



REFERRAL PACKET

T: (818) 654-6874

F: (818) 334-2100

intake@abizhealth.com

Please return documents and signed consent forms.

Original forms are client's copies.

	SNF / Hospital Face Sheet, Medication List, History and Physical (H&P)
	Consent to Receive Services and Certification
	Consent for Telehealth
	Authorization to Release Health Information
	POA/ Conservator/ Advanced Healthcare Directive (If any)
	Freedom of Choice
	Amenity Form
	Patient's Rights
	ALW Waitlist Request

A-Biz Health Systems Consents

1. Consent to Receive Services- Consent to start application process for the ALW Program.
2. Consent for Telehealth – Disclosure that part of the services performed is done through telehealth.
3. Consent to Release Information - Authorization to release information to the facilities.

State Forms

1. Freedom of Choice - Right to choose service providers, their role and responsibility.
Acknowledgment that the ALW program was explained.
2. Amenity Form - Entitled to amenities of private room, microwave, refrigerator.
3. Patient's Rights – Informed that a Plan of Care will be created by the nurse initiating the development of the ISP. Continued Client involvement is solicited when nurse performs further evaluation and assessment. Copy of completed ISP will be provided to the Client.

❖ Client Handbook shall be provided after transition to an RCFE / ARF.



Resident Transition to the RCFE/ARF Under the ALW Program

To avoid gaps in payment, please be sure that the following is completed in a timely manner. Calling Medi-Cal and Social Security offices can sometimes take multiple attempts and long wait times. Assist the residents with the following:

1. ALW Program residents should change their address with their local Medi-Cal office and Social Security Administration. The resident or legal representative must call both organizations and request a change of address. As directed, send by fax, a copy of the RCFE/ARF admission agreement.
2. If the resident is receiving SSI that is below the ALWP room and board rate, resident or legal representative must call their local Social Security office and request the NonMedi-Cal out of Home Care Rate of **\$1,626.07**. To receive this rate, the resident or legal representative must inform Social Security that they have moved into an assisted living facility. As directed, send by fax, a copy of the RCFE/ARF admission (lease) agreement.
3. If the resident has a Medi-Cal Share of Cost (SOC), this must be removed before DHCS will approve enrollment to the ALW program and before any Billing to Medi-Cal can occur. To remove SOC, the resident or legal representative must call the local Medi-Cal office. Inform Medi-Cal that they have moved to an assisted living facility and request the SOC be removed. As directed, send by fax, a copy of the RCFE/ARF admission agreement.
4. A-Biz Health Systems, Care Coordination Agency (CCA), will send you an Informing Notice, the official enrollment to the ALWP, after receiving approval from the DHCS.

Thank you for accepting and working with the Assisted Living Waiver Program. We look forward to continued collaboration with your facility and ALWP residents.

Sincerely,

Mary Ann Isbell RN
A-Biz Health Systems



ALWP Eligibility and Application Process

The Assisted Living Waiver Program (ALWP) is designed to assist Medi-Cal beneficiaries to remain in their community as an alternative to receiving care in a Skilled Nursing Home (SNF). The program provides specified benefits to eligible seniors and persons with disabilities. A key goal of the program was to enable low-income, Medi-Cal eligible seniors and persons with disabilities, to remain in or relocate to a community setting in a Residential Care Facility for the Elderly (RCFE) or Public Subsidized Housing.

The specific criteria for eligibility for ALWP are:

- Full scope Medi-Cal
- Source of Income (Social Security, Pension, SSI)
- Medi-Cal with no Share of Cost (SOC)
- Meeting the ADL/IADL criteria (Activities of Daily Living/Instrumental Activities of Daily Living)

*Members may be placed on the **ALWP waitlist** while enrolled in Cal MediConnect/Cal Optima 1.

Members MUST be disenrolled from Cal MediConnect/Cal Optima 1 before an ALW application can be submitted.

Members may be placed on the waitlist and submit an application while receiving services from IHSS, MSSP, NF/AH, PACE, SCAN or other Medi-Cal service plan that would duplicate services but **MUST coordinate discontinuation of these services before enrollment in the ALWP can be completed.

Steps to enroll in ALWP:

1. The client must be enrolled in MediCal.
2. The client selects a CCA.
3. CCA does assessment and submits application to the State.

Participants must be eligible for full-scope, no-share-of-cost Medi-Cal benefits and require a nursing facility level of care. The latter requirement is the key to eligibility because the program is designed to serve people who would otherwise need nursing home care.

As a Waiver recipient, you will be required to pay for room and board to the facility, but the ALWP covers your personal and health care costs.

Room and Board	\$ 706.07
Care and Supervision (maximum)	\$ 738.00
Amount Payable for Basic Services	<u>1,444.07</u>
Personal and Incidental Needs Allowance (minimum) (Must be provided to the recipient)	<u>\$ 182.00</u>
Total NMOHC Payment Standard	\$ 1,626.07

Assisted Living Waiver Waitlist Request

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: _____

Where is the applicant currently residing: Acute Hospital At Home Homeless
Residential Care Facility or the Elderly(RCFE) Skilled Nursing

Other (please specify): _____

Who has the legal authority to make the applicant's health care decisions?

Applicant

Other: _____

Was the legal representative notified of this request for the ALW waitlist? Yes No

Is there Adult Protective Services or Long-Term Care Ombudsman 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 Program of All Inclusive Care for the Elderly (PACE)

Senior Care Action Network (SCAN) Hospice Regional Center

Home Health Agency – Hours per week: _____
Type of Services Received: Attendant Care Certified Home Health Aide (CHHA)
Nursing: RN LVN

In-Home Support Services (IHSS) – Hours Authorized Per Month: _____

Multipurpose Senior Services Program (MSSP) California Community Transitions (CCT)

Home and Community-Based Alternatives (HCBA) Waiver

When completed, please return this form to the ALW inbox at Intake@abizhealth.com.



CONSENT FOR TELEHEALTH SERVICE

CLIENT NAME: _____ BIRTHDATE: _____

Telehealth Service:

Telehealth Service involves the use of electronic communications to enable A-Biz Health Systems staff and providers at different locations to share individual personal/medical information for the purpose of healthcare management and coordination. The information may be used for assessment, evaluation, therapy, follow-up and/or education, and may include:

- Medical records and images
- Live two-way audio and video
- Output data from medical devices, sound and video recordings

Communication systems used incorporates safety and security protocols to protect patient/participant information and include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to medical care by enabling a patient/participant to remain in his/her place of residence.
- More efficient and timely medical evaluation and management.

Possible Risks:

There are potential risks associated with the use of Telehealth Service. These risks include, but may not be limited to:

- Information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate clinical evaluation and assessment.
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
- Security protocols could fail, causing a breach of personal or medical information.

Certification:

- I understand that the laws that protect privacy and confidentiality of personal/medical information also apply to Telehealth Service.
- I understand that I have the right to inspect all information obtained during a Telehealth Service interaction and may receive copies of this information.
- I understand that Telehealth Service may involve electronic communication of my personal/medical information to other medical practitioners who may be in other areas.
- I understand that I have the right to withhold or withdraw my consent to the use of Telehealth Service during my care at any time, without affecting my right to future care or treatment.

I have read and understand the information provided regarding Telehealth Service. I hereby give my informed consent for the use of Telehealth Service.

Patient or Legal Representative Printed Name / Signature / Date



AUTHORIZATION TO RELEASE PERSONAL AND HEALTH INFORMATION

CLIENT NAME: _____ BIRTHDATE: _____

Authorization to Release Information:

Protected Health Information (PHI), Personally Identifiable Information (PII) are individually identifiable health and personal information including demographics transmitted or maintained in any form that relates to an individual's physical or mental health or the provision of payment for services.

- I consent to the release of personal information and medical records by any recognized health care institution or organization in which I have been a patient to A-Biz Health Systems (Agency).
- I hereby authorize A-Biz Health Systems for the disclosure of my PHI and/or PII for the purpose of coordination of my health care, personal needs and housing needs.
 - The following person(s) or class of persons may receive disclosures of my PHI and/or PII:
 - Physicians and Healthcare Providers
 - Family Members
 - Potential Landlord and Assisted Living Facilities
 - Transportation Services
 - Insurance Carriers
 - Other: _____
 - The purpose or use of the information is for the coordination of:
 - Health Care
 - Housing
 - Personal Needs
 - Other: _____

Exception:

Any individual that you **do not want** to be in contact with or receive any information? Yes No

*The following is **NOT** to receive any of my information:*

Name of Individual / Relation to Individual / Instructions if this individual tries to make contact:

Certification:

I have read and understand the information provided. I may revoke this authorization by notifying the **Agency at Tel: (818) 654-6874**. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Patient or Legal Representative Printed Name / Signature / Date



CONSENT TO RECEIVE SERVICES AND CERTIFICATION

CLIENT NAME: _____ BIRTHDATE: _____

I hereby consent and authorize **A-Biz Health Systems (Agency)** and its associates to provide services for the following Health Care Program(s) at my home or alternate place of residence. I consent to an initial evaluation, during which the Agency will determine my eligibility for the Program or Service:

Health Care Programs and Services: *(mark selection)*

_____ **Assisted Living Waiver Program (ALWP):** Supports Medi-Cal beneficiaries in remaining within their communities instead of residing in a licensed healthcare facility. Eligible seniors and individuals with disabilities receive specified benefits, with Medi-Cal covering service costs. Residents are responsible for room and board expenses. Care Coordination Agency (CCA) Services: Develops and implements an Individualized Service Plan (ISP) to assess the participant needs and establishes methods for fulfilling them under the ALW program.

The following are Medi-Cal plan benefits offered through select Managed Care Plans, such as Anthem Blue Cross, Blue Shield Promise Health Plan, Health Net, L.A. Care Health Plan, Molina Healthcare, and Kaiser Permanente, etc. To receive these services, individuals must be enrolled in a participating Managed Care Plan.

_____ **Enhanced Care Management (ECM) Services:** Provides members with complex needs access to Lead Care Manager for comprehensive care coordination.

_____ **Community Support (CS) Services:** Provides members with rehabilitative and supportive services that help individuals with disabilities or mental health challenges live independently and access necessary resources.

(service) _____

_____ **Community Health Worker (CHW) Services:** Preventive health services to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health.

A-Biz Health Systems Services and Health Care Programs:

Transition Care and/or Care Management services are designed to help coordinate care, access resources, and achieve set goals. These services may include:

- Assessment of needs and strengths. Development and implementation of a personalized care plan.
- Coordination of care with healthcare providers.
- Referral to appropriate community resources.
- Ongoing monitoring and evaluation of progress.

Confidentiality: Responsibility to safeguard patients' personal and medical information.

- All shared information will remain confidential, except as required by law or with my explicit consent.
- My case manager may share relevant information with healthcare providers or other necessary parties for care coordination, with my knowledge and consent.

Your Rights and Responsibilities: A set of duties under which individuals seek and receive health care services.

- I understand that I have the right to be treated with respect and dignity.
- I understand that I have the right to be informed about my case management plan and any modifications.
- I understand that I have the right to participate in the development of my care plan.
- I understand that I have the responsibility to communicate my needs and concerns.
- I understand that I have the responsibility to follow through with the agreed-upon care plan.
- I understand that I have the right to refuse any specific service or intervention.

Agency Payment Request and Assignment of Benefits:

I authorize the Agency to request insurance or other health care payment on my behalf and release all records necessary for claims processing. I authorize payment and assign all payable benefits directly to the Agency. Agency accepts Medicare, Medi-Cal and other Insurance reimbursement as full payment for all services provided.

Acknowledgement of Provided Information: I confirm that I have received and/or been informed about the following.

- Ethics/Grievance Complaint Procedure & Complaint Hotline:
 - A-Biz Health Systems: **(818) 654-6874**
 - DHCS ALWP Hotline: **(916) 552-9322**
 - CDPH Hotline: **(800) 228-1019**
 - Medi-Cal Helpline: **(800) 541-5551**
- Notice of Privacy Practices (HIPAA); Patient Rights and Responsibilities; Right to a Fair Hearing

Certification of Understanding:

- I certify that I have read and understand this agreement and agree to the stated conditions.
- I may revoke this agreement at any time by verbally notifying the **Agency via phone at (818) 654-6874.**

Community Health Services

Community Supports may be available to you under your Individualized Care Plan. You do not have to pay for Community Supports, and they do not replace the benefits you already receive under Medi-Cal.

1. **Asthma Remediation** - Members receive modifications to their homes to avoid acute asthma caused by environmental triggers like mold. Modifications can include filtered vacuums, air filters, etc.
2. **Community Transition Services/Nursing Facility Transition to a Home** - Members transitioning from a nursing facility to a private residence, receive funding assistance for set-up services, such as security deposits, utilities, and health-related appliances, such as hospital beds.
3. **Day Habilitation** - Day Habilitation Programs are provided in a member's home or an out-of-home, non-facility setting.
4. **Environmental Accessibility Adaptations (Home Modifications)** - Physical adaptations to a home to ensure the health and safety of the Member and may include ramps and grab bars.
5. **Housing Deposits** - Housing Deposits assists with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household.
6. **Housing Tenancy and Sustaining Services** - Members receive support to maintain stable tenancy once housing is secured, such as coordination with landlords to address issues, assistance with the annual housing recertification process, and linkage to community resources to prevent eviction.
7. **Housing Transition Navigation Services** - Members experiencing homelessness or at risk of experiencing homelessness receive help to find, apply for, and secure housing.
8. **Medically Supportive Food/Medically Tailored Meals** - Members receive deliveries of prepared meals and healthy groceries to support their health needs, vouchers for healthy food and/or nutritional education.
9. **Nursing Facility Transition/Diversion to Assisted Living Facilities** - Members living at home or in a nursing facility are transferred to an assisted living facility. ALF provides services such as support with daily living activities, medication oversight, and 24-hour onsite direct care staff.
10. **Personal Care and Homemaker Services** - Supports individuals who need assistance with daily activities, such as bathing, getting dressed, personal hygiene, cooking and eating.
11. **Recuperative Care (Medical Respite)** - Members with unstable housing and no longer require hospitalization but still need to heal from an injury or illness, receive short-term residential care. The residential care includes housing, meals, ongoing monitoring of the member's condition, and other services like coordination of transportation to appointments.
12. **Respite Services** - Short-term services provided to caregivers of those who require occasional temporary supervision to give relief to the caregiver.
13. **Short-Term Post-Hospitalization Housing** - Members who do not have a residence, and who have high medical or mental health and substance use disorder needs, receive short-term housing for up to six months to continue their recovery. Members must also have been discharged from an inpatient clinical setting, residential substance use disorder facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care.
14. **Sobering Centers** - Alternative destinations for individuals who are found to be publicly intoxicated and would otherwise be transported to the emergency department or jail.



Richard Figueroa
Acting Director

Assisted Living Waiver Amenity Form



Gavin Newsom
Governor

The Medi-Cal Home and Community-Based Services (HCBS) waiver program is authorized in § 1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medi-Cal beneficiaries to live in the community and avoid institutionalization.

Each beneficiary of the ALW program is eligible and offered, at enrollment, the following benefits per Appendix C: Participant Services C-1/C-3 Service Specification):

1. Private or semi-private room with full bathroom (shared by not more than two beneficiaries). The choice of roommate is independent of the ALW.
2. Kitchenette, equipped with a refrigerator, a microwave (or cooking appliance) and adequate storage space for utensils and supplies.

Following receipt of the above information,

I Name: _____ Prefer to:

Waive my right to a private room.

Waive my right to a refrigerator.

Waive my right to a microwave.

(Signature)

(Date)



Richard Figueroa
Acting Director

Assisted Living Waiver Freedom of Choice Form



Gavin Newsom
Governor

Date:

Beneficiary's Name:

Caregiver's Name:

Address:

City/State/Zip:

Dear _____:

The Department of Health Care Services (DHCS), Medi-Cal Operation Integrated Systems of Care Division (ISCD), has received a request for HCBS Waiver services for _____ under the Assisted Living Waiver (ALW). This HCBS Waiver is intended to provide Medi-Cal beneficiaries with a choice to reside in an assisted living setting as an alternative to care in a nursing facility.

Whether accepting or declining these services, the Department is required to obtain written confirmation of your choice.

Your acceptance of refusal of ALW services is based on the following:

You or your authorized representative has been informed of the services available to you under the waiver as an alternative to care in a skilled nursing facility.

1. You have the right to choose an HCBS Waiver service provider who has been identified under the waiver as an able provider of the service(s) requested; and,
2. You are aware of your role and responsibility, and that of the providers, in the waiver program.

After you have selected, signed, and dated the enclosed Freedom of Choice Document, please return it to your Care Coordinator.

If you **agree** to accept the HCBS Assisted Living Waiver Services as an alternative to care in a skilled nursing facility, please check the “**Accept**” box below, print your name, date the form, and sign your name. If you are unable to sign the form, your authorized representative should then complete the form as indicated.

Accept HCBS Assisted Living Waiver

Client or Authorized Representative Signature

Printed Name of Client or Authorized Representative

Date

If Signed by Authorized Representative:

Relationship to Client

If you **do not agree** to accept the HCBS Assisted Living Waiver Services as an alternative to care in a skilled nursing facility, or have other alternatives available to you, please check the “**Decline**” box below, print your name, date the form, and sign your name. If you are unable to sign the form, your authorized representative should complete the form as indicated.

Decline HCBS Assisted Living Waiver

Client or Authorized Representative Signature

Printed Name of Client or Authorized Representative

Date

If Signed by Authorized Representative:

Relationship to Client

Assisted Living Waiver Patient's Rights

Name: _____

Client Identification Number (CIN): _____

This document confirms the following: (Check all that apply)

I had freedom of choice in choosing my services and provider(s).

I had freedom of choice in choosing where I live.

I participated in a person-centered planning process.

My care coordinator explained my rights and responsibilities.

My care coordinator explained my right to a fair hearing.

My care coordinator provided me with their contact information and their supervisor's contact information (if applicable).

My care coordinator discussed setting options, including non-disability settings and options for a private unit.

Care Coordinator Contact Information:

Name: _____

Phone: _____

Email: _____

Care Coordinator Supervisor Name: _____

Care Coordinator Supervisor Phone: _____

Rights Modification Consent (Do not complete if a rights modification does not exist)

My individual service plan includes the modification of my rights, as explained below.

By signing this form, I agree to the services and supports in my individual service plan, including any modification to my rights. I agree to this plan being shared with myself, the people involved in this process, and the people that need it to provide my services.

Individual/Legally Responsible Person (Print Name): _____

Individual/Legally Responsible Person Signature

Date

Care Coordinator (Print Name): _____

Care Coordinator Signature

Date

Other ISP meeting participants:

Chosen by Individual		Providing Services (if applicable)	
Name:	Title:	Agency:	
Signature:		Date:	

Chosen by Individual		Providing Services (if applicable)	
Name:	Title:	Agency:	
Signature:		Date:	

Chosen by Individual		Providing Services (if applicable)	
Name:	Title:	Agency:	
Signature:		Date:	

<input type="checkbox"/> Chosen by Individual <input type="checkbox"/> Providing Services (if applicable)		
Name:	Title:	Agency:
Signature:		Date:

<input type="checkbox"/> Chosen by Individual <input type="checkbox"/> Providing Services (if applicable)		
Name:	Title:	Agency:
Signature:		Date:

<input type="checkbox"/> Chosen by Individual <input type="checkbox"/> Providing Services (if applicable)		
Name:	Title:	Agency:
Signature:		Date:

If you feel like your rights have been violated contact your Care Coordination Agency or local Ombudsman. The phone number for the local Ombudsman office and the Statewide CRISISline number is 1-800-231-4024. The CRISISline is available 24 hours a day, 7 days a week.