

Pennsylvania Home and Community Based Services 0192 AIDS Waiver Application Instructions

Please complete the requested information in Section I. Forward to your physician Section II (Physician's Certification Form). Ask your physician to return the completed form to you.

SECTION I: Individual Information - To be completed by applicant or applicant designee.

1. Check proper blocks for application type (page 2)
2. Indicate: Name, Phone, Address, Recipient Identification Number, Social Security Number, Date of Birth, and Sex (page 2)
3. Indicate: Physician's Name, Phone and Fax, Address, and License Number (page 2)
4. Indicate: Case Manager/Care Coordinator's Name, Phone and Fax number, Provider Number, Organization Name, and Organization's Phone Number (page 2)
5. Indicate any Medical Insurance coverage (page 2)
6. Complete Health and safety section (page 3)
7. Indicate: Symptoms or other health problems you are currently experiencing or have experienced in the past. (page 4)
8. List all medications that are currently prescribed by your medical care providers (page 4)
9. Give a brief history of your nutritional intake and weight status (page 5)
10. Please choose your option to enroll/not enroll with the waiver program and sign the document. If you are having a designee complete this application please have them sign in the appropriate space. (page 6)

SECTION II: Physician Certification Form - To be completed by applicant's Physician.

1. Indicate: Applicant's current and past clinical symptomatology (page 7)
2. Indicate: Current laboratory test results with dates (page 7)
3. Indicate: Applicant's current level of care and service(s) that will meet their health needs (page 8)
4. Sign and date Physician's Certification Form and return to applicant (page 8)
5. **Attach any supporting documentation relating to application.**

Choosing Potential Providers: Please indicate all potential providers for services (page 9)

1. All providers of the waiver services must be enrolled in the MA program and the AIDS Waiver program. If not yet enrolled, please contact the AIDS Waiver staff at 717-772-2525. Please provide the 13 digit provider number
2. **Attachment A: Definitions of Services provided through the 0192 AIDS Waiver Program** (page 10)

Send completed application to:

Waiver Implementation Unit
P. O. Box 2675
Harrisburg, PA 17105-2675

Fax Application to: 717-265-7698 attention Aids waiver unit

**Pennsylvania Home and Community Based Services
0192 AIDS Waiver Application**

SECTION I: Individual information

Type of Application: (Please check one) New Reapplication/Changes Re-evaluation

Applicant:

Name: (First, M.I., Last)		Area Code	Phone Number
Residence: (Number, Street, Apt No., City, State, Zip Code)		County	
Recipient ID #	Social Security #	Date of Birth	Sex Male: _____ Female: _____

Physician:

Physician: (First, Last)	Phone: () -
	Fax: () -
Address: (Number, Street, City, State, Zip Code)	License #

Case Manager/Care Coordinator:

Care Coordinator: (First, M.I., Last)	Phone: () -
	Fax: () -
Address: (Number, Street, City, State, Zip Code)	MA Provider number:
	E-mail Address:
Organization:	Phone: () -
	Fax: () -

Is English your primary language? Yes No If not please indicate primary language _____

Does the client currently have medical coverage other than Medical Assistance? Yes No
 If yes, Insurer's Name: _____ Insurance. Effective 7/1/03, you may have Medicare.

Managed Care Organization (MCO): _____ (If applicable)

Applicant's Name:

Health and Safety

Is adequate housing available to you? Yes No

Do you have difficulty accessing your home because of the lack of handicap modifications, etc.? Yes No

Do you have working smoke detectors in your home? Yes No

Do you have working carbon monoxide detector in your home? Yes No

Are there any repairs needed to keep you safe in your home? Yes No If yes, please describe _____

Who lives in the home with this Applicant? Alone Friend Significant Other Family:
Relationship _____

Relationship _____

Relationship _____

Are you under any medical restrictions or precautions? Yes No If yes, please describe _____

Is there a non-professional to help with your care needs? Yes No

Relationship _____ Name _____

Describe the care they provide? _____

Are you comfortable with the care they provide? Yes No _____

Do you belong to any social organizations? Yes No

If Yes what type and the name of the group or organization _____

Applicant's Name:

Have you experienced or are you experiencing any of the following? Please put a check, in the box, next to any problem.

<input type="checkbox"/>	Headache	<input type="checkbox"/>	Chills
<input type="checkbox"/>	Disorientation	<input type="checkbox"/>	Skin sores / rash: Where are they located?
<input type="checkbox"/>	Depressed	<input type="checkbox"/>	Diarrhea: How frequent?
<input type="checkbox"/>	Pain: Where is it located?	<input type="checkbox"/>	Weakness: Where is it located?
<input type="checkbox"/>	Confused or Forgetful	<input type="checkbox"/>	Mouth sores
<input type="checkbox"/>	Persistent fevers	<input type="checkbox"/>	Vomiting: How frequent?
<input type="checkbox"/>	Lower extremity paralysis	<input type="checkbox"/>	Loss of Appetite
<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>	Prolonged fatigue
<input type="checkbox"/>	Agitated	<input type="checkbox"/>	Problems maintaining control of bowels or bladder?
<input type="checkbox"/>	Blurred vision	<input type="checkbox"/>	Require a Wheelchair or walker
<input type="checkbox"/>	Legally blind	<input type="checkbox"/>	Require assistance with Transfer bed/chair
<input type="checkbox"/>	Hearing Impaired	<input type="checkbox"/>	Difficulty breathing: How frequent?
<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	Joint pain?
<p>Describe additional symptoms or medical conditions that interrupt your daily activities.</p>			

Please list all prescribed medications you are taking, attach separate page if necessary:

Medication	Dose	How Often

Applicant's Name

Nutritional Status: Height and Weight History: Client's height _____

Typical weight prior to HIV _____ Current weight _____ 6 months ago _____

A. What does the client eat on a typical day?

Breakfast:	
Lunch:	
Dinner:	
Snacks:	

B. Do you have adequate food available?

Yes No

C. Do you prepare your own meals?

Yes No

Eat solid foods?

Yes No

Eat soups?

Yes No

D. Does the consumer use supplements?

Yes No

If yes, specify supplement: _____ and date started: _____

E. Previous nutritional evaluation?

_____ Yes _____ No

If yes, please attach most recent evaluation.

F. Previous nutritional intervention?

_____ Yes _____ No

If yes, please attach most recent documentation.

G. Are your portion sizes the same as:

1 year ago?

Yes

No

3 years ago?

Yes

No

Prior to illness?

Yes

No

H. Describe any symptoms that you currently have or have had that affect your nutritional intake:

**COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE**

**0192-AIDS WAIVER AGREEMENT FOR CHOICE OF CARE
AND RELEASE OF INFORMATION**

Applicant's Name:	1. [<input type="checkbox"/>] I want to be enrolled in the 0192-AIDS Waiver Program
Address:	2. [<input type="checkbox"/>] I do not want to be enrolled in the 0192-AIDS Waiver Program. Instead, I want to remain in an appropriate institutional setting.
Social Security Number:	Recipient ID Number: 1901878866

Please read the following information carefully.

If I choose to participate in the 0192-AIDS Waiver Program, I agree that:

1. I certify the information contained on this application is accurate to the best of my knowledge.
2. I authorize the release of any medical information, including information pertaining to HIV/AIDS, by my attending physician and/or case manager to the Department of Public Welfare or its agents, for purposes of determining eligibility for the waiver and obtaining waiver services. I also authorize the release/receipt of information appropriate to the management of my care.
3. This authorization remains revocable until acted upon.

<p>_____</p> <p>Applicant/Guardian's Signature</p> <p>_____</p> <p>Date</p>	<p>_____</p> <p>Preparer's Signature</p> <p>_____</p> <p>Date</p> <p>I authorize the information on this application is accurate to the best of my knowledge and have been authorized by the applicant/designee to apply for services.</p>
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ALL INFORMATION IN THIS APPLICATION WILL BE KEPT CONFIDENTIAL

LEVEL OF CARE SUMMARY

Check the appropriate block that applies to the applicant's current level of care and identify the services needed to meet the needs for the identified applicant. The level of care certified must be substantiated by identified services documented below.

Applicant's Name: _____

Level of Care*	Definition of Level of Care
<input type="checkbox"/> Acute	Describe as care requiring daily or more frequent nursing services Provided only by a skilled health professional or a trained informal caregiver and monitoring of the patient's condition by a skilled health professional on a daily or more frequent basis. Monitoring must include intensive nursing assessment and/or the venapuncture for lab studies. Service activities and monitoring are of the intensity requiring an acute care hospital bed in the absence of home and community-based waiver services.
<input type="checkbox"/> Skilled Nursing Facility (SNF)	Described as care provided only by a skilled health professional or a trained informal caregiver and monitoring of the patient's condition by a skilled health professional less frequently than daily. Monitoring must include nursing assessment and/or venapuncture for lab studies. Service activities and monitoring are of the nature provided in an SNF setting in the absence of home and community-based waiver service.
<input type="checkbox"/> Intermediate Care Facility (ICF)	Described as care requiring one or more, less intensive health or personal care services, with emphasis on personal supervision, protection, and assistance. Services are performed by a home health aid/homemaker or a trained informal caregiver to assist the applicant who does not have the capacity for independent living. Monitoring of the applicant's care is done intermittently by a skilled health professional. In addition, an applicant may meet this level of care if documented waiver services are needed to prevent or delay further disability and worsening of an existing condition to the level of dependent living.

Below is a list of services that are available under the waiver. Please indicate the service or services you believe are necessary to meet the applicant's needs, should they choose to remain in the community. (See **Attachment A** for descriptions of waiver services listed below)

- Durable Medical equipment and Supplies: Please indicate _____
- Nutritional Consultation
- Home Health Services: Nursing Care: **Specify:** ____ hours ____ visits/week
- Home Health Services: Home Health Aide **Specify:** ____ hours ____ visits/week
- Homemaker Services: **Specify:** ____ hours ____ visits/week

Please indicate the type of Homemaker service bathing, housecleaning, caregiver relief, laundry, shopping, meal prep

Physician's Certification (* Must complete Level of Care section)

I certify to the medical need for the waiver services documented on the application, and to the accuracy of the medical information provided.

Physician's Signature

Date

CHOOSING POTENTIAL PROVIDERS:

Applicants have the right of “Freedom of Choice,” which means they have the right to choose their own providers. The applicant must choose providers that are enrolled as Medical Assistance providers and enrolled in the waiver program. **Please list suppliers or companies who will be providing the waiver services.**

Applicant’s Name:

Name:	Address:
Contact Person:	Phone Number:
MA ID Number	Type of service being supplied:

Name:	Address:
Contact Person:	Phone Number:
MA ID Number	Type of service being supplied:

Name:	Address:
Contact Person:	Phone Number:
MA ID Number	Type of service being supplied:

Attachment A Waiver Service Descriptions

Home Health Services:

1. **Home Nursing Visits** – supplemental home nursing visits beyond the maximum number of visits permitted through the state plan. Nursing visits provided through the waiver can only be authorized by the Waiver Implementation Unit, after a denial is obtained from prior authorization, for services beyond regular state plan. Waiver authorized nursing visits will be reviewed at intervals not to exceed sixty (60) days.
2. **Home Health Aide Visits** – supplemental home health aide visits beyond the maximum number of visits permitted through the state plan. Home Health aide visits provided through the waiver can only be authorized by the Waiver Implementation Unit, after a denial is obtained from prior authorization, for services beyond regular state plan. Waiver authorized nursing visits will be reviewed at intervals not to exceed sixty (60) days.
3. **Homemaker Services** – homemaker services are non-medical services for the recipient who has lost daily functioning abilities, i.e. bathing, dressing, light housekeeping, meal preparation, washing dishes, grocery shopping, instructional services (nutrition) and care giver relief. This service will be provided through enrolled home health agencies, enrolled personal care agencies, or enrolled homemaker agencies. Homemaker visits will be authorized by the Waiver Implementation Unit, in 15-minute blocks of time with a minimum visit of 4 units (1 hour), and a maximum of 40 units per day, or 280 units per week.

Nutritional Consultations:

Initial nutritional assessment, reassessment, or nutritional counseling can be provided to the waiver client. This service is reimbursable to a **Medical Assistance registered dietitian, who is enrolled as a 0192-Aids Waiver Provider**. Services are to be provided in 15-minute blocks with each waiver client limited to 90 minutes of nutritional consultations per calendar month.

Medical Equipment and Supplies

Medical equipment and supplies are approved after the provider dispenses beyond the maximum number permitted through the state plan. Providers will be approved for equipment and/or supplies after receiving a denial from program exception or prior authorization.