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

Personal Care Services
Amendment to Service Plan

Recipient name | Medicaid number

Agency name | Provider number

Agency contact

Contact telephone number | Agency FAX number

Basis for this amendment request

The recipient has experienced a material change in his/her

- ☐ medical condition or functional capacity
- ☐ physical living environment
- ☐ unpaid supports, caregivers, or services
- ☐ paid supports, caregivers, or services

Requested adjustments to the Service Level Authorization

Specify the activity, and the frequency, scope, and length of time for each activity, to be adjusted because of the change in the recipient's condition.

Activity	**Frequency** *Times per day*	**Scope** *Times per week*	**Length** *How long needed*

Description of changes

Date of the change

Describe the change.

For each activity listed, describe how the requested adjustments to frequency, scope, and length are necessary because of the material change.

Required documentation

Attach documentation that supports the specific adjustments to the Service Level Authorization as required by *Personal Care Services Policy and Procedures 10-13*.

Recipient Assurances

I acknowledge the change described in this request for amendment of my Personal Care Services service level authorization, and the impact of that change on my life. I have participated in the planning of my care, and agree that the adjustments in activities are related to the described change and are appropriate for my care. I request amendment of my Service Level Authorization as indicated in the activities table.

I understand that this is an application for Medicaid benefits, and that any misrepresentation, omission, or concealment of a material fact may subject me to civil monetary penalties, fines, or criminal prosecution. I certify that the information I have provided is true, accurate, and complete to the best of my knowledge.

Recipient/Legal representative signature Date

If the recipient signs with and "X", the signature of a witness who is not the recipient's care coordinator, personal care assistant, or representative of the personal care services agency is required.

Witness signature Date

Witness printed name Date

Care Coordinator Assurances (To be signed if the recipient receives Home and Community-based Services)

I acknowledge that the change described in this request for amendment has impacted the life of the recipient, and that the recipient has chosen to adjust Personal Care Services rather than Home and Community-based Services to address needs brought about by the change. I have submitted a request to amend the recipient's Plan of Care that corresponds to this request to amend the recipient's Service Level Authorization

Care Coordinator signature Date

Agency assurances

I certify that the adjustments indicated in the activities table are necessary because of the described material change in the named recipient's condition and the impact of that change on the recipient's life.

I understand that this is an application for Medicaid benefits, and that any misrepresentation, omission, or concealment of a material fact may subject me to civil monetary penalties, fines, or criminal prosecution. I certify that the information I have provided is true, accurate, and complete to the best of my knowledge.

Agency representative signature Date