GEORGIA DEPARTMENT *of* COMMUNITY HEALTH

APPENDIX F

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby request and authorize: _____
(Name of Person or Agency Requesting Information)

_____
(Address)

to obtain from: _____
(Name of Person or Agency Holding the Information)

_____
(Address)

the following type(s) of information from my records (and any specific portion thereof):

_____

_____

for the purpose of : _____

_____

All information I hereby authorize to be obtained from this agency will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for:

☐ ***Ninety (90) days, unless I specify an earlier expiration date here:*** _____
(Date)

☐ ***One year***

☐ ***The period necessary to complete all transactions on accounts related to services provided to me***

I understand that, unless otherwise limited by state or federal regulations and except to the extent that action has been taken based on my consent, I may withdraw this consent at any time.

_____ _____
(Date) (Signature of Member/Parent/Applicant)

_____
(Signature of Witness) (Title or Relationship to Member)

_____
(Signature of Parent or Authorized Representative, where applicable)

_____
(Date)

USE THIS SPACE ONLY IF THE MEMBER WITHDRAWS CONSENT

_____ _____
(Date the member withdraws this consent) (Signature of Member)

INDEPENDENT CARE PARTICIPANT APPLICATION

Note: Read all information concerning the Independent Care Waiver Program (ICWP) prior to completing this application. It is important to become familiar with the ICWP rules and regulations pertaining to your Plan of Care. For questions, call Alliant Health Solutions at 1-888-669-7195. Please return the application to Alliant Health Solutions at P. O. Box 105406, Atlanta, Georgia 30348; or fax to 678-527-3001; or email HCBSWaivers@AlliantHealth.org

1. Personal Information

Name:_____

Address:_____

_____
County City State Zip

Medicare#_____

Medicaid#_____

Private Insurance ____ **Yes** ____ **No**

Social Security#_____

Male ____ Female ____

Phone#: (_____)_____ Date of Birth: _____ Age: _____

Email: _____ Income: $_____(per. month)

Contact Person:_____ Phone: (____)_____

2. Disability Information

(Check all that best describes the reason for your disability)

☐	Spinal Cord Injury: Paraplegic	☐	Amputation	☐	Cerebral Palsy
☐	Level of injury:	☐	Of what?	☐	Muscular Dystrophy
☐	Spinal Cord Injury: Quadriplegic	☐		☐	Multiple Sclerosis
☐	Level of injury:	☐	Parkinson's Disease	☐	
☐	Head Injury	☐	Spina Bifida	☐	
☐	Stroke	☐	CHF/ heart failure	☐	
☐	Aneurysm	☐	COPD/ Emphysema	☐	
☐	Tumor	☐	Diabetes	☐	
☐	Arthritis or Rheumatism	☐	Non-verbal	☐	

Additional Diagnosis _____

_____

Date of onset of disability: _____

How would you describe your general health? (Check One)

Poor	Fair	Good	Excellent
☐	☐	☐	☐

3. If you had a choice, where would you live? Is there a person(s) you would like to live with, or would you live alone? Please explain.

_____

_____

_____

4. What is your present living arrangement? Check one of the following:

____House: is the home ____ owned or ____ rented?

____ Apartment

____ Nursing Home ____ Hospital ____ Group Home ____ ALS/PCH ____ Other: _____

The ICWP does not allow members to live in personal care homes. Would you be willing to move into an alternative living services (ALS) home? ____ **YES** ____ **NO**

Nursing Home/ALS/ PCH Name: _____

Address: _____

Phone number: _____

Social Worker: _____ Phone: (____) _____

Email:_____

Date admitted: _____ Date discharged: _____

If the application is being submitted by MFP:

Does the facility have internet capability? _____

Does the facility have access to a device with a webcam? _____

Is the applicant currently receiving: _____ PT _____ OT _____ Speech _____ Wound Care

Please submit: _____ History and Physical _____ Current medication

5. Transfer Method (Please Check One Item That Best Describes How You Transfer)

_____Two people assist with adaptive equipment _____
Specify

_____Two people assist without adaptive equipment

_____One person assists with adaptive equipment _____
Specify

_____One person assists without adaptive equipment

_____Can transfer without human assistance but with adaptive equipment _____
Specify

_____Can transfer without assistance

_____Other: _____

6. Activities of Daily Living Needs
In each row, indicate how much assistance you need:

	TOTAL	PARTIAL	MINIMAL	NONE
Bathing	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Eating	☐	☐	☐	☐
Bowel/ Bladder Care	☐	☐	☐	☐
Reposition to Prevent sores	☐	☐	☐	☐
Other:	☐	☐	☐	☐

7. Equipment You Use Daily

	Use	Needed/Requested
Ventilator or Respirator	☐	
Modified Power Wheelchair	☐	
Regular Power Wheelchair	☐	
Modified Manual Wheelchair	☐	
Regular Manual Wheelchair	☐	
Hoyer Lift	☐	
Transfer Board	☐	
Mouth-stick	☐	

Walker	☐	
Brace(s)	☐	
Prosthesis	☐	
Crutches	☐	
Cane	☐	
Hospital Bed	☐	
Hospital Bed w. Special Mattress	☐	
Reacher	☐	
Shower/Commode Chair	☐	
Splints	☐	

8. Do you require any of the following interventions?

Tracheostomy requiring suctioning	☐	**BG checks/ insulin injections**	☐
Ventilator	☐	**Wound Care**	☐
Tube Feeding	☐	**Colostomy**	☐
Urinary Catheter	☐	**Medication administration assistance**	☐

9. Relationships

Do you have regular visitors? ____Yes ____ No

Who visits? **(Check ALL that apply)**

(Frequency)

☐ Spouse _____

☐ Parents _____

☐ Other relative(s) _____

☐ Friends _____

☐ Pastor or Rabbi _____

Do you live with someone or plan to live with someone? _____

If yes, with whom? _____

Does that person provide any care? _____

10. Help needed at the following times (Check all that apply)

☐	Night	10:00 p.m. to 6:00 a.m.
☐	Morning	9:00 a.m. to Noon
☐	Afternoon	Noon to 4:00 p.m.
☐	Early Evening	4:00 p.m. to 7:00 p.m.
☐	Evening	7:00 p.m. to 10 p.m.

Total hours requested:_____

11. Identify caregivers who will commit to providing daily care.

_____ _____ (____)_____
Name Relationship Phone #

_____ _____ (____)_____
Name Relationship Phone #

_____ _____ (____)_____
Name Relationship Phone #

12. List all medications you are currently taking:

Name of Medication	Dose strength	How is it given? Oral/ inhaler/ injection	How often is it given?

13. List current doctors you routinely see:

Doctors Name	Specialty	City/Location	When did you last see the doctor?

14. How many times have you needed hospital care in the past year? _____

Diagnosis for your hospital admission?	How long were you there?	Approximate dates?

15. Are you currently receiving services from another waiver program? ____ Yes _____ No

a. If so, from which program do you receive services? _____

b. How many hours per day or week do you receive? _____

c. Do these services sufficiently meet your needs? ☐ Yes ☐ No

Why or Why not? _____

Provide additional information that would help identify your needs.

_____

_____

_____

ALLIANT HEALTH SOLUTIONS

ATTESTATION STATEMENT

The information I have provided in this ICWP application is true and complete to the best of my knowledge.

_____ _____

Client / Client Representative Signature Date

ALLIANT HEALTH SOLUTIONS

Independent Care Waiver Program

Potential ICWP Medicaid Financial Application Worksheet

Client's Name: _____ **Date of Birth:** _____

Section I	**INCOME**	**AMOUNT**
	Social Security	$ _____
	VA Benefits	$ _____
	Retirement / Pension	$ _____
	Interest / Dividends	$ _____
	Other (specify)	$ _____
	TOTAL INCOME	$ _____

Note: If monthly income exceeds the limit, stop here.

Section II	**RESOURCES**	**ESTIMATED VALUE**
	Cash	$ _____
	Checking	$ _____
	Savings Account	$ _____
	Credit Union Account	$ _____
	Certificate of Deposit or IRA	$ _____
	Stocks or Bonds	$ _____
	Patient Fund Account (held by nursing home)	$ _____
	House or Property other than home	$ _____
	Place that is not producing income	$ _____
	Other (specify)	$ _____
	TOTAL RESOURCES	$ _____
	Subtract Individual or Spousal Impoverishment Resource Limit	$ _____