**Section 21 Waiver Information Form**

(for use by DS Case Mangers)

1. **MEMBER INFORMATION:**

|  |  |
| --- | --- |
| **Member Legal Name:** Click here to enter text. |  **Date of Birth:**Click here to enter text. |
| **EIS # (If known):** Click here to enter text. | **MaineCare #:**Click here to enter text. |
| **Mailing Address and Telephone Number:** Click here to enter text. |
| **Legal Guardian (s):** Click here to enter text.**Guardian Address:** Click here to enter text. | **Guardian Email Address:** Click here to enter text.**Guardian Phone #:** Click here to enter text. |
| **Case Manager:** Click here to enter text.**CM Agency:** Click here to enter text. | **Case Mgr. Email address:**Click here to enter text.**Case Mgr. Phone #:**Click here to enter text. |
| **Person Completing Form:**Click or tap here to enter text. | **Date Form Completed:**Click or tap to enter a date. |

[ ]  **Initial Application** / [ ]  **Reconsideration of Priority** / [ ]  **Annual WL Notice\***

1. Is the member receiving any services other than Case Management? [ ]  Yes [ ]  No

If yes, please choose: Choose an item.

If other, please explain: Click here to enter text.

1. Types of Services that are needed (check all that apply and explain below):

[ ]  Home Support – please choose the type of home support Choose an item.

[ ]  Community Support

[ ]  Work Support

[ ]  Assistive Technology (assessment, devices, transmission fees)

[ ]  Crisis services

[ ]  Behavioral Consultation

[ ]  Communication Devices/Assessments

[ ]  Other Consultation Services/Assessments

[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please explain: Click here to enter text.

1. Do you want to remain on the Waiting List? [ ]  Yes [ ]  No

\* Section I of this form is used for the Member’s Annual Waiting List Confirmation Review as outlined in MaineCare Benefits Manual Chapter II §21.03-6d. It must be completed and emailed to the OADS Waiver Manager when requested. OADS will mail the form to the Member and/or Guardian and Case Manager (if known) annually. **If OADS does not receive a completed form the Member may be removed from the Waiting List.**

1. **Living Situation**
2. Where is the member currently living? Choose an item.

If other, please explain: Click here to enter text.

1. Are there safety concerns where the member is living?

[ ]  No [ ]  Yes – for the Member [ ]  Yes – for others in the home

If yes, please explain: Click here to enter text.

1. Is there a caregiver in the home? [ ]  No [ ]  Yes - Choose an item.

 If yes, please explain how this affects the Member’s health and safety: Click here to enter text.

1. Are there any other caregivers willing and able to support the Member? [ ]  No [ ]  Yes

If yes, who are they and where do they currently live? Click here to enter text.

1. Is the Member having increased medical, mental health, and/or behavioral needs?

 [ ]  No [ ]  Yes

1. Is there a change in the member’s medical condition? [ ]  No [ ]  Yes
2. Has the member been admitted to the hospital three (3) or more times in the past 12 months?

 [ ]  No [ ]  Yes

1. Was there frequent or regular crisis contact in the past 12 months? [ ]  No [ ]  Yes
2. Is the member exhibiting any criminal behavior (conviction not required)? [ ]  No [ ]  Yes
3. Are there Reportable Events in the Member’s EIS record in the past 12 months? [ ]  No [ ]  Yes
4. Are there any referrals to Adult Protective Services (APS)? [ ]  No [ ]  Yes

**Details for the above questions must be included in the Member’s PCP.**

Please make sure the following questions are answered in the Member’s Person-Centered Plan (PCP) in EIS:

* What are the Member’s **current health and safety needs** (not just medical and dental appointments)? Which are met and which are unmet?
* Which **specific Waiver services will meet the Member’s needs** above? (please use the service names from the MaineCare Benefits Manual)
* What of **levels of support will paid staff provide** for each Waiver service needed? (Summary of DS Comprehensive/Support HCB Waiver in EIS)
* If the Member is receiving any paid support, why are these services not meeting the Member’s needs? (for example, Member is aging out of children’s services, or Member needs ancillary services not available on Section 29 Waiver).
* If the Member is still in High School, what is the expected graduation or completion month and year?

This form, a copy of the signed PCP Face Sheet, and a [Yearly Cost Estimate for Services](https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/documents/Combined%20Calculator%2021%20%2029%20Yearly%20Cost%20Estimate%201.31.xls) must be emailed to the Waiver Specialist. Please complete a DS Comprehensive Waiver assessment (aka BMS-99) in the Member’s EIS record before emailing the application packet.

**Applications packets must be complete. All forms and assessments must be in EIS or submitted via email to** **HCBS.Waiver@maine.gov****.**