Care Coordination Agency
For the
"Assisted Living Waiver Program"

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HUNTINGTON
HOME CARE

Application Form

Name: ______________________ DOB: __________ Age: _____ Gender: __________

Applicant's Phone #: ____________________ Email: ______________________________

Medi-Cal #:__________________________ Medicare # (If available):____________________

Marital Status: ________ Day programs attended? ______________________Days/Hours: ________

Other Medi-Cal / Medicare services being received? ______________________Days/Hours: ________

Total Monthly Income: $__________ Income Type(s): ☐ SS ☐ SSD ☐ SSI ☐ Other __________

Applicant's primary language? __________________ Can the applicant speak English? ☐ Yes ☐ No

Is the applicant capable of making decisions about their Health Care Services? ☐ Yes ☐ No

Does the applicant have a legal representative for Advance Health Care Directives? ☐ Yes ☐ No

Family/Contact 1: __________________ Phone number: ______________ Relationship__________

Email: ______________________________________ Other Phone Number: ____________________

Family/Contact 2: __________________ Phone number: ______________ Relationship__________

Email: ______________________________________ Other Phone Number: ____________________

Applicant is currently residing at: ☐ Home ☐ B&C ☐ Assisted Living ☐ Nursing Home ☐ Hospital

Address of Current Residence: ____ Apt #:__________

City:__________________________ State:_______ Zip Code:________ County: ______________

Name of Facility (If Applies): ____

What **County** are you looking to reside in? (Please keep in mind that we do not service all waiver counties)

☐ Los Angeles ☐ San Bernardino ☐ Riverside ☐ Orange ☐ San Diego ☐ Other

In what City or Area are you looking for placement: ____

List three facilities that that are options for placement where you would like to reside if any: (Optional)

Facility (1st) : ____________________________Contact:______________Phone:____________

Facility (2nd) : ____________________________Contact:______________Phone:____________

Facility (3rd) : ____________________________Contact:______________Phone:____________

How did you hear about **Huntington Home Care** and the **ALW Program**? Check all that apply:

☐Medi-Cal Website ☐Placement Agency ☐Assisted living Facility ☐Friend/Family

☐Social Worker ☐Marketing Group ☐Skilled Nursing Facility ☐Other

Name of facility, Agency or Person who referred you: ____

1. Is the applicant on Hospice? ☐ Yes ☐ No If Yes, is it being covered by Medi-Cal? ☐ Yes ☐ No

2. Is the applicant receiving Home Health or Physical Therapy services? ☐ Yes ☐ No

3. Has the applicant been diagnosed with Dementia/Alzheimer's disease? ☐ Yes ☐ No

4. Does the applicant have a history of verbally abusive or combative behavior? ☐ Yes ☐ No
If yes, is it related to Dementia/Alzheimer? ☐ Yes ☐ No
Briefly describe behavior: ______________________________

____

5. Does the applicant suffer from any of the following conditions (check all that apply):

☐ Shortness of breath with activity ☐ Vertigo ☐ Wandering behavior
☐ Shortness of breath requiring oxygen ☐ Dizziness ☐ Impaired judgment
☐ Loss of balance ☐ Forgetfulness ☐ Difficulty remembering

6. Does the applicant have any abrasions, rashes or itches? ☐ Yes ☐ No
If yes, what treatment is being provided: ______________________________

____

7. Does the applicant have any open sores, skin tears, cuts or lesions? ☐ Yes ☐ No
If yes, what treatment is being provided: ______________________________

____

8. Does the applicant need an assistive device to ambulate? ☐ Yes ☐ No
If yes, check all that apply:

☐ Cane ☐ Walker ☐ Wheel Chair (W/C) ☐ Motorized W/C ☐ Safety rails on walls

9. Does the applicant need assistance with ambulating? ☐ Yes ☐ No
If yes, explain how (ex: he/she need to be pushed in w/c): ______________________________

____

10. Does the applicant need help getting out of bed and into a chair? (transferring) ☐ Yes ☐ No
If yes, describe assistance provided: ______________________________

____

11. Does the applicant need help turning or moving in bed? ☐ Yes ☐ No

12. Does the applicant need assistance with toileting? (transferring, cleaning) ☐ Yes ☐ No
If yes, describe assistance provided and how often: ______________________________

____

13. Does the applicant wear adult briefs, diaper, or pads? ☐ Yes ☐ No
If yes, describe why: ______________________________

____

14. Does the applicant need help changing adult briefs, diaper, or pads? ☐ Yes ☐ No
If yes, describe assistance provided and how often: ______________________________

____

15. Does the applicant need help getting dressed? ☐ Yes ☐ No
If yes, describe assistance provided and how often: ______________________________

____

16. Does the applicant need help with bathing or taking a shower? (transferring) ☐ Yes ☐ No
If yes, describe assistance provided and how often equipment used if any: ______________________________
____

17. How many medications is the applicant currently taking: _______ (make sure to provide a list of medication)

18. Does the applicant need help with medication management/administration? ☐ Yes ☐ No
If yes, please answer the following questions?
- Does the applicant know what the medications are taken for? ☐ Yes ☐ No
- Does the applicant know how to take the medications? ☐ Yes ☐ No
- Does the applicant know how often to take the medications? ☐ Yes ☐ No

19. Is the client Diabetic? ☐ Yes ☐ No
If yes, please answer the following questions?
- Does the applicant know how to monitor his/her blood sugar levels? ☐ Yes ☐ No
- Does the applicant take insulin? ☐ Yes ☐ No
- Does the applicant receive injections? ☐ Yes ☐ No
- Is the applicant able to administer his/her own injections? ☐ Yes ☐ No

20. Does client have a special diet that needs to be followed? ☐ Yes ☐ No
If yes, describe the special diet: ____
____

21. Does the applicant need help eating? (ex: feeding him/her) ☐ Yes ☐ No
If yes, describe assistance provided and how often: ____
____

22. Does the applicant need help with transportation? ☐ Yes ☐ No
If yes, check all that apply: ☐ Doctors appointments ☐ Shopping ☐ Senior Centers ☐ Other
If other was checked, briefly describe: ____
On a monthly average about how many times would transportation be needed: ________

Thank you for taking the time to complete this questionnaire. This questionnaire will be reviewed to determine the candidate's pre-eligibility for the Assisted Living Waiver Program. If the candidate meets the criteria for the program, our registered nurse will call to set up an appointment to conduct a face to face assessment.

By signing below, the Applicant or Legal Representative acknowledges that:
- ✓ He/ She has a general understanding of the process for participating for the "Assisted Living Waiver Program"
- ✓ He/ She is interested in participating in the "Assisted Living Waiver Program"
- ✓ He/ She is requesting that an assessment be conducted by Huntington Home Care to determine eligibility for the "Assisted Living Waiver Program"
- ✓ He/ She authorize the release of medical records to Huntington Home Care's evaluating staff.

____
Applicant's Name (Print) Signature Date

____
Legal Representative's Name (Print) Signature Date

Please make sure that all requested documents in the "Instructions Sheet" are included when submitting this application. An assessment will <u>NOT</u> be scheduled until all the documents are received. The date received on our database will be identified as the date that we receive a complete application packet.