COUNTY of VENTURA
Human Services Agency
Area Agency on Aging

Home and Community-Based Alternatives (HCBA) Waiver Application

►Para recibir esta información en español, por favór llámenos al número siguiente: (805) 477-7300.
Complete and submit this six-page application to apply for the HCBA Waiver.

Applicant's Name:

Phone Number: **Date of Birth:** **Age:** **Married:** ☐ Yes ☐ No

Gender: ☐ Male: ☐ Female: ☐ Transgender Male to Female: ☐ Transgender Female to Male

Date of Application Submission:

County of Residence:

Type of Residence (type of housing):

☐ 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 hospital:

Facility name:

Facility city:

☐ Other – identify type of residence:

Other name:

Other city: Date of admission (if applicable):

Applicant's Current Mailing Address:

Street: Apt./Ste/Room:

City: Zip Code:

Applicant's Name: Date of Submission:

Applicant's Current Physical Address (if different from mailing address):

Street: Apt./Ste/Room:

City: Zip Code:

Healthcare Insurance:

Medi-Cal? ☐ Yes ☐ No

If "yes", provide the applicant's Medi-Cal number / Client Index Number (CIN):

(Medi-Cal identification numbers are found on the Medi-Cal Benefits Identification Card (BIC))

Medicare: ☐ Yes ☐ No

If "yes", which part? ☐ Part A ☐ Part B ☐ Part A&B ☐ Part D

Other Insurance? ☐ Yes ☐ No

If "yes", name of insurance:

Applicant's Current Medical Diagnosis: What is the applicant's current medical diagnosis (main illness or injury)?

Additional Medical Need(s):

Check the box(es) 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:
- ☐ Tracheostomy
- ☐ Continuous Positive Airway Pressure (CPAP) Device, identify the number of hours the applicant uses the CPAP each day:
- ☐ Tracheal Suctioning, identify the 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:
- ☐ Oral Suctioning, identify the number of times per day:
- ☐ Respiratory Treatments, identify the number of treatments the applicant receives each day:
- ☐ Nasal Suctioning, identify the number of times per day:

Applicant's Name: _____ Date of Submission: _____

- ☐ 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
- ☐ 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 _____

Applicant's Name: Date of Submission:

Is this application 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," please provide the following information:

Full Name:

Relationship: Telephone Number:

If applicable, does this applicant have signed documentation for the legal representative or Durable Power of Attorney for healthcare purposes:

☐ Yes ☐ No

If applicable, was the applicant or the representative notified the application was submitted to enroll him or her in the HCBA Waiver? ☐ Yes ☐ No

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

Full Name:

Title: Telephone Number:

Identify all of the applicant's current service providers:

☐ **Home Health Agency (HHA);** provide the following information:

HHA Name:

Number of hours of home health services received each week:

Types of services received: ☐ Attendant Care

☐ Certified Home Health Aide (CHHA)

☐ Nursing Services, provided by an: ☐ RN ☐ LVN

☐ **In-Home Supportive Services (IHSS);** provide the following information:

Number of IHSS hours authorized per month:

To obtain IHSS eligibility information, contact the County Department of Social Services office and ask for IHSS intake support.

☐ **California Children Services (CCS)**

☐ **Regional Center;** provide the following information:

Center's Name:

Service Coordinator's Name:

Applicant's Name: _____ Date of Submission: _____

☐ **Adult (CBAS) or Pediatric Day Health Center;** 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

Does the school provide a non-medical attendant during school hours: ☐ 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:

https://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 primary care 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 1-877-633-7223, or go to https://CALPACE.org.

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

SCAN Health Plan is a Medicare Advantage Special Needs Plan that 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:

https://www.scanhealthplan.com

When complete, mail this application to the following address:

Ventura County Area Agency on Aging
646 County Square Drive, Suite 100, Ventura, CA 93003

Or submit the application by secure FAX: (805) 477-7312

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

HOME AND COMMUNITY-BASED ALTERNATIVES (HCBA) WAIVER AGENCY COMPLIANCE WITH THE DEPARTMENT OF HEALTH CARE SERVICES' (DHCS) NON-DISCRIMINATION POLICY AND LANGUAGE ACCESS

As a DHCS-delegated administrator of the HCBA Waiver, Ventura County Area Agency on Aging (VCAAA) complies with applicable Federal and State civil rights laws. VCAAA does not unlawfully discriminate on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation. VCAAA does not unlawfully exclude people or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation.

Ventura County Area Agency on Aging:

- Provides free aids and services to people with disabilities to communicate effectively with VCAAA, such as:
    - Qualified sign language interpreters
    - Written information in other formats such as large print, audio, accessible electronic formats and other formats
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, call VCAAA at (800) 510-2020 or email lois.vcaaa@ventura.org.

If you believe VCAAA has failed to provide these services or you have been discriminated against in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation, you can file a grievance with the Department of Health Care Services' Office of Civil Rights.

PO Box 997413, MS 0009
Sacramento, CA 95899-7413
(916) 440-7370, 711 (California State Relay)
Email: CivilRights@dhcs.ca.gov

If you need help filing a grievance, the Office of Civil Rights can help you. Complaint forms are available at: http://www.dhcs.ca.gov/Pages/Language_Access.aspx

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. You can file electronically through the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf

Or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, TTY 1-800-537-7697

You can get a complaint form at: https://www.hhs.gov/ocr/complaints/index.html

ATTENTION: If you need help in your language call (805) 510-2020 (TTY: 711). Auxiliary aids and services for people with disabilities are also available free of charge.

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al *(805) 510-2020* (TTY: *711)*.
Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số *(805) 510-2020* (TTY: *711*).
Tagalog (Tagalog–Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa *(805) 510-2020* (TTY: *711*).
한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수

있습니다.*(805) 510-2020* (TTY: *711*)번으로 전화해 주십시오.

繁體中文(Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 *(805) 510-2020*

(TTY: *711*)。

Հայերեն (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք *(805) 510-2020* (TTY (հեռատիպ)՝ *711*):
Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните *(805) 510-2020* (телетайп: *711*).
(Farsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با *(805) 510-2020* (TTY: تماس بگیرید *711*)
日本語 (Japanese)

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注意事項：日本語を話される場合、無料の言語支援をご利用いただけます(805) 510-2020 (TTY: *711*) まで、お電話にてご連絡ください。

Hmoob (Hmong)
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau *(805) 510-2020* (TTY: *711*).

ਪੰਜਾਬੀ (Punjabi)
ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। *(805) 510-2020* (TTY: *711*) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic)
ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .اتصل برقم *(805) 510-2020* (رقم هاتف الصم والبكم) *(TTY: 711)*

िहंदी (Hindi)
ध्यान दें: यिद आप िहंदी बोलते ह तो आपके िलए मु मत भाषा सहायता सेवाएं उपल ह। *(805) 510-2020* (TTY: *711*) पर कॉल कर।

ภาษาไทย (Thai)
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร *(805) 510-2020* (TTY: *711*).

ែខរ (Cambodian)
ប្រយ័ត៖ បើសិនអកនិយ ែខរ, បសជំនួយខនកែ ដោយមិនគិតឈ្លែ គឺចនសំរួលបើអក។ ចូរ ទូរស័ព *(805) 510-2020* (TTY: *711*)។

ພາສາລາວ (Laoation)
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ (805) 510-2020 (TTY: 711).

Mein
Waac-mbungh: Se gorngv meih gongv mien waac nor, maaivzuqc cutv nyaanh gunv korh waam mingh tuax (805) 510-2020, (TTY: 711) yiem wuov maaih mienh tengfaan waac bunmeih hiuv duv.

Українська (Ukrainian)
Увага: Якщо вам потрібна допомога в мовному дзвінку (805) 510-2020 або TTY: 711. Допоміжні засоби та послуги для людей з обмеженими можливостями також доступні безкоштовно.