Amendment to Service Plan

Complete all of the information requested, obtain signatures and upload as specified in your Harmony Guide:

Demographics:

Recipient name:

Recipient's Medicaid number:

For CFC-PCA Only

Care Coordinator name:

Basis for this amendment request

The recipient has experienced a material change(s) in his/her (check all that apply):

- Medical condition ☐
- Physical living environment ☐
- Unpaid supports, caregivers, or services ☐
- Paid supports, caregivers, or services ☐
- State plan services (CFC) ☐

Description of changes(s)

Date(s) of the change(s):

Describe the change(s) in the text box below, if you need additional space use the text box for additional information on page 3:

Requested adjustments to the Service Level Authorization for Personal Care Services or Community First Choice Personal Care Services

For each activity for which you are requesting an adjustment, list the frequency (times per day), scope (times per week), and length of time for the adjustment, based on the recipient's material change in condition(s).

Activity, Frequency, Scope, Length:

Activity, Frequency, Scope, Length:

Activity, Frequency, Scope, Length:

Activity, Frequency, Scope, Length:

Activity, Frequency, Scope, Length:

Activity, Frequency, Scope, Length:

Activity, Frequency, Scope, Length:

Activity, Frequency, Scope, Length:

Activity, Frequency, Scope, Length:

Activity, Frequency, Scope, Length:

Required documentation and Recipient/Legal representative signature:
Attach documentation that supports the specific adjustment to the Service Level authorization as required by *7 AAC 125.026* and *7 AAC 127.095.*

Recipient Assurances:
I acknowledge the change described in this request for amendment of my Personal Care Services, and the impact of that change on my life. I have participated in the planning of my care and agree that the adjustments in activities are related to the described change and are appropriate for my care. I request amendment of my Service Level Authorization as indicated in the activities table. I understand that this is an application for Medicaid benefits, and that any misrepresentation, omission or concealment of a material fact may subject me to civil monetary penalties, fines, or criminal prosecution. I certify that the information I have provided is true, accurate, and complete to the best of my knowledge.

Signatures:

Recipient/Legal Representative Signature:

Date Recipient Signed:

The signature of a witness is required if the recipient signs with an "X." The witness must not be the recipient's care coordinator, personal care assistant, or a representative of the personal care services agency.

Witness Signature:

Date Witness Signed:

Witness Printed Name:

Witness Relationship to Recipient:

Care Coordinator Assurances -Required for Community First Choice Personal Care Services only:
I certify that the adjustments indicated in the activities table are necessary because of the described material changes in the named recipient's condition and the impact of that change on the recipient's life. I understand that this is an application for Medicaid benefits, and that any misrepresentation, omission, or concealment of a material fact may subject me to civil monetary penalties, fines, or criminal prosecution. I certify that the information I have provided is true, accurate, and complete to the best of my knowledge.

Care Coordinator Signature (Required for CFC-PCS Recipients only):

Date Care Coordinator signed:

Care Coordinator Printed Name:

Agency Representative Signature:

Date Agency Representative signed:

Agency Representative Printed Name:

Text box for additional information: