



## 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 favor llámenos al número siguiente: 1 (833) 503-5910*

**Applicant's name:**

**Home phone:**  **Date of birth:**  **Sex:** Male  Female

**Married:** Yes  No  **Age:**  **Transgender M to F:**  **Transgender F to M:**

**County of Residence:**

### Where is the applicant currently residing?

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 facility:**

**Facility name:**

**Facility city:**

Other, type of residence:

**Other name:**

**Other city:**

**Date of admission, if applicable:**

### Applicant's Current Mailing Address

**Street:**  **Apt./Ste./Room**

**City:**

**ZIP Code:**

### Street Address (if different from Mailing Address)

**Street:**  **Apt./Ste./Room**

**City:**

**ZIP Code:**

**Date of Submission:**

Applicant's Name:

Date of Submission:

**Health Care Insurance**

**Medi-Cal?** Yes  No

If yes, Medi-Cal number:  (located on Medi-Cal Beneficiary I.D. Card (BIC))

**Medicare?** Yes  No

If yes, what part? Part A  Part B  Part A & B  Part D

**Other Insurance?** Yes  No

If yes, name of the insurance:

**List the applicant's current medical diagnoses (main illness or injury):**

*Check the boxes 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, 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, number of times per day:

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

Nasal Suctioning, 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

Urostomy/Colostomy

*Medical diagnoses continued on the next page*

Applicant's Name:  Date of Submission:

- 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

**If this application is 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, provide the following information:

Name:   
Relationship:   
Telephone Number:

2. If applicable, was the applicant or the legal representative notified that this application was submitted to enroll the applicant in the *HCBA Waiver*? Yes  No

If yes, provide the name and title of person completing the application:

Name:   
Title:   
Telephone Number:

**Identify all of your 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 applicant's county of Department of Social Services office and ask for the IHSS Intake Department.*

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 Care**, 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 provides general services and nursing support. For further information on this program, go to: <http://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 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 1-888-633-7223, or go to: [www.CALPACE.org](http://www.CALPACE.org).*

**Senior Care Action Network (SCAN)**

*SCAN Health Plan, as a Medicare Advantage Special Needs Plan, 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](http://www.scanhealthplan.com).*

---

When complete, mail this application to the following address:

**San Ysidro Health  
HCBA Waiver Agency  
1800 Maxwell Road  
Chula Vista, CA 91911**

Or submit the application by secure FAX: (619) 205-6323

*As a contracted delegate of the Department of Health Care Services, San Ysidro Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.*