Jennifer Kent
DIRECTOR

State of California-Health and Human Services Agency

Department of Health Care Services

EDMUND G. BROWN JR.
GOVERNOR

Assisted Living Waiver (ALW) Waitlist Request

To request a place on the ALW waitlist, please complete the following information and submit to DHCSALWCCAassessments@dhcs.ca.gov .

Member's Name: _____ **Home Phone:** (____) _____
Date of Birth: _____ Male ☐ Female ☐ Married: ☐ Yes ☐ No

9-digit Medi-Cal Number_____

Address:_____ **City:** _____ **ZIP:** _____
County in which the applicant currently resides _____
Care Coordination Agency (CCA) Name: Partners in Care Foundation

Where is the applicant currently residing? ☐ Acute Hospital ☐ At home ☐ Homeless
☐ RCFE ☐ Skilled Nursing Facility ☐ Other: _____
Please Specify

Who has the legal authority to make the applicant's health care decisions?
☐ Applicant ☐ Other: _____ _____ (____) _____
Name Relationship Telephone Number
Was the legal representative notified of this request for the ALW waitlist? ■ Yes ☐ No

Is there Adult Protective Services involvement? ☐ Yes ☐ No
If yes, please attach supporting documentation.

Please identify all current programs and services:
See Instructions for ALW Waitlist Request Form for more information on the programs listed below.

☐ **Adult Day Health Care** ☐ **California Community Transitions (CCT)** ☐ **Cal Medi-Connect***

☐ **Home Health Agency** – Hours per week: _____Type of services received: ☐ Attendant Care
☐ Certified Home Health Aide (CHHA) Nursing: ☐ RN ☐ LVN

☐ **Hospice** ☐ **In-Home Supportive Services (IHSS)** - Hours Authorized Per Month: _____

☐ **Multipurpose Senior Services Program (MSSP)** ☐ **Nursing Facility/Acute Hospital Waiver (NF/AH)**

☐ **Program of All Inclusive Care for the Elderly (PACE)** ☐ **Regional Center**

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

When completed, please return this form to the ALW inbox listed above. Should the applicant relocate, have a significant change in health care needs, or have a change in Medi-Cal insurance status, please contact ALW to remove the member's name from the waitlist.

Partners in Care
FOUNDATION
changing the shape of health care

732 Mott Street
Suite 150
San Fernando, CA 91340
Phone 818-837-3775
Fax 818-837-3799
www.picf.org

Pre-Screening Assessment

Applicant's Name:	Date:
Person filling out application (if applicable): Email address:	Relationship to Applicant: Phone number:

Applicant's Current Location
(Please check the most applicable box):

☐ Home/Apt ☐ Assisted Living ☐ Nursing Home ☐ PSH ☐ Hospital/ER

Address:	Phone Number:
13 Digit Medi-Cal Number:	Applicant's Language:
Date of Birth:	Gender Identity:
Total Monthly Income:	SSI Monthly Income:

Emergency Contact Information:

Emergency Contact Name:	
Mailing Address:	
Email Address:	
Phone Number:	

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Conservator Information:

Is there a Conservator, Public Guardian, or Healthcare POA? Yes ☐ No ☐

If so, indicate Name:	
Phone number:	
Email:	

Attach a copy of the notarized LEGAL document with ALL required signatures

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Current Health Issues/Medication List/FULL Diagnoses is needed

Please list or attach all current medications that are being taken by applicant

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Does the Applicant have or use any of the following? Check all that apply	Yes	No
Stage 3, 4 or Unstageable Pressure Sores (Bed Sores)	☐	☐
Nasogastric Tubes (NG Tube)	☐	☐
Ventilator Dependency	☐	☐
BiPap Dependency w/out the ability to self-administer	☐	☐
Coma	☐	☐
Continuous IV or TPN (Total Parental Nutrition) therapy	☐	☐
Chemotherapy	☐	☐
Wound Vacuum Therapy	☐	☐
Active Communicable Tuberculosis	☐	☐
Restraints (except as permitted by licensing for RCFE clients)	☐	☐
Hospice	☐	☐
Requires Hoyer Lift	☐	☐
Gastronomy Tubes	☐	☐

For the following, please check all that apply to applicant's needs

1. **Activities of Daily Living:**

   ☐ Dressing ☐ Bathing ☐ Toileting ☐ Eating ☐ Mobility ☐ Transferring

   ☐ Incontinence Care ☐ Medication Management

2. **Cognitive Impairment:**

   ☐ Alzheimer's ☐ Dementia ☐ Confused ☐ Wandering/Exiting ☐ No Impairment

3. **Mental Health Diagnosis:**

   ☐ Anxiety ☐ Bipolar ☐ Depression ☐ Schizophrenia ☐ No Diagnosis

Once completed, please submit to secure fax: ***818-979-0537*** *or secure email:* ***alw@picf.org***