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

Personal Care Services Renewal Application

See Instructions for Completion of Personal Care Services Initial Application on how to complete and submit this form

Participant Name: _____ Medicaid #: _____

Program Type: ☐ Agency-Based ☐ Consumer-Directed

Personal Care Services Agency

Agency/Center Name: _____ Provider #: _____

Agency Center Representative: _____

Phone: _____ E-mail: _____

Section I Participant Information

1.) **Participant Profile**

Date of Birth: _____

Gender Identification: ☐ Male ☐ Female ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Primary language: _____ Interpreter needed? ☐ Yes ☐ No

If primary language is not English, provide the name of English-speaker for communication purposes.

Name: _____ Phone: _____

Relationship to Participant: _____

2.) **Participant Address**

Physical Address: _____ City/State/Zip: _____

☐ ***If this a Facility/Other Location:***

Name of Facility/Other Location: _____

Expected Date of Discharge: _____

☐ Acute Care Facility ☐ Long Term Care Facility ☐ Assisted Living Home ☐ Other: _____

Mailing Address: _____ City/State/Zip: _____

Cell Phone: _____ Landline Phone: _____

Participant Name: _____ Medicaid #: _____

3.) **Participant Current Service**

	Yes	No
Has the Participant applied for HCBW services?	☐	☐
Does the Participant receive chore services as a waiver service?	☐	☐
Has the Participant applied for grant services?	☐	☐
Does the Participant receive chore services through a grant?	☐	☐
Is the Participant a U.S. Veteran?	☐	☐

4.) **Participant Representative**

Does the Participant have a legal Representative? ☐ Yes ☐ No

**If marked "Yes" complete representative information below; if marked "No" skip to Section II*

Representative Type (*Attach Documentation*)

- ☐ Public Guardian (OPA)
- ☐ Parent
- ☐ Power of Attorney
- ☐ Representative Payee
- ☐ Other: _____
- ☐ Full Guardian
- ☐ Conservator
- ☐ Partial Guardian
- ☐ Delegated Parental Authority

Representative's Full Name: _____
Mailing Address: _____
City/State/ Zip: _____ Phone: _____
Email:_____

Does the Participant want SDS documents mailed to the Participant's legal representative?

☐ Yes ☐ No

Does the legal representative plan to be physically present to manage personal care services for the Participant?

☐ Yes ☐ No

Is the legal representative involved in the day-to-day care of the Participant, in person or telephonically?

☐ Yes ☐ No

Has the legal representative designated an individual to act as the representative's designee in accordance with 7 AAC 125.100(c) and Approved Form PCA-10?

☐ Yes ☐ No

**If marked "Yes" complete the representative's designee information below; if marked "No" skip to Section II*

Representative's Designee's Full Name: _____
Mailing Address: _____
City/State/ Zip: _____ Phone: _____
Email: _____

Participant Name: _____ Medicaid #: _____

Section II Personal Care Services Review

1.) **Physical Condition**

Full Name of Primary Health Care Provider / Primary Health Care Clinic: _____
Phone: _____ Fax: _____

I (Participant) _____ declare that I have a chronic or permanent physical condition that is stable and predictable and that I have not experienced any changes during the previous service plan year that would affect my current service level authorization. I continue to need hands on help for the activities I have checked from the following list:

**Check "Yes" or "No" to indicate where you continue to need help to perform the activity (Must be answered by the participant).*

Activities	YES	NO	Activities	YES	NO
Bed Mobility	☐	☐	Light Meal Preparation	☐	☐
Transferring	☐	☐	Main Meal Preparation	☐	☐
Locomotion	☐	☐	Light/Routine Housework	☐	☐
Dressing	☐	☐	Shopping	☐	☐
Eating/Drinking	☐	☐	Laundry	☐	☐
Toileting	☐	☐	Administering of Medication	☐	☐
Personal Hygiene	☐	☐	Minor Maintenance of Respiratory Equipment	☐	☐
Bathing	☐	☐	Dressing Changes and Wound Care	☐	☐
Escort	☐	☐	Passive Range of Motion Exercise	☐	☐

Per 7 AAC 125.012(d), I am requesting a renewal of my Personal Care services at the current level without a reassessment. ☐ Yes ☐ No

**If "Yes" proceed to Sections III and IV; if "No" refer to the PCA -03 Personal Care Services Amendment to Service Plan form.*

***Per 7 AAC 125.020 SDS reserves the right to conduct an assessment as determined necessary by SDS staff.**

Participant Name: _____ Medicaid #: _____

Section III Participant Signature Page

Participant Assurances

I, (print / type Participant name) _____ *understand that, although I claim that I need physical assistance with the activities specified in this application for Personal Care Services, the decision to authorize personal care services for those activities will be made by Senior and Disabilities Services on the basis of a review of my current clinical documentation and a functional assessment of my capacity to perform the activities. I understand that failure to provide all or any part of the information requested could affect the determination made by Senior and Disabilities Services to authorize services for me.* ***I certify that I have reviewed and signed SOA approved form Uni-07 Recipient Rights and Responsibilities and that the content of this form SOA PCA-08 Personal Care Services Renewal Application has been explained to me by the agency/resource center representative in language that I understand; that I agree to the content of this form; and that this is an application for medical assistance program benefits.***

I understand that knowingly making a false statement may subject me to criminal prosecution or civil sanction, including, without limitation, monetary penalties. I understand that knowingly making a false statement may constitute the crimes of perjury (AS 11.56.200), medical assistance fraud (AS 47.05.210) and/or unsworn falsification (AS 11.56.210).

I certify, under penalty of perjury, that the information I have provided herein is true, accurate, and complete to the best of my knowledge.

Participant/Representative Signature: Date: _____

Print or Type Participant/Representative Name:

_____

Witness

If the Participant signs with a mark, the signature of a witness who is NOT the Participant's care coordinator, personal care assistant or representative of the personal care services agency is required.

Witness Signature: Date: _____

Print / Type Witness Name:

_____

Participant Name: _____ Medicaid #: _____

Agency Name: _____ Provider #: _____

Agency Assurances

I certify that I have screened the Participant's need for physical assistance with activities covered by the Personal Care Services regulations. I understand that the decision to authorize Personal Care Services will be made by Senior and Disabilities Services on the basis of a review of the Participant's current clinical documentation and a functional assessment of capacity to perform the activities indicated in this request.

I, (print / type Agency Representative name) _____ *understand that knowingly making a false statement may subject me or the named agency or resource center to criminal prosecution or civil sanction, including, without limitation, monetary penalties. I understand that knowingly making a false statement may constitute the crimes of perjury (AS 11.56.200), medical assistance fraud (AS 47.05.210) and/or unsworn falsification (AS 11.56.210). My initials are my certification, under penalty of perjury, that the following statements are true to the best of my knowledge.*

Initials	Sworn Statement
	I represent the named agency/resource center; by signing this application, I am acting within the scope of my employment.
	I have read the Participant's answers to the question on this application, and believe the answers to be true, accurate and complete to the best of my knowledge.
	I believe the Participant needs physical assistance with the personal care services activities specified in this application.
	If I learn that the Participant does not need personal care services, I will notify Senior & Disabilities Services immediately.
	I have included clinical records as supportive of the Participant's claim of a functional limitation and need for physical assistance with ADLs, IADLs and other covered services specified in this application.

As required, I have attached the following:

- ☐ *Release of Information Form*
- ☐ *Verification of Diagnosis Form*
- ☐ *Clinical records that are not older than one year prior to the date of this application and that support the Participant's diagnosis and need for physical assistance*
- ☐ *Documentation showing representative's authority to act for the Participant (if applicable)*

  ** Submit only if there has been a change in legal representation within the last year. The documentation must include language that gives the representative authority to make medical decisions on behalf of the Participant and must not be expired.*
- ☐ *PCA-02 Request for Passive Range of Motion(if applicable)*

Agency Representative Signature: _____ Date: _____