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: | | | | | |

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| **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* |  |  | |  |

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| --- | --- | --- | --- |
| **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 |