



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

Personal Care Services Representative Designee
or
Community First Choice Personal Care Services Representative Designee

Name of recipient: _____ Phone: _____

Email: _____

Name of recipient representative: _____ Phone: _____

Email: _____

Recipient Representative Statement:

I am not present in the recipient's community and involved in the day-to-day care of the recipient.

I hereby designate _____ to act on my behalf in accordance with 7 AAC.125.030(c), during the time period _____ to _____

Designee name: _____ Phone number: _____

Street address: _____

Email: _____

Designee Statement:

- ❖ I am at least 18 years old.
- ❖ I live in the recipient's community and am involved in day-to-day care of recipient.
- ❖ I am willing to manage and evaluate the recipient's personal care services as those services are provided in the recipient's home.
- ❖ I am not a public home care provider or affiliated with a public home care provider as defined in AS 47.05.017(c).

Recipient representative signature

Date

Designee signature

Date

For CFC/PCS Only: Name of Care Coordinator: _____

Copy of this form sent to Care Coordinator via DSM at: _____

Signature of Agency Representative

Date

Name Agency Representative: _____