

# 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 Based 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)

<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	<p style="text-align: center;"><b>MFP CODES ONLY</b></p> <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
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## 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
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**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
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**TERMINATION OF HCBS PROGRAM**

<input type="checkbox"/> HCBS Terminated	Reason	Date of Termination
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**CHANGE OF INDIVIDUAL'S FINANCIAL STATUS**

<input type="checkbox"/> Change in Individual's Financial Status. Documentation Attached.
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**OTHER INFORMATION**

<input type="checkbox"/> Other (Specify)
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**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 CAO 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	
<input type="checkbox"/> <b>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: <input type="text"/>  SERVICE BEGIN DATE: <input type="text"/>	Check the box to indicate that the individual was determined eligible for 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.
<input type="checkbox"/> <b>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:</b>  ASSESSMENT DATE: <input type="text"/>	Check the box to indicate that the individual was determined <u>ineligible</u> for HCBS. In the box enter the date that the assessment agency conducted the level of care and functional assessment and found the individual <u>ineligible</u> for HCBS.
<input type="checkbox"/> <b>NEW APPLICANT</b>  <input type="checkbox"/> <b>CHANGE</b> <input type="checkbox"/> <b>TRANSFER</b> <input type="checkbox"/> <b>TERMINATION</b> (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. <b>For a Change, Transfer or Termination use the reverse side of the form to enter additional information.</b>
<input type="checkbox"/> 38 Aging <input type="checkbox"/> 68 Per. Fam. Direct. Supp <input type="checkbox"/> 40 Attendant Care <input type="checkbox"/> 70 Infants, Toddlers & Fam. <input type="checkbox"/> 42 Independence Program <input type="checkbox"/> 77 Consolidated (ACAP) <input type="checkbox"/> 79 OBRA <input type="checkbox"/> 51 Adult Community Autism <input type="checkbox"/> 80 0192 <input type="checkbox"/> 52 Autism Waiver <input type="checkbox"/> 96 LIFE <input type="checkbox"/> 59 COMMCARE	For applicants - Check the appropriate HCBS program in which 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.
<input type="checkbox"/> 16 MFP Participant Living in a Dom. Care Facility <input type="checkbox"/> 17 MFP Participant Living in Own Residence <input type="checkbox"/> 18 MFP Participant Living with a Family Member <input type="checkbox"/> 19 MFP Participant Living in Other Group Setting with Less Than Five People	For Money Follows the Person (MFP) applicants – Check the appropriate MFP code in which the individual was determined eligible or ineligible to receive services. For MFP recipients – Check the appropriate MFP code to indicate which MFP code is affected by a change, transfer or termination of services. In order to be eligible for MFP, an individual must be enrolled or enrolling in one of the following six HCBS programs: Aging Waiver, Attendant Care Waiver, Independence Waiver, COMMCARE Waiver, Consolidated Waiver, OBRA Waiver.

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

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

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

<b>CURRENT ADMISSION TO A LTC FACILITY INFORMATION</b>	
<input type="checkbox"/> <b>INDIVIDUAL WAS ADMITTED TO LONG TERM CARE FACILITY OR PERSONAL CARE HOME / DOMICILIARY CARE FACILITY</b>	Check the box to indicate that the individual was admitted to a LTC facility, Personal Care Home (PCH) or Domiciliary Care (DC) facility.
<b>ADMISSION DATE</b>	Enter the date that the individual was admitted.
<input type="checkbox"/> <b>SHORT TERM ADMISSION (SERVICES EXPECTED TO RESUME AT DISCHARGE)</b>	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.
<b>LTC FACILITY OR PCH/DC FACILITY NAME</b>	Enter the name of the LTC facility, PCH or DC facility.
<b>ADDRESS</b>	Enter the LTC, PCH or DC facility's mailing address, including street, city, state and zip code.
<input type="checkbox"/> <b>AREA AGENCY ON AGING OFFICE NOTIFIED TO INITIATE PCH/DC APPLICATION (IF APPLICABLE)</b>	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.

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

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**CHANGE OF ADDRESS INFORMATION - SAME COUNTY**

<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.

**CHANGE OF COUNTY RESIDENCE INFORMATION**

<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.

**TRANSFERRING HCBS PROGRAM INFORMATION**

<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 <b>new</b> 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.

**PROGRAM WITHDRAWAL INFORMATION**

<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.

**TERMINATION OF HCBS PROGRAM INFORMATION**

<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.

**CHANGE IN INDIVIDUAL'S FINANCIAL STATUS**

<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.
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**OTHER INFORMATION**

<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.
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