[x] 

Date Stamp Here:

APPLICATION FOR ALI/APDD/CCMC/CFC

**(NEW and RENEWAL)**

**Completed by Care Coordinator:**

**Recipient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CC Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CC Agency Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Waiver Type (choose one):**

[ ]  **ALI - Alaskans Living Independently**

[ ]  **APDD - Adults with Physical and Developmental Disabilities**

[ ]  **CCMC - Children with Complex Medical Conditions**

**Community First Choice (choose one):**

[ ]  **CFC - Community First Choice**

[ ]  **Waiver and CFC – Waive rand Community First Choice**

[ ]  **New Application**

**Note: If you do not qualify for Waiver or CFC services would you like to be**

**considered for State Plan Personal Care Services?** [ ]  **Yes** [ ]  **No**

**If yes, please state your preferred Personal Care Services Agency**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

[ ]  **Renewal Application**

**Note: Re-application is required for the ALI/APDD/CCMC Waivers and the**

**CFC Program annually, per 7 AAC 130.213 and 7 AAC 127.030.**

***Section I ~ Demographic Information***

POC Type (Select one): ALI [ ]  APDD [ ]  CCMC [ ]  CFC only [ ]  Waiver and CFC [ ]

Medicaid#: DOB:

Male [ ]  Female [ ]  Married [ ]  Single [ ]  Height: Weight: Primary Language:

If non-verbal,-primary mode of communication:

***If a communication barrier exists, please provide an English speaking contact for scheduling:***

**Contact name: Contact Phone: Relationship:**

### Applicant’s Physical Address or directions to home in rural areas (No P.O. Boxes)

Address:

City: State: Zip:

Work-Phone: Home-Phone:

Cell-Phone: Email:

### Mailing address (if different than physical)

Address:

City: State: Zip:

### Applicant’s Legal Representative

Does the applicant want SDS documents mailed to the Power of Attorney (POA)? **Yes** [ ]  **No** [ ]

Name: Role/Relationship: Guardian [ ]  POA [ ]

Mailing Address:

City: State: Zip:

Work-Phone: Home-Phone: Cell-Phone:

Email:

***Care Coordinator***

**Name: Cell-Phone: Email:**

**Agency: Work Phone: Fax #:**

**Address:**

 **City: State: Zip:**

**Provider ID#: Provider Group ID#:**

# Section II ~ Diagnosis & Medical

### Primary Diagnosis from the Verification of Diagnosis (VOD):

### Secondary Diagnosis(es) from the VOD:

***Source(s) for diagnostic information (including the medical professional from the VOD):***

*Health Summary-* Specify and attach appropriate supporting documentation. Summarize the applicant’s health over the past 12 months.

### Document emergency room visits, hospitalizations, surgeries/ or treatments:

### Describe significant changes in the applicant’s health or behavior in the last year. If a renewal application:

Has the applicant received a new primary diagnosis?

Has the applicant been diagnosed with any new health problems, mental health issues, or other problems that might affect his/her functional abilities?

# Section III ~ Current Medical Data

***Medical and/or Psychiatric Contacts (Highlight, right-click & insert additional rows as needed)***

Include a fax number for a primary physician as well as a contact phone number for all providers listed.

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name** | **Address** | **Phone & Fax** | **Reason for visits and frequency** |
|  |  |  |  |
|  |  |  |  |
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***Current Medications (Highlight, right-click & insert additional rows as needed)***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication** | **Dosage** | **Prescriber** | **Reason Prescribed** | **Administered how?** |
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### Adaptive Medical Equipment (DME/SME)

List all adaptive medical equipment currently in use/available to the applicant regardless of funding source:

|  |  |  |
| --- | --- | --- |
|  [ ]  Bath Bench |  [ ]  Gait Belt | [ ]  Lift/Hoyer |
|  [ ]  Braces/AFOs |  [ ]  Grab Bars | [ ]  Stair Glide |
| [ ]  Cane |  [ ]  Hand Held Shower | [ ]  Wheelchair |
| [ ]  Commode [ ]  Elevated Toilet |  [ ]  Hospital Bed [ ]  P.E.R.S/Lifeline | [ ]  Walker |
|  [ ]  Other:  |  |  |

List adaptive medical equipment needed:

### Environmental Modifications (EMODs)

### List all environmental modifications completed for this applicant regardless of funding source:

### List environmental modifications needed:

# Statement of Reasonable Expectation of the Need for Long Term Care

I believe that there is reasonable indication the applicant might need services at a level of care provided in a hospital, nursing facility, or ICF/MR 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.

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.

***Section IV ~ Signatures:***

N**o** (there are no known relationships)

**Yes**

**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 any employment or family relationship to a certified provider agency? *Applicant please initial***

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

|  |  |  |  |
| --- | --- | --- | --- |
| Recipient Signature | Date | Parent or Legal Representative | Date |
| Care Coordinator | Date | Other Natural Support | Date |

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

|  |  |  |  |
| --- | --- | --- | --- |
| Witness Printed Name | Signature | Relationship | Date |
| Witness Printed Name | Signature | Relationship | Date |