State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

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: **(833) 388-4551.**

Applicant's Name:
Phone Number: **Date of Birth:** **Age:** **Married:** Yes ◯ No ◯
Gender: Male ◯ Female ◯ Transgender Male to Female ◯ Transgender Female to Male ◯

Date of Application Submission:

County of Residence:

Type of Residence (type of housing):

◯ 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 hospital:
Facility name:
Facility city:

◯ Other - identify type of residence:
Other name:
Other city: Date of admission, if applicable:

Applicant's Current Mailing Address:
Street: Apt./Ste./Room:
City: Zip Code:

Applicant's Current Physical Address (if different from mailing address):
Street: Apt./Ste./Room:
City: Zip Code:

Integrated Systems of Care Division
P.O. Box 997437, MS 4502
Sacramento, CA 95899-7437
Phone: (833) 388-4551
Internet Address: http://www.DHCS.ca.gov

Health Care Insurance

Medi-Cal? Yes ◯ No ◯

If yes, provide the applicant's Medi-Cal Number:

(Medi-Cal identification numbers are found on the Medi-Cal Beneficiary I.D. Card (BIC))

Medicare? Yes ◯ No ◯

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

Other insurance? Yes ◯ No ◯

If yes, name of insurance:

Applicant's Current Medical Diagnosis

What is the applicant's current medical diagnosis (main illness or injury)?

Additional Medical Need(s)

Check the box(es) that identify the applicant's current 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, identify the 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, identify the number of times per day: ☐

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

☐ Nasal Suctioning, identify the 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

Medical diagnoses continued on the next page

Applicant's Name: _____ Date of Submission: _____

☐ Urostomy/Colostomy
☐ 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 for the applicant? Yes ○ No ○

1. Who has the legal authority to make the applicant's health care decisions?
   ○ Applicant
   ○ Other – If "other," please provide the following information:
   Full Name: _____
   Relationship: _____ Telephone Number: _____
2. If applicable, was the applicant or the legal representative notified that this application is being submitted to enroll him or her in the HCBA Waiver? Yes ○ No ○
   If yes, provide the name and title of the person completing the application:
   Full Name: _____
   Title: _____ Telephone Number: _____

Identify all of the applicant's 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

☐ **In-Home Supportive Services (IHSS)**; provide the following information:
Number of IHSS hours authorized per month: ☐

To obtain IHSS eligibility information, contact the County Department of Social Services office and ask for IHSS intake support.

Applicant's Name: _____ Date of Submission: _____

☐ **California Children Services (CCS)**

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

Center's Name: _____

Service Coordinator's Name: _____

☐ **Adult or Pediatric Day Health Center**; 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 provided general services and nursing support. For further information on this program, go to: https://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 primary care 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 1-877-633-7223, or go to: www.CALPACE.org

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

SCAN Health Plan is a Medicare Advantage Special Needs Plan that 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

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When complete, mail this application to the following address:

Integrated Systems of Care Division
HCBS Programs Eligibility/Intake Unit
311 South Spring Street, Ste. 800
Los Angeles, CA 90013

Or submit the application by FAX: (213) 620-4448