Supplement to the PA 600WD

If you are receiving or applying for MAWD benefits, you may choose to apply to participate in a Waiver program. You must meet clinical (level of care) requirements to be eligible for the services provided by the waiver program you select. A staff member from the program office associated with the waiver program will contact you and determine whether you meet clinical eligibility requirements for the waiver program. Medical documentation will be required for the clinical determination.

Waiver programs offer MAWD recipients access to home and community-based services (HCBS) while allowing them to maintain their current level of income and resources. HCBS provide a variety of medical and non-medical services designed to help individuals with disabilities and the elderly live independently in their homes or in a community setting.

Individuals, age 55 and older who receive home and community-based services in their home or in a community setting must comply with the requirements of the Medicaid Estate Recovery Program. The Department of Public Welfare requires reimbursement for the cost of services paid by the Medicaid Program for home and community-based services and any related hospital and prescription drug service provided while receiving care in a community setting. The cost of these services will be paid from the probate of your estate.

Complete the following if you choose to apply for a waiver program:

1. Please check the types of services that you feel you need to help you live independently:

   □ Habilitation services (residential, day, supported employment)
   □ Homemaker/chore
   □ Adaptive appliances and equipment
   □ Attendant Care
   □ Therapies (physical, occupational, speech and visual)
   □ Respite Services

2. Are you receiving or have you received long-term care, support or home and community-based services?

   □ Yes   □ No

   If you are receiving or have received long-term care, supports or services, how were your expenses being paid?

   _____

   _____

Name	Social Security Number	Phone Number
_____	_____	_____
Signature	Date	
_____	_____	