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. Initial Intake Form
2. Release of PHI & Authorization to Release Information
3. 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)Initial Intake 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 Face Sheet

*This form must be submitted with all required documents to avoid application delays

Personal Information

Who is completing this form: ◯ Applicant ◯ Social Worker ◯ Family ◯ Other:_____

***Name:**_____ ***Date of Birth:** _____ **Phone:**(___)___-____

☐ I agree to receive communications by text message about inquiry updates, or application updates from All Hours Adult Care. You may opt-out by replying STOP or ask for more information by replying HELP. Message frequency varies. Message and data rates may apply. You may review our Privacy Policy to learn how your data is used. Privacy Policy & Terms.

Email: _____ **Gender:** ◯ M ◯ F Preferred Language: ◯ English ◯ Spanish

Marital Status: ◯ Married ◯ Divorced ◯ Single ◯ Widowed

Referred By: ◯ Greg Steen ◯ Marnice Smith ◯ Carol Costa Smith ◯ Self ◯ Family ◯ Adult Protective Services (APS) ◯ Other:_____

Social Worker Name:_____ Email:_____ Phone:(___)___-____

Have you submitted a waitlist request to another agency? ◯ Y ◯ N - **Agency**_____

Requesting CCA Change? ◯ Y ◯ N **Requested By** ◯ Applicant ◯ Representative ◯ Facility

Insurance & Income

*FAX or Email our office IMMEDIATELY to report discharge, death or loss of Medi-Cal coverage

***First 9 digits of Medi-Cal # or Social Security #:** _____

Insurance ◯ SCAN Duals Plan (SCAN FIDE-SNP) ◯ IEHP Dual Choice ◯ Other

Pending Medi-Cal Approval? ◯ **Y** ◯ **N** **Share of Cost (SOC):** ◯ **Y** ◯ **N** ◯ **Unknown**

Total Monthly Income Amount: $_____ *If no income, representative payee required

Representative Payee: (optional unless no income)

Name:_____ Phone Number (____) - ____ - _____

Income Source: ◯ Social Security ◯ VA ◯ Retirement ◯ Other:_____

(select all that apply)

Health Information (select all that apply)

G-Tube ◯ Y ◯ N **Injections** ◯ Y ◯ N **Catheter** ◯ Y ◯ N **Wounds** (stage) ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4

Kidney Dialysis ◯ Y ◯ N **Incontinence** ◯ Full ◯ Partial ◯ None

Memory

☐ Alzheimer's ☐ Wanders ☐ Dementia ☐ Sundowners

Details:_____

Other Diagnoses

☐ Non Ambulatory ☐ TBI (current & documented) ☐ Deaf / Hard of Hearing ☐ Blind

☐ Mental Health Diagnosis *Based on DHCS guidelines, a mental health diagnosis alone does not meet the min ALW requirements

Details: _____

Behaviors:

☐ Flight Risk ☐ Aggressive ☐ Disrespectful to staff/others ☐ Inappropriate toward staff/others

Abusive? ☐ Physically ☐ Verbally ☐ History of Substance Abuse / Current frequency:_____

Assisted Living Waiver Initial Intake Form (cont)

Location

Home Address:_____ **City** _____ **Zip** _____

County where the applicant CURRENTLY resides:_____

Current Location: ☐ At Home ☐ Homeless ☐ Assisted Living Facility/ RCFE ☐ Other:_____

☐ Hospital/Acute Rehab/Skilled Nursing Facility: _____/_____

(Facility Name / Admission Date)

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

Please Identify at least 3 facilities or cities for placement where you are willing to move.

*We require the assistance of the referral source and/or social worker to secure placement

_____

POA/Authorized Representative/Alternative Contact:

Who has the legal authority to make the applicant's HEALTHCARE decisions?

***Must provide Designated Power of Attorney (DPOA) or Advanced Healthcare Directive (AHCD)**

◯ **Applicant** ◯ **Public Guardian** ◯ **Legally Authorized Representative** ☐ **Financial** ☐ **Medical** ☐ **Other**

Was the legal representative notified of this request for the ALW waitlist? ◯ **Y** ◯ **N**

Please provide the best contact number and email address to reach you:

_____ (___)-___-____ _____ _____

(Name) (Phone) (Email Address) (Relationship)

Do you wish to be present at the time of the assessment? ◯ Y ◯ N

Please indicate any other person(s)/ facility staff members you want present:

_____

Active Adult Protective Services (APS) or Ombudsman case? ◯ APS ◯ Ombudsman ◯ None

Each applicant has the right to choose an in person or virtual assessment for the program.

*Due to scheduling, the wait time for an IN-PERSON assessment may be increased

◯ I prefer an IN PERSON assessment ◯ I prefer a VIRTUAL/TELE-HEALTH assessment

Other Programs (select all that apply) *programs below the red line may delay the enrollment process

☐ Home Health Agency - Hours Per Week:

Services Received: ☐ Attendant Care ☐ Certified Home Health Aide (CHHA) Nursing: ☐ RN ☐ LVN

☐ Hospice ☐ IHSS ☐ Adult Day health Care ☐ California Community Transitions(CCT)

☐ Multipurpose Senior Services Program (MSSP) ☐ Regional Center

☐ Program of All Inclusive Care for the Elderly (PACE) ☐ Other Nursing Facility/Acute Hospital Waiver

Notes:_____

Applicant or Legal Representative Signature:_____ Date:_____

*By signing this form, I agree that the applicant or their authorized representative has expressed interest in finding placement through the ALW program and the proper legal entity has been notified of the submission of this form

Authorization for Release of Protected Health Information (PHI)

Client Name: _____ DOB: _____ 9 Digit Medi-Cal #_____

Address: _____

I authorize _____ to give and receive information and medical records listed below to:

All Hours Adult Care Care Coordinating Agency

- ☐ Order Summary (H&P)
- ☐ Assessments/Evaluations
- ☐ Needs and Services Plan
- ☐ Progress Notes
- ☐ Conservator Letters
- ☐ Medication Records
- ☐ Medical/Psychiatric Lab Results
- ☐ Discharge Paperwork
- ☐ Death Records

I understand that these records are protected under State and Federal law for privacy regulations and cannot be disclosed without written consent unless otherwise provided by law. I understand I have the right to refuse to supply the information being requested, however, without this information, I understand the agency will be limited to provide the services that I am requesting.

I understand this consent expires automatically one year after signing, which is the date next to my signature. I understand this information will be shared only with staff and oversight agencies as needed only for treatment and administration of the program. This document may be revoked at any time by the client or Conservator.

Signature of Participant or representative

_____ Date:_____

Name of representative (if not signed by client: _____ ◯ POA ◯ County Conservator

Signature of All Hours Staff/ Title: *Marie Vernon* / Program Director

PLEASE FORWARD THE EXECUTED FORM TO THE APPROPRIATE FACILITY ADMINISTRATOR WITH INSTRUCTIONS TO SEND TO ALL HOURS ASAP.

Phone: 844-657-4748 | Fax: 844-746-7646

EMAIL: info@allhoursadultcare.com

Authorization to Release Information to Family Members

Participants may allow advocates or family members such as their spouse, significant other, parents or children to call and request the status of applications, housing updates and financial information. Under the requirements for HIPAA we are not allowed to give this information to anyone without the patient's consent.

If you wish to have your application status, housing updates and/or financial information released to any family members you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize All Hours Adult Care to release my records and any information requested to the following individuals. (Leave empty if there are no authorized family members

1. _____ Relation to Participant:_____
2. _____ Relation to Participant:_____
3. _____ Relation to Participant:_____
4. _____ Relation to Participant:_____

Authorization Regarding Messages (please check all that apply)

☐ I authorize you to leave a detailed message on my home or cell number regarding my application status

☐ I authorize you to leave a detailed message on my home or cell number regarding housing updates and financial information

☐ I authorize you to leave a message with anyone who answers the phone

☐ Messages may only be left with _____

_____ _____

Participant Name (PLEASE PRINT) Date

_____

Participant or Legal Representative Signature

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 Elderly 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 Social Security Administration (SSA) publishes the maximum SSI benefits available to beneficiaries in different living arrangements.

For more information on federal SSI benefits, 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.ca.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.

2025 Room and Board Fees

If your SSI/SSP income is $1,599.07 or less, you may be responsible for **$1,420.07 per month** in room & board **fees.** If your income is $1,599.07. or more, you may be responsible for **$1,440.07 per month** in room & board fees.
Some facilities **may charge more for a private room. The extra charge for a private room is limited to **10%** of the Room and Board portion of the SSI/SSP grant. **$694.07 x .10 = $69.41***

Please note: if you are receiving Social Security benefits and you receive less than the $1,420,07 needed to participate in the ALW program, you may qualify for a benefit increase with the Social Security Administration department. You will need to let them know 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 Security Administration to see if I am eligible for an increase.
Initials

_____I agree to participate in my enrollment process including contacting Medi-Cal or the SSA for any needed updates.
Initials

_____ _____
Applicant or Representative Signature Date

Non-Medical Out-of-Home Care (NMOHC)
Payment Standard for Individuals-Licensed Facility or
Without In-Kind Room and Board
Effective January 1, 2025

Source	Amount
Supplemental Security Income (SSI)	$ 967.00
State Supplementary Payment (SSP)	$ 632.07
Total NMOHC Payment Standard	$ 1,599.07*

The NMOHC Payment Standard includes the following components:

Component	Amount
Room and Board	$ 694.07
Care and Supervision (maximum)	$ 726.00
Amount Payable for Basic Services	**$1,420.07[1]**
Personal and Incidental Needs Allowance (minimum) (Must be provided to the recipient)	$ 179.00
Total NMOHC Payment Standard	$1,599.07*

*This total NMOHC payment standard is doubled for SSI/SSP couples

[1]NOTE: Recipients who have income in addition to their SSI/SSP check (for example, a pension, Social Security retirement, or disability benefits) can be charged the $1,420.07 amount for basic services plus an additional $20. Because federal rules do not count the first $20 of a recipient's income against his/her SSI/SSP grant, an SSI/SSP recipient with other income has an extra $20 that people who receive only an SSI/SSP check do not have. Neither federal nor state law restricts the recipient in how this additional $20 amount is spent. Thus, if the recipient agrees in the admission agreement to pay the additional $20 for basic services, the facility may charge the additional amount.