OKLAHOMA DEPARTMENT OF HUMAN SERVICES

AD*vantage* Program

Consumer-Directed Personal Assistance Services and Supports (CD-PASS)

CD-PASS Application

INSTRUCTIONS

Please fully complete all sections of this form, as applicable. This information is required for application to the CD-PASS service option.

MEMBER INFORMATION

Member last name _____ First name _____ Middle name _____ Medicaid number _____

Street address _____ ( ) - Phone Number

City _____ County _____ State _____ Zip _____

Member Email address _____

DESCRIPTION OF CD-PASS

CD-PASS is an AD*vantage* service option that gives Members budget and employer authority of their personal assistance services. This opportunity for self-direction and determination requires the Member to assume additional responsibilities and additional risks they do not have when receiving personal assistance services from an agency. Members will create a budget, hire/fire and set wages, and manage their services with the assistance of a financial management services provider, case manager, and DHS.

SELF-ASSESSMENT

Member and/or legal agent must complete the following self-assessment:

1. I have read the Self-Guided Orientation (DHS Pub. No. 10-02). _____Initial

2. I understand that I may return to agency care at any time. _____Initial

3. I am able to sign all documentation, as necessary. _____Initial

4. I understand that I will be the sole Employer-of-Record for the person(s) that I hire to perform my personal care tasks. _____Initial

5. I am able to participate in the development of my annual Service Plan and to inform my Case Manager of any changes needed throughout the service plan year. _____Initial

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6. I understand that I will be responsible for recruiting, hiring, training, setting wages, supervising, and terminating my employees. _____Initial

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7. I understand that I will be responsible for approving and submitting timesheets by mail, fax, or online submission to the payroll agent twice a month. _____Initial

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8. I understand that I will be responsible for keeping track of the personal care hours I have used. _____Initial

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9. I understand that failure to manage my responsibilities or follow the program rules could result in removal from this service option and a return to agency-provided care. _____Initial

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10. I am able to fulfill all of the responsibilities required of a CD-PASS Member OR I am willing to appoint an Authorized Representative to assist me if needed or required. _____Initial

SIGNATURE(S)

Signature(s) below indicates voluntary and informed choice to apply to the CD-PASS service option. Signer(s) understand and accept the added Member roles and responsibilities associated with this service option.

_____ _____
Member Signature (Required, unless LG or POA appointed) Date

_____ _____
Signature of Guardian, POA, or Authorized Representative (Required if appointed or Member is unable to sign) Date