Recipient Name:_______________________________________ Medicaid ID:_____________________

# NFLOC-04 APPLICATION FOR ALI/APDD/CCMC

***Select one:*** **Initial Application** **Renewal Application**

## 1. Applicant Information:

1.a. Recipient Name: ___________________________________

1.b. Care Coordinator Name: _____________________________

1.c. Care Coordinator Agency Name: ____________________

1.d. Application Date: ____________________________

1.e. Medicaid ID: _________________________

## 2. Select Program:

Alaskans Living Independently (ALI)

Adults with Physical and Developmental Disabilities (APDD)

Children with Complex Medical Conditions (CCMC)

**If applying or renewing application for Community First Choice (CFC), also complete CFC-06 Community First Choice Application – NOTE: Children under 6 years are not eligible for Personal Care Services. Applicants intending to live and recipients living in assisted living homes (ALHs) cannot receive CFC services (whether Personal Care Services, Personal Emergency Response Systems, or Chore services**

## 3. Checklist

Please refer to Application Requirements Care Coordinator Checklist for specific details regarding application requirements.

**Person-Centered Intake Completed in Harmony for Initial Applicants Only:**
Date of PCI: ______________________

**For APDD Initial Applications Only**
Attach the SDS Developmental Disabilities Determination Approval Letter

**Uni-07 Recipient Rights & Responsibilities**
Attach to Application Note

**Uni-09 Verification of Diagnosis**
Attach to Application Note

**Medical Documentation within the last 12 months**
Attach to Application Note

**Legal Representative documents, if applicable**
Attach to Application Note

Recipient Name:______________________________________ Medicaid ID:_____________________

## SECTION I-DEMOGRAPHIC INFORMATION

**4. Gender:**

**5. DOB:** ________________________

**6. Preferred Pronouns:** ________________

**7. Marital Status:** _______________

**8. Primary Language:** ______________________

**9. Interpreter needed:**

**10. If non-verbal, primary mode of communication:** __________________________________________

**11. Assessment Scheduling**

**11.a. Who should be contacted for the purpose of scheduling an assessment?** __________________________

**11.b. Contact Phone Number for scheduling**:__________________________

**11.c. Phone Type:**

**11.d. If you selected "other" for 11a. please indicate:** **(Please ensure this person is listed on the ROI)**

First and last name: __________________________________________

Relationship to applicant:

**12. Applicant Address:**

**12.a. Physical Address:**

Street: _______________________________________

City: ___________________________ State: ______________ Zip: _______________

**12.b. Is this address a facility? (Hospital, Long Term Care facility, DOC, IMD):**

Yes

**a.** Facility Type: _________________________

**b.** Facility Name: ____________________________________________

**c.** Expected Date of Discharge: _____________

No

**13. Is this address an assisted living home?**

Yes ALH name: ___________________________________

No

**14. For applicants residing in private residences (non-ALH) only: Do any other household members receive Medicaid waiver or personal care services (PCS)?** **(If applicant lives in ALH, skip to #15)**

Yes

No

**15. Where should SDS documents and notices be mailed?**

**15.a.** _____________________

**15.b. Name:** ____________________________ ***(Must match name on legal representative document)***

**15.c. Mailing Address where SDS documents and notices will be sent:**

Street: ____________________________________________________

City: ___________________________ State: ______________ Zip: _______________

**16. Applicant's Legal Representative (if applicable):**

**16.a. Participant has a legal representative:**

Yes

**16.b. Name:** ________________________________________

**16.c. Legal Relationship:** _______________________

**16.d. Contact Phone Number for Legal Representative:** ________________________

**16.e. Phone Type:** _______________________

No

Recipient Name:______________________________________ Medicaid ID:_____________________

## SECTION II – DIAGNOSIS & MEDICAL INFORMATION

**17. Document emergency room visits, hospitalizations, surgeries and/or treatments over the past 12 months. If none check NA here:**

*(If description exceeds available space, add additional information in Section V as necessary)*

| Date of Event | Visit Type – Check All That Apply | Brief Description of Event SDS Assessor Should Be Aware of | Identify Attached Supporting Documentation or Medical Records that will be submitted with the Application | Was a CIR submitted for this event? Yes/No |
|---|---|---|---|---|
| | ER Visit<br>Hospitalization<br>Surgery<br>Treatment | | | Yes<br>No |
| | ER Visit<br>Hospitalization<br>Surgery<br>Treatment | | | Yes<br>No |
| | ER Visit<br>Hospitalization<br>Surgery<br>Treatment | | | Yes<br>No |
| | ER Visit<br>Hospitalization<br>Surgery<br>Treatment | | | Yes<br>No |
| | ER Visit<br>Hospitalization<br>Surgery<br>Treatment | | | Yes<br>No |
| | ER Visit<br>Hospitalization<br>Surgery<br>Treatment | | | Yes<br>No |

**18. Is the applicant currently receiving physical therapy, occupational therapy, speech therapy and/or nursing care?**

Yes No *(If no, skip to #19)*

| Therapy Type | Frequency per Week | Identify Attached Supporting Documentation |
|---|---|---|
| Physical Therapy | | |
| Occupational Therapy | | |
| Speech Therapy | | |
| Nursing Care | | |

Recipient Name:______________________________________ Medicaid ID:_____________________

**19. Describe significant changes in the applicant's life, health and/or behavior in the last year:** ***(If description exceeds available space, add additional information in Section V as necessary)***

**20. Is there other information about the applicant's health the SDS assessor should be aware of?** ***(If description exceeds available space, add additional information in Section V as necessary)***

## SECTION III – Medical Providers and Medication

**21. Medical Providers:** ***(For each medical provider listed, please complete all fields. Put N/A if field is not applicable. If you need additional space, please add the information in Section V)***

**21.a.** Provider Name: ____________________________________________________
Phone Number:__________________________ Fax Number: ______________________
Provider Specialty: _______________________ Number of visits last 12 months: ____________

**21.b.** Provider Name: ____________________________________________________
Phone Number:__________________________ Fax Number: ______________________
Provider Specialty: _______________________ Number of visits last 12 months: ____________

**21.c.** Provider Name: ____________________________________________________
Phone Number:__________________________ Fax Number: ______________________
Provider Specialty: _______________________ Number of visits last 12 months: ____________

Recipient Name:______________________________________ Medicaid ID:_____________________

**21.d.** Provider Name: _____________________________________________________
Phone Number:__________________________ Fax Number: _______________________
Provider Specialty: _______________________ Number of visits last 12 months: ____________

**21.e.** Provider Name: _____________________________________________________
Phone Number:__________________________ Fax Number: _______________________
Provider Specialty: _______________________ Number of visits last 12 months: ____________

**21.f.** Provider Name: _____________________________________________________
Phone Number:__________________________ Fax Number: _______________________
Provider Specialty: _______________________ Number of visits last 12 months: ____________

**21.g.** Provider Name: _____________________________________________________
Phone Number:__________________________ Fax Number: _______________________
Provider Specialty: _______________________ Number of visits last 12 months: ____________

**22. Current Medications:** ***(Put NA if the applicant is not taking any medications. If number of medications exceeds available space, add additional information in Section V as necessary.)***

| Medication Name | Dosage | Route of Administration | Frequency | Status |
|---|---|---|---|---|
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## 23. Additional Information:

**23.a. Has the recipient been approved for waiver for the past 2 or more consecutive years?**

**Yes** **No**

**23.b. Does the recipient want to undergo an assessment instead of a comprehensive file review (if he/she qualifies for the file review)?**

**Yes** **No**

**23.c. Are there material changes in health or functional status within the past year? If yes, please provide an explanation in space provided in Questions 19 & 20.**

Yes No

## 24. Statements of/Documentation of Reasonable Expectation of the Need for Long Term Care

**Both** statements must be checked for a complete application

**24.a.** **Yes** I believe there is a reasonable indication that the applicant might need services at a level of care provided in a hospital, nursing facility, IMD, or ICF/IID in 30 or fewer days unless the applicant receives home and community-based waiver services under 7 AAC 130 or Community First Choice services under 127.

**24.b.** **Yes** I have provided appropriate and contemporaneous documentation that addresses each medical and functional condition and indicates the applicant's need for home and community-based waiver services.

## 25. Conflict of Interest – Applicant Acknowledgement

7 AAC 127.020, 7 AAC 130.217 and 7 AAC 130.240 protect you from conflict of interest by putting definitions around who can serve you as care coordinator. **Has your care coordinator informed you of the care coordinator's employment by or family relationship to a certified provider agency?**

**Yes**, my care coordinator has informed me of possible conflicts, and I wish to proceed.

**Or**

**Yes**, my care coordinator has informed me that they have no conflicts, and I wish to proceed.

## SECTION IV – SIGNATURES

By signing below, I certify that the information included in this application is true and accurate to the best of my knowledge.

_________________________________________________ ________________

Applicant or Legal Representative Signature (only one signature requested) Date

_________________________________________________

Printed Name of Signer (Applicant or legal representative)

_________________________________________________ ________________

Care Coordinator Signature Date

Two witnesses are required if recipient signs with an X or a stamp. The care coordinator may not serve as a witness.

_________________________________________________ ________________

Witness #1 Signature Date

______________________________________ ___________________________

Witness #1 Printed Name Relationship

_________________________________________________ ________________

Witness #2 Signature Date

______________________________________ ___________________________

Witness #2 Printed Name Relationship

Recipient Name:______________________________________ Medicaid ID:_____________________

## SECTION V – ADDITIONAL NOTES AND DOCUMENTATION

Provide any additional information carried over from any section which did not provide sufficient room and/or add any additional information that SDS staff should be aware of that was not otherwise documented within the application.