



State of Alaska • Department of Health and Social Services
 Division of Senior and Disabilities Services
**Consumer Directed Personal Care Services (CDPCS) and
 Community First Choice Consumer Directed Personal Care Services (CFC/CDPCS)
 Recipient and CDPCS or CFC/CDPCS Provider Agency Contract**

7 AAC 125 PCS

7 AAC 127 CFC-PCS

Recipient Name (Last, First): _____

Medicaid#: _____

Service Plan Start Date: _____

Service Plan End Date: _____

The Consumer Directed Personal Care Service Program (CDPCS) and the Community First Choice Consumer Directed Personal Care Services Program (CFC/CDPCS) allow the recipient or the recipient’s representative (defined in 7 AAC 160.990(b)), to manage the recipient’s personal care services. This includes hiring, training, scheduling and managing the personal care assistant (PCA). The Consumer Directed Provider Agency selected by the recipient provides administrative support and agency orientation. CDPCS or CFC/CDPCS also allows the recipient to manage specific health maintenance tasks specified in 7 AAC 125.030(b) - (d) and 7 AAC 127.040(a)(2).

This agreement is made between: _____

Consumer Directed Provider Agency name

and: _____

Recipient or legal representative name

for the purpose of establishing the relationships, roles, and responsibilities of the parties as outlined below. The Consumer Directed Provider Agency, enrolled as a Medicaid provider with the Division of Health Care Services, is authorized to provide administrative tasks and fiscal intermediary tasks related to the CDPCS and the CFC CDPCS programs. The recipient is an individual approved by the Division of Senior & Disabilities Services (DSDS) to receive services under the CDPCS or the CFC/CDPCS program.

Responsibilities of the Recipient receiving CDPCS (7 AAC 125.140) or CFC/CDPCS (7 AAC 127.125)

To participate in the CDPCS program, I understand that I am responsible for the following:

1. Demonstrating that I have decision making capacity to determine my needs and preferences for help with activities of daily living, instrumental activities of daily living and allowable specific health maintenance tasks;
2. Acknowledging with this contract that I have designated a CDPCS Agency or a CFC/CDPCS Agency to fulfill the responsibilities of 7 AAC 125 or 7 AAC 127;
3. Hiring the individual(s) who will work as my personal care assistant(s); understanding the impact of, and assuming responsibility for, training, supervising and managing my personal care assistant(s); signing the timesheets for my personal care assistant(s); and terminating the employment of my personal care assistant(s) if services are unsatisfactory or no longer needed;
4. Notifying the Consumer Directed Provider Agency when my needs for personal care services change, when the contact information changes for me, my representative or the representative’s designee;
5. Cooperating with the Department of Health and Social Services (DHSS) to accomplish level-of-care assessments, support plan development and service level authorizations (SLA).

For CFC/PCS consumer/recipients only. I understand that, as a recipient of CFC/PCS, I may receive optional self-directed training materials to help me manage my PCA(s).

I accepted from my Consumer Directed Provider Agency or Care Coordinator these self-directed training materials: 1) the training manual “YOUR PERSONAL CARE ASSISTANT (PCA) AND YOU, Senior and

Disabilities Services Department of Health and Social Services State of Alaska” and 2) instructions on how to access additional resources on the SDS training web page and the SDS “You Tube” training platform.

I declined to receive the self-directed training materials offered to me.

N/A (I do not receive CFC/CDPCS)

As a recipient of CDPCS, I understand that my services must be prior-authorized and I must follow all Medicaid regulations concerning Personal Care Services or Community First Choice Personal Care Services. I understand that knowingly making a false statement may subject me to criminal prosecution or civil sanction, including, without limitation, monetary penalties. I understand that knowingly making a false statement may constitute the crimes of perjury (AS 11.56.200), medical assistance fraud (AS 47.05.210) and/or unsworn falsification (AS 11.56.210). If I have additional questions regarding the CDPCS or the CFC/CDPCS programs, I understand that I should contact the Division of Senior and Disabilities Services.

Responsibilities of the CDPCS (7 AAC 125.130) or a CFC/CDPCS (7 AAC 127.130) Agency

1. Comply with the requirements of 7 AAC 125 and 7 AAC 127
2. Every six months, unless 7 AAC 7 125.130(b) applies, perform a review of the recipient’s services to include:
 - A. an interview of the recipient in the recipient’s residence to evaluate whether services were provided as authorized and to evaluate that those services are sufficient to meet the recipient’s continuing needs;
 - B. an interview of the recipient’s PCA(s) to evaluate the service record and timesheets prepared by the PCA(s);
 - C. documentation in the recipient’s service record the extent to which the review concludes that the services provided are consistent with the recipient’s service level authorization;
 - D. when there is a material change in the recipient’s needs, submitting an amendment to the recipient’s service level authorization;
3. Maintain communication with the recipient, the recipient’s health care provider(s), and the recipient’s PCA(s).
4. Maintain a service record for each recipient that includes:
 - A. a copy of each service level authorization, each assessment, each amendment and documentation and conclusions of reviews and interviews;
 - B. a copy of all timesheets for PCA(s), signed by the recipient, (recipient’s representative or representative’s designee);
 - C. records of all contacts between the agency and the recipient, the recipient’s health care provider(s), and the recipient’s PCA(s).
5. Collect and verify timesheets for the recipient’s PCA(s); only submit claims based on verified timesheets.
6. Work with the recipient or the recipient’s representative to identify the possible risks to the recipient’s health, safety or welfare if the recipient’s regularly scheduled PCA is unable to provide services.
7. Work with the recipient or the recipient’s representative to develop a back-up plan that identifies the responsibilities of the agency and the responsibilities of the recipient for obtaining personal care services or other backup services if the recipient’s regularly scheduled PCA is unable to provide those services.

The agency agrees to follow all Medicaid regulations; all personal care regulations (7 AAC 125.010 through 7 AAC 125.199) and all Community First Choice personal care regulations (7 AAC 127.010 through 7 AAC 127.990) and all Agency policies and procedures. The agency understands that knowingly making a false statement may subject the agency to criminal prosecution or civil sanction, including, without limitation, monetary penalties. The Agency understands that knowingly making a false statement may constitute the crimes of perjury (AS 11.56.200), medical assistance fraud (AS 47.05.210) and/or unsworn falsification (AS 11.56.210).

I have read this document, I understand and agree to follow the terms and requirements as stated in this document.

Signatures

Recipient Signature

Date

Witness Signature

Date

CDPCS or CFC/CDPCS Provider Agency Representative Signature

Date

I am a legal representative for the recipient named above. I understand that I must be directly involved in the day-to-day care of this recipient, and I assume all of the responsibilities for managing this consumer's care as listed above. If I am unable or unavailable, I must designate, in a format approved by SDS, a "Representative Designee" under 7 AAC 125.030(c) to be directly involved in the day-to-day care of the recipient.

Legal Representative Signature

Date

Witness Signature

Date

***For CFC/PCS only* Send a copy of CFC-04 to the Consumer/Recipient's Care Coordinator**

Name of Care Coordinator

Date CFC-04 sent