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

Personal Care Services (PCA) Application

If an item is not applicable, enter "N/A" in the fill-in box. Blank responses will be considered incomplete and the application will not be processed.

Applicant Legal Name (Last, First): _____

Applicant Medicaid #: _____ Date of Birth: _____ Gender: _____

☐ Initial
☐ Reauthorization

Model: ☐ Consumer Directed (CDPCA) or ☐ Agency Based (ABPCA)

Has applicant applied for or are they receiving waiver services? ☐ Yes ☐ No

Does another recipient or applicant live in the home? ☐ Yes ☐ No Total in residence: _____

If yes, which are they receiving? ☐ PCA ☐ CHORE ☐ N/A ☐ OTHER

PCA Agency: McKinley Services Agency MMIS ID / PCG#: 1584220

Agency Representative: Angela Jimenez Contact Phone: (907) 258-5100

Recipient Information

Marital Status: _____ Primary Language: _____ Interpreter Needed? ☐ Yes ☐ No

If a communication barrier exists, please list an English speaking contact for scheduling:

Contact Name: _____ Contact Phone: _____ Relationship to Applicant: _____

Does applicant live in the state of Alaska? ☐ Yes ☐ No

Physical Address:

_____

City: _____

State: _____ Zip: _____

Home Phone: _____

Mailing Address:

_____

City: _____

State: _____ Zip: _____

Cell Phone: _____

Is residence an assisted living home or long term care facility? ☐ Yes ☐ No

Name of Facility: _____ Expected Date of Discharge: _____

Medical Provider Information

Primary Physician: _____ ☐ MD ☐ PA ☐ ANP

Phone: _____ Fax: _____

Legal Representative Information

#1: ☐ Guardian ☐ Power of Attorney

Name: _____

Address: _____

City: _____

State, Zip: _____

H Phone: _____ W Phone: _____

#2: ☐ Guardian ☐ Power of Attorney

Name: _____

Address: _____

City: _____

State, Zip: _____

H Phone: _____ W Phone: _____

Verification/ Signatures

I verify that all information contained in this application is true and correct to the best of my knowledge and that my PCA agency representative has informed me of my rights and responsibilities, including penalties for fraud as described on page 2 of this application.

_____ _____
Applicant/Legal Representative Signature Date

_____ _____
PCA Agency Representative Signature Date

What changes in my status or condition must be reported?

- You must report any change that occurs, within 15 days:
  - Living situation, such as moving into or out of an assisted living home or nursing home
  - Contact information, such as name change, mailing address or telephone number
  - Legal representative appointee, his/her contact information, mailing address, telephone number
  - Change of medical provider including dental provider
  - Duplicative services, such as hospitalization, hospice, Waiver Services, Meal Service, and VA Services
  - Mental, physical, or medical condition, including improvements or decline
  - Instrumental Activities of Daily Living eligibility, such as:
    - turning 18 years of age
    - marital status
    - capability to perform Instrumental Activities of Daily Living
  - Personal care assistant agency provider

When do I need to report changes?

- Changes must be reported to your PCA provider agency no more than 15 days after the change occurred.
- Your personal care agency shall report any change that occurs in your mental, physical, or medical condition, including improvements or decline, no more than 15 days after the change occurred.

What other documents must be submitted by my provider agency along with this application?

- A Verification of Diagnosis (VOD) completed by your medical provider as defined in 7AAC125.020(b) A copy
- of the Guardianship order or Legal Power of Attorney document for managing medical care (if applicable)

What other application documents must be completed and retained by my Provider Agency?

- Your Recipient Rights form
- Your Consumer/Legal Representative Agreement form (if Consumer Directed PCA)
- A Release of Information from your medical provider to Senior and Disabilities Services
- A copy of the Verification of Diagnosis completed by your medical provider as defined in 7AAC125.012(a)
- A copy of the Guardianship order or Legal Power of Attorney document for managing medical care (if applicable)
- A copy of the completed current application form

To assist with processing your application, copies of medical and functional documentation from the past 12 months should be submitted prior to the scheduled assessment.

What happens if I do not follow the rules?

I certify that the above is true and complete to the best of my knowledge. I understand that any falsification, omission, or misrepresentation of the communication could result in:

1. Denial, suspension, or termination of the recipient's application for Medicaid services.
2. Recovery of Medicaid expenditures that were improperly obtained in accordance with 7 AAC 100.910.
3. Referral to the Alaska Department of Law for civil or criminal action in the state or federal court.

I understand that misrepresentation can constitute fraud and be criminally prosecuted as an unsworn falsification under AS 11.56.210 or as Medical Assistance Fraud under AS 47.05.210.