CENTER FOR ELDERS' independence

Your life just got better

Home and Community-Based Alternatives (HCBA) Waiver Application

Complete and submit this four-page application to apply for the *HCBA Waiver.*

➡ *Para recibir esta información en español, por favór llámenos al número siguiente:* 510-318-7375

Applicant's name:

Home phone: **Date of birth:** **Sex:** Male ◯ Female ◯

Married: Yes ◯ No ◯ **Age:** Transgender M to F ◯ Transgender F to M ◯

County of Residence:

Where is the applicant currently residing?

◯ At home

◯ Hospital Date of admission: Estimated date of discharge:

Number of consecutive days in the hospital:

◯ Nursing Facility

Date of admission: Estimated date of discharge:

Number of consecutive days in the facility:

Facility name:

Facility city:

◯ Other, type of residence:

Other name:

Other city:

Date of admission, if applicable:

Applicant's Current Mailing Address

Street: Apt./Ste./Room

City:

ZIP Code:

Street Address (if different from Mailing Address)

Street: Apt./Ste./Room

City:

ZIP Code:

Date of Submission:

Applicant's Name: _____ Date of Submission: _____

Health Care Insurance

Medi-Cal? Yes ◯ No ◯

If yes, Medi-Cal number: _____ (located on Medi-Cal Beneficiary I.D. Card (BIC))

Medicare? Yes ◯ No ◯

If yes, what part? Part A ☐ Part B ☐ Part A & B ☐ Part D ☐

Other Insurance? Yes ◯ No ◯

If yes, name of the insurance: _____

List the applicant's <u>current</u> medical diagnoses (main illness or injury):

*Check the boxes that identify the applicant's **<u>current</u>** medical needs. Use the blank spaces below to identify additional medical needs that are not listed. You may provide additional comments on the back of the application.*

☐ Ventilator, identify the number of hours the applicant uses the ventilator each day: ____ hours

☐ Tracheostomy

☐ Continuous Positive Airway Pressure (CPAP) Device, identify the number of hours the applicant uses the CPAP each day: ____ hours

☐ Tracheal Suctioning, number of times per day: ____

☐ Bi-Level Positive Airway Pressure (BiPAP) Device, identify the number of hours the applicant uses the BiPAP Device each day: ____ hours

☐ Oral Suctioning, number of times per day: ____

☐ Respiratory Treatments, identify the number of treatments the applicant receives each day: ____ treatments

☐ Nasal Suctioning, number of times per day: ____

☐ Room Air Mist

☐ Continuous Use of Oxygen

☐ Oxygen as needed

☐ Oral (by mouth) Medications

☐ Oral (by mouth) Feedings; able to feed self? Yes ◯ No ◯

☐ Urinary Incontinence

☐ Gastric Tube (GT) Medications

☐ Gastric Tube (GT) Feedings

☐ Bladder Catheterizations

☐ Intravenous (IV) Medications

☐ Intravenous (IV) Nutrition

☐ Bowel Incontinence

☐ Routine Bowel Care

☐ Urostomy/Colostomy

Medical diagnoses continued on the next page

Applicant's Name: Date of Submission:

- ☐ Chronic Pain Treatment
- ☐ Pressure Sores/Open Wounds
- ☐ Skin or Wound Treatments, number of sores/open wounds:
  Location of wounds:
- ☐ Contractures
  Location of contractures:
- ☐ Some ability to move arms or legs, but needs some help with care needs. *Briefly explain on back.*
- ☐ No movement of arms or legs, and needs total help with care needs. *Briefly explain on back.*
- ☐ Special equipment needs (e.g. wheelchair, lift system, ramp, etc.). *Briefly explain on back.*
- ☐ Other
- ☐ Other
- ☐ Other

Is this application being submitted <u>for</u> the applicant? Yes ◯ No ◯

1. Who has the legal authority to make the applicant's health care decisions?
   - ◯ Applicant
   - ◯ Other; if other, provide the following information:
     Name:
     Relationship:
     Telephone Number:

2. If this application was submitted by someone other than the applicant or the legal representative, was the applicant or the legal representative notified that this application was submitted to enroll in the *HCBA Waiver?* Yes ◯ No ◯

If yes, provide the name and title of person completing the application:
Name:
Title:
Telephone Number:

Identify all of your current service providers:

☐ **Home Health Agency (HHA)**, provide the following information:
HHA Name:
Number of hours of home health services received each week:

Type of services received:
- ☐ Attendant Care
- ☐ Certified Home Health Aide (CHHA)
- ☐ Nursing Services, provided by an: RN ☐ , and/or LVN ☐

Applicant's Name: _____ Date of Submission: _____

☐ **In-Home Supportive Services (IHSS)**, provide the following information:

Number of IHSS hours authorized per month: _____

To obtain IHSS eligibility information, contact the applicant's county of Department of Social Services office and ask for the IHSS Intake Department.

☐ **California Children Services (CCS)**

☐ **Regional Center**, provide the following information:

Center's name: _____

Service Coordinator's name: _____

☐ **Adult or Pediatric Day Health Care**, provide the following information:

Center's name: _____

Number of days per week: _____

☐ Applicant attends **school** outside of the home, provide the following information:

Number of days per week: _____

Number of hours per day: _____

Does the school provide medical care services at school? Yes ◯ No ◯

☐ **Multipurpose Senior Services Program (MSSP)**

MSSP is an HCBS waiver benefit for Medi-Cal beneficiaries over the age of 65 that provides general services and nursing support. For further information on this program, go to: http://www.dhcs.ca.gov/services/medi-cal/Pages/MSSPMedi-CalWaiver.aspx

☐ **Hospice**

Hospice is a Medicare/Medi-Cal benefit for beneficiaries with a terminal diagnosis. For further information on this benefit, contact the applicant's physician.

☐ **Program of All Inclusive Care for the Elderly (PACE)**

PACE is a Medi-Cal benefit that provides all needed preventative, primary, acute, long-term care, social and rehabilitative services through one comprehensive program to eligible seniors, 55 years or older. For further information, call 1-888-633-7223, or go to: www.CALPACE.org.

☐ **Senior Care Action Network (SCAN)**

SCAN Health Plan, as a Medicare Advantage Special Needs Plan, offers health and long-term care services to eligible Medicare/Medi-Cal beneficiaries over the age of 65 years. For further information, call 1-877-452-5898, or go to: www.scanhealthplan.com.

When complete, mail this application to the following address:

Center for Elders' Independence
510 17th Street, Oakland, CA 94612

Or submit the application by secure FAX: 510-255-6078

Or email application to: HCBA@cei.elders.org

As a contracted delegate of the Department of Health Care Services, Center for Elders Independence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age disability, or sex

CENTER FOR ELDERS' independence

Consent for the use and disclosure of health information for treatment, payment, or healthcare operations.

I understand that as part of my healthcare, this Waiver Agency (WA) originates, obtains, and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. The WA will use and disclose my protected health information as defined by federal and state law as described below:

- A basis for planning my care and treatment
- A means of communication among the healthcare professionals contributing to my care
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

Medical Information:

As an HCBA applicant or beneficiary, I understand that the Center for Elders' Independence (CEI) consent for the use and disclosure of health information:

- Allows me or my authorized/legal representative access to my medical information
- Allows CEI to provide my medical information to providers and agencies involved in my care as deemed necessary by the WA
- Allows CEI to provide copies of my medical record for purposes of medical management, verification and payment, grievances and related activities necessary for the proper administration of WA services.

This consent is valid for the duration of participant's associated with the WA unless revoked by participant.

Name of HCBA beneficiary/applicant or legal representative: _____

Relationship to beneficiary/applicant: _____

_____ _____

*Signature of CEI participant/applicant or legal representative Date

*A copy of scanned image of my signature shall be as valid as the original.