THE CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM APPLICATION

Human Resources Administration
Department of Social Services

M-13d (E) 04/09/2018

1A. Consumer Identifying Information

Last Name	First Name	M.I.	Social Security Number

Address No.	Street Name	Apt No/Fl.	Borough	Zip Code	Telephone Number

Age	Date of Birth	Medicaid Number	Sex	Medicare A	Medicare B
			☐Male ☐Female		

Language(s) Spoken	Language(s) Understood

Living Arrangement

☐ One-family House
If Walk-up indicate the no. of flights _____

☐ Apartment

☐ Boarding House

☐ Senior Citizen Housing

☐ Multi-family House
If Walk-up indicate the no. of flights _____

☐ Furnished Room

☐ Hotel

☐ Other

1B. Parent/Legal Guardian/Designated Representative Information

Last Name	First Name	Relationship to Consumer	

Address	Zip Code	Telephone Number

Business Address (if any)	Business 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:

☐ Ostomy care (specify) _____
☐ Decubitus care
☐ Indwelling catheter care
☐ Suctioning
☐ Measuring glucose, sugar and/or acetone to monitor medical condition
☐ 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

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? Does this condition make it hard for you to get other services at HRA? **We can help you.** Call us at 212-331-4640. You can also ask for help when you visit an HRA office. You have a right to ask for this kind of help under the law.