Assisted Living Waiver Program for Medi-Cal Recipients

The Assisted Living Waiver Program (ALW) is an alternative to long-term placement in a skilled nursing facility and is presently available to Medi-Cal recipients in Sacramento County. As a Care Coordination Agency for the ALW program, Elder Options conducts in-takes, establishes preliminary eligibility, conducts initial R.N. assessments, assists families in finding appropriate placement and provides monthly face-to-face care coordination for all approved clients.

Program Requirements:

- Full Scope Medi-Cal
- Source of Income (Social Security, Pension, SSI)

ALW Eligibility:

- Medi-Cal- no share of cost (SOC)
- Meeting the ADL/IADL Criteria
- Desire to move into an Assisted Living Facility (Sacramento County)

Elder Options, Inc. contracts with the California Department of Health Care Services (DHCS) to provide care coordination for the Assisted Living Waiver (ALW) Program. Elder Options has been participating in the ALW program since its initiation in 2006. Our staff is well versed in the program and can provide support to clients, families, and administrators.

REQUIRED DOCUMENTS

Please call our office to have forms emailed to you.

- ☐ Individuals Full Name
- ☐ Date of Birth
- ☐ Medi-Cal Number
- ☐ Address & Telephone Number
- ☐ Total Monthly Income
- ☐ ADL status
- ☐ Completed 602A (Physician Statement)
- ☐ E-Tar and Face Sheet (SNF only)
- ☐ Power of Attorney Documents (if any)
- ☐ At least 2 facility choices (we strongly recommend visiting sites in-person)

Elder Options, Inc.

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Setting the Standard for Care Managed Home Care, Since 1988.

FACT SHEET FOR NEW PARTICIPANTS

THE ASSISTED LIVING WAIVER (ALW) PROGRAM

- *Making affordable housing with personal and health-related services available to seniors and individuals with disabilities*
- *Maximizing dignity, privacy, independence and autonomy*
- *Providing an alternative to long-term care placement in a nursing home*

The ALWP is designed to assist Medi-Cal beneficiaries to remain in their community as an alternative to residing in a licensed health care facility. The program provides specified benefits to eligible seniors and persons with disabilities. Medi-Cal reimburses for the services provided to residents enrolled in the ALW, however, the resident is responsible to pay for their own room and board. For 2015, for those with SSI income of $1,145.00, room and board is $1,014.00 and those with income of $1,165.00 or greater, room and board is $1,034.00.

The ALW is an alternative to long-term placement in a nursing facility and is presently available in the following counties: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Joaquin, San Mateo, Santa Clara, and Sonoma. The ALW is currently enrolling beneficiaries residing in skilled nursing facilities and in the community, into licensed Residential Care Facilities (RCF) and Public Subsidized Housing (PSH).

DETERMINING MEDI-CAL ELIGIBILITY

Assisted Living Waiver (ALW) eligible individuals are those who are enrolled in Medi-Cal and meet the level of care provided in a nursing facility due to their medical needs. Individuals with Medi-Cal benefits that include a share of cost may not be enrolled in the ALW. Please contact your local county office to obtain information about how to apply for Medi-Cal benefits. Please note: the state does not determine eligibility for Medi-Cal benefits.

DETERMINING LEVEL OF CARE ELIGIBILITY

Determination of care needs is done by registered nurses (RN) employed by a Care Coordination Agency (CCA). A list of ALW CCAs for each of the participating counties is available on our website. Click on the Care Coordination Agencies link and contact one of the CCAs in your county of residence to request an assessment. A pre-screening "assessment" will be done over the phone before an appointment is set up for the actual assessment.

Elder Options, Inc.
Care Management and Home Care

ASSISTED LIVING WAIVER INTAKE FORM

CLIENT INFORMATION (person needing program)

Residing:
☐ Alone ☐With Family ☐Assisted Living ☐SNF ☐Other

Name:_____ DOB: _____ Does client have POA?: Yes No

Address: _____ Phone Number: _____
(Include facility name if applicable)

Medi-Cal Number: _____ Issue Date: _____

Share of Cost? Yes No Monthly Income: _____ SS/SSI/Disability

Diagnosis (use actual and detailed diagnosis information –whatever info you can think of):

Approximate Weight: _____ Approximate Height: _____

Open Wounds: Yes No If Yes, where and why? _____

Diabetes: Yes No If Yes, do they require injections? Yes No

If Yes, are they administering their own injections and taking their own blood sugar levels? Yes No

Using a Hoyer Lift: Yes No

Is the client considered physically non-ambulatory (requiring more than a cane to move or walk around)? Yes No

Can the client mentally and physically leave a building without assistance? Yes No

If client needs assistance what type?

Is the client a fall's risk? Yes No Does the client have a history of falls? Yes No

Primary Care Physician: _____ Phone Number: _____

Activities of Daily Living (ADL's) –SCORE USING RUBRIC:
Scoring (Must be scored 0-4):
0 Independent-No assistance or oversight
1 Supervision-Oversight, encouragement, cueing, or set up assistance needed
2 Limited Assistance- Motivated by activity, but receives physical assistance
3 Extensive Assistance-Performs part of activity, weight bearing support is provided
4 Total Hands On-Needs complete hands on assistance to complete activity.
* Must require assistance with numerous ADL activities in order to qualify.

_____ **Bed Mobility:** Can the individual move and position themselves in bed?
_____ **Transferring:** Can the client safely transfer between surfaces, i.e. bed to chair, etc?
_____ **Ambulation:** Can the client move about their room or other areas of the residence safely, i.e. walk independently to dinner, for a walk, etc.
_____ **Dressing:** How much assistance is required for dressing or undressing?
_____ **Eating:** Can the client eat if a meal is prepared? Is additional assistance needed, i.e. cutting of food, feeding, etc.
_____ **Toilet Use:** Can client toilet independently? Assistance needed with transfers on and off? Assistance with depends changes?
_____ **Personal Hygiene:** Can client maintain personal hygiene independently? Are cues required?
_____ **Bathing:** Assistance needed for full bath and shower, i.e. set up, stand by, etc?

Assistive Devices:
☐ Walker ☐ Wheel Chair ☐ Bed Rails ☐Shower Chair ☐ Cane
☐ Feeding Device ☐ Dressing Device ☐ Other

Continence:
☐ Bowel ☐ Bladder Assistance Needed, how? _____

Medication Information:
_____ Total Number of Medications (Include PRN, OTC, and Prescribed)

Injections Required: Yes No Able to Administer Injections: Yes No

Medication Allergies: Yes No List: _____

Food Allergies: Yes No List: _____

Requires Assistance: Yes No How: _____

Mental Health/Cognitive Impairment:

☐ Dementia ☐ Alzheimer's ☐ Depression ☐ Bi Polar ☐ Anxiety
☐ Schizophrenia ☐ Developmental Delay ☐ Other: _____

POA OR CLIENT REPRESENATIVE INFORMATION

Name: _____ Relationship: _____ POA: Yes No

Address: _____
(Only if client is living with caller or caller is POA for healthcare)

Home Phone: _____Cell Phone: _____ Email: _____

How did you hear about the ALW Program: _____

Have you looked at ALW facilities? _____

Is the individual aware and willing to enter the ALW program? _____ YES _____ NO

Chosen Facilities (from list, need top two choices): _____

ADDITIONAL NOTES:

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Care Management and Home Care

APPROVED ALW FACILITIES-SACRAMENTO COUNTY

Facility Name	Address	Phone Number	Capacity	Comments
A Cozy Retirement Home	8781 Kelsey Drive, Elk Grove	(916) 667-8821	6	
A Cozy Retirement Home II	8609 Banff Vista Dr., Elk Grove	(916) 502-3008	6	
Camelot Care Home #1	8006 Bucks Harbor Way, Sacramento	(916) 689-5491	6	
Camelot Care Home #2	9237 Crosscourt Way, Elk Grove	(916) 688-3214	6	
Camelot Care Home #3	8604 Banff Vista Drive, Elk Grove	(916) 686-1253	6	
Camelot Care Home #4	974 Park Ranch Way, Sacramento	(916) 391-1763	6	
Caring Families EGF	9308 Elk Grove-Florin Rd, Elk Grove	(916) 685-1134	10	Locked Facility
Caring Families BV1	8712 Bray Vista Way, Elk Grove	(916) 685-0404	10	Locked Facility
Caring Families BV2	8716 Bray Vista Way, Elk Grove	(916) 686-0420	10	Locked Facility
Citrus Heights Terrace	7952 Old Auburn Road, Citrus Heights	(916) 727-4400	6	Hoyer Available
Country Club Manor	2100 Butano Drive, Sacramento	(916) 481-9240	112	
Eskaton Fountainwood	8773 Oak Avenue, Orangevale	(916) 988-2200	32	
Felicia's	9495 Deanna Avenue, Orangevale	(916) 987-1843	6	
Gramercy Court	2200 Gramercy Drive, Sacramento	(916) 482-2200	85	
Hillside Manor	5125 Chicago Avenue, Fair Oaks	(916) 965-7045	6	
Jerida Lane	8830 Jerida Lane, Fair Oaks	(916) 836-6151	6	
Living Waters	7504 Chipmunk Way, Citrus Heights	(916) 722-4056	6	
Nazareth Park Place	1922 Morse Avenue, Sacramento	(916) 482-7745	160	
The Residences at Fair Oaks	4804 Chicago Avenue, Fair Oaks	(916) 967-2439	6	
St. Francis	6254 66th Avenue, Sacramento	(916) 393-2324	121	
Sagebrook	7125 Fair Oaks Blvd, Carmichael	(916) 481-7105		Pending ALW Approval
Seva Assisted Living	421 San Juan Rd, Sacramento	(916) 993-8435	48	
Sky Park Gardens	5510 Sky Parkway, Sacramento	(916) 422-5650	144	Locked

Facility Name	Address	Phone Number	Capacity	Comments
Stacie's Chalet	9847 Folsom Blvd, Sacramento	(916) 363-9468	90	Locked-On Hold
Sunrise Guest Home 1	8705 Great Court, Elk Grove	(916) 685-6910	6	
Sunrise Guest Home II	8818 Sharkey Avenue, Elk Grove	(916) 714-0853	6	
Walnut House	3401 Walnut Ave, Carmichael	(916) 483-6613	110	
Zenith Care Home	8302 Foss Lake Way, Antelope	(916) 725-4872	6	

PHYSICIAN'S REPORT FOR RESIDENTIAL CARE FACILITIES FOR THE ELDERLY (RCFE)

I. FACILITY INFORMATION *(To be completed by the licensee/designee)*

1. NAME OF FACILITY		2. TELEPHONE ( )
3. ADDRESS	CITY	ZIP CODE

4. LICENSEE'S NAME	5. TELEPHONE ( )	6. FACILITY LICENSE NUMBER

II. RESIDENT/PATIENT INFORMATION *(To be completed by the resident/resident's responsible person)*

1. NAME	2. BIRTH DATE	3. AGE

III. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(To be completed by resident/resident's legal representative)

I hereby authorize release of medical information in this report to the facility named above.

1. SIGNATURE OF RESIDENT AND/OR RESIDENT'S LEGAL REPRESENTATIVE

2. ADDRESS	3. DATE

IV. PATIENT'S DIAGNOSIS *(To be completed by the physician)*

NOTE TO PHYSICIAN: The person named above is either a resident or prospective resident of a residential care facility for the elderly licensed by the Department of Social Services. The license requires the facility to provide primarily non-medical care and supervision to meet the needs of that person. THESE FACILITIES DO NOT PROVIDE SKILLED NURSING CARE. The information that you provide about this person is required by law to assist in determining whether the person is appropriate for care in this non-medical facility. It is important that all questions be answered.
(Please attach separate pages if needed.)

1. DATE OF EXAM	2. SEX	3. HEIGHT	4. WEIGHT	5. BLOOD PRESSURE

6. **TUBERCULOSIS (TB) TEST**

a. Date TB Test Given	b. Date TB Test Read	c. Type of TB Test	d. Please Check if TB Test is: ☐ Negative ☐ Positive

e. Results: mm _____ f. Action Taken (if positive): _____

_____

g. Chest X-ray Results: _____

h. Please Check One of the Following:

☐ Active TB Disease ☐ Latent TB Infection ☐ No Evidence of TB Infection or Disease

7. PRIMARY DIAGNOSIS:

a. Treatment/medication (type and dosage)/equipment:

b. Can patient manage own treatment/medication/equipment? ☐ Yes ☐ No

c. If not, what type of medical supervision is needed?

8. SECONDARY DIAGNOSIS(ES):

a. Treatment/medication (type and dosage)/equipment:

b. Can patient manage own treatment/medication/equipment? ☐ Yes ☐ No

c. If not, what type of medical supervision is needed?

9. CHECK IF APPLICABLE TO 7 OR 8 ABOVE:

☐ Mild Cognitive Impairment: Refers to people whose cognitive abilities are in a "conditional state" between normal aging and dementia.

☐ Dementia: The loss of intellectual function (such as thinking, remembering, reasoning, exercising judgement and making decisions) and other cognitive functions, sufficient to interfere with an individual's ability to perform activities of daily living or to carry out social or occupational activities.

10. CONTAGIOUS/INFECTIOUS DISEASE:

a. Treatment/medication (type and dosage)/equipment:

b. Can patient manage own treatment/medication/equipment? ☐ Yes ☐ No

c. If not, what type of medical supervision is needed?

11. ALLERGIES:

a. Treatment/medication (type and dosage)/equipment:

b. Can patient manage own treatment/medication/equipment? ☐ Yes ☐ No

c. If not, what type of medical supervision is needed?

12. OTHER CONDITIONS:

a. Treatment/medication (type and dosage)/equipment:

b. Can patient manage own treatment/medication/equipment? ☐ Yes ☐ No

c. If not, what type of medical supervision is needed?

13. PHYSICAL HEALTH STATUS	YES	NO	ASSISTIVE DEVICE (If applicable)	EXPLAIN
a. Auditory Impairment				
b. Visual Impairment				
c. Wears Dentures				
d. Wears Prosthesis				
e. Special Diet				
f. Substance Abuse Problem				
g. Use of Alcohol				
h. Use of Cigarettes				
i. Bowel Impairment				
j. Bladder Impairment				
k. Motor Impairment/Paralysis				
l. Requires Continuous Bed Care				
m. History of Skin Condition or Breakdown				

14. MENTAL CONDITION	YES	NO	EXPLAIN
a. Confused/Disoriented			
b. Inappropriate Behavior			
c. Aggressive Behavior			
d. Wandering Behavior			
e. Sundowning Behavior			
f. Able to Follow Instructions			
g. Depressed			
h. Suicidal/Self-Abuse			
i. Able to Communicate Needs			
j. At Risk if Allowed Direct Access to Personal Grooming and Hygiene Items			
k. Able to Leave Facility Unassisted			

15. CAPACITY FOR SELF-CARE	YES	NO	EXPLAIN
a. Able to Bathe Self			
b. Able to Dress/Groom Self			
c. Able to Feed Self			
d. Able to Care for Own Toileting Needs			
e. Able to Manage Own Cash Resources			

16. MEDICATION MANAGEMENT	YES	NO	EXPLAIN
a. Able to Administer Own Prescription Medications			
b. Able to Administer Own Injections			
c. Able to Perform Own Glucose Testing			
d. Able to Administer Own PRN Medications			
e. Able to Administer Own Oxygen			
f. Able to Store Own Medications			

17. AMBULATORY STATUS:

a. 1. This person is able to independently transfer to and from bed: ☐ Yes ☐ No

2. For purposes of a fire clearance, this person is considered:
☐ Ambulatory ☐ Nonambulatory ☐ Bedridden

Nonambulatory: A person who is unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshal, or to an oral instruction relating to fire danger, and/or a person who depend upon mechanical aids such as crutches, walkers, and wheelchairs.
Note: A person who is unable to independently transfer to and from bed, but who does not need assistance to turn or reposition in bed, shall be considered non-ambulatory for the purposes of a fire clearance.

Bedridden: For the purpose of a fire clearance, this means a person who requires assistance with turning or repositioning in bed.

b. If resident is nonambulatory, this status is based upon:

☐ Physical Condition ☐ Mental Condition ☐ Both Physical and Mental Condition

c. If a resident is bedridden, check one or more of the following and describe the nature of the illness, surgery or other cause:

☐ Illness: _____

☐ Recovery from Surgery: _____

☐ Other: _____

NOTE: An illness or recovery is considered temporary if it will last 14 days or less.

d. If a resident is bedridden, how long is bedridden status expected to persist?

1. _____ (number of days)

2. _____ (estimated date illness or recovery is expected to end or when resident will no longer be confined to bed)

3. If illness or recovery is permanent, please explain: _____

_____

_____

_____

e. Is resident receiving hospice care?

☐ No ☐ Yes If yes, specify the terminal illness: _____

18. PHYSICAL HEALTH STATUS: ☐ Good ☐ Fair ☐ Poor

19. COMMENTS:

20. PHYSICIAN'S NAME AND ADDRESS (PRINT)

21. TELEPHONE ( )	**22. LENGTH OF TIME RESIDENT HAS BEEN YOUR PATIENT**
23. PHYSICIAN'S SIGNATURE	**24. DATE**