal representative, if designated, must sign and date
 - witness signature is optional

- IDD-13 Qualifying Diagnosis Certification Form (QDC)**
 - The QDC must be completed by the appropriate provider.
 - The QDC must provide an ICD-10 code that matches the qualifying diagnosis supported by the comprehensive evaluation.
 - The provider must initial where each ICD-10 is provided.
 - The age of onset must be indicated on the QDC, regardless of the participant's age at the time of application.
 - The provider must provide their license number, their printed name, their signature, and must date the form.

- Legal representative documents, if applicable**
 - For participants who are over the age of 18, and have a designated guardian, a copy of the guardianship order must be submitted. This order must be a copy that has the judge's signature as well as the judge's seal.
 - In circumstances where the participant has identified a legal representative through a power of attorney, the division must have a copy of the power of attorney designation. This document must be notarized. Additionally, this document must indicate that the identified representative has the authority to make medical decisions on their behalf.
 - For minors, who are in custody of the Office of Children's Services (OCS) a current order must be submitted to the division. This order must be the most current order and cannot be expired

- Medical documents**
 - Medical documents and evaluations are required by the division in order to support the qualifying diagnosis.
 - The evaluations must be dated within 36 months of the date of submission of the ICAP packet.
 - When the qualifying diagnosis is Intellectual Disability or Other Intellectual Disability a comprehensive diagnostic evaluation is required. This evaluation must include IQ/Cognitive testing, and adaptive testing.
 - For the diagnosis of ID or Other ID the evaluation must be completed by a licensed psychologist, neuropsychologist, or psychological associate.
 - When Autism is the qualifying diagnosis of the individual a comprehensive evaluation completed within 36 months is required. The evaluation must include IQ/Cognitive and adaptive testing. Accepted evaluations for the diagnosis of Autism must be completed by clinical level psychologists, neurologists, or developmental pediatricians.

- When the qualifying diagnosis is Seizure Disorder or Cerebral Palsy a QDC completed by a M.D. is required. This must provide the correct ICD-10 code, provider's initials where indicated, age of onset must be included regardless of the participant's age. This form must also contain the provider's printed name, date, license number and signature.



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IDD RENEWAL APPLICATION PACKET
Attachment C

- Determine the individual circumstances of the recipient and establish the procedure to assess level of care that is designated for the age and medical status of the recipient**

- IDD-03 ICAP Assessment Information and Consent**
 - Check all applicable boxes
 - 3 appropriate respondents must be identified
 - The initials of the participant or their legal representative must be included on page 2.
 - The participant or their legal representative must sign on page 2

- HSS-06-5870 Release of Information (ROI)**
 - Complete a Release of Information form for each ICAP respondent and agency.
 - The ROI must contain language that releases information from the respondent to SDS
 - The ROI must be signed by the recipient and/or legal representative
 - Do not have the recipient sign the “revocation” option on the second page unless consent is actually being revoked.
 - Be sure to include both pages of the ROI
 - Each ROI must be dated within 12 months of submission

- Uni-05 Appointment for Care Coordination Services**
 - Only if different from initial Uni-05 Appointment for Care Coordination Services

- Medical documents**
 - Upon renewal new evaluations are required at the discretion of the department
 - If new evaluations have been completed that are relevant to the participant’s progress and functional abilities then they should be submitted to the division.

- Supportive evaluation/documentation from health care providers who determined the qualifying diagnosis and/or signed the IDD-13 form.**
 - This is required only if there has been a change in the Qualifying Diagnosis from previous Level of Care.

- The supportive documentation for the new Qualifying Diagnosis and ICD 10 code must have been completed within the previous 36-month period

IDD-13 Qualifying Diagnosis Certification Form (QDC)

- The QDC must be completed by the appropriate provider.
- The QDC must provide an ICD-10 code that matches the qualifying diagnosis supported by the comprehensive evaluation.
- The provider must initial where each ICD-10 is provided.
- The age of onset must be indicated on the QDC, regardless of the participant's age at the time of application.
- The provider must provide their license number, their printed name, their signature, and must date the form.

Legal representative documents, if applicable

- For participants who are over the age of 18, and have a designated guardian, a copy of the guardianship order must be submitted. This order must be a copy that has the judge's signature as well as the judge's seal.
- In circumstances where the participant has identified a legal representative through a power of attorney, the division must have a copy of the power of attorney designation. This document must be notarized. Additionally, this document must indicate that the identified representative has the authority to make medical decisions on their behalf.
- For minors, who are in custody of the Office of Children's Services (OCS) a current order must be submitted to the division. This order must be the most current order and cannot be expired

Telehealth Regions

- A photocopy of the recipient's identification card
- A signed "Consent for Telehealth Assessment"
- A completed Environmental Telehealth Assessment Questionnaire



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CCMC INITIAL SCREENING PACKET
Attachment D

- Screening Tool**
 - Must be dated and signed by DD RN within 30 days of submission
 - From DD RN; not scored
 - *All fields are to be filled with the requested information or marked “n/a” because any field left blank will be considered incomplete*

- UNI-09 Verification of Diagnosis**
 - The provider must include the license number and state where licensed on the form
 - The form must have an accurate ICD-10 code
 - The form must be signed and dated within 6 months of the time that the initial screening packet is submitted to SDS
 - Electronic signatures are not acceptable
 - The provider name, telephone, facsimile number and license number must be included in either hand printed or typewritten format.

- Medical Information**
 - Medical records must be within the previous 12 months prior to screening; submit the most recent information
 - File medical records that support the screening from the DD RN
 - File medical records that support the diagnosis listed in the ICD-10 code

- HSS-06-5870 Release of Information --- Nurse to SDS**
 - Must be signed and dated by recipient or legal representative
 - The back or second page which includes the “revocation” information must be submitted with the form.
 - Must be dated within 12 months of submission
 - *Note: There cannot be 2 entities listed on the releaser line. If there is a backup DD RN this provider needs an ROI with their name on the releaser line.*

- HSS-06-5870 Release of Information --- Medical Provider to SDS**
 - Must be signed and dated by recipient or legal representative
 - The back or second page which includes the “revocation” information must be submitted with the form.
 - Must be dated within 12 months of submission
 - *Note: There cannot be 2 entities listed on the releaser line. If there are additional medical providers these providers each need an ROI with their name on the releaser line.*

- Documentation of POA/Guardianship**
 - This is necessary only if there is a POA/Guardianship other than natural or adoptive parents
 - The document verifying POA must have a notary seal present
 - The court order verifying Guardianship must be a copy certified by the court

- Proof of Medicaid Eligibility and Identity**
 - Must document active coverage with current Denali Card or a print out from DPA or a print out from Enterprise showing active coverage
 - Copy of ID for parent or guardian

- Telehealth Regions**
 - A photocopy of the recipient’s identification card
 - A signed “Consent for Telehealth Assessment”
 - A completed Environmental Telehealth Assessment Questionnaire



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CCMC RENEWAL APPLICATION

Attachment E

- UNI-04 Waiver Application for ALI/APDD/CCMC**
 - Must be dated and signed by Recipient no sooner than 120 days and no later than 90 days prior to end of preceding Level of Care assessment date
 - Must include all 6 pages
 - Complete every line and every page; use “n/a” if the information does not apply
 - Medicaid number must be present on the application
 - List the full name, contact information and reason and frequency of visits for each doctor or health provider listed
 - Complete every block under current medications including reason prescribed (can’t be unknown)
 - If there is a parent or legal representative, they must sign where designated (not on recipient line)

- UNI-05 Appointment for Care Coordination Services**
 - Only necessary if different than the initial care coordinator

- UNI-07 Recipient Rights & Responsibilities**
 - Applicant or legal representative must initial every line
 - Applicant or legal representative must sign and date
 - Care coordinator must sign and date
 - witness signature is optional

- UNI-09 Verification of Diagnosis**
 - The provider must include the license number and state where licensed on the form
 - The form must have an accurate ICD-10 code
 - The form must be signed and dated by the provider within 6 months prior to the end of the current Level of Care assessment date
 - Electronic signatures are not acceptable
 - The provider name, telephone, facsimile number and license number must be included in either hand printed or typewritten format.

- Medical Information**
 - File medical records that support the diagnosis listed in the ICD-10 code
 - Medical documentation must be from within the previous 12 months

- HSS-06-5870 Release of Information --- Nurse to SDS**
 - Must be signed and dated by recipient or legal representative
 - The back or second page which includes the “revocation” information must be submitted with the form.
 - Must be dated within 12 months of submission
 - *Note: There cannot be 2 entities listed on the releaser line. If there is a backup DD RN this provider needs an ROI with their name on the releaser line.*

- HSS-06-5870 Release of Information --- Medical Provider to SDS**
 - Must be signed and dated by recipient or legal representative
 - The back or second page which includes the “revocation” information must be submitted with the form.
 - Must be dated within 12 months of submission
 - *Note: There cannot be 2 entities listed on the releaser line. If there are additional medical providers these providers each need an ROI with their name on the releaser line.*

- Documentation of POA/Guardianship**
 - This is necessary only if there has been a change from a previously filed POA or Guardianship other than natural or adoptive parents and
 - document verifying POA must have a notary seal present
 - The court order verifying Guardianship must be a copy certified by the court

- Proof of Medicaid Eligibility and Identity**
 - Must document active coverage with current Denali Card or a print out from DPA or a print out from Enterprise showing active coverage
 - Copy of ID for parent or guardian

- Telehealth Regions**
 - A photocopy of the recipient’s identification card
 - A signed “Consent for Telehealth Assessment”
 - A completed Environmental Telehealth Assessment Questionnaire



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ALI/APDD INITIAL APPLICATION
Attachment F

- Confirm that the applicant has completed the State wide ADRC Pre Screen and Options Counseling Process**
 - Participation in the ADRC Pre Screen process can be confirmed in Harmony
 - If applicant has not completed the process, refer the individual to the State wide “ADRC Pre Screen and Options Counseling” prescreening program

- UNI-04 Waiver Application for ALI/APDD**
 - Must be dated and signed by Recipient no sooner than 120 days and no later than 90 days prior to end of preceding Level of Care assessment date
 - Must include all 6 pages
 - Complete every line and every page; use “n/a” if the information does not apply
 - Medicaid number must be present on the application
 - List the full name, contact information and reason and frequency of visits for each doctor or health provider listed
 - Complete every block under current medications including reason prescribed (can’t be unknown)
 - If there is a parent or legal representative, they must sign where designated (not on recipient line)

- FOR APDD ONLY –Proof of DD eligibility see Attachment D**

- UNI-05 Appointment for Care Coordination Services**
 - Signed and dated by Recipient and Care Coordinator

- UNI-07 Recipient Rights & Responsibilities**
 - Applicant or legal representative must initial every line; do not use check marks
 - Applicant or legal representative must sign and date
 - Care coordinator and/or PCA agency representative must sign and date
 - witness signature is optional

- UNI-09 Verification of Diagnosis**
 - The license number and State where licensed of the provider must be included on the form
 - The form must have an accurate ICD-10 code
 - The form must be signed and dated by the provider within 6 months of submission to SDS
 - The provider name, telephone, facsimile number and license number must be included in either hand printed or typewritten format.

- Medical Information**
 - Medical documents related to any visits or consultations with medical professionals within the 12 months preceding the date of submission of the application; including all visits to clinics or emergency rooms
 - Medical documents that are related to long term care need
 - Records of residential stays including a nursing facility, hospital, psychiatric institution or assisted living home. If the stay lasted for more than 15 days you may include records from the first and last 15 days of their admission
 - Records of therapies provided by a qualified therapist for any of the following: physical, speech/language, occupational or respiratory
 - Special treatments received such as IV medications, parenteral nutrition, testing, home health services or hospice services
 - Outpatient treatments such as chemotherapy, radiation or dialysis

- HSS-06-5870 Release of Information --- Care Coordinator to SDS**
 - Must be signed and dated by recipient or legal representative
 - The back or second page which includes the “revocation” information must be submitted with the form.
 - Must be dated within 12 months of submission
 - *Note: There cannot be 2 entities listed on the releaser line. If there is a backup Care Coordinator this provider needs an ROI with their name on the releaser line.*

- HSS-06-5870 Release of Information --- Medical Provider(s) to SDS**
 - Must be signed and dated by recipient or legal representative
 - The back or second page which includes the “revocation” information must be submitted with the form.
 - Must be dated within 12 months of submission
 - *Note: There cannot be 2 entities listed on the releaser line. If there are additional medical providers these providers each need an ROI with their name on the releaser line.*

- Legal Representative documents, if applicable**
 - The documentation must include language that gives the representative authority to make medical decisions on behalf of the Recipient and must not be expired
 - Electronic signatures are not acceptable

**Proof of Medicaid Eligibility and Identity**

- Must document active coverage with current Denali Card or a print out from DPA or a print out from Enterprise showing active coverage
- Copy of Applicant ID

**Telehealth Regions**

- A photocopy of the recipient's identification card
- A signed "Consent for Telehealth Assessment"
- A completed Environmental Telehealth Assessment Questionnaire



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ALI/APDD RENEWAL APPLICATION
Attachment G

- UNI-04 Annual Application for ALI/APDD/CCMC Waiver**
- Must be dated and signed by Recipient no sooner than 120 days and no later than 90 days prior to end of preceding Level of Care assessment date
 - Must include all 6 pages
 - Complete every line and every page; use “n/a” if the information does not apply
 - Medicaid number must be present on the application
 - List the full name, contact information and reason and frequency of visits for each doctor or health provider listed
 - Complete every block under current medications including reason prescribed (can’t be unknown)
 - If there is a parent or legal representative, they must sign where designated (not on recipient line)
- UNI-05 Appointment for Care Coordination Services**
- Only required if there has been a change in Care Coordinator services
 - Signed and dated by Recipient and Care Coordinator
- UNI-07 Recipient Rights & Responsibilities**
- Applicant or legal representative must initial every line; do not use check marks
 - Applicant or legal representative must sign and date
 - Care coordinator and/or PCA agency representative must sign and date
 - witness signature is optional
- UNI-09 Verification of Diagnosis**
- The provider must include the license number and state where licensed on the form
 - The form must have an accurate ICD-10 code
 - The form must be signed and dated by the provider within 6 months prior to the end of the current Level of Care assessment date
 - Electronic signatures are not acceptable
 - The provider name, telephone, facsimile number and license number must be included in either hand printed or typewritten format.
- Medical Information**

- Medical documents related to any visits or consultations with medical professionals within the 12 months preceding the date of submission of the application; including all visits to clinics or emergency rooms
- Medical documents that are related to long term care need
- Records of residential stays including a nursing facility, hospital, psychiatric institution or assisted living home. If the stay lasted for more than 15 days you may include records from the first and last 15 days of their admission
- Records of therapies provided by a qualified therapist for any of the following: physical, speech/language, occupational or respiratory
- Special treatments received such as IV medications, parenteral nutrition, testing, home health services or hospice services
- Outpatient treatments such as chemotherapy, radiation or dialysis

Legal Representative documents, if applicable

- Submit only if newly appointed or there is a change in legal representative
- The documentation must include language that gives the representative authority to make medical decisions on behalf of the Recipient and must not be expired

HSS-06-5870 Release of Information --- Care Coordinator to SDS

- Must be signed and dated by recipient or legal representative
- The back or second page which includes the “revocation” information must be submitted with the form.
- Must be dated within 12 months of submission
- *Note: There cannot be 2 entities listed on the releaser line. If there is a backup Care Coordinator this provider needs an ROI with their name on the releaser line.*

HSS-06-5870 Release of Information --- Medical Provider(s) to SDS

- Must be signed and dated by recipient or legal representative
- The back or second page which includes the “revocation” information must be submitted with the form.
- Must be dated within 12 months of submission
- *Note: There cannot be 2 entities listed on the releaser line. If there are additional medical providers these providers each need an ROI with their name on the releaser line.*

Proof of Medicaid Eligibility and Identity

- Must document active coverage with current Denali Card or a print out from DPA or a print out from Enterprise showing active coverage
- Copy of ID for parent or guardian

Telehealth Regions

- A photocopy of the recipient’s identification card
- A signed “Consent for Telehealth Assessment”
- A completed Environmental Telehealth Assessment Questionnaire