State of Alaska • Department of Health • Division of 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: _____