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Department of Health Care Services



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Assisted Living Waiver (ALW) Waitlist Request

To request a place on the ALW waitlist, please complete the following information and submit to DHCSALWassessments@dhcs.ca.gov.

Member's Name: _____ **Home Phone:** (____) _____

Date of Birth: _____ Male Female Married: Yes No

9-digit Medi-Cal Number _____

Address: _____ **City:** _____ **ZIP:** _____

County in which the applicant currently resides _____

Care Coordination Agency (CCA) Name: _____

Where is the applicant currently residing? Acute Hospital At home Homeless

RCFE Skilled Nursing Facility **Other:** _____

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

Applicant Other: _____ (____) _____

Was the legal representative notified of this request for the ALW waitlist? Yes No

Is there Adult Protective Services involvement? Yes No

If yes, please attach supporting documentation.

Please identify all current programs and services:

See Instructions for ALW Waitlist Request Form for more information on the programs listed below.

Adult Day Health Care **California Community Transitions (CCT)** **Cal Medi-Connect***

Home Health Agency – Hours per week: _____

Type of services received: Attendant Care Certified Home Health Aide (CHHA)

Nursing: RN LVN

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

Multipurpose Senior Services Program (MSSP) **Nursing Facility/Acute Hospital Waiver (NF/AH)**

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

Senior Care Action Network (SCAN)

When completed, please return this form to the ALW inbox listed above. Should the applicant relocate, have a significant change in health care needs, or have a change in Medi-Cal insurance status, please contact ALW to remove the member's name from the waitlist.