PROJECT AIDS CARE WAIVER ENROLLMENT APPLICATION

1. APPLICANT

Name: _____

Date of Birth: _____/_____/_____ Medicaid ID#: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____)_____

Age: _____ Sex: _____ Race: _____ Languages spoken: _____

Annual Income: $_____ Assets: $_____

Name of designated representative: _____ Phone: (_____)_____

2. THIRD PARTY PAYOR INFORMATION

Applicant receives Medicare? ____YES ____NO

Medicare #:_____ _____ Effective Date: Part A: _____ Part B: _____

Applicant has Other/Private Insurance? ____YES ____NO

Name of Insurance Company: _____

Policy #:_____ Date _____ Phone Number: _____

Address: _____

Applicant currently enrolled with a HMO? ____YES ____NO

If YES complete the following: Name of HMO(s)_____

Commercial HMO? ___YES ___NO Medicare HMO? ___YES ___NO

Additional information such as policy number, phone number and comments:

3. ELIGIBILITY

Medical diagnosis of AIDS? ___YES ____NO

(If NO the applicant is not eligible for enrollment in the PAC Waiver. Refer applicant to other funding sources such as Ryan White services.)

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Medicaid eligible? ___YES ____NO If YES, specify the Medicaid program:

SSI Effective Date: _____

MEDS-AD Effective Date: _____

Cash Assistance (was AFDC) Effective Date: _____

Other (specify) Effective Date: _____

Medically Needy The applicant is not eligible for enrollment in the PAC Waiver. Refer applicant to other funding sources such as Ryan White.

If NO, applicant is NOT eligible for enrollment in the PAC Waiver. Refer applicant to apply for Medicaid at Social Security Administration for SSI or the Department of Children and Families, or refer to other funding sources such as Ryan White services.

Enrolled in a Medicaid HMO? ___YES* ____NO

Elected Hospice services? ___YES* ____NO

*If the answer is YES for either, the applicant is NOT eligible for enrollment in the PAC Waiver.

Applied for Social Security Disability (SSDI) benefits? ___YES ___NO Date of application: _____

If Approved: Effective Date of SSDI Award: _____

If Denied: Effective Date of SSDI Denial: _____

Has decision been appealed? ____YES ____NO Date of appeal: _____

Applicant has never applied and plans to apply for SSDI on (Date) _____

Comments:

4. LEVEL OF CARE (LOC) DETERMINATION BY DOEA/CARES FOR RISK OF HOSPITALIZATION OR PLACEMENT IN A NURSING FACILITY:

Evaluation completed on: _____ Effective Date of LOC: _____

Applicant chooses to receive services in the home? ___YES ____NO

Can applicant be served safely in the home: ___YES ____NO

Comments:

PRIMARY CARE PROVIDER

Currently under the care of a primary medical care provider? ___YES ____NO

Primary Care Provider's Name: _____ Phone #_____

Address:

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List other current medical care providers.

Name: _____ Phone #_____Address:_____

Name: _____ Phone #_____Address:_____

Name: _____ Phone #_____Address:_____

Name: _____ Phone #_____Address:_____

5. SUPPORT SYSTEMS

Source of referral to PAC Waiver program: _____

The applicant receives assistance with daily activities: ___YES ____NO

If Yes: Name of helper:_____ Phone #: _____

The applicant has legal representation: ___YES ____NO

If Yes: Name:_____ Phone #: _____

Household is aware that the applicant has been diagnosed with AIDS? ___YES ____NO

Person to be notified in case of an emergency: Name:_____

Relationship: _____ Phone: _____

Persons designated by the applicant to participate in the planning and provision of care:

Name:_____ Relationship: _____Phone #: _____

Name:_____ Relationship: _____Phone #: _____

Agencies or entities currently providing services:

Service:_____Provider: _____

Phone _____Address:_____

Service:_____Provider: _____

Phone _____Address:_____

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PARTICIPANT RIGHTS AND RESPONSIBILITIES

Rights and Responsibilities of participants in the Project AIDS Care waiver program:

I. FREEDOM OF CHOICE

- You choose enrollment in the PAC waiver program instead of placement in a nursing home or hospital.
- You choose to receive services in your home.
- You have the right to choose any qualified, available, service provider to receive PAC waiver services.
- You have the right to choose any enrolled case management agency to receive case management services from a case manager, to the extent available.
- You have the right to receive waiver services you need; these may or may not include all the services you desire.

II. RIGHT OF APPEAL AND REQUEST FOR A FAIR HEARING

- You have the right to appeal a decision that denies you a service you believe you are eligible to receive.
- You have the right to request a fair hearing if services are reduced, terminated or denied. Your case manager can assist you in requesting a hearing from the local office of Economic Self Sufficiency, Department of Children and Families or the Office of Appeal Hearings, Department of Children and Families.

III. RESPONSIBILITIES

- You are responsible for assisting your case manager in developing your Plan of Care and scheduling services.
- You are responsible for keeping scheduled appointments and accepting offered and necessary services.
- You are responsible for demonstrating behavior that is cooperative, assertive, and respectful of others.
- You are responsible for notifying your case manager when you will not be available to receive services or sign a delivery log acknowledging receipt of services.
- You are responsible for notifying your case manager of the name, phone number and address of a person you have designated for a period not longer than one week, to sign a delivery log on your behalf.
- You are responsible for notifying your case manager when you are dissatisfied with the services you receive.
- You are responsible for following health care instructions to the best of your ability.
- You are responsible for maintaining required contact with your case manager and cooperating with other requirements of the program

_____ _____

Signature of the Applicant ***Date***

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PARTICIPANT ENROLLMENT

☐ I am applying for enrollment in the Project AIDS Care (PAC) waiver program. I understand that there are multiple components in the application process, which I agree to complete to the best of my ability. I understand my PAC waiver case manager will notify me when I am fully enrolled.

☐ I authorize the PAC waiver case manager to obtain information needed to determine my eligibility to enroll in PAC waiver and to develop a personalized Plan of Care.

☐ I authorize the disease management organization nurse care manager to obtain information needed to complete an annual medical assessment and determine an acuity level to receive PAC waiver services.

☐ My rights and responsibilities have been explained to me.

☐ I choose to enroll in Project AIDS Care waiver if I am eligible.

☐ I choose to receive my case management services from:

Name of Case Management Agency: _____

Agency Address: _____

_____ Agency Phone Number: _____

Signature of Applicant: _____ Date: _____

Print name of applicant: _____ **Slot Number:** _____

***Signature of Witness*:** _____ Date: _____

Print name of witness: _____

***Signature of Case Manager*:** _____ Date: _____

Print name of case manager: _____

Name of Public Assistance Worker: _____ Date Notified: _____

_____

CASE MANAGER'S NOTES:

PROJECT AIDS CARE WAIVER AUTHORIZATION
FOR RELEASE OF PROTECTED HEALTH INFORMATION TO
THE MEDICAID CONTRACTED DISEASE MANAGEMENT ORGANIZATION

I, _____ authorize my Project AIDS Care (PAC) Waiver case management agency _____ to release information to the Registered Nurse Care Manager, from the Medicaid contracted disease management organization _____ for the completion of a medical needs assessment at home and an acuity level determination, required by PAC Waiver to receive services.

This authorization will remain in effect until I request in writing at any future date, that it be withdrawn.

I am aware that by refusing to have a medical needs assessment completed by the Registered Nurse Care Manager from the disease management organization, I will not be eligible to receive PAC Waiver services.

Print Name of Case Manager: _____

PAC Waiver Medicaid Provider #:_____

Date: _____ PAC Case Manager's Signature: _____

Print Name of Recipient: _____ **Medicaid ID#**_____

Date of Consent: _____ **Date of Refusal:** _____

Recipient's Signature:_____