Home and Community-Based Alternatives (HCBA) Waiver Application

Complete and submit this six-page application to apply for the HCBA Waiver.
►Para recibir esta información en español, por favór llámenos al número siguiente: (833) 388-4551.

Applicant's Name:

Phone Number: **Date of Birth:** **Age:** **Married:** Yes No

Gender: Male: Female: Transgender Male to Female: Transgender Female to Male

Date of Application Submission:

County of Residence:

Type of Residence (type of housing):

At home

Hospital

Date of admission: Estimated date of discharge:

Number of consecutive days in the hospital:

Nursing Facility

Date of admission: Estimated date of discharge:

Number of consecutive days in the hospital:

Facility name:

Facility city:

Other – identify type of residence:

Other name:

Other city: Date of admission (if applicable):

Applicant's Current Mailing Address:

Street: Apt./Ste/Room:

City: Zip Code:

Department of Health Care Services
Integrated Systems of Care Division
1501 Capitol Avenue, MS 4502
P.O. Box 997437
Sacramento, CA 95899-7437
Phone: (916) 552-9105
Internet Address: https://www.dhcs.ca.gov

Applicant's Name: Date of Submission:

Applicant's Current Physical Address (if different from mailing address):

Street: Apt./Ste/Room:

City: Zip Code:

Healthcare Insurance:

Medi-Cal? ☐ Yes ☐ No

If "yes", provide the applicant's Medi-Cal number / Client Index Number (CIN):

(Medi-Cal identification numbers are found on the Medi-Cal Benefits Identification Card (BIC))

Medicare: ☐ Yes ☐ No

If "yes", which part? ☐ Part A ☐ Part B ☐ Part A&B ☐ Part D

Other Insurance? ☐ Yes ☐ No

If "yes", name of insurance:

Applicant's Current Medical Diagnosis: What is the applicant's current medical diagnosis (main illness or injury)?

Additional Medical Need(s):

Check the box(es) that identify the applicant's current medical needs. Use the blank spaces below to identify additional medical needs that are not listed. You may provide additional comments on the back of the application.

- ☐ Ventilator, identify the number of hours the applicant uses the ventilator each day:
- ☐ Tracheostomy
- ☐ Continuous Positive Airway Pressure (CPAP) Device, identify the number of hours the applicant uses the CPAP each day:
- ☐ Tracheal Suctioning, identify the number of times per day:
- ☐ Bi-Level Positive Airway Pressure (BiPAP) Device, identify the number of hours the applicant uses the BiPAP Device each day:
- ☐ Oral Suctioning, identify the number of times per day:
- ☐ Respiratory Treatments, identify the number of treatments the applicant receives each day:
- ☐ Nasal Suctioning, identify the number of times per day:

Applicant's Name: _____ Date of Submission: _____

- ☐ Room Air Mist
- ☐ Continuous Use of Oxygen
- ☐ Oxygen as needed
- ☐ Oral (by mouth) medications
- ☐ Oral (by mouth) Feedings, able to feed self? ☐ Yes ☐ No
- ☐ Urinary Incontinence
- ☐ Gastric Tube (GT) Medications
- ☐ Gastric Tube (GT) Feedings
- ☐ Bladder Catheterizations
- ☐ Intravenous (IV) Medications
- ☐ Intravenous (IV) Nutrition
- ☐ Bowel Incontinence
- ☐ Routine Bowel Care
- ☐ Urostomy / Colostomy
- ☐ Chronic Pain Treatment
- ☐ Pressure Sores / Open Wounds
- ☐ Skin or Wound Treatments, number of sores / open wounds: _____
  Location of wounds: _____
- ☐ Contractures
  Location of contractures: _____
- ☐ Some ability to move arms or legs but needs some help with care needs. *Briefly explain on back.*
- ☐ No movement of arms or legs and needs total help with care needs. *Briefly explain on back.*
- ☐ Special equipment needs (e.g. wheelchair, lift system, ramp, etc.) *Briefly explain on back.*
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Applicant's Name: Date of Submission:

Is this application being submitted for the applicant? Yes No

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

Applicant

Other – If "other," please provide the following information:

Full Name:

Relationship: Telephone Number:

If applicable, does this applicant have signed documentation for the legal representative or Durable Power of Attorney for healthcare purposes:

Yes No

If applicable, was the applicant or the representative notified the application was submitted to enroll him or her in the HCBA Waiver? Yes No

If yes, provide the name and title of the person completing the application:

Full Name:

Title: Telephone Number:

Identify all of the applicant's current service providers:

Home Health Agency (HHA); provide the following information:

HHA Name:

Number of hours of home health services received each week:

Types of services received: Attendant Care

Certified Home Health Aide (CHHA)

Nursing Services, provided by an: RN LVN

In-Home Supportive Services (IHSS); provide the following information:

Number of IHSS hours authorized per month:

To obtain IHSS eligibility information, contact the County Department of Social Services office and ask for IHSS intake support.

California Children Services (CCS)

Regional Center; provide the following information:

Center's Name:

Service Coordinator's Name:

Applicant's Name: _____ Date of Submission: _____

☐ **Adult (CBAS) or Pediatric Day Health Center;** provide the following information:

Number of days per week: _____ Number of hours per day: _____

Does the school provide medical care services at school? ☐ Yes ☐ No

Does the school provide a non-medical attendant during school hours: ☐ 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, go to:

https://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 primary care 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, call 1-877-633-7223, or go to https://CALPACE.org.

☐ **Senior Care Action Network (SCAN)**

SCAN Health Plan is a Medicare Advantage Special Needs Plan that offers health and long-term care services to eligible Medicare / Medi-Cal beneficiaries over the age of 65 years. For further information, call 1-877-452-5898, or go to:

https://www.scanhealthplan.com

Attn: HCBA Intake Coordinator
Department of Health Care Services
Integrated Systems of Care Division
1501 Capitol Avenue, MS 4502
P.O. Box 997437
Sacramento, CA 95899-7437

Or submit the application by FAX: (916) 552-9149
or email to caremanagement@dhcs.ca.gov

Applicant's Name: Date of Submission:

DHCS complies with applicable Federal and State civil rights laws. DHCS does not unlawfully discriminate on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation. DHCS does not unlawfully exclude people or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation. The personal and medical information collected on and with this form is confidential, subject to the Department of Health Care Services (DHCS) Notice of Privacy Practices that can be found here: https://www.dhcs.ca.gov/formsandpubs/laws/priv/Documents/Notice-of-Privacy-Practices-English.pdf. The Department of Health Care Services needs the information to determine the applicant's preliminary needs and potential eligibility for medical/behavioral services through the Home and Community Based Services (HCBS) Waivers. DHCS will not use or share the information for other purposes except with your permission or as permitted by law. You must provide all information requested on this form. If you do not provide all information requested, we cannot process your request for enrollment in the HCBS Waivers. The individual(s) to whom this information pertains has the right to access it.

DHCS is authorized to collect this information pursuant to Welfare & Institutions (W&I) Code Section 14000 and as the CMS approved agency responsible for the administration of the Home and Community Based Alternatives (HCBA) Waiver. This privacy notice provided here is required by California Civil Code Section 1798.17.