

State of Alaska Department of Health and Social Services
Senior and Disabilities Services Personal Care Assistance Program

Request for Expedited Assessment Consideration

Applicant/Recipient

Request for an Expedited Assessment Request for an Expedited Amendment

Name:

Date of Birth:

Medicaid Number:

Service Plan Start Date:

Service Plan End Date:

Agency information

Date of Request:

Requesting Agency:

Name of staff completing form:

Agency Telephone Number:

Agency Fax Number:

Current Medical Certification form: Attached Requested

Fax request form and documentation to (907) 269-8164 or email to

pcamailbox@health.state.ak.us. Please call 1-800-478-9996 or (907) 269-3666 to verify this request has been received by SDS.

Reasons for request

Supports are not available currently and the following circumstances are present:

- Imminent or recent discharge from an acute care or nursing facility.
- Terminal diagnosis (0-6 months to live).
- Significant change in physical condition, not already captured in the most recent PCAT, which will require immediate hospitalization or placement in a nursing facility if PCA services are not provided or increased.
- Primary caregiver absence because of an emergency or because declining health makes him/her unable to continue to provide care to the applicant/recipient, and the applicant recipient will require immediate hospitalization or placement in a nursing facility if PCA services are not provided or increased.

Identify the location where assessment is needed:

Describe the conditions underlying this request:

For SDS Use Only

- Approved on Reason:
- Denied on Reason:
- Other:
- Agency notified on

SDS Nurse Signature: _____ Date:

Verification of Diagnosis

for

Older Alaskans Program • Adults with Physical Disabilities Program

Personal Care Services Program

The information requested by this form, which must be completed by a physician, a physician assistant, or an advanced nurse practitioner, will assist SDS to determine if the applicant/participant qualifies for services.

Please send to the care coordinator or PCA agency representative at the fax number or email address indicated below.

(This section to be completed by care coordinator or PCA agency representative)

Applicant/participant name: _____

Care coordinator or PCA agency representative: _____

Fax number: _____ Email: _____

Date of birth: _____ Medicaid number: _____

Diagnosis (Please check all that apply to the applicant/participant and circle primary diagnosis):

Cardiac/circulatory

- Arteriosclerotic heart disease
- Cardiac dysrhythmia
- Congestive heart failure
- Deep vein thrombosis
- Hypertension
- Hypotension
- Peripheral vascular disease
- Other cardiovascular disease

Endocrine/renal

- Diabetes mellitus
- Hyperthyroidism
- Hypothyroidism
- Renal failure

Eye

- Cataracts
- Diabetic retinopathy
- Glaucoma
- Macular degeneration

Musculoskeletal

- Amputation/missing limb
- Arthritis
- Hip fracture
- Osteoporosis
- Pathological bone fracture

Neurological

- Alzheimer's disease
- Aphasia
- Cerebral palsy
- Cerebrovascular accident
- Dementia, not Alzheimer's
- Hemiplegia/hemiparesis
- Multiple sclerosis
- Paraplegia
- Parkinson's disease
- Quadriplegia
- Seizure disorder
- Transient ischemic attacks
- Traumatic brain injury

Psychiatric

- Anxiety disorder
- Bipolar disorder
- Depression
- Other psychiatric diagnosis
- Schizophrenia
- Substance abuse

Respiratory

- Asthma
- Bronchitis
- Emphysema/COPD
- Pneumonia
- Tuberculosis

Other

- Anemia
- Allergies
- AIDS/HIV
- Cancer
- Explicit terminal prognosis
- Mental retardation

Additional: _____

The applicant/recipient is cognitively capable to manage his/her own care in a consumer-directed Personal Care Assistance Program yes no

To the best of my knowledge, the above information is true, accurate, and complete.

Physician, PA, or ANP signature

Date

ID#

Name (please print)

Telephone number

Questions may be directed to Senior and Disabilities Services at 269-3666 or 1-800-478-9996.