

# 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: \_\_\_\_\_

# **PROJECT AIDS CARE WAIVER ENROLLMENT APPLICATION**

## **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

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***Signature of the Applicant***

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***Date***

# PROJECT AIDS CARE WAIVER ENROLLMENT APPLICATION

## **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:** \_\_\_\_\_