

# HOME AND COMMUNITY BASED SERVICES (HCBS) ELIGIBILITY / INELIGIBILITY / CHANGE FORM

OFFICE INFORMATION			
County Assistance Office Name		District Office Name	
Assessment Agency			Date
APPLICANT/RECIPIENT DEMOGRAPHIC INFORMATION			
Applicant / Recipient Last Name		First Name	
Address			
City	State	Zip Code	Telephone Number
Date of Birth		Social Security Number	
Name of Applicant's Representative			Telephone Number
ELIGIBILITY/PROGRAM ASSESSMENT INFORMATION			
<input type="checkbox"/> This is to verify that the individual listed has been determined to meet the level of care appropriate for Home and Community Based Services through the program indicated below.			
<b>Assessment Date:</b> <input style="width: 150px;" type="text"/>		<b>Service Begin Date:</b> <input style="width: 150px;" type="text"/>	
<input type="checkbox"/> This is to verify that the individual listed does NOT meet the level of care appropriate for Home and Community Based Services through the program indicated below.			
<b>Assessment Date:</b> <input style="width: 150px;" type="text"/>			
<input type="checkbox"/> New Applicant <input type="checkbox"/> Change <input type="checkbox"/> Transfer <input type="checkbox"/> Termination (Complete additional information on reverse side of form for change, transfer or termination)			
<input type="checkbox"/> 38 Aging Waiver <input type="checkbox"/> 40 Attendant Care Waiver <input type="checkbox"/> 42 Independence Waiver <input type="checkbox"/> 51 Adult Community Autism Prog. (ACAP) <input type="checkbox"/> 52 Autism Waiver <input type="checkbox"/> 59 COMMCARE Waiver <input type="checkbox"/> 68 Person / Family Directed Support	<input type="checkbox"/> 70-Infants, Toddlers & Families <input type="checkbox"/> 77 Consolidated Waiver <input type="checkbox"/> 79 OBRA Waiver <input type="checkbox"/> 80 0192 Waiver <input type="checkbox"/> 96 LIFE	<b>MFP CODES ONLY</b> <input type="checkbox"/> 16 MFP - DOM Care <input type="checkbox"/> 17 MFP - Own Residence <input type="checkbox"/> 18 MFP - Family Member <input type="checkbox"/> 19 MFP - Group Setting	
AGENCY INFORMATION			
Enrolling Agency Contact Person		Telephone Number	
Enrolling Agency Name and Address		Fax Number	
		E-Mail	
Comments			
Assessor's Signature			Telephone Number

INDIVIDUAL IDENTIFICATION INFORMATION	
Name	MA Record Number
CURRENT RESIDENT IN A LONG TERM CARE (LTC) FACILITY	
<input type="checkbox"/> Individual currently residing in a LTC Facility	Date of Discharge
LTC Facility Name	Address
	<input type="checkbox"/> Applying for HCBS
	HCBS Name:
CURRENT ADMISSION TO A LTC FACILITY	
<input type="checkbox"/> Individual was admitted to LTC Facility or Personal Care Home (PCH) / Domiciliary Care (DC) Facility	Admission Date
	<input type="checkbox"/> Short Term Admission (Services Expected to Resume at Discharge)
LTC Facility or PCH/DC Facility Name	Address:
<input type="checkbox"/> Area Agency on Aging Office notified to initiate PCH / DC application (if applicable)	
INFORMATION REGARDING DEATH OF AN INDIVIDUAL	
<input type="checkbox"/> Deceased	Date of Death
Contact Person	Telephone Number
CHANGE OF ADDRESS INFORMATION - SAME COUNTY	
<input type="checkbox"/> Individual Moved	Date of Move
New Address	Telephone Number
<input type="checkbox"/> Services Continued	<input type="checkbox"/> Services Terminated
	Date of Termination
<input type="checkbox"/> Verification of Shelter Expenses Attached for Food Stamps	
CHANGE OF COUNTY RESIDENCE	
<input type="checkbox"/> Individual Moved to _____ County	Date of Move
New Address	Telephone Number
<input type="checkbox"/> Services Continued	<input type="checkbox"/> Services Terminated
	Date of Termination
TRANSFERRING HCBS PROGRAM	
Name of HCBS Transferring From	Services End Date
Name of HCBS Transferring To	Services Begin Date
PROGRAM WITHDRAWAL INFORMATION	
<input type="checkbox"/> Individual Voluntarily Withdrew	Date of Termination
TERMINATION OF HCBS PROGRAM	
<input type="checkbox"/> HCBS Terminated	Reason
	Date of Termination
CHANGE OF INDIVIDUAL'S FINANCIAL STATUS	
<input type="checkbox"/> Change in Individual's Financial Status. Documentation Attached.	
OTHER INFORMATION	
<input type="checkbox"/> Other (Specify)	



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INSTRUCTIONS FOR COMPLETION OF THE PA 1768**

AGENCY INFORMATION	
ENROLLING AGENCY CONTACT PERSON	Enter the name of the person from the enrolling agency who may be contacted if information is needed by the CAO. This may be the person who conducted the level of care and functional assessment.
TELEPHONE NUMBER	Enter the contact person's telephone number.
ENROLLING AGENCY NAME AND ADDRESS	Enter the name of the agency and the agency's mailing address, including street, suite number, city, state and zip code.
FAX NUMBER	Enter the agency FAX number. This may be a dedicated FAX machine that the agency uses only for HCBS documents.
E-MAIL	Enter the contact person's e-mail address.
COMMENTS	Enter any comments that may be useful to the CAO.
ASSESSOR'S SIGNATURE	Enter the signature of the person who conducted the level of care and functional assessment.
TELEPHONE NUMBER	Enter the telephone number of the assessor.

INDIVIDUAL IDENTIFICATION INFORMATION	
NAME	Enter the individual's Last Name, First Name and Middle Initial.
MA RECORD NUMBER	Enter the individual's Medical Assistance record number including county code/ record number/ category.

CURRENT RESIDENT IN LTC FACILITY INFORMATION	
<input type="checkbox"/> INDIVIDUAL IS RESIDING IN LONG TERM CARE FACILITY	Check the box to indicate that the individual is residing in a LTC facility and is requesting HCBS upon discharge.
DATE OF DISCHARGE	Enter the date (month, day and year) that the individual will be discharged from the LTC facility.
LTC FACILITY NAME	Enter the name of the LTC facility where the individual resides.
ADDRESS	Enter the LTC facility's mailing address, including street, city, state and zip code.
<input type="checkbox"/> APPLYING FOR HCBS	Check the box to indicate the individual is requesting HCBS upon discharge from the LTC facility.
HCBS NAME:	Enter the name of the HCBS Program the individual is expecting to receive services from upon discharge from the LTC facility.

CURRENT ADMISSION TO A LTC FACILITY INFORMATION	
<input type="checkbox"/> INDIVIDUAL WAS ADMITTED TO LONG TERM CARE FACILITY OR PERSONAL CARE HOME / DOMICILIARY CARE FACILITY	Check the box to indicate that the individual was admitted to a LTC facility, Personal Care Home (PCH) or Domiciliary Care (DC) facility.
ADMISSION DATE	Enter the date that the individual was admitted.
<input type="checkbox"/> SHORT TERM ADMISSION (SERVICES EXPECTED TO RESUME AT DISCHARGE)	Check the box to indicate that the individual's admission to the LTC facility is for a short period of time and HCBS are expected to resume upon the individual's discharge from the facility.
LTC FACILITY OR PCH/DC FACILITY NAME	Enter the name of the LTC facility, PCH or DC facility.
ADDRESS	Enter the LTC, PCH or DC facility's mailing address, including street, city, state and zip code.
<input type="checkbox"/> AREA AGENCY ON AGING OFFICE NOTIFIED TO INITIATE PCH/DC APPLICATION (IF APPLICABLE)	Check the box to indicate that the Area Agency on Aging has been notified that the individual who was receiving HCBS has been admitted to a PCH or DC facility and an application may be needed.

INFORMATION REGARDING DEATH OF THE INDIVIDUAL	
<input type="checkbox"/> DECEASED	Check the box to indicate that the individual has died.
DATE OF DEATH	Enter the date (month, day and year) that the individual died.
CONTACT PERSON	Enter the name of an individual from the agency who may be contacted.
TELEPHONE NUMBER	Enter the telephone number of the contact person.

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<b>CHANGE OF ADDRESS INFORMATION - SAME COUNTY</b>	
<input type="checkbox"/> <b>INDIVIDUAL MOVED</b>	Check the box to indicate that the individual has moved.
<b>DATE OF MOVE</b>	Enter the date (month, day and year) that the individual moved.
<b>NEW ADDRESS</b>	Enter the new address, including street, apartment number, city, state and zip code.
<b>TELEPHONE NUMBER</b>	Enter the individual's telephone number, including a message number (where a contact can be made to reach the recipient).
<input type="checkbox"/> <b>SERVICES CONTINUED</b>	Check the box to indicate that the individual continues to receive HCBS.
<input type="checkbox"/> <b>SERVICES TERMINATED</b>	Check the box to indicate that the individual's HCBS stopped.
<b>DATE OF TERMINATION</b>	Enter the month, day and year that the individual's HCBS stopped.
<input type="checkbox"/> <b>VERIFICATION OF SHELTER EXPENSES ATTACHED FOR FOOD STAMPS</b>	Check the box to indicate that the individual's new mortgage, rent, utility, and phone expenses have been verified and documentation is attached.

<b>CHANGE OF COUNTY RESIDENCE INFORMATION</b>	
<input type="checkbox"/> <b>INDIVIDUAL MOVED TO _____ COUNTY</b>	Check the box to indicate that the individual has moved to a new county. Enter the name of the new county of residence.
<b>DATE OF MOVE</b>	Enter the date (month, day and year) that the individual moved.
<b>NEW ADDRESS</b>	Enter the individual's new address, including street, apartment number, city, state and zip code.
<b>TELEPHONE NUMBER</b>	Enter the individual's telephone number including a message number (where a contact can be made to reach the recipient).
<input type="checkbox"/> <b>SERVICES CONTINUED</b>	Check the box to indicate that the individual continues to receive HCBS.
<input type="checkbox"/> <b>SERVICES TERMINATED</b>	Check the box to indicate that the individual's HCBS stopped.
<b>DATE OF TERMINATION</b>	Enter the month, day and year that the individual's HCBS stopped.

<b>TRANSFERRING HCBS PROGRAM INFORMATION</b>	
<b>NAME OF HCBS TRANSFERRING FROM</b>	Enter the name of the current HCBS providing services to the individual. Services under this HCBS program will end and be continued under another HCBS program.
<b>SERVICES END DATE</b>	Enter the last date (month, day and year) that the individual will be eligible for services. This is the last day that services will be provided under the present HCBS program.
<b>NAME OF HCBS TRANSFERRING TO</b>	Enter the name of the new HCBS that the individual will be enrolled in for continued services.
<b>SERVICES BEGIN DATE</b>	Enter the first date (month, day and year) that the individual will be eligible to receive services under the new HCBS program.

<b>PROGRAM WITHDRAWAL INFORMATION</b>	
<input type="checkbox"/> <b>INDIVIDUAL VOLUNTARILY WITHDREW</b>	Check the box to indicate that the individual requested that services not be authorized or that services be stopped. Enter the reason in the section labeled "OTHER INFORMATION."
<b>DATE OF WITHDRAWAL</b>	Enter the month, day and year that the individual requested a withdrawal.

<b>TERMINATION OF HCBS PROGRAM INFORMATION</b>	
<input type="checkbox"/> <b>HCBS SERVICES TERMINATED</b>	Check the box to indicate that the individual's HCBS stopped.
<b>REASON</b>	Enter the reason that the individual's HCBS were stopped.
<b>DATE OF TERMINATION</b>	Enter the month, day and year that the individual's HCBS stopped.

<b>CHANGE IN INDIVIDUAL'S FINANCIAL STATUS</b>	
<input type="checkbox"/> <b>CHANGE IN THE INDIVIDUAL'S FINANCIAL STATUS DOCUMENTATION ATTACHED</b>	Check the box to indicate that the individual's finances have changed and that documents are attached to verify the changes.

<b>OTHER INFORMATION</b>	
<input type="checkbox"/> <b>OTHER (SPECIFY)</b>	Check the box to indicate that additional information is being provided, including the reason(s) for non-participation in the HCBS Program.