State of Alaska • Department of Health and Social Services • Senior and Disabilities Services
Personal Care Assistance Program

# Shared Agency Service Agreement

**Complete all of the information requested, print the form, record original signatures and scan and e-mail to: dsds.pcamailbox@direct.dhss.akhie.com, or fax to DSDS PCA Program at 907-269-8164**

**When a Recipient is receiving services from two PCA Provider Agencies, it is necessary to complete and submit the information in this form, listed below.**

**Name:**________________________________ **Medicaid Number:** ____________________

Effective Date of Shared Services:

Primary PCA Agency:

Medicaid Provider #:

Total Weekly Hours Being Provided:

Modifier: U3 None

Secondary PCA Agency:

Medicaid Provider #:

Total Weekly Hours Being Provided:

Modifier: U3 None

**The above named "Current PCA Agency" will provide the "New PCA Agency" with copies of the contents of the recipient's file, in accordance with the "Authorization for Release of Information" form. The "New PCA Agency" must submit a completed transfer form to SDS within 10 calendar days of receipt of the recipient's information.**

NAMES/SIGNATURES

Print Client's Name or Legal Representative if applicable:

________________________________________ Date:

Signature Client or Legal Representative

Print Name of "Primary PCA Agency" Representative

________________________________________ Date:

Signature of "Primary PCA Agency" Representative

Print Name of "Secondary PCA Agency" Representative:

________________________________________ Date:

Signature Client or Legal Representative