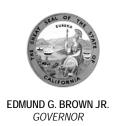


## State of California-Health and Human Services Agency





## **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 I	Phone: ()
Date of Birth:	_ Male  Female  Ma	rried: Yes No
9-digit Medi-Cal Number		
Address:	City:	ZIP:
County in which the applican	t currently resides	
Care Coordination Agency (C	CA) Name:	
Where is the applicant curren	atly residing?   Acute Hospit	al
☐ RCFE ☐ Skilled Nursing F	Facility Other:	
Who has the legal authority to	o make the applicant's health o	care decisions?
Applicant Other:		()
Was the legal representative	notified of this request for the	ALW waitlist?  Yes  No
Is there Adult Protective Serv If yes, please attach supporting do	rices involvement? Yes	No
Please identify all current pro See Instructions for ALW Waitlist F	ograms and services: Request Form for more information	on the programs listed below.
☐ Adult Day Health Care ☐	California Community Transit	ions (CCT) Cal Medi-Connect*
☐ Home Health Agency – Ho	ours per week:	
Type of services received:	Attendant Care  Certified Home	e Health Aide (CHHA)
	Nursing: RN LVN	
☐ Hospice ☐ In-Home Supp	ortive Services (IHSS) - Hours	Authorized Per Month:
☐ Multipurpose Senior Servi (NF/AH)	ces Program (MSSP) 🗌 Nurs	ing Facility/Acute Hospital Waiver
☐ Program of All Inclusive C	are for the Elderly (PACE)	Regional Center
☐ Senior Care Action Netwo	ork (SCAN)	
relocate, have a significant cl	rn this form to the ALW inbox hange in health care needs, or tact ALW to remove the memb	

1