NEW HORIZONS
CARE COORDINATORS

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waitlist@nhccacares.com
Office: (916) 745-3754
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Thank you for entrusting New Horizons Care Coordinators (formally known as NorCal Care Coordinators) as your Community Care Agency. We are looking forward to the next steps with you. The Care Coordinator Agencies (CCA) are third party contractors for the program and handle the application paperwork for the state. You have the right to choose which agency you work with.

Community Referrals: Clients at home, at a Assisted living/Board and Care facility, homeless

As of March 2023, there is still a waitlist for clients that are living in the community. The current waitlist is approximately 12- 18 months. This is a best guess.
Our Waitlist Coordinator's phone number is: 916-745-3754. waitlist@nhccacares.com
We would need some basic information to put the client on the waiting list for the Assisted Living Wavier Program (ALW Program). Once the client is on the waitlist, we will inform you by email or phone. If there are any changes in the client's information like location, contact information, or Adult protective service involvement please let us know. So, we can update the client's chart.

Inpatient and Skilled Nursing Referrals

Per the Medi-Cal Assisted Living Waiver Program:
Clients need to be admitted to a higher level of care for at least 60 consecutive days for us to start the application process.
Via Email (office@nhccacares.com) OR HIPPA secure Fax (916-512-3473) send the following information:

- Admission Face Sheet
- History & Physical
- Current Medication List
- Point of contact at the facility.

Once this paperwork has been received, it will be given to one of or Nurses for initial review.

CLIENT REQUIREMENTS FOR THE ASSISTED LIVING WAIVER PROGRAM

To be eligible to receive services as an ALW Participant, an individual must meet the following ALW eligibility criteria:
Age 21 or older.
Have full-scope Medi-Cal eligibility with zero share of cost.
Have care needs equal to those of Medi-Cal-funded residents living and receiving care in nursing facilities.
Willing to live in an assisted living setting as an alternative to a nursing facility.
Able to reside safely in an assisted living facility
Willing to live in an assisted living setting located in one of the following counties providing ALW services: **Alameda, Contra Costa, Fresno, Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, and Sonoma counties**.
Income- they need to have a monthly income to cover the Room and Board Rate

If the client has Alzheimer's, dementia, or another Cognitive Impairment diagnosis we need a Health Care Power of Attorney OR an Advance Healthcare Directive. This is required by the ALW program. If the client has ALZ, dementia, etc... and does NOT have these documents in place, we are unable to help them.

Please fill out the form below and return to New Horizons CCA

Beneficiary Information

Beneficiary Full name:_____ Date: _____

Gender: ☐ Male ☐ Female Married: ☐ Yes ☐ No

Does your client have Medi-Cal? ☐ Yes ☐ No with No Share of Cost? ☐ Yes ☐ No

Does your client have income? ☐ Yes ☐ No If yes Total amount per month: _____

SSA/SSI/SSD Amount: _____Pension Amount: _____ Other Income: _____

Medi-Cal/SSN: _____ Date of Birth: _____

Contact Person_____Relationship: _____

Phone: _____ Email: _____

Contact Person_____Relationship: _____

Phone: _____ Email: _____

Currently Residing: ☐ Assisted Living Facility ☐ Home ☐ Skilled Nursing ☐ Hospital

Name of Facility (if Applicable):_____

Current Address:_____

City: _____ State: _____ Zip: _____

Pre-screen assessment

Please complete all questions to the best of your ability

Scoring: 0=Independent 1=supervision: reminding and/or set-up of supplies 2=limited: Client able to do most tasks, and hands-on assist <3x/week 3= Extensive: Most, but not all, tasks done by others> 3x/week 4= Total Dependence: all aspects of activities of daily living, requires hands-on assistance

	0	1	2	3	4
Bed Mobility – (how client moves and positions self.)	☐	☐	☐	☐	☐
Transfer – (how client moves between bed, wheelchair, Toilet, Etc.)	☐	☐	☐	☐	☐
Locomotion in residence – (how client moves around residence, walker, cane, Etc.)	☐	☐	☐	☐	☐
Dressing – (how client puts on, fastens, and takes off clothing)	☐	☐	☐	☐	☐
Eating – (how client eats and drinks)	☐	☐	☐	☐	☐
Toilet use/incontinent – transfers on/off toilet of commode)	☐	☐	☐	☐	☐
Personal hygiene – (washing up, brushing teeth, combing hair, shaving)	☐	☐	☐	☐	☐
Bathing – (how client takes Bath/shower)	☐	☐	☐	☐	☐

MEDICATIONS		
☐ Five or less prescription medications ☐ Six or more prescription medications		
	Yes	No
Is the client physically capable of taking medications without assistance (opening bottles, etc.)	☐	☐
Does the client know what the medications are for?	☐	☐
Does the client know how to take the medications? (by mouth or topically).	☐	☐
Does the client know how often to take the medications?	☐	☐
Is the client capable of communicating if the medication has unintended side effects?	☐	☐
Does the client require supplemental oxygen?	☐	☐

Additional Information

Check all that apply.

Memory Diabetes, Mental, and Other Information

Cognitive Issues: ☐ Confused ☐ Alzheimer's ☐ Dementia ☐ Wanders/exits ☐ TBI

If their is cognitive diagnosis is there a healthcare power of attorney or advance healthcare directives? ☐ Yes ☐ No

Mental Health Diagnosis? ☐ Yes ☐ No

☐ Schizophrenia ☐ Bi-Polar ☐ Depression ☐ Other:_____

History Of Substance Abuse? ☐ Yes ☐ No

History of Behavioral Issues? (Verbal or physical violence, etc.) ☐ Yes ☐ No

Diabetes: ☐ Yes ☐ No If Yes: Finger Sticks: ☐ Yes ☐ No Insulin: ☐ Yes ☐ No

If yes, is the beneficiary able self-Inject? ☐ Yes ☐ No

Does the beneficiary have pressure sores or open wounds? ☐ Yes ☐ No

Does the applicant require a Hoyer or bariatric lift? ☐ Yes ☐ No

Is Adult Protective Services actively involved? ☐ Yes ☐ No

(If yes, we will need a letter stating that there is an open case from APS)

If you answered yes to the questions above, please briefly explain: