NJFAMILYCARE
Affordable health coverage. Quality care.

Personal Preference Program
Services Options

Member Name		Telephone	
Home Address			
Medicaid ID		Date of Birth	
MCO Name			

Services Options Check List

Program Rules and Requirements	Member/APR Initials
1. I understand and acknowledge receipt of information detailing that enrolling in the Personal Preference Program (PPP) self-directed option means I am the Employer of Record.	
2. I understand and acknowledge receipt of information detailing the role of an Authorized Program Representative (APR).	
3. If needed, I have selected an APR. The identified APR's name and phone number is: _____	
4. I understand and acknowledge receipt of information detailing that I must complete a Risk Assessment Profile.	
5. If determined necessary, I understand that I must have a Back-up Plan on file with the Fiscal Intermediary.	
6. I understand and acknowledge receipt of information detailing that I may choose to complete a background check on potential PPP employees paid for through my Cash Management Plan.	
7. I understand and acknowledge receipt of information detailing what "Duplication of Services" means and will contact my health plan if this occurs.	
8. I understand and acknowledge receipt of information detailing the meaning of fraud, waste and abuse.	
9. I understand and acknowledge that I must report fraud, waste and abuse to my health plan and the Fiscal Intermediary.	
10. I understand and acknowledge receipt of information detailing recoupment, recoupment of wages and examples of why a recoupment may occur.	
11. I understand that if I wish to disenroll or am unable to self-direct my personal care service needs I may disenroll from the Personal Preference Program and receive my services from an agency through my health plan.	
12. I understand that I must be reassessed annually for PCA services by my health plan to maintain my PPP enrollment.	
13. I have been offered PCA agency services while awaiting enrollment into the PPP.	
14. I **accept / decline** (circle) PCA agency services while awaiting enrollment into the PPP.	

MCO Representative Name (Please Print):			
MCO Representative Signature:		Date:	

Member/APR Name (Please Print):			
Member/APR Signature:		Date:	

Please retain this form in the Member's care record.

- For Managed Care Use Only -

Date of Last PCA Assessment:		
Monthly Budget Amount:		
Number of Hours Assessed:	IND:	GRP: