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

# Home and Community-Based Services • Personal Care Services and Community First Choice Personal Care Services Request for Expedited Consideration

**Applicant/Recipient**

Name Medicaid number

This request is for an ☐ Initial application/assessment ☐ Amendment of current service plan

for the following program: ☐ IDD ☐ ISW ☐ APDD ☐ ALI ☐ PCS ☐ CCMC

For an initial application, provide the address of the location where an assessment can be performed:

**Basis for expedited consideration**

The recipient has no natural supports able to meet his /her needs, and qualifies for expedited consideration because of

- ☐ a diagnosis of terminal illness with a life expectancy of six months or less
- ☐ imminent/recent discharge on from an acute care or nursing facility
- ☐ unplanned absence of primary unpaid caregiver due to medical/family emergency or hospitalization
- ☐ declining health of his/her primary unpaid caregiver
- ☐ the death of his/her primary unpaid caregiver on
- ☐ Adult Protective Services/Office of Children's Services referral

For Personal Care Services only

- ☐ an immediate need for a time-limited increase in services related to functional capacity

Describe the circumstances that qualify the applicant/recipient for expedited consideration.

**Required documentation** *Attach documentation that supports expedited consideration.*

**Provider agency requesting expedited consideration**

Agency name Provider number

Agency contact Phone number

DSM/encrypted Email address Agency FAX number

_____ _____

Agency representative signature Date

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*For SDS use only* Date of review _____ Request ☐ approved ☐ denied

Reason for decision_____

_____

☐ Follow-up on _____ Purpose_____

_____

_____ _____

SDS reviewer signature Date