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

Jennifer Kent
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

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.