

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX B – LT-PCS AGREEMENT TO PROVIDE SERVICES

DEPARTMENT OF HEALTH & HOSPITALS
Long Term-Personal Care Services Program

Agreement to Provide Services

Recipient Name: _____ Date: _____

Recipient Medicaid #: _____ Provider #: _____
(Your Agency's Provider Number)

Recipient SSN: _____ Provider Name: _____
(Your Company's Name)

A representative from our agency met with _____
(Recipient's Name)

on _____ We have reviewed his/her Plan of Care that has been approved by
(Date of Meeting with Recipient)
the Department of Health and Hospitals.

We agree to provide services to this recipient according to the:

- Initial Plan of Care dated _____
Reassessment Plan of Care dated _____
Status Change Plan of Care dated _____

We understand that Affiliated Computer Systems (ACS) will not be able to issue an authorization to our agency until they receive this form signed by both the recipient or their personal representative and our agency representative.

Recipient Signature _____

Date of Signature

Personal Representative Signature _____

Date of Signature

Provider Agency Representative Signature _____

Date of Signature

LT-PCS 17 Agreement to Provide Services
Re-issued 06/01/08