THE CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM APPLICATION

1a. CONSUMER IDENTIFYING INFORMATION

Consumer's Surname	First Name	M.I.	Social Security Number

Address (No. & Street)	FL./Apt. No.	Boro	Zip	Telephone No.

Age	Date of Birth	Medicaid Number	Sex	Medicare A	Medicare B
			☐M ☐F		

Language(s) Spoken	Language(s) Understood

LIVING ARRANGEMENTS

☐ One Family House ☐ Multi-Family House ☐ Furnished Room ☐ Hotel
If Walk-Up ☐ Apartment ☐ Boarding House ☐ Senior Citizen Housing
number of flights _____ ☐ Other (Specify)_____

1b. PARENT, LEGAL GUARDIAN, OR DESIGNATED REPRESENTATIVE INFORMATION

Name	Relationship to Consumer

Address (No. & Street)	FL./Apt. No.	Boro	Zip	Telephone No.

Business Address (if any)	Business Telephone No.

2. CONSUMER'S NEXT OF KIN

Name	Relationship	Telephone Number

Address (No. & Street)	FL./Apt. No.	City	State	Zip

3. PARENT, LEGAL GUARDIAN, OR DESIGNATED REPRESENTATIVE BACK-UP *

Name	Relationship	Telephone Number

Address (No. & Street)	FL./Apt. No.	City	State	Zip

*** BACK-UP (MUST BE ABLE AND WILLING TO MAINTAIN SIGNIFICANT CONTACTS AND COMPLETE PAGE 5***

4. DESCRIBE CONSUMER'S MEDICAL CONDITION AND PERSONAL SITUATION.

5. SCREENING AND RECRUITMENT PLAN:

A. Describe how the consumer, legal guardian or designated representative will screen and recruit prospective personal assistants.

B. Describe how the consumer, legal guardian, or designated representative will screen and recruit sufficient, additional personal assistants to serve as replacement workers when needed.

C. Describe how the consumer, legal guardian or designated representative will arrange for emergency coverage to maintain continuity of service in the absence of the regularly assigned personal assistant.

D. Explain how the consumer, legal guardian or designated representative will provide orientation to conditions of employment for new personal assistants.

E. Describe how the consumer, legal guardian or designated representative plans to direct and monitor the personal assistant's job performance.

F. Describe how the designated representative will supervise the personal assistant when he/she is performing skilled nursing tasks.

G. Describe how the consumer, legal guardian, or designated representative will resolve all personal assistant complaints.

H. Describe how the consumer, legal guardian or designated representative will **train** personal assistants to provide the needed services.

6. CONSUMER'S DECLARATION:

I, the consumer, parent, legal guardian or designated representative, am willing to assume all of the required obligations in the Consumer Directed Personal Assistance Program.

Signature _____

Relationship to Consumer _____

Date _____

If the consumer has skilled nursing tasks, a registered nurse must complete the attached certification.

REGISTERED NURSE'S CERTIFICATION

Consumer's Name: _____ Social Security Number: _____

If the consumer is not self-directing, the nurse must assess the ability of the parent, legal guardian, or designated representative to supervise the performance of skilled nursing tasks by a personal assistant.

Name of Designated Representative (if needed):_____

THE CONSUMER IS CURRENTLY RECEIVING SERVICES FROM:

Home Care Provider or Hospital: _____

Name of Contact Person: _____

Title:_____ Telephone Number:_____

In my opinion as a registered nurse who has assessed this consumer's service needs and training capabilities, I have determined the following:

☐ The consumer is self-directing and is capable of providing assistance, supervision and direction to the personal assistant performing skilled nursing tasks.

☐ The designated representative is capable of providing assistance, supervision and direction to the personal assistant performing skilled nursing tasks.

Please indicate nursing tasks. Check all that apply:

☐ Ostomy Care (specify) _____
☐ Decubitus Care
☐ Indwelling Catheter Care
☐ Measuring glucose, sugar and/or acetone to monitor medical condition
☐ Suctioning
☐ Tube feeding
☐ Administering medication
☐ Administering oxygen
☐ Nebulizer treatment
☐ Other _____

Comments _____

_____

_____

NURSE'S NAME _____SIGNATURE_____DATE_____

AGENCY_____LICENSE NUMBER _____TELEPHONE NUMBER _____

DESIGNATED REPRESENTATIVE BACK-UP STATEMENT

The Designated Representative **Back-Up** must write a statement **below** confirming that she or he is willing to direct and supervise the Personal Assistant (Aide) in the event of the temporary inability or absence of the Designated Representative. **The Designated Representative Back-Up** must **sign and date** the statement in the spaces provided below.

SIGNATURE: _____DATE:_____