**Section 21 Waiver Information Form**

(for use by Children’s and Mental Health 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
2. **Living Situation**
3. 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 or Incident Reports in the past 12 months? [ ]  No [ ]  Yes
4. Are there any referrals to Adult Protective Services (APS)? [ ]  No [ ]  Yes

Please complete the following forms and assessments for the application to Section 21:

* [Personal Plan Update](https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/documents/Personal-Plan-Update-for-Children%27s-and-Mental-Health-Case-Management%202.12.docx) – must be signed by Member/Guardian and case manager
* [Yearly Cost Estimate](https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/documents/Combined%20Calculator%2021%20%2029%20Yearly%20Cost%20Estimate%201.31.xls)
* [Developmental Home and Community Based Waiver Assessment (BMS-99)](https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/documents/Developmental-Services-Home-and_Community-Based-Waiver-Assessment%20%28BMS-99%29%202.12.docx) – must be in **Word**; do not scan and attach as a pdf

**Please email the complete application packet to** **HCBS.Waiver@maine.gov**. You should receive a response within 2 business days confirming receipt of the packet. If you do not receive a response, please email again asking if we received the original packet and include the Member’s name/initials and MaineCare number.

**A complete packet includes:**

* **Section 21 Waiver Information Form**
* **Member’s current service/treatment plan for case management**
* **Personal Plan Update**
* **Yearly Cost Estimate**
* **Developmental Home and Community Based Waiver Assessment (BMS-99) in Word**

You may include any other assessments, evaluations, or documents that document the member’s current service and support needs and are not more than three (3) years old.