

MEDICAID ELIGIBILITY for the H&CB WAIVER PROGRAM

TO/FROM: _____ DATE: _____
Office/Unit Name Worker or Contractor Name Phone No. FAX No.

FROM/TO: _____ DATE: _____
Office/Unit Name Worker or Contractor Name Phone No. FAX No.

CASE NAME: _____ CASE NO: _____

CLIENT NAME: _____ CLIENT ID/SSN: _____

I. Referral is being made for a determination of Medicaid eligibility for the H&CB Waiver Program

A. Individual is eligible as a candidate for the following home and community based (H&CB) waiver program pending Medicaid eligibility:

1. **NURSING HOME WITHOUT WALLS (NHWW)**

2. **RESIDENTIAL ALTERNATIVES COMMUNITY CARE PROGRAM (RACCP)**

EC-ARCH 1
(Expanded Care)

EC-ARCH 2

ALF

RACC/FOSTER FAMILY HOME
(Assisted Living Facility)

3. **DEVELOPMENTALLY DISABLED/MENTALLY RETARDED PROGRAM (DDIMR)**

DD Dom

DD Foster Home

ARCH1/ECARCH1

ARCH2/EC-ARCH2

OTHER

4. **HIV COMMUNITY CARE PROGRAM (HCCP)**

5. **MEDICALLY FRAGILE COMMUNITY CARE PROGRAM (MFCCP)**

6. **PROGRAM FOR ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)**

7. **OTHER:** _____

B. **APM** (Admission Pending Medicaid)

YES Date of APM determination: _____ **NO** - Date of waiver admission: _____

Name of Home

Address

Phone

C. Individual is: Single, Divorced, Widowed

Married with spouse in the community Married with institutionalized spouse

II. Determination for Medicaid eligibility was completed for the applicant/recipient of the H&CB program

A. Application approved on: _____ Eligible effective: _____

Full coverage

with monthly spend down \$

B. Application denied on: _____

Excess Assets

Excess Income

Other

C. Case closed effective: _____

Reason: _____

D. Other: _____

III. Status of individual for H&CB Waiver Program

A. Individual was not admitted to the H&CB Waiver Program.

Reason: _____

B. Individual is terminated (discharged) from H&CB Waiver Program effective: _____

Reason: _____

C. Other: _____

D. Additional comments: _____