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: (818-788-7824)*

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 comments on the back 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 _____

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

1. Who has the legal authority to make the applicant's health care decisions?
   - ◯ Applicant
   - ◯ Other; if other, provide the following information:
     - Name: _____
     - Relationship: _____
     - Telephone Number: _____

2. If this application was submitted by someone other than the applicant or the legal representative, was the applicant or the legal representative notified that this application was submitted to enroll in the *HCBA Waiver?* Yes ◯ No ◯

If yes, provide the name and title of person completing the application:
- Name: _____
- Title: _____
- Telephone Number: _____

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 ☐ , and/or LVN ☐

Applicant's Name: _____ Date of Submission: _____

☐ **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: _____

☐ **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.

When complete, mail this application to the following address:

5805 Sepulveda Boulevard, Suite 605,

Sherman Oaks, CA 91411

Tel: (818) 902-5000

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

Or submit the application by secure FAX: (818) 788-7824

LIBERTANA HOME HEALTH

Authorization to Release Personal and Health Information

Protected Health Information (PHI), Personally Identifiable Information (PII) – Individually identifiable health and personal information including demographics transmitted or maintained in any form that relates to an individual's physical or mental health or the provision of payment for services.

I, Insert Client's Name hereby authorize Libertana Home Health the disclosure of my PHI / PII as described below:

- ☑ Demographics (previous and current)
- ☑ Diversity and Ethnicity
- ☐ Religious Affiliations
- ☐ Financial Information
- ☑ Medical Information
- ☐ Criminal Background Check
- ☐ Social Security
- ☑ Family and Friend Relations
- ☐ Other or Exclusions: Kaiser Permanente Medical Record Number if Applicable

The following person(s), specified by name, or class of persons may receive disclosure of my PHI / PII:

- ☑ Family members: Please include the best contact information
- ☑ Caregivers: Please include the best contact information
- ☐ Spiritual and Religious Advisors _____
- ☐ Potential Landlords and Facility Managers _____
- ☐ Transportation Services _____
- ☐ Financial Institutions: _____
- ☑ Other / Relation: Insert Contact Information for Primary Care Physician & Fax Number

The purpose/use of the information is for the coordination of:

- ☑ Health Care
- ☑ Housing
- ☐ Financial Status
- ☑ Personal Needs
- ☐ Other: _____

I may revoke this authorization by notifying Libertana Home Health of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Libertana Home Health
5805 Sepulveda Blvd. Suite 605 Sherman Oaks,
CA 91411
Tel. 818-902-5000 Fax. 818-902-5008

_____

Client Printed Name / Signature / Date

_____

Witness Printed Name / Signature / Date