

State of Alaska
Department of Health and Social Services • Senior and Disabilities Services
Personal Care Services (PCA) - Application Form

Applicant Legal Name (Last, First): _____ Provider Name: _____
Applicant Medicaid #: _____ Provider PCG#: _____

*Each of the fill-in boxes within this form must be completed. If an item is not applicable, enter "n/a" in the fill-in box. **Blank responses will be considered incomplete and may result in processing delays.***

Application is the same as last plan year (except age): yes no Has applicant applied for waiver services: yes no
 Consumer Directed PCA model (CDPCA) Agency Based PCA model (ABPCA)

Date Verification of Diagnosis Requested by Agency: _____

Recipient Information

Physical Address: _____ Mailing address: _____
City: _____ City: _____
State: _____ State: _____
Zip Code: _____ Zip Code: _____
Date of birth: _____ Current age: _____
Other Health Insurance (1): _____ Other Health Insurance (2): _____
Home phone: _____ Work phone: _____ Cell phone: _____
Primary spoken language: _____ Marital Status: _____
Primary means of expression (i.e. verbal, sign): _____ Gender: _____
Living arrangements: _____ Total in residence: _____
If applicant does not live alone, indicate number of persons under each category:
Applicant's spouse: _____ Children (under age 18): _____
Applicant's parent(s): _____ Other relatives: _____
Applicant's siblings: _____ Others (ex: friends, roommates): _____
Present Location: Residence is an assisted living home or long term care facility: yes no
Name of residential facility: _____ Phone: _____
Physical address: _____

If a communication barrier exists, please list an interviewee below:

Interviewee name: _____ Contact phone: _____ State: _____
Relationship to applicant: _____ City: _____ Zip Code: _____

Legal Representative Information

Guardian Medical Power Surrogate Guardian Medical Power Surrogate
 of Attorney Decision Maker of Attorney Decision Maker
Name (Last, First): _____ Name (Last, First): _____
Mailing address: _____ Mailing address: _____
City: _____ State: _____ Zip Code: _____ City: _____ State: _____ Zip Code: _____
Home phone: _____ Work phone: _____ Home phone: _____ Work phone: _____

Primary Medical Provider (MD, PA, ANP) Information

Name (Last, First): _____ MD PA ANP
Phone #: _____ Fax #: _____

I certify that 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 in this application.

Applicant/Legal representative Date

Provider agency representative Date

State of Alaska
Department of Health and Social Services • Senior and Disabilities Services
Personal Care Services (PCA) - Application Form

What changes in my status or condition need to be reported?

You must report any change that occurs such as your:

- Mental, physical, or medical condition, including improvements or decline
- Living situation, such as moving into or out of an assisted living home, nursing home
- Contact information, such as name change, mailing address, telephone number
- Legal representative appointee, his/her contact information, mailing address, telephone number
- Personal care assistant agency provider
- Primary medical provider
- Routine medical and dental appointments
- Duplicative services, such as hospitalization, hospice, Waiver Chore, Meal, or Residential Habilitation Services
- Instrumental Activities of Daily Living eligibility, such as
 - turning 18 years of age,
 - marital status, and
 - capability to perform Instrumental Activities of Daily Living

When do I need to report changes?

- Changes must be reported to your PCA provider agency no more than 15 days after the date that the change occurred.

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

- A Verification of Diagnosis completed by your primary 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 current application documents must be completed and retained by my Provider Agency?

- Your Recipient Rights form
- Your Consumer/Legal Representative Agreement form (if CDPCA)
- A Release of Information from your primary medical provider to Senior & Disabilities Services
- A copy of the Verification of Diagnosis completed by your primary 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)
 - A copy of the completed current application form

What happens if I do not follow the rules?

If the department has reason to believe that an individual has committed an intentional program violation or program abuse, the department will conduct a full investigation in accordance with federal regulations at 42 C.F.R. 455.15.

If, after a full investigation, the department determines that an individual applying for or receiving Medicaid benefits has committed an intentional program violation or program abuse, the department may:

- deny an application for Medicaid, subject to a hearing under regulations at 7 AAC 49;
- proceed with recovery of Medicaid expenditures in accordance with regulations at 7 AAC 100.910, including a hearing under 7 AAC 49; and
- refer the matter to the appropriate authorities for civil or criminal action in a state or federal court.

An "intentional program violation" means an action that an individual takes for the purpose of establishing and maintaining an individual's eligibility for Medicaid benefits; and intentionally misrepresents, conceals, or withholds a material fact. "Program abuse" means an action that an individual takes to misuse or overuse Medicaid benefits, including medical transportation, which results in unnecessary cost to the Medicaid program.

You may be prosecuted if you knowingly give false, incorrect, or incomplete information to get or try to get Personal Care Assistant Service benefits for which you are not eligible, or to help someone else get benefits for which they are not eligible. You must repay any benefit you wrongly receive.