

CD-PASS Self-Assessment

Planning Your Services

Experience/Knowledge/Skill

I know when, where, and how I want all of my services delivered. YES NO

If no, please describe.

I am able to train each employee who works with me on what assistance I need and how I want my services delivered. YES NO

If no, please describe.

I am confident in my ability to monitor and communicate when I am satisfied or dissatisfied with my services. YES NO

If no, please describe.

I am confident in my abilities to coordinate support from family, friends, and others including my employee to meet all of my assistance needs. YES NO

If no, please describe.

I am confident in my ability to work with my Consumer-Directed Agent in planning for my CD-PASS services. YES NO

If no, please describe.

Managing Your PSA

Experience/Knowledge/Skill

I have or can create a private and secure area in my home to maintain confidential employee records. YES NO

If no, please describe.

I am confident in my ability to interview potential employees. YES NO

If no, please describe.

Managing Your PSA, *Continued*

Experience/Knowledge/Skill

I am confident in my ability to train employees.	YES	NO
If no, please describe.		
I am confident I can organize records, paperwork, and legal documents.	YES	NO
If no, please describe.		
I am confident in my ability to evaluate my employee's work performance.	YES	NO
If no, please describe.		
I am confident in my ability to fire an employee.	YES	NO
If no, please describe.		
I am confident in my ability to provide feedback to my employee to improve service performance.	YES	NO
If no, please describe.		
I am able to adjust my schedule with my employee as needed to meet my service needs.	YES	NO
If no, please describe.		
I am able to provide my employee with the necessary supplies and materials to complete all PSA/APSA tasks.	YES	NO
If no, please describe.		
I know what would cause me to fire an employee.	YES	NO
If no, please describe.		

Managing Your Budget

Experience/Knowledge/Skill

I am able to negotiate wages and benefits with my employee and stay within the limits of my yearly budget. YES NO

If no, please describe.

I feel confident I can manage my personal care hours as authorized on my service plan. YES NO

If no, please describe.

Managing Your Health & Safety

Experience/Knowledge/Skill

I am confident in my ability to create an emergency back-up plan, including identification and recruitment of another person to fill in for the times when my regular employee does not show up for work. YES NO

If no, please describe.

I am confident in my ability to handle my own health and safety issues. YES NO

If no, please describe.

I am confident in my ability to access medical attention if needed. YES NO

If no, please describe.

Member Name

Member Signature

Date

**ADvantage Program
Consumer-Directed Personal Services and Supports (CD-PASS)**

Acknowledgment of Informed Choice, Designation of Authorized Representative, and Application for CD-PASS

Member Information

SoonerCare ID Number _____ Date of Birth _____ / _____ / _____

Last Name _____ First Name _____ M.I. _____

Address _____

_____ (____) _____ - _____
City State Zip Phone

Introduction

Consumer-Directed Personal Assistance Services and Supports (CD-PASS) is an ADvantage service that gives you authority and control over who provides your personal assistance services and how your personal assistance services are provided. This opportunity for self-direction and determination also requires you to assume additional responsibilities and perhaps additional risks that you do not have under the existing service that provides personal care services to you.

Guardianship

Do you have a legal Guardian? If yes, please have your guardian complete this form on your behalf:

Guardian Last Name _____ First Name _____ M.I. _____

Address _____

_____ (____) _____ - _____
City State Zip Phone

Acknowledgment of Responsibilities for CD-PASS Services

Please circle **Yes** or **No** indicating your agreement with and acknowledgment of the following:

1.	I have received and read the Self-Guided <u>Orientation</u> and understand what will be expected of me in CD-PASS.	Yes No
2.	I have completed the <u>Self-Assessment Tool</u> .	Yes No
3.	I understand my <u>Roles and Responsibilities</u> in receiving CD-PASS services.	Yes No
4.	I am making a <u>Voluntary and Informed Choice</u> to receive CD-PASS services.	Yes No
5.	<p>I understand that I may designate a family member or friend as an <u>Authorized Representative</u> to assist me in my employer responsibilities to the extent that I prefer.</p> <ul style="list-style-type: none"> • I understand that by choosing to designate an Authorized Representative that I do not give up any of my decision-making authority. • I understand that an individual hired to provide Personal Services Assistance to me may not be my designated Authorized Representative. • I understand that I may change my mind and revoke my designation of an Authorized Representative at any time by notifying my Case Manager/Consumer Directed Agent and the FMS. 	Yes No

6.	<p>Do you want to <u>designate</u> an <u>Authorized Representative</u> to assist you in receiving CD-PASS services? <i>By circling yes, you confirm that:</i></p> <ul style="list-style-type: none"> You have discussed with your designated Authorized Representative the specific assistance you would like from him/her regarding your CD-PASS services. You give permission for your CD-PASS support team to contact your designated Authorized Representative listed below: <p>Last Name _____ First Name _____ M.I. _____</p> <p>Address _____</p> <p>_____ () - _____</p> <p>City _____ State _____ Zip _____ Phone _____</p> <p>Relationship to You: _____</p> <p>Please have your designated Authorized Representative sign below if he or she agrees with the following:</p> <ul style="list-style-type: none"> I agree to serve as the Member's designated Authorized Representative and I have read the Self-Guided Orientation. <p>_____</p> <p>Authorized Representative Signature Date</p>	<p>Yes No</p>
7.	<p>Do you have a <u>Power of Attorney</u> (POA)?</p> <p>Does the Power of Attorney responsibility include decisions regarding health care?</p> <p>Do you give permission for your CD-PASS support team to contact your POA? <i>If yes, please provide the following information:</i></p> <p>Last Name _____ First Name _____ M.I. _____</p> <p>Address _____</p> <p>_____ () - _____</p> <p>City _____ State _____ Zip _____ Phone _____</p> <p>**** You must attach a copy of your POA to this application prior to mailing to the Administrative Agent (LTCA).</p>	<p>Yes No</p> <p>Yes No</p> <p>Yes No</p>

Signature of Member

Date

Signature of Guardian

Date

Signature of Administrative Agent (LTCA)

Date