# CFC-06 Application Instructions

The CFC-06 Application is posted on the Senior and Disabilities Services (SDS) Approved Forms website and is to be completed by a Care Coordinator.

**To use the CFC-06 Application form you must have the most current version of Adobe Acrobat Reader.** Adobe Acrobat Reader is a free, safe application that allows you to fill out portable data file (.pdf) forms. Please use the latest version. You can download it free at https://get.adobe.com/reader/ . Please complete the form by entering a response for each item listed unless directed to skip that item. There are features included on the form to assist you such as: free text boxes, date selectors, and radio buttons. You will need to save the form to your computer. To do this go to the File menu, click Save As, type in a file a name, choose a file destination on your computer and then click Save. Documents with file names that include special characters cannot be opened in Harmony when using the Chrome browser. SDS requests that all Harmony users do not use the following special characters when naming files that will be uploaded in Harmony as Note attachments: comma (,) and semi column (;).

This is an SDS Approved Form so please do not make any changes to the form.

Print page 2 as necessary for signatures. This is where the Applicant or the applicant's legal representative signs, dates and prints name. Page 2 is also where the Care Coordinator signs and dates. If the Applicant signs with an X or stamp, then two witnesses are needed. Both witnesses must print name, sign, date and provide their relationship to the Applicant. *Note – ensure printer settings are set to grayscale if you wish to avoid printing in color.

The completed form contains Protected Health Information (PHI) and must be submitted through the SDS secure **Harmony Data System**. Please refer to the T24 Harmony Training Guide for the correct steps to follow.

## CFC-06 – Application Page 1

### Applicant Information

| Information Requested | What to enter | Example |
|---|---|---|
| (Top of Page) Header: Applicant Name | Enter Applicant's first and last name<br>Applicant name entered here will autofill 1a.<br>Applicant Name and header on subsequent page | John Smith |
| (Top of Page) Header: Medicaid ID | Enter applicant's Medicaid Number<br>Medicaid numbers are ten digits and begin with either **06** or **20**. | 0600000000 |
| Select one: | Select one radio button for either: **Initial Application** or **Renewal Application** | ⊙Initial Application |
| 1.a. Recipient Name | Enter Applicant's first and last name (if this did not autofill from header) | John Smith |
| 1.b. Care Coordinator Name | Enter Care Coordinator's first and last name | Jane Doe |
| 1.c. Care Coordination Agency Name | Enter Care Coordination Agency's name | Doe and Friends Care Coordination |
| 1.d. Application Date | Enter the date the application is being completed (if this did not autofill from header) | 5/20/2021 |
| 2a. Select the level of care applicant is pursuing or has already met: | Select radio button next to one of the following:<br>Nursing Facility Level of Care<br>or<br>Intermediate Care Facility for Individuals with Intellectual Disabilities<br>or<br>Other level of care | ⊙Nursing Facility Level of Care |
| 2b. Is the applicant considering Personal Care Services (PCS)? | Select one radio button for either: **Yes** or **No**<br>If **No** = ***Skip to 3***<br>If **Yes** = *continue to 2c.* | ⊙Yes, considering Personal Care Services (PCS) |

| Information Requested | What to enter | Example |
|---|---|---|
| 2c. If you answered yes to 2b.: If the applicant does not meet level of care for CFC, does the applicant want to be considered for automatic enrollment into State Plan Personal Care Services? | Select one radio button for either: **Yes** or **No** | ⊙Yes |

## CFC-06 – Application Page 2

### Signatures

| Information requested | What to enter | Example |
|---|---|---|
| Applicant or Legal Representative Signature | Applicant or Legal Representative signs here – only one signature requested | *Anne Smith* |
| Date | Enter the date signed by the Applicant or Legal Representative | 5/19/2021 |
| Printed Name of Signer (Applicant or legal representative) | Enter first and last name of person who signed | Anne Smith |
| Care Coordinator signature | Care Coordinator signs here | *Jane Doe* |
| Date | Enter the date signed by the Care Coordinator | 5/20/2021 |
| Two witnesses are required if recipient signs with an X or a stamp. The care coordinator may not serve as a witness: **Witness #1 Signature** | First witness signs here | *Deb Crane* |
| Two witnesses are required if recipient signs with an X or a stamp. The care coordinator may not serve as a witness: **Date** | Enter the date signed by first witness | 5/20/2021 |
| Two witnesses are required if recipient signs with an X or a stamp. The care coordinator may not serve as a witness: **Witness #1 Printed Name** | Enter first and last name of first witness | Deb Crane |

| Information requested | What to enter | Example |
|---|---|---|
| Two witnesses are required if recipient signs with an X or a stamp. The care coordinator may not serve as a witness: **Relationship** | Select Relationship from drop down list | Friend |
| Two witnesses are required if recipient signs with an X or a stamp. The care coordinator may not serve as a witness: **Witness #2 Signature** | Second witness signs here | *Rob Stowe* |
| Two witnesses are required if recipient signs with an X or a stamp. The care coordinator may not serve as a witness: **Date** | Enter the date signed by first witness | 5/20/2021 |
| Two witnesses are required if recipient signs with an X or a stamp. The care coordinator may not serve as a witness: **Witness # 2 Printed Name** | Enter first and last name of second witness | Rob Stowe |
| Two witnesses are required if recipient signs with an X or a stamp. The care coordinator may not serve as a witness: **Relationship** | Select Relationship from drop down list | Friend |