All Smilez
LLC | CARE AT HOME

314-467-8116
Info@allsmilez.org

CLIENT APPLICATION & CONSUMER PAPERWORK

Client CDS application

Please complete the sections that apply. Fields marked * are requested for initial contact.

1. CLIENT INFORMATION

Client full legal name *

Preferred name

Date of birth

Phone number *

Email address

Home address

Apt. / Unit

City

State

ZIP code

County

Preferred method of contact *

- [ ] Phone
- [ ] Text
- [ ] Email

Best time to contact

- [ ] Morning
- [ ] Afternoon
- [ ] Evening
- [ ] Any time

2. AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

Representative full name

Relationship to client

Representative phone

Representative email

Does this person have legal authority to act for the client?

- [ ] Legal guardian
- [ ] Power of attorney
- [ ] Other
- [ ] No / not applicable

3. SERVICE REQUEST

- [ ] Missouri Consumer Directed Services (CDS)
- [ ] Personal care
- [ ] Home healthcare information
- [ ] Other

If other, please describe

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CLIENT APPLICATION & CONSUMER PAPERWORK

Your support needs

Information below helps us understand your inquiry. Do not include detailed medical information.

4. CDS / PROGRAM INFORMATION

Are you currently enrolled in MO HealthNet (Missouri Medicaid)?

☐ Yes ☐ No ☐ Not sure

Have you already been assessed or referred for Missouri CDS?

☐ Yes ☐ No ☐ Not sure

If yes, agency / contact or referral source (optional)

Are you able to direct your own care, or do you have an approved representative?

☐ I can direct my care ☐ I have a representative ☐ Not sure

5. GENERAL SUPPORT NEEDS

Please select the general types of assistance you would like to discuss. This is not a clinical assessment or authorization of services.

☐ Bathing / personal hygiene
☐ Dressing
☐ Grooming
☐ Meal preparation
☐ Mobility / transfers
☐ Toileting
☐ Light household tasks
☐ Other / not sure

In a few words, what kind of support are you looking for?

6. EMERGENCY CONTACT (OPTIONAL)

Name

Relationship

Phone number

Alternate phone

For an emergency, call 911. Do not use this application to request urgent care or emergency assistance.

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CLIENT APPLICATION & CONSUMER PAPERWORK

Notices & acknowledgment

7. IMPORTANT PROGRAM AND PRIVACY NOTICES

This is a preliminary All Smilez LLC inquiry/application. It is not an official Missouri Department of Health and Senior Services (DHSS) or MO HealthNet form.

Submitting this form does not establish eligibility, guarantee CDS enrollment, authorize services, confirm coverage, or create a provider-client relationship.

Missouri agencies or their designees determine program eligibility, assessments, service authorization, and applicable requirements.

Services discussed are subject to applicable program rules, authorizations, provider availability, and any required agreements.

Do not send Social Security numbers, Medicaid/insurance ID numbers, financial account details, identity documents, medical records, diagnoses, medications, or other sensitive information through ordinary email.

If additional protected health or personal information is needed, ask All Smilez LLC about an appropriate secure method before providing it.

8. CLIENT / REPRESENTATIVE ACKNOWLEDGMENT

I confirm that the information I provided is accurate to the best of my knowledge. I authorize All Smilez LLC to contact me about this inquiry using the contact details provided. I understand that this form is only a request for information and does not guarantee eligibility or services.

☐ I have read and understand the notices above.

Client / representative printed name *

Relationship (if representative)

Signature (type full name) *

Date signed *

9. ALL SMILEZ LLC FOLLOW-UP (STAFF USE ONLY)

Date received

Staff member

Follow-up status

Notes / next steps

Please contact us if you need help completing this preliminary application.

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CONSUMER DIRECTED SERVICES

Attendant backup plan

Consumer's name

Phone number

Street address

City

State

ZIP code

The person(s) listed below have agreed, and will serve to back up your current Personal Care Attendant. They will provide care when your regular Attendant is unable to render services.

BACKUP ATTENDANT

Backup name

Relationship

Backup address

City

State

ZIP code

The above person(s) must meet the qualifications to become a Personal Care Attendant, which include: Pass 4 required criminal background checks, be registered with the Family Care Safety Registry, have 2 forms of valid identification, and be applicable to all state laws and regulations.

The Attendants will be interviewed and hired by me, the Consumer. The Attendant will fill out an application through All Smilez Home Health Care, the agency will then complete all required screenings. Upon being hired, the Attendant will then go through orientation training with me, the Consumer, with the assistance of All Smilez Home Health Care.

This plan will be reviewed and discussed with the Agency on a regular basis for updates or changes.

Consumer signature (type full name)

Date

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CONSUMER DIRECTED SERVICES

Consumer's emergency plan

This form is in case of an emergency and will describe the process taken if the Consumer is in need of this Emergency Plan. All Smilez Home Health Care will follow the following plan that you, the Consumer, have decided.

CHOOSE YOUR EMERGENCY PLAN

Check the box for the emergency plan you would like to follow.

- [ ] Please contact my Attendant.
- [ ] Please contact my backup Attendant.
- [ ] Please follow the Emergency Plan already stated in my Plan of Care provided.
- [ ] Contact a family member.
- [ ] Other

Other plan / details

PRIMARY CARE PHYSICIAN

Name

Phone

I authorize All Smilez Home Health Care to follow the above plan in case of an emergency.

Consumer signature (type full name)

Date

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Acknowledgment of receipt

Consumer name

CDS representative

CDS PARTICIPANT MANUAL

The CDS participant manual contains All Smilez policy and procedure for the CDS program. All Smilez employees will follow the policies and procedures contained in the CDS participant manual.

All Smilez CDS participants are required to follow the instructions in the CDS participant manual. All Smilez CDS participants must inform their Attendants of applicable policies and procedures.

Your CDS Representative is available to give clarification or further training on the contents of the manual. If you need a replacement copy of the CDS participant manual, it is your responsibility to request one from your CDS Representative.

I have received a copy of the All Smilez CDS participant manual.

I understand the policies and procedures contained in the manual applied to me, and as applicable my CDS Attendant while I am a CDS participant with All Smilez. I have also had the opportunity to ask any questions about the manual with my CDS representative.

CDS participant signature (type full name)

Date

All Smilez representative signature (type full name)

Date

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CONSUMER DIRECTED SERVICES

Personal care attendant requirements

To become a Consumer Directed Services (CDS) attendant in Missouri, there are certain requirements that need to be met. Firstly, individuals interested in becoming a personal care attendant must be at least 18 years old and legally eligible to work in the United States. Prospective CDS attendants in Missouri need to undergo several criminal background checks to ensure the safety and well-being of the clients they will be assisting. The spouse of the disabled medicaid participant can NOT be the PCA.

Personal Care Attendants (PCAs) should also have good communication skills, as they will be working closely with individuals who are disabled and require personal care and assistance. It is important for CDS attendants to have a genuine passion for helping others and a strong commitment to maintaining the dignity and independence of the individuals they serve.

In addition to the previous requirements, it is essential for Consumer Directed Services attendants to have proficient knowledge and skills in using technology, particularly for clocking in and out of their shifts. It is a Department of Health and Senior Services requirement that all CDS attendants utilize electronic timekeeping systems that require attendants to accurately record their work hours. Familiarity with using a smartphone and the ability to follow instructions for using our timekeeping application is crucial for accurately documenting employee work hours and ensuring proper compensation.

I, the Consumer, understand that it is my responsibility to know if my personal care attendant is qualified for the position.

CDS participant signature (type full name)

Date

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Filing a grievance

POLICY AND PROCEDURES

All Attendants, family members, Consumers, and Agency contractors are mandatory reporters of abuse, neglect, and exploitation. The Consumer, as well as the employee, may file a grievance.

When a complaint is received from the Consumer or employee, verbally, or in writing, that complaint will be discussed with the Consumer and employee. A statement will be documented and filed with details of the complaint/grievance for recording purposes. The program Director will investigate the complaint /grievance and make every effort to resolve the grievance to the Consumer or employee satisfaction. The Consumer and employee will be given a written notice of the resolution.

All Consumers and employees will be given a written notice, as to where to send a written grievance.

INFORMATION SHOULD BE SENT TO

All Smilez LLC
Attention: CDS Coordinator
13975 Manchester Rd Suite 2 Unit 14
Ballwin, MO 63011
314-467-8116

Include the problem and the date of the occurrence, if known. If the grievance cannot be resolved to the Consumer's satisfaction, the Consumer may notify their case manager with the Department of Health and Senior Services.

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Filing a grievance: external agencies

You may also file a complaint or discrimination with one of the external agencies listed below. If you choose to do so, you must include your name, mailing address, telephone number, and a brief description of the complaint/grievance.

INFORMATION SHOULD BE SENT TO

Department of Public Social Services Office for Civil Rights
PO Box 1527
Jefferson City, MO 65102
800.776.8014 or 800.877.6916

Department of Health and Human Services Office for Civil Rights
601 East 12th Street
Kansas City, MO 64105
573.751.9092 or 816.426.7277

If you need assistance with filing a separate complaint, All Smilez LLC staff will be available to assist you.

My signature below acknowledges that I have received a copy of the Grievance Policy and Procedure.

Attendant signature (type full name)

Date

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DUE TO SUSPENSION OF SERVICES

Consumer right to a hearing

The Consumer may request in writing a hearing with the department of social services within 90 days of denial of financial assistance, discontinuation of services, suspension, or reduction of CDS services.

CONSUMER ACKNOWLEDGMENT

Consumer signature (type full name)

Social Security number

Date

Vendor agency

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CONSUMER DIRECTED SERVICES

Understanding consumer spend downs

I, the Consumer, understand that If my Spend Down is not met, my worker will not be compensated by the agency.

The Consumer is responsible for compensating the worker for the days worked while the Consumer Spend Down is not met.

Once the Consumer's Spend down is met, All Smilez LLC will be able to bill for the hours worked from the time the Consumer became eligible for Medicaid.

The agency will not give your worker a special check. If your worker misses pay due to your Spend Down not being met, your worker will see those days and hours on the next paycheck (assuming your timesheet is correct for processing).

Visit https://dss.mo.gov/mhd/files/spend-down-faq.pdf for a detailed guide on Spenddowns, automatic payment, and more information provided by the state of Missouri.

Consumer signature (type full name)

Date

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CONSUMER DIRECTED SERVICES

Participant rights & responsibilities

PARTICIPANTS ARE EXPECTED TO

- Explain any specific information about tasks authorized on the care plan.
- Provide supplies needed for tasks in the care plan.
- Sign a completed timesheet each time you receive services.
- Ensure that information on the timesheet is accurate.
- Notify the HCBS provider in advance when you will not be home to receive care.
- Notify the HCBS provider if you have problems with your care delivery.
- Accept or select an aide without regard to race, color, national origin, sex, age, religion, political beliefs, or disability.

PARTICIPANTS HAVE THE RIGHT TO

- Appeal decisions regarding your person centered care plan, including the denial, reduction, or termination of services.
- You must appeal within ninety (90) calendar days of the date of the decision.
- You must request a hearing within ten (10) days of the date of the notice if you wish to continue receiving services pending the hearing decision.
- If the Division's decision is upheld, you may be held responsible for the cost of any services received while the appeal is pending.
- Appeal any disagreement with decisions about my person centered care plan.
- Receive services without regard to race, color, national origin, sex, age, religion, political beliefs, or disability.

PARTICIPANTS MAY NOT

- Threaten or abuse or allow other members of your household (or guests) to threaten or abuse provider staff (physically, verbally, or sexually). This will result in your services being terminated.
- Expect care to be provided to your pets, friends, or visitors.
- Allow services to be provided in your home when you are not at home.
- Engage in activities that would be considered fraud of the program; for example signing timesheets attesting to care (or time of care) that has not actually been provided.

CDS participant signature (type full name)

Date

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CDS OPTION HCBS

Your responsibilities as a participant

YOU ARE RESPONSIBLE FOR

- Selecting and hiring your aide.

- Training your aide to perform the tasks authorized on the person centered care plan.

- Supervising the work performed by your aide and ensuring the aide is able to meet your personal needs.

- Firing or terminating aides.

- Receiving care only from aides registered and screened by the Missouri Family Care Safety Registry.