ACCESS TLC
Home Health Care

Home and Community-Based Alternatives (HCBA) Waiver Application

Complete and submit this four-page application to apply for the *HCBA Waiver.*

➡ *Para recibir esta información en español, por favór llámenos al número siguiente:* ***1-800-852-9887***

Applicant's name:

Home phone: **Date of birth:** **Sex:** Male ◯ Female ◯

Married: Yes ◯ No ◯ **Age:** Transgender M to F ◯ Transgender F to M ◯

County of Residence:

Where is the applicant currently residing?

◯ 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 facility:

Facility name:

Facility city:

◯ Other, type of residence:

Other name:

Other city:

Date of admission, if applicable:

Applicant's Current Mailing Address

Street: Apt./Ste./Room

City:

ZIP Code:

Street Address (if different from Mailing Address)

Street: Apt./Ste./Room

City:

ZIP Code:

Date of Submission:

Applicant's Name: _____ Date of Submission: _____

Health Care Insurance

Medi-Cal? Yes ◯ No ◯

If yes, Medi-Cal number: _____ (located on Medi-Cal Beneficiary I.D. Card (BIC))

Medicare? Yes ◯ No ◯

If yes, what part? Part A ☐ Part B ☐ Part A & B ☐ Part D ☐

Other Insurance? Yes ◯ No ◯

If yes, name of the insurance: _____

List the applicant's <u>current</u> medical diagnoses (main illness or injury): _____

_____

*Check the boxes that identify the applicant's **<u>current</u>** medical needs. Use the blank spaces below to identify additional medical needs that are not listed. You may provide additional information and comments on Page 5 of the application.*

☐ Ventilator, identify the number of hours the applicant uses the ventilator each day: ____ hours

☐ Tracheostomy

☐ Continuous Positive Airway Pressure (CPAP) Device, identify the number of hours the applicant uses the CPAP each day: ____ hours

☐ Tracheal Suctioning, 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: ____ hours

☐ Oral Suctioning, number of times per day: ____

☐ Respiratory Treatments, identify the number of treatments the applicant receives each day: ____ treatments

☐ Nasal Suctioning, number of times per day: ____

☐ 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

Medical diagnoses continued on the next page

Applicant's Name: Date of Submission:

- ☐ 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

If this application is being submitted <u>for</u> the applicant? Yes ◯ No ◯

1. Who has the legal authority to make the applicant's health care decisions?
   - ◯ Applicant: Email
   - ◯ Other; if other, provide the following information:
     Name:
     Relationship:
     Telephone Number: Email
2. If applicable, was the applicant or the legal representative notified that this application was submitted to enroll the applicant in the *HCBA Waiver*? Yes ◯ No ◯
   If yes, provide the name and title of person completing the application:
   Name:
   Title:
   Telephone Number: Email:

Primary Caregivers and Back-up Caregivers Information:

Name: Phone:
Rel: Email:
Name Phone:
Rel: Email:

Primary Care Physician:

Name: Phone:
Address: Fax:
City: Zip:
*Date of last Physician Visit:

*__Annual Physician visits are required to keep medical records current.__

Applicant's Name: _____ Date of Submission: _____

Identify all of your current service providers:

☐ **Home Health Agency (HHA)**, provide the following information:

HHA Name: _____

Number of hours of home health services received each week: _____

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

☐ Nursing Services, provided by an: RN

☐ **In-Home Supportive Services (IHSS), provide the following information:**

Number of IHSS hours authorized per month: _____

To obtain IHSS eligibility information, contact the applicant's county of Department of Social Services office and ask for the IHSS Intake Department.

☐ **California Children Services (CCS)**

☐ **Regional Center, provide the following information:**

Center's name: _____

Service Coordinator's name: _____

Another Medi-Cal Waiver: ☐ Developmentally Disability Waiver ☐ Self-Determination Waiver

☐ **Adult or Pediatric Day Health Care**, provide the following information:

Center's name: _____ Number of days per week: _____

☐ **Applicant attends school outside of the home, 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 ◯

☐ **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: *http://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 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 1-888-633-7223, or go to: www.CALPACE.org.

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

SCAN Health Plan, as a Medicare Advantage Special Needs Plan, 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: www.scanhealthplan.com.

☐ **Other All-Inclusive Healthcare Programs:** ☐ ECM (Enhanced Care Management)

☐ One-Care (Cal-Optima)

☐ Other: _____

_____

Applicant Name: Date of Submission:

Please provide any additional information and/or Explanation:

IMPORTANT INFORMATION

HCBA Waiver Agencies are local, non-governmental organizations contracted with the Department of Health Care Services to enroll HCBA Waiver Participants, perform level of care assessments, provide case management, and develop and review participant Plan of Treatments. HCBA Waiver Participants are assigned to HCBA Waiver Agencies based on their geographical locations.

The HCBA Waiver provides care management services to persons at risk of nursing home or institutional placement. The care management services are provided by a multidisciplinary Care Management Team (CMT) comprised of a nurse and social worker.

The CMT coordinates Waiver and State Plan services (i.e. medical, behaviorial health, In-Home Supportive Services, etc.), and arranges for other long-term services and supports available in the local community. Care management and Waiver services are provided in the participant's community-based residence. This residence can be privately owned, secured through a tenant lease arrangement, or the residence of a participant's family member.

The HCBA Waiver Program is a Medi-Cal Program and all applicants must have Medi-Cal Benefits in place or be in the process of applying for Medi-Cal Benefits.

All HCBA Waiver Participants and/or their Legal Representatives are required to have an active and current Plan of Treatment. Participants and/or their Legal Representatives are required to review and sign their Plan of Treatment timely, AND ensure their Primary Care Physicians (PCPs) sign the Plan of Treatment and return it to Access TLC Home Health Care in a timely manner.

All HCBA Waiver Participants and/or their Legal Representatives must ensure current Medical Records (less than 8 months old) are submitted to Access TLC Home Health Care in a timely manner.

When complete, mail or fax this application to the following:

Access TLC Home Health Care
5401 Tech Circle
Attn: HCBA Intake
Moorpark, CA 93021
1-800-856-9887

or

Submit the application by secure Fax:
1-805-764-4430

As a contracted delegate of Department of Health Care Services, Access TLC Home Health Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.