Other Related Conditions Waiver Application Date:

| **1. Participant Information** |
| --- |
| Name: |  | DOB:  |  |
| Gender: |  M F | Medicaid #: |  | Medicare #: |  |
| Street Address: |  |
| Mailing Address, if different |  |  |  |  |  |
| Town: |  | State: | Maine | Zip: |  |
| Phone Number: |  | Marital Status: |  |

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| --- |
| **2. Current Living Situation**  |
| Facility Name (as applicable): |  |
| Street Address: |  |
| Mailing address, if different: |  |
| City: |  | County: |  | State: | ME | Zip: |  |
| Social Worker/Discharge Planner’s Name (as applicable): |  |
| Phone #: |  | Fax #: |  |
| Email address: |  |
| Admission date: (mm/dd/yyyy): |  |
| Current (MED Assessed) Level of Care:  | Date: |

|  |
| --- |
| **3. Person/Agency Making Referral *(if applicable)*** |
| Name of Person/Agency: |  |
| Street Address: |  |
| City: |  | County: |  | State: | ME | Zip: |  |
| Phone #: |  | Fax #: |  |
| Email address: |  |

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| **4. Legal Representative, Guardian, Power of Attorney****(Provide a copy of paperwork to OADS with this application)** |
| Name: |  |
| Street Address: |  |
| City: |  | County: |  | State: | ME | Zip: |  |
| Phone #: |  | Alternate Phone #: |  |
| Relationship to Client: |  |

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| --- |
| **5. Emergency Contact (i.e., Guardian, closest family member)** |
| Name: |  |
| Street Address: |  |
| City: |  | County: |  | State: | ME | Zip: |  |
| Phone #: |  | Alternate Phone #: |  |
| Relationship to Client: |  |

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| **6. Preferred Living Arrangements** |
| Does participant currently have a place to live outside the facility?  |  [ ] Yes [ ]  No  |
| Living Preference: | Consumer’s Choice | Guardian’s Choice(if applicable) | Comments |
| With relatives/caregiver in home |[ ] [ ]   |
|  -Relative’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ -Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| With relatives/caregiver in apartment |[ ] [ ]   |
|  -Relative’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ -Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Alone in apartment |[ ] [ ]   |
| Alone in own home |[ ] [ ]   |
| In 4-bed or less group home (4 unrelated individuals) *Please note that availability is very limited and may not be an option* |[ ] [ ]   |

|  |
| --- |
| **7. Information about Related Diagnosis**  |
| Date of Diagnosis |  | Age at time of Diagnosis: |  |
| Current Needs: |  |
| Current Diagnosis:***Confirmed by letter of Medical Necessity*** | 1. |
| 2. |
| 3. |

**Section 20 – Other Related Conditions Waiver**

**Complete this application and fax/mail along with all items listed below to:**

*Neurobehavioral Services/Other Related Conditions @ (****fax****) 207-287-9229*

*-or-*

*(****mail to:****)*

*DHHS - OADS*

*Attn: Other Related Conditions Care Monitor*

*41 Anthony Avenue, SHS #11*

*Augusta, Maine 04333-0011*

|  |
| --- |
| * Completed Application
* Release of Information
* Letter of Medical Necessity (to be completed by a physician)
* Power of Attorney, Representative Payee, or Guardianship Documents (if applicable)
* Choice Letter
 |