CHICO OFFICE
1398 Ridgewood Drive
Chico, CA 95973
Call: (800)400-0727
Fax: (530)895-1703

REDDING OFFICE
1647 Hartnell Ave., Ste 11
Redding, CA 96002
Call: (530) 226-0120
Fax: (530) 224-7186

www.homeandhealthcaremgmt.com

Assisted Living Waiver (ALW) Program Referral

Applicant Information

Applicant Name: ______________________ Date of Referral: ______________

Medi-Cal Number: ______________________ Date of Birth: ______________

Medicare Number (if applicable): ______________ County of residence: ______________

Mailing Address: ____

Phone Number: ______________ Email: ______________________

Marital Status:

☐	Married
☐	Single
☐	Divorced
☐	Widowed
☐	Separated
☐	Significant other

Monthly Income: ______________________

Medi-Cal Share of cost: ______________________

Sources of Income (i.e. SSI, disability, Social Security, etc.):

____

____

____

Current Physical Address: ____

Current Residence:

☐ Home or Apartment
☐ Skilled Nursing Facility
☐ Homeless
☐ Assisted Living/Board & Care
☐ Acute Hospital
☐ Other: ______________

If currently in a skilled facility, what date was applicant admitted to the facility: ______________

Name of facility (if applicable): ______________________________

Facility address: ______________________ Facility phone: ______________

DC Planner Name (if applicable): ______________ Email: ______________________

General Application Information

Is this application being submitted **for** the applicant? ☐ Yes ☐ No

Submitted by (if not the applicant): ______________ Relationship: ______________

Submitter's phone: ______________________Email: ______________________

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

Applicant: ____________Other: ____________Relationship: ____________Phone: ____________

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Applicant's Health Information

Current weight: __________________ Height: _____________

Current health problems (Please list/explain):

____
____
____
____
____
____
____

Routine medical treatments needed at home on a regular basis (i.e. every day or weekly):

____
____
____
____
____
____

Any mental health or memory problems (Please list/explain):

____
____
____
____
____

Is the applicant able to transfer and walk on their own?	Yes	No
Does the applicant receive insulin?	Yes	No
Does the applicant wander away from home without supervision?	Yes	No
Has a referral been made to County Adult Protective Services (APS)?	Yes	No

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Programs and Services Applicant Currently Receives

- ☐ California Community Transitions (CCT)
- ☐ Hospice
- ☐ Multipurpose Senior Services Program (MSSP)
- ☐ Home and Community Based Alternatives Waiver (HCBA)
- ☐ Regional Center
- ☐ Home Health Agency Services
- ☐ In Home Supportive Services (IHSS)
- ☐ Community-Based Adult Services (CBAS)/Adult Day Health Care

Additional details we should know:

____
____
____
____
____
____
____
____

Please complete application and fax back to *530-895-1703 - Attention: ALW Department*
For questions, call: *1-800-400-0727* - ask for the *ALW Department*