

Facsimile Transmittal

To: Special Touch CRPU Fax: 347-462-0190

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**FAX THE COMPLETED CDPAP APPLICATION (M13D) TO 347-462-0190. If you
have any questions call 718-627-1122 Ext. 9030 for assistance.**

Notes: Is there anything else you would like us to know? Tell us here....

CONFIDENTIAL

Tips on accurate completion of the CDPAP Application (M-13D)

1. A consumer or designated responsible representative who wishes to participate in the Consumer Directed Personal Assistance Program must answer all questions on the application, Form M-13D and sign the Consumer's Declaration agreeing to assume all the required obligations of the program. (Please note #6 on page 3.)
2. In the event of an emergency, if the responsible adult is unable to meet his/her responsibilities there must be a designated back up for the responsible adult whether he/she resides with the consumer or maintains a daily presence. (*Please note page 5)
3. Explain how the consumer or designated responsible representative will screen prospective personal assistants for the basic job qualifications suited to meet the consumer's needs, maintain time sheets and other personnel data to be submitted to the Home Care Services Program.
4. Describe the consumer's or designated responsible representative's plan for finding additional personal assistants to serve as replacement workers and the formal or informal referral sources that will be used.
5. Explain how the consumer or designated responsible representative will arrange for and contact back-up service in the absence of the regularly assigned personal assistant.
6. Describe the consumer or designated responsible representative's plan to familiarize personal assistants with their general duties.
7. Consumers who require skills typically provided by a Home Health Aide, Licensed Practical Nurse must have a Registered Nurse complete the required certification. (*Please note page 4)
8. The Registered Nurse must certify that either the consumer or designated responsible representative is self-directing and capable of providing such instruction and sign, date and provide his/her license number on the certification form.



Have questions?
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THE CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM APPLICATION

1A. Consumer Identifying Information						
Last Name		First Name		M.I.	Social Security Number	
Address No.	Street Name	Apt No/FI.	Borough	Zip Code	Telephone Number	
Age	Date of Birth	Medicaid Number	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Medicare A	Medicare B	
Language(s) Spoken			Language(s) Understood			
Living Arrangement <input type="checkbox"/> One-family House If Walk-up indicate the no. of flights _____ <input type="checkbox"/> Multi-family House If Walk-up indicate the no. of flights _____ <input type="checkbox"/> Apartment <input type="checkbox"/> Furnished Room <input type="checkbox"/> Boarding House <input type="checkbox"/> Hotel <input type="checkbox"/> Senior Citizen Housing <input type="checkbox"/> Other						

1B. Parent/Legal Guardian/Designated Representative Information		
Last Name	First Name	Relationship to Consumer
Address		Zip Code
Business Address (if any)		Business Telephone Number
		Telephone Number

2. Consumer's Next of Kin		
Last Name	First Name	Relationship to Consumer
Address		Zip Code
		Telephone Number

3. Parent/Legal Guardian/Designated Representative Back-Up*		
Last Name	First Name	Relationship to Consumer
Address		Zip Code
		Telephone Number

* The back-up must be able and willing to supervise the Personal Assistant (Aide) in the event of temporary inability or absence of the designated representative. Please complete, sign and date the Designated Back-up Statement on 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: _____

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

REGISTERED NURSE'S CERTIFICATION

Consumer 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/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:

- | | |
|---|---|
| <input type="checkbox"/> Ostomy care (specify) _____ | <input type="checkbox"/> Tube feeding |
| <input type="checkbox"/> Decubitus care | <input type="checkbox"/> Administering medication |
| <input type="checkbox"/> Indwelling catheter care | <input type="checkbox"/> Administering oxygen |
| <input type="checkbox"/> Suctioning | <input type="checkbox"/> Nebulizer treatment |
| <input type="checkbox"/> Measuring glucose, sugar and/or acetone to monitor medical condition | <input type="checkbox"/> 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

Do you have a medical or mental health condition or disability?

Does this condition make it hard for you to understand this notice or to do what this notice is asking?

We can help you.

Reach out to your Special Touch Home Care Account Manager for assistance (call 718-627-1122 Ext. 9030).