

Member Name		Telephone	
Home Address			
Medicaid ID		Date of Birth	
MCO Name			

Services Options Check List

Program Rules and Requirements

Member/APR Initials

1. I understand and acknowledge receipt of information detailing that enrolling in the Personal Preference Program (PPP) self-directed option means I am the Employer of Record.	
2. I understand and acknowledge receipt of information detailing the role of an Authorized Program Representative (APR).	
3. If needed, I have selected an APR. The identified APR's name and phone number is: _____	
4. I understand and acknowledge receipt of information detailing that I must complete a Risk Assessment Profile.	
5. If determined necessary, I understand that I must have a Back-up Plan on file with the Fiscal Intermediary.	
6. I understand and acknowledge receipt of information detailing that I may choose to complete a background check on potential PPP employees paid for through my Cash Management Plan.	
7. I understand and acknowledge receipt of information detailing what "Duplication of Services" means and will contact my health plan if this occurs.	
8. I understand and acknowledge receipt of information detailing the meaning of fraud, waste and abuse.	
9. I understand and acknowledge that I must report fraud, waste and abuse to my health plan and the Fiscal Intermediary.	
10. I understand and acknowledge receipt of information detailing recoupment, recoupment of wages and examples of why a recoupment may occur.	
11. I understand that if I wish to disenroll or am unable to self-direct my personal care service needs I may disenroll from the Personal Preference Program and receive my services from an agency through my health plan.	
12. I understand that I must be reassessed annually for PCA services by my health plan to maintain my PPP enrollment.	
13. I have been offered PCA agency services while awaiting enrollment into the PPP.	
14. I accept / decline (circle) PCA agency services while awaiting enrollment into the PPP.	

MCO Representative Name (Please Print):			
MCO Representative Signature:		Date:	

Member/APR Name (Please Print):			
Member/APR Signature:		Date:	

Please retain this form in the Member's care record.

- For Managed Care Use Only -

Date of Last PCA Assessment:			
Monthly Budget Amount:			
Number of Hours Assessed:	IND:	GRP:	