Home and Community-Based Alternatives (HCBA) Waiver Application

Complete and submit this five-page application in full 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: Email address:

Date of Submission:

Applicant's Name: _____ Date of Submission: _____

Health Care Insurance

Medi-Cal? Yes ◯ No ◯ **REQUIRED**

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 or attach the most recent medical history (medication list and diagnosis).*

☐ 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 Email address:
   - ◯ Other; if other, provide the following information:
     Name:
     Relationship:
     Telephone Number: Email Address:

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: Email Address:

Identify all of your current service providers:

Primary Care Physician

Name:
Address:
Phone Number: **Fax#**

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

Number of hours of home health services received each week:

Applicant's Name: _____ Date of Submission: _____

Type of services received:
- ☐ Attendant Care
- ☐ Certified Home Health Aide (CHHA)
- ☐ Nursing Services, provided by an: RN ☐ , and/or LVN ☐

☐ **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)** Case Worker Name and Phone#

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.

Primary Caregiver and Back-up Caregiver Information

Name: _____ Phone number: _____

Name: _____ Phone number: _____

Applicant's Name: | Date of Submission:

When complete, mail this application to the following address:

5805 Sepulveda Boulevard, Suite 605,
Sherman Oaks, CA 91411

Tel: (818) 902-5000

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

A Libertana Representative will be in contact with you after the application is processed.

Any incomplete applications will cause further delay

Please note: HCBA Applicants must meet the medical criteria for the HCBA waiver and applying doesn't guarantee enrollment.

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. DHCS_HCBA App

Brief Overview and Libertana's Role as a Waiver Agency.

HCBA Waiver Program provides care management services to persons at risk for nursing home or institutional placement. The care management services are provided by a multidisciplinary care team that includes a nurse and a social worker.

The care management team coordinates Waiver and the State Plan Services and arranges for other available long-term services and supports available in the local community. Care management and waiver services are provided in the participant's community-based residence which can either be privately owned, secured through a tenant lease arrangement, or the residence of a participant's family member.

What is Libertana's role as a Waiver Agency?

Waiver Agencies are local, non-governmental organizations that will contract with the State to enroll Waiver participants, perform level of care evaluations, provide case management, develop and review participant Plan of Treatment.

There are several agencies contracted with the Department of HealthCare Services to manage the waiver and the members are assigned to an agency based on their geographical location.

Libertana does not send providers or caregivers at home. In cases where skilled nursing care is needed requiring a skilled nurse to provide the care, Libertana can assist in finding a Home Health Agency to provide the skilled nursing care needed for the participant.