Assisted Living Waiver Community Intake Packet

- Included in this packet are the documents required for **ALL COMMUNITY 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***
- **APS Social Workers:** remember to submit a current APS letter to our inbox

Included Documents:

1. Waitlist Request Form
2. Financial Consent Form

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_____

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

Current Location ☐ At Home ☐ Homeless ☐ ALF/RCFE

☐ Hospital/Acute Rehab/ Skilled Nursing Facility

_____/_____
(facility name / admission date)

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
☐ Y
☐ N

Catheter
☐ Short Term
☐ Long Term

Injections
☐ Self Administered
☐ Needs assistance

Memory
☐ Alzheimer's ☐ Wanders
☐ Dementia ☐ Sundowners

Other Diagnoses
☐ Non Ambulatory ☐ TBI (Diagnosed Only)
☐ 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