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

❒ **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.**

Assessment Date: _____ **Service Begin Date:** _____

❒ **This is to verify that the individual listed does NOT meet the level of care appropriate for Home and Community Base Services through the program indicated below.**

Assessment Date: _____

❒ **New Applicant** ❒ **Change** ❒ **Transfer** ❒ **Termination**

(Complete additional information on reverse side of form for change, transfer or termination)

❒ 33 Elwyn Waiver	❒ 77 Consolidated Waiver
❒ 38 PDA Waiver	❒ 78 Michael Dallas Waiver
❒ 40 Attendant Care Waiver	❒ 79 OBRA Waiver
❒ 42 Independence Waiver	❒ 80 0192 Waiver
❒ 59 COMMCARE Waiver	❒ 96 LTC Cap. Assist. Program. (LTCCAP)
❒ 68 Person / Family Directed Support	
❒ 70 Infants, Toddlers & Families	❒ Bridge Program

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 FACILITY

❒ Individual currently residing in a Long Term Care Facility	Date of Discharge

LTC Facility Name	Address	❒ Applying for HCBS
		HCBS Name:

CURRENT ADMISSION TO A LONG TERM CARE FACILITY

❒ Individual was admitted to LTC Facility or PCH / Domiciliary Care (DC) Facility	Admission Date
	❒ Short Term Admission (Services Expected to Resume at Discharge)

Nursing Facility or PCH / DC Facility Name	Address

❒ Area Agency on Aging Office notified to initiate PCH / DC application (if applicable)

INFORMATION REGARDING DEATH OF AN INDIVIDUAL

❒ DECEASED	Date of Death

Contact Person	Telephone Number

CHANGE OF ADDRESS INFORMATION - SAME COUNTY

❒ Individual Moved	Date of Move

New Address	Telephone Number

❒ Services Continue	❒ Services Terminated	Date of Termination

❒ Verification of Shelter Expenses Attached for Food Stamps

CHANGE OF COUNTY RESIDENCE

❒ Individual Moved to _____ County	Date of Move

New Address	Telephone Number

❒ Services Continue	❒ 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

❒ Individual Voluntarily Withdrew	Date of Withdrawal

TERMINATION OF HCBS PROGRAM

❒ HCBS Terminated	Reason	Date of Termination

CHANGE IN INDIVIDUAL'S FINANCIAL STATUS

❒ Change in Individual's Financial Status. Documentation Attached.

OTHER INFORMATION

❒ Other (Specify)

HOME AND COMMUNITY BASED SERVICES (HCBS) ELIGIBILITY / INELIGIBILITY / CHANGE FORM
INSTRUCTIONS FOR COMPLETION OF THE PA 1768

OFFICE INFORMATION	
COUNTY ASSISTANCE OFFICE NAME	Enter the name of the County Assistance Office (CAO) where the information is being sent.
DISTRICT OFFICE NAME	Enter the name of the District Office where the information is being sent (if applicable).
ASSESSMENT AGENCY	Enter the name of the Agency conducting the assessment.
DATE	Enter the date (month, day and year) that the information is being sent to the County Assistance Office by the assessment agency.
APPLICANT/RECIPIENT DEMOGRAPHIC INFORMATION	
APPLICANT/RECIPIENT LAST NAME	Enter the individual's Last Name.
FIRST NAME	Enter the individual's First Name and Middle Initial.
ADDRESS	Enter the street address, including the apartment number where the individual resides.
CITY	Enter the city.
STATE	Enter the state.
ZIP CODE	Enter the Zip Code.
TELEPHONE NUMBER	Enter the individual's telephone number, including a message number (where a contact can be made to reach the applicant/recipient).
DATE OF BIRTH	Enter the individual's Date of Birth.
SOCIAL SECURITY NUMBER	Enter the individual's Social Security Number (SSN).
NAME OF APPLICANT'S REPRESENTATIVE	Enter the name of the individual who is completing the application on behalf of the applicant (if applicable).
TELEPHONE NUMBER	Enter the representative's telephone number, including a message number (where a contact can be made to reach the representative).
ELIGIBILITY/PROGRAM ASSESSMENT INFORMATION	
❒ **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:** **ASSESSMENT DATE:** ☐☐/☐☐/☐☐☐☐ **SERVICE BEGIN DATE:** ☐☐/☐☐/☐☐☐☐	Check the box to indicate that the individual was determined eligible for Home and Community Based Services (HCBS). In the box enter the date that the assessment agency conducted the level of care and functional assessment and found the individual eligible for HCBS. In the box enter the date that the individual will start to receive services under a HCBS program.
❒ **THIS IS TO VERIFY THAT THE INDIVIDUAL LISTED HAS BEEN DETERMINED NOT TO MEET THE LEVEL OF CARE APPROPRIATE FOR HOME AND COMMUNITY BASED SERVICES THROUGH THE PROGRAM INDICATED BELOW:** **ASSESSMENT DATE:** ☐☐/☐☐/☐☐☐☐	Check the box to indicate that the individual was determined ineligible for Home and Community Based Services (HCBS). In the box enter the date that the assessment agency conducted the level of care and functional assessment and found the individual ineligible for HCBS.
❒ **NEW APPLICANT** ❒ **CHANGE** ❒ **TRANSFER** ❒ **TERMINATION** **(COMPLETE INFORMATION ON REVERSE SIDE)**	Check the appropriate box to indicate whether the individual is a new applicant for a HCBS or a Change, Transfer or Termination of services has occurred for an individual who is currently receiving services. **For a Change, Transfer or Termination use the reverse side of the form to enter additional information.**
❒ **33 Elwyn** ❒ **38 PDA** ❒ **40 Attendant Care** ❒ **42 Independence** ❒ **59 COMMCARE** ❒ **68 Per. Fam. Direct. Support** ❒ **70 Infants, Toddlers & Fam.** ❒ **77 Consolidated** ❒ **78 Michael Dallas** ❒ **79 OBRA** ❒ **80 0192** ❒ **96 LTCCAP** ❒ **Bridge Program**	For applicants - Check the appropriate HCBS program the individual was determined eligible or ineligible to receive services. For recipients - Check the appropriate HCBS program to indicate which HCBS program is affected by a change, transfer or termination of services.
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.

INSTRUCTIONS FOR BACK OF FORM - PA 1768

INDIVIDUAL IDENTIFICATION INFORMATION	
NAME	Enter the individual's Last Name, First Name and Middle Initial.
MA RECORD NUMBER	Enter the individual's Medicaid (Medical Assistance) record number including county code/ record number/ category.
CURRENT RESIDENT IN LONG TERM CARE FACILITY INFORMATION	
❒ **INDIVIDUAL IS RESIDING IN LONG TERM CARE FACILITY**	Check the box to indicate that the individual is residing in a Long Term Care (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.
❒ **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 HCBS Program the individual is expecting to receive services from upon discharge from the LTC facility.
CURRENT ADMISSION TO A LONG TERM CARE FACILITY INFORMATION	
❒ **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.
❒ **SHORT TERM ADMISSION (SERVICES EXPECTED TO RESUME AT DISCHARGE)**	Check the box to indicate that the individual 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.
❒ **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	
❒ **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.
CHANGE OF ADDRESS INFORMATION - SAME COUNTY	
❒ **INDIVIDUAL MOVED**	Check the box to indicate that the individual has moved.
DATE OF MOVE	Enter the date (month, day and year) that the individual moved.
NEW ADDRESS	Enter the new address, including street, apartment number, city, state and zip code.
TELEPHONE NUMBER	Enter the individual's telephone number, including a message number (where a contact can be made to reach the recipient).
❒ **SERVICES CONTINUED**	Check the box to indicate that the individual continues to receive HCBS.
❒ **SERVICES TERMINATED**	Check the box to indicate that the individual's HCBS stopped.
DATE OF TERMINATION	Enter the month, day and year that the individual's HCBS stopped.
❒ **VERIFICATION OF SHELTER EXPENSES ATTACHED FOR FOOD STAMPS**	Check the box to indicate that the individual's new mortgage, rent, utility, and phone expenses have been verified and documentation is attached.
CHANGE OF COUNTY RESIDENCE INFORMATION	
❒ **INDIVIDUAL MOVED TO _____ COUNTY**	Check the box to indicate that the individual has moved to a new county. Enter the name of the new county of residence.
DATE OF MOVE	Enter the date (month, day and year) that the individual moved.
NEW ADDRESS	Enter the individual's new address, including street, apartment number, city, state and zip code.
TELEPHONE NUMBER	Enter the individual's telephone number including a message number (where a contact can be made to reach the recipient).
❒ **SERVICES CONTINUED**	Check the box to indicate that the individual continues to receive HCBS.
❒ **SERVICES TERMINATED**	Check the box to indicate that the individual's HCBS stopped.
DATE OF TERMINATION	Enter the month, day and year that the individual's HCBS stopped.

INSTRUCTIONS FOR BACK OF FORM - PA 1768

TRANSFERRING HCBS PROGRAM INFORMATION	
NAME OF HCBS TRANSFERRING FROM	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.
SERVICES END DATE	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.
NAME OF HCBS TRANSFERRING TO	Enter the name of the **new** HCBS that the individual will be enrolled in for continued services.
SERVICES BEGIN DATE	Enter the first date (month, day and year) that the individual will be eligible to receive services under the new HCBS program.
PROGRAM WITHDRAWAL INFORMATION	
❒ **INDIVIDUAL VOLUNTARILY WITHDREW**	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."
DATE OF WITHDRAWAL	Enter the month, day and year that the individual requested a withdrawal.
TERMINATION OF HCBS PROGRAM INFORMATION	
❒ **HCBS SERVICES TERMINATED**	Check the box to indicate that the individual's HCBS stopped.
REASON	Enter the reason that the individual's HCBS were stopped.
DATE OF TERMINATION	Enter the month, day and year that the individual's HCBS stopped.
CHANGE IN INDIVIDUAL'S FINANCIAL STATUS	
❒ **CHANGE IN THE INDIVIDUAL'S FINANCIAL STATUS DOCUMENTATION ATTACHED**	Check the box to indicate that the individual's finances have changed and that documents are attached to verify the changes.
OTHER INFORMATION	
❒ **OTHER (SPECIFY)**	Check the box to indicate that additional information is being provided, including reason for non-participation in HCBS Program.