State of California-Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
*DIRECTOR*

EDMUND G. BROWN JR.
*GOVERNOR*

## Nursing Facility/Acute Hospital (NF/AH) Waiver Application

⇒ *Para recibir esta información en español, por favór llámenos al número siguiente: (916) 552-9105.*

To apply for the NF/AH Waiver administered by the In-Home Operations (IHO) Branch, please complete this two-page application.

**Applicant's Name:** _____ **Home Phone:** (____) _____
**Date of Birth:** _____ **Age:** _____ **Male** ☐ **Female** ☐ **Married:** ☐ Yes ☐ No
**County in which the applicant currently resides:**
_____

**Where is the applicant currently residing?** At home ☐ Hospital ☐
☐ Nursing Facility: _____ Other: _____
Facility Name and City — Please Specify

**Mailing Address:**_____ **City:** _____, **CA ZIP:** _____

**Street Address:**_____ **City:** _____, **CA ZIP:** _____
*(If different from Mailing Address)*

**Health Care Insurance:**

**Medi-Cal?** ☐ Yes ☐ No If yes, Medi-Cal Number _____
Located on the applicant's Medi-Cal Beneficiary Identification Card (BIC)

**Medicare?** ☐ Yes ☐ No If yes, ☐ Part A ☐ Part B ☐ Part A & B ☐ Part D

**Other Medical Insurance?** ☐ Yes ☐ No If yes, identify _____

List <u>current</u> medical diagnoses (main illness or injury): _____
_____

Check the boxes that identify your <u>current</u> medical needs. Use the blank spaces below to write-in your specific medical needs that are not listed. You may provide additional comments on the back of the application.

☐ Ventilator - Hours Used Per Day (hrs/day) ___/___
☐ Continuous Positive Airway Pressure (CPAP) Device – hrs/day ___/___
☐ Bi-Level Positive Airway Pressure (BiPAP) Device – hrs/day ___/ ___
☐ Respiratory Treatments - number per day _____
☐ Room Air Mist
☐ Oral (by mouth) Medications
☐ Gastric Tube (GT) Medications
☐ Intravenous (IV) Medications
☐ Chronic Pain Treatment
☐ Contractures
☐ Continuous Use of Oxygen
☐ Oral (by mouth) Feedings
☐ Gastric Tube (GT) Feedings
☐ Intravenous (IV) Nutrition
☐ Pressure Sores/Open Wounds
☐ Skin or Wound Treatments
☐ Tracheostomy
☐ Tracheal Suctioning
☐ Oral Suctioning
☐ Nasal Suctioning
☐ Oxygen as needed
☐ Urinary Incontinence
☐ Bladder Catheterizations
☐ Bowel Incontinence
☐ Routine Bowel Care
☐ Urostomy/Colostomy
☐ Some ability to move arms or legs. Needs some help with care needs. Briefly explain on back.
☐ No movement of arms or legs. Needs total help with care needs. Briefly explain on back.
☐ Special equipment needs. (ex: wheelchair, lift system, ramp) Briefly explain on back.
☐ Other_____

## NF/AH Waiver Application, *continued*

**If this application is being submitted <u>for</u> the applicant:**

1. Was he/she or the legal representative notified of this application for the NF/AH Waiver? ☐ Yes ☐ No

2. Who has the legal authority to make the applicant's health care decisions?

☐ Applicant ☐ Other: _____ _____ (____) _____
Name Relationship Telephone Number

_____ (____) _____ _____
**Print name and title of person completing the application** **Contact Telephone** **Date**

**Please identify all of your current providers of service:**

☐ **Home Health Agency** – Name: _____ Hours per week: _____
Type of services received: ☐ Attendant Care ☐ Certified Home Health Aide (CHHA)
Nursing: RN ☐ LVN ☐

☐ **In-Home Supportive Services (IHSS)** - Hours Authorized Per Month: _____

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

☐ **California Children Services (CCS)**

☐ **Regional Center** _____ Service Coordinator: _____
Center Name Name

☐ **Adult or Pediatric Day Health Care**: _____ Days per week: _____
Center Name

☐ **Attends school outside of the home?** If yes, # days/week? _____ # hours/day? _____
Does the school provide medical care services at school? (Ex; nursing care, therapy) ☐ 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, please 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, please 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 please call 1-877-452-5898, or go to: www.scanhealthplan.com.*

*When completed, please return this form to IHO at the address on first page. Should the applicant relocate, have a significant change in health care needs, or have a change in Medi-Cal insurance status, please contact IHO at (916) 552-9105.*

Enclosures