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 info@guidantcare.com

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: GUIDANT CARE MANAGEMENT

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.

Date: _____

Name of Medi-Cal Beneficiary: _____
first middle last

Current Address: _____

13 digit Medi-Cal Number: _____ Card Issue Date: _____

Total Monthly Income: $_____ Monthly SSI Income: $_____

Social Security Number: _____

Name of person completing form: _____

Relationship to applicant? _____

Daytime Phone: (____) _____ Alternate Daytime Phone: (____) _____

Email: _____

Are you the Responsible Party? Y N If yes, do you have Medical Power of Attorney? Y N

(please attach copy of Advance Health Care Directive/MPOA)

List of Primary Diagnoses:

_____

_____

_____

_____

List of Prescription medications:

_____

_____

_____

_____

_____

_____

Please check all that apply:

1. Activities of Daily Living (check all that apply):

☐ Dressing ☐ Bathing ☐ Toileting ☐ Eating ☐ Mobility

☐ Transferring ☐ Incontinence Care ☐ Medication Management

2. Cognitive Impairment (check all that apply): ☐ No Impairment

☐ Alzheimer's ☐ Dementia ☐ Confused ☐ Wandering/Exiting

3. Mental Health Diagnosis: ☐ No Diagnosis

☐ Anxiety ☐ Bipolar ☐ Depression ☐ Schizophrenia

For Office Use Only:

_____

_____

_____