***Type only. No handwritten applications will be accepted.***

**Date:**

**Agency Name:**

**Name of Branch site:**

**Branch site street address:**

**Branch site telephone:**

**City:** **Zip Code:**

**ALW counties where the agency intends to provide service:**

**Address of parent company (agency), if different:**

**Telephone:**

**Website:**

**National Provider Identification (NPI) number (required):**

**Contact Information**

(***Information provided will be used to communicate with the applicant regarding the status of this submission.)***

**Name:**

**Title:**

**Telephone number:**

**Email Address:**

**Please provide detailed responses to the following questions.** Inadequate responses will result in delay and/or denial of application.

**🡺*This electronic document will expand to accommodate your responses.***

1. Agencies enrolling as Care Coordinators in the Assisted Living Waiver Program (ALW) must have at minimum one year’s experience conducting facility transitions, de-institutionalization service planning, and/or transition work to assisted living facilities.
* Submit documentation of the organization’s experience in these specialized transitions
* How many of these transitions have been completed in the last 12 month period?
1. A minimum of five years’ experience in conducting assessments, developing care plans, arranging for and monitoring service delivery, maintaining progress notes and case records, conducting quality assurance reviews, and collecting data is required. Submit samples of assessments, care plans, and case records for current case load with personal health information redacted.
2. Describe the organization in terms of its history and its present operations.
* Cite significant aspects of the current general management and health services delivery activities.
* What is the extent of the current Medicare/Medicaid population served by the agency if any?
* What is the maximum number of ALW participants that could be served with the agency’s current staffing?
1. Describe how the agency is connected to the community(ies) in which it proposes to operate.
2. Describe how the agency is connected to local Medi-Cal Managed Care plans.
3. What are your policies regarding in-service training?
* What training do you require of your staff?
* How frequent is the training?
* What method is used to keep record of all training?
1. Describe the agency’s proposed service delivery plan in the event of an emergency.
* Explain the procedures used in the event of a natural disaster.
* How are residents advised and prepared for emergency action?
1. With regard to a “person-centered service plan,” please explain the agency’s process for obtaining feedback from participants, their families, and/or advocate.
2. Does the agency offer specialized care (i.e., dementia, hospice, mental health, language/culture)?
3. **Please include the following documents with this initial application:**
* Copy of the CMS/National Plan and Provider Enumeration System (NPPES) confirmation
* List of Skilled Nursing Facilities the agency is currently associated with.
* List of Assisted Living Facilities the agency is currently associated with, one of which must be an Adult Residential Facility.
* Letters of reference from the following:
	+ Two Skilled Nursing Facilities
	+ Two Assisted Living or Adult Residential Facilities
	+ Two clients who have been successfully transitioned
* Agency organization chart
* Résumé and copy of license for each professional staff member
* Assisted Living Waiver Program Provider Agreement (See [ALW Provider Enrollment](http://www.dhcs.ca.gov/services/ltc/Pages/ALW-Provider-Enrollment.aspx) webpage).

**Submit completed application and attachments requested above to:**

**Department of Health Care Services**

**Long-Term Care Division**

**Assisted Living Waiver Program**

**1501 Capitol Avenue, MS 4503**

**PO Box 997437**

**Sacramento, CA 95899-7437**

**🡺*Incomplete applications will be returned without processing***

**🡺*Do not submit the non-refundable application fee with this form***.

When the review of this submission has been completed, you will be contacted regarding the status of your application. If this application is approved, a site review will be performed by ALW staff to verify applicant and facility qualifications.  Qualified providers will receive direction regarding the Medi-Cal provider enrollment requirements prior to rendering Medi-Cal services for the ALW program.

Contact’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Title \_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DHCS LTCD Representative