# State of Alaska

**Department of Health and Social Services**
**Senior and Disabilities Services**

# Personal Care Assistant Agency Recertification Application

**for**

**Agency-Based Personal Care Assistant Agency**
**and/or**
**Consumer-Directed Personal Care Assistant Agency**

**Name of Agency: _____PCG_____**

Name of person completing this document: _____Phone:_____

**Instructions:** Identify your agency as one of the following and submit the materials listed

☐ Agency-Based PCA Agency (ABPCA)

1. Signed and dated ABPCA agency assurances and agreement.
2. Required attachments.

☐ Consumer-Directed PCA Agency (CDPCA)

1. Signed and dated CDPCA agency assurances and agreement.
2. Required attachments.

☐ Agency-Based PCA Agency and Consumer-Directed PCA Agency (AB & CDPCA)

1. Signed and dated ABPCA agency assurances and agreement.
2. Signed and dated CDPCA agency assurances and agreement.
3. One set of required attachments.

☐ Agency with multiple office locations.

1. Signed and dated ABPCA and/or CDPCA agency assurances and agreement for each location, and required personnel attachments for the administrator, PCA Manager or supervising registered nurse for each location (if personnel are different in the various locations).
2. One set of required attachments, and attachments for personnel as indicated.

## Return Completed Packet to:

PCA Provider Renewals
Provider Certification Unit
Senior & Disabilities Services
550 West 8th Ave.Anchorage, AK 99501

## Recertification process:

Senior and Disabilities Services (SDS) will renew the certification of a Personal Care Assistance Agency after review a completed packet of the items requested above, as well as receiving a signed agreement by the agency to meet all standards and requirements for participation.

Because the Certification Application Packet has been adopted by reference, 7 AAC 125.060 the requirements in this packet carry the same weight as regulations.

Agencies operating multiple, staffed office locations where recipient records are maintained must submit an agreement and the specified additional materials for each office location.

When an incomplete packet is received, SDS will notify the agency of missing documents and/or the need for revised materials which must be provided by the date specified in the notice. If, after review of the additional materials, they are determined to be inadequate for renewal purposes, or renewal cannot be accomplished within 30 days after the initial notification of the need for additional materials because of an agency failure to provide them in a timely manner, the entire packet will be returned to the agency and the PCA Agency will no longer qualify as a Medicaid provider, and will not be paid for services rendered after certification ends. The PCA Agency may submit a new, complete application at any time.

After review and approval of the packet materials, DSDS will mail a Provider Certification form indicating the personal care services which the agency has been approved to provide. The renewal certification will be for two years.

**You must submit a copy of the SDS renewal certification to Affiliated Computer Services (ACS) along with a copy of your current Alaska Business License in order to continue billing past the end of your original certification date.**

The information on your file is the source of data for all mailing lists, telephone lists, and provider lists posted on the SDS website. If your agency address, phone number(s) have changed, and you have not also changed it with ACS, please submit a Change of Medicaid Provider Information form with ACS (forms are available on line at http://www.medicaidalaska.com/).

If your PCA Agency program manager and/or Registered Nurse (as required) have changed since your original application, and you have NOT provided SDS the education and experience credentials (as required), please attach them to this application, too.

## Required Attachments:

The following documents must be submitted for review in addition to the signed agency assurances pages:

1. Current State of Alaska business license in the name of the already certified and enrolled agency with ACS (they should all be the same name).

2. Insurance policy certificate indicating workers' compensation, general liability, and automobile liability coverage for personal care assistants, and naming the Division of Senior and Disabilities Services, (Provider Certification, 550 West 8th Ave., Anchorage, AK 99501) as a certificate holder. Instruct insurance agencies to send future copies to:

SDS – Provider Certification Unit
550 West 8th Ave. Anchorage, AK 99501

3. An organization chart showing lines of authority (the supervisor of each employee) within your organization, position titles as listed on the job descriptions, and the name of each employee in the positions.

4. Personal care assistant training schedule and topics covered during the prior two year period of certification – include required and voluntary training – and future trainings planned for the next 2 years.

5. A written report of the past two annual assessments (which you agreed to perform in the initial certification packet) which includes the following elements for each certified agency-based program and/or consumer-directed program:

a) Evaluation of recipient satisfaction with services based a form you prepare, distribute and collect from the people receiving PCA services from your agency. The survey should ask questions about how well the PCA services provided meet the recipient's needs, (examples of questions you might ask: are you getting the care you need? does the PCA treat you well? does your back up plan work well? do you need different services than what the PCA can do?). Each question should allow the recipient of PCA services to reply using a range of answers.
b) Evaluation of whether the services delivered met the assessed needs (listed on the service plan) of the recipient.
c) Evaluation of the how well the PCA training provided by your agency or received by the recipient from other training courses, met the needs of your agency.
d) Evaluation of quality assurance and quality improvement activities necessitated by problem areas brought to light by the assessment or recipient grievance process.

6. A written list with the names of all the people for whom your agency has requested a criminal background check in the past two years.

## Agency-Based Personal Care Services

Agency Name_____

Mailing Address_____

Physical Address_____

Areas of the state, or communities served_____

Agency Billing Number/Numbers_____

NPI Number_____

Owner/Administrator_____

Telephone number: _____Email_____

PCA Program Manager_____

Telephone number: _____Email_____

Supervising Registered Nurse_____

Telephone number: _____Email_____

**General Assurances**. The agency agrees to:

1. Provide services in accordance with an approved service plan, 7 AAC 125.010(b) in the recipient's personal residence, 7 AAC 125.050(a);
2. Determine that personal care assistants are qualified, 7 AAC 125.090(a)(b); and submit requests for criminal history record information, 7 AAC 125.090(c);
3. Verify that personal care assistants meet their responsibilities for maintaining records, 7 AAC 125.120(a);
4. Follow reporting requirements regarding child protection, 7 AAC 125.120(f); and adult protection, 7 AAC 125.100;
5. Employ an administrator, who has attended mandatory division orientation, 7 AAC 125.150(d) and (e);
6. Employ a supervising registered nurse to perform specified duties regarding services every six months or every 12 months where a waiver is in effect, 7 AAC 125.170(a)(2) ;
7. Delineate agency responsibility for personal care services when the personal care assistant is unavailable, and for working with the recipient to develop a contingency plan, 7 AAC 125.020(b)(6);
8. Provide for confidentiality of records in accordance with applicable federal and state laws, including HIPAA/Health Insurance Portability and Accountability Act of 1996.

**Agency Agreement**

Your signature indicates that the agency agrees to fulfill all the standards and requirements pertaining to the personal care services program, 7 AAC 125.010-125.199; to meet all administrative standards and requirements for participation in the Medicaid program, 7 AAC 105.200-290, 7 AAC 105.600-610, 7 AAC 145.005-025, and 7 AAC 105.400-105.490; and to accept this agreement as notice that failure to do so can be cause for decertification and disenrollment, 7 AAC 125.080, and for Medicaid sanctions, 7 AAC 105.400, including recoupment of payment for services, 7 AAC 105.410.

Your signature indicates the State of Alaska, its officers, agents and employees, shall be indemnified, held harmless, and defended from all liability, including costs and expenses, for

all actions and claims resulting from injuries or damages sustained by any person or property arising directly or indirectly as a result of any error, omission, or negligent act of your agency, agency subcontractors or anyone directly or indirectly employed by the agency in the delivery of personal care assistant services.

As authorizing agent, I affirm that I have read and will fulfill all the standards and requirements for participation in the personal care services program and in the Medicaid program; that all staff meet the required levels of experience, education and training to provide personal care services; and that the information in this application is true and correct.

_____

Name of Agency

_____

Signature of Authorized Agent Position Title

_____

Printed Name Date

# Consumer-Directed Personal Care Services

Agency Name_____

Mailing Address_____

Physical Address_____

Areas of the state, or communities served_____

Agency Billing Number/Numbers_____

Owner/Administrator_____

Telephone number: _____Email_____

PCA Program Manager_____

Telephone number: _____Email_____

Telephone number: _____Email_____

**General Assurances**. The agency agrees to:
1. Provide services in accordance with an approved service plan, 7 AAC 125.010(b) in the recipient's personal residence, 7 AAC 125.050(a);
2. Determine that personal care assistants are qualified, 7 AAC 125.090(a), and submit requests for criminal history record information, 7 AAC 125.090(c);
3. Verify that personal care assistants meet their responsibilities for maintaining records, 7 AAC 125.120(a);
4. Follow reporting requirements regarding child protection, 7 AAC 125.120(f), and adult protection, 7 AAC125.100;
5. Employ an administrator who has attended mandatory division orientation, 7 AAC 125.130(c)and(d);
6. Delineate agency responsibility for personal care services when the personal care assistant is unavailable, and for working with the recipient to develop a contingency plan, 7 AAC 125.020(c);
7. Provide for confidentiality in accordance with applicable federal and state laws, including HIPAA/Health Insurance Portability and Accountability Act of 1996;
8. Negotiate contracts for services with recipients, 7 AAC 125.140(a)(6);
9. Review recipient needs annually, 7 AAC 125.130(a) and
10. Collect and verify personal care assistant timesheets and submit claims for services to the Medicaid fiscal intermediary, 7 AAC 125.130(b).

**Agency Agreement**
Your signature indicates that the agency agrees to fulfill all the standards and requirements pertaining to the personal care services program, 7 AAC 43.125.010-125.199; to meet all administrative standards and requirements for participation in the Medicaid program, 7 AAC 105.200-290, 7 AAC 105.600-610, 7 AAC 145.005-025, and 7 AAC 105.400-105.490 and to accept this agreement as notice that failure to do so can be cause for decertification and disenrollment, 7 AAC 125.080, and for Medicaid sanctions, 7 AAC 105.400, including recoupment of payment for services, 7 AAC105.410.
Your signature indicates the State of Alaska, its officers, agents and employees, shall be indemnified, held harmless, and defended from all liability, including costs and expenses, for all actions and claims resulting from injuries or damages sustained by any person or property

arising directly or indirectly as a result of any error, omission, or negligent act of your agency, agency subcontractors or anyone directly or indirectly employed by the agency in the delivery of personal care assistant services.

As authorizing agent, I affirm that I have read and will fulfill all the standards and requirements for participation in the personal care services program and in the Medicaid program; that all staff meet the required levels of experience, education and training to provide personal care services; and that the information in this application is true and correct.

_____

Name of Agency

_____

Signature of Authorized Agent Position Title

_____

Printed Name Date