Assisted Living Waiver Intake Packet

- Included in this packet are the documents required for **ALL PARTICIPANTS** to move forward with the Assisted Living Waiver (ALW) program with All Hours Adult Care.

Disclaimer: Due to the end of the COVID 19 state of emergency, as of June 1, 2023, DHCS is now requiring wet signatures or docusign from all ALW Applicants.

- Please complete the forms attached to the best of your ability. The signature of the applicant or the **documented** authorized representative are required in all designated areas.
- **If you are the authorized representative for the ALW applicant,** you must also include supporting paperwork. **EX: *DPOA, AHCD, Conservatorship Documents***

Included Documents:

1. Waitlist Request Form
2. Financial Consent Form
3. Amenity Form
4. Freedom of Choice Form
5. Release of PHI

Please reach out to our office with any questions or concerns.

Phone: 844-657-4748 | Fax: 844-746-7646 | Email: info@allhoursadultcare.com

Assisted Living Waiver (ALW) Waitlist Request Form

Please complete this form and submit it by email to info@allhoursadultcare.com or by fax to 844-746-7646

SNFs and Hospitals: DO NOT SUBMIT without Order Summary, Med List, LIC602 and Face Sheet

*This form must be submitted with ALL required documents to avoid application delays

Member Name________________________ **Member Phone** (___) ___-____ **Date of Birth**______________ Medicare #____________

Email__________________________ **Gender** M F **Marital Status** Married Divorced Widowed Single

Preferred Language English Spanish

First 9 digits of Medi-Cal Number or SSN ________________ Pending Medi-Cal Approval Share of Cost______

Total Monthly Income____________ NO INCOME *representative payee required

Income Source SSI VA Retirement Other_______________

Name of Rep Payee______________________________ Phone (___) ___-____

Home Address ____ City__________________ Zip_____________

County where applicant currently resides______________

Current Location At Home Homeless ALF/RCFE Hospital/Acute Rehab/ Skilled Nursing Facility

___________________________________/_____________
(facility name / admission date)

Desired County Alameda Contra Costa Fresno Kern Orange Los Angeles Riverside Sacramento San Bernardino San Diego San Fransisco San Joaquin San Mateo Santa Clara Sonoma

Referred By: Gregory Steen Marnice Smith Carol Costa Smith Adult Protective Services Other _________________________

Please identify at least 3 cities or facilities for placement where you are willing to move *we require the assistance of the referral source and/or social worker to secure placement

ALW Facilities : https://www.dhcs.ca.gov/services/ltc/Documents/List-of-RCFE-facilities.pdf

____

Who has legal authority to make the applicant's HEALTHCARE decisions? * Must provide Designated Power Of Attorney (DPOA) or Advanced Health Care Directive (AHCD)

Applicant Public Guardian Legally Authorized Representative **Financial** **Medical** **Other**________________

POA/Alternate Contact ________________________________ ***Phone (____)_____-_______ Relationship to Applicant***____________________________

Was the legal representative notified of this request for the ALW Waitlist? Y N

Is there Adult Protective Service (APS) involvement? Y N ***If APS, DO NOT SUBMIT without APS Referral Letter***

Health Information (select all that apply)

G- Tube	**Catheter**	**Injections**	**Memory**		**Other Diagnoses**	
Y	Short Term	Self Administered	Alzheimer's	Wanders	Non Ambulatory	TBI (Diagnosed Only)
N	Long Term	Needs assistance	Dementia	Sundowners	Ambulatory	Other_______________
					Deaf/Hard of Hearing	Blind

Mental Health Diagnosis (please provide details below) *Based on DHCS guidelines, a mental health diagnosis alone does not meet the min ALW requirements

Details:____

Behaviors: Flight Risk Aggressive Disrespectful to staff Inappropriate toward staff Verbally Abusive Physically Abusive History of Substance Abuse/current use frequency______________

Other Programs (select all that apply) *must disenroll from programs below the red line before assessment

Home Health Agency - Hours Per Week___________

Services Received: Attendant Care Certified Home Health Aide (CHHA)

Nursing RN LVN Hospice In-Home Supportive Services (IHSS) - Hours Authorized per month

Adult Day Health Care California Community Transitions (CCT) Senior Care Action Network Embrace Plan

---

Multipurpose Senior Services Program (MSSP) Senior Care Action Network Duals Plan (SCAN FIDE-SNP) Regional Center

Program of All Inclusive Care for the Elderly (PACE) IEHP Dual Choice Nursing Facility/Acute Hospital Waiver

Have you submitted a waitlist request to another agency? Y N - Agency______________________________

CCA Change Requested? Y N Requested by Applicant Representative Facility

FAX or Email our office IMMEDIATELY to report discharge, death or loss of Medi-Cal coverage

Applicant or Legal Representative Signature:______________________________

*by signing this form, I agree that the applicant or their authorized representative has expressed interest in placement through the ALW program and the proper legal entity has been notified of the submission of this form

Updated 1/31/24

Assisted Living Waiver Program Financial Consent Form

The assisted living waiver does not pay for participants' Room and Board. Waiver participants are responsible for making Room and Board payments (AKA rent) to Adult Residential Facilities, Residential Care Facilities for the EElderly or Public Subsidized Housing property owners

Most ALW participants use their Social Security Income/State Supplementary Payment (SSI/SSP) to pay for rent/ Each year, the federal socual security Administration (SSA) publishes maximum SSI benefits available to beneficiaries in different living arrangements.

For more information on feeral SSI benefirs, Living Arrangements, and personal needs allowance, visit **https://www.ssa.gov/ssi/text-living-ussi.htm** For more information on California's SSP, visit **https://www.cdss.cs.gov/inforesources/ssi-ssp**

ATTN Authorized Representatives: By signing this document, you are only agreeing to manage the finances of the applicant and are not responsible for providing financial assistance unless listed as the representative payee.
Please **DO NOT** alter this document by adding additional verbiage to the signature line or it will be voided and require a new form to be filled out.

2024 Room and Board Fees

If your income is **$1,575.07 or less**, you will be responsible for **$1,398.07 per month** in room & board fees.
If your income is **$1,576.00 or more**, you will be responsible for **$1,418.07 per month** in room & board fees.

Please note: if you are receibving SSI benefits and you receive less that the $1,398.07 needed to participate in the ALW program, you may qualify for a benefit increasae with Social Security Administration department. You will need to let them youw you are moving into an assisted living facility with the Assisted Living Waiver Program with the State of California.

______I understand that the applicant is responsible for the rent (room & board fee) at an ALW approved facility.
Initials

______I consent to contact the Social Securit Administration to see if I am eligible for an increase.
Initials

______I agree to participate in my enrollment process including contacting Medi-Cal or SSA for any needed updates.
Initials

________________________________ ____________________
Applicant or Representative Signature Date

Updated 1/31/2024

Assisted Living Waiver Amenity Form

Richard Figueroa
Acting Director

Gavin Newsom
Governor

The Medi-Cal Home and Community-Based Services (HCBS) waiver program is authorized in § 1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community- based services that assist Medi-Cal beneficiaries to live in the community and avoid institutionalization.

Each beneficiary of the ALW program is eligible and offered, at enrollment, the following benefits per Appendix C: Participant Services C-1/C-3 Service Specification):

1. Private or semi-private room with full bathroom (shared by not more than two beneficiaries). The choice of roommate is independent of the ALW.
2. Kitchenette, equipped with a refrigerator, a microwave (or cooking appliance) and adequate storage space for utensils and supplies.

Following receipt of the above information,

I Name: ______________________________ Prefer to:

☐ Waive my right to a private room.

☐ Waive my right to a refrigerator.

☐ Waive my right to a microwave.

______________________________ (Signature)

______________ (Date)

DEPARTMENT OF HEALTH CARE SERVICES
HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER
FREEDOM OF CHOICE LETTER/DOCUMENT

If you **agree** to accept the *HCBS Assisted Living Waiver Services* as an alternative to care in a skilled nursing facility, please check the "**Accept**" box below, print your name, date the form, and sign your name. If you are unable to sign the form,your authorized representative should then complete the form as indicated.

☒ Accept HCBS Assisted Living Waiver

X____
Client or Authorized Representative Signature

____
Printed Name of Client or Authorized Representative Date Signed:

If signed by Authorized Representative:

____
Relationship to Client

If you **do not agree** to accept the *HCBS Assisted Living Waiver Services* as an alternative to care in a skilled nursing facility, or have other alternatives available to you, please check the "**Decline**" box below, print your name, date the form, and sign your name. If you are unable to sign the form, your authorized representative should complete the form as indicated.

☐ Decline HCBS Assisted Living Waiver

____
Client or Authorized Representative Signature

____
Printed Name of Client or Authorized Representative Date Signed: ___________

If signed by Authorized Representative:

____
Relationship to Client

Authorization for Release of Public Health Information (PHI)

Client Name: ________________________ DOB: ____________ 9 Digit Medi-Cal #___________________

Address: ______________________________________

I authorize ____________________________ to give and receive information and medical records listed below to:
(Dr Office or SNF/Hospital Name)

All Hours Adult Care Care Coordinating Agency

Order Summary (H&P)	Conservator Letters
Assessments/Evaluations	Medication Records
Needs and Services Plan	Medical/Psychiatric Lab Results
Progress Notes	

I understand that these records are protected under State and Federal law for privacy regulations and cannot be disclosed without written consent unless otherwise provided by law. I understand I have the right to refuse to supply the information being requested, however, without this information, I understand the agency will be limited to provide the services that I am requesting.

I understand this consent expires automatically one year after signing, which is the date next to my signature. I understand this information will be shared only with staff and oversight agencies as needed only for treatment and administration of the program. This document may be revoked at any time by the client or Conservator.

Signature of Client or representative

__________________________________ Date:_________________________

Name of representative (if not signed by client): ________________________ POA County Conservator

Signature of All Hours Staff/ Title: Marie Vernon/Program Director Date: ________, 2024

PLEASE FORWARD THE EXECUTED FORM TO THE APPROPRIATE FACILITY ADMINISTRATOR WITH INSTRUCTIONS TO SEND TO ALL HOURS ASAP.

Phone: 844-657-4748 | Fax: 844-746-7646

EMAIL: info@allhoursadultcare.com