Department of Health and Human Services
Maine People Living
Safe, Healthy and Productive Lives

Paul R. LePage, Governor
Ricker Hamilton, Commissioner

Department of Health and Human Services
Aging and Disability Services
41 Anthony Avenue
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-9200; Toll Free (800) 262-2232; Fax (Aging): (207) 287-9229
Fax (Disability): (207) 287-9915; TTY Users: Dial 711 (Maine Relay)

4/6/2018

[redacted]

Re: [redacted]

MaineCare ID: [redacted]

Dear [redacted]:

[redacted] is currently on the Section 21 waiting list. We need to make sure [redacted] wants to stay on the waiting list. This is also an opportunity to provide updated information, about a change in needs.

To remain on the waiting list for Section 21, please complete the **Section 21 Waiver Information Form** and return it to the department within **6 months** from the date of this letter. Please contact your casemanager to help with completing this form. If we do not receive this form you may be removed from the waiting list.

If you do not have a casemanager, and have additional questions please call me at (207)287-9392

21.03-6(D) Annual Waiting List Confirmation: The member must confirm on an annual basis his/her interest in remaining on the Section 21 waiting list in accordance with the following process:

1. The Office of Aging and Disability Services will notify the member, his/her guardian, and the member's Case Manager of the need to complete the Section 21 Waiver Information Form to confirm the member's continued interest in remaining on the waiting list.
2. The member, his/her guardian, and the member's Case Manager will complete the Section 21 Waiver Information Form and submit the form to the Department.
3. If the Section 21 Waiver Information Form is not received within forty-five (45) days of notice to the member, his/her guardian, and Case Manager, then the Department will issue a second reminder notice.
4 .In the event that the Section 21 Waiver Information Form is not received by the Department within six (6) months of the initial notice to the member, his/her guardian, and Case Manager, then the Department will notify the member of his/her removal from the waiting list. The member can reapply for Section 21 services thereafter.

Sincerely,

Robert Hyer

Robert Hyer
Acting Waiver Manager for Developmental Services
Office of Aging and Disability Services
Department of Health and Human Services

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# Section 21 Waiver Information Form

## I. MEMBER INFORMATION:

| | |
|---|---|
| **Member Legal Name:** | **Date of Birth:** |
| **EIS # (If known):** | **MaineCare #:** |
| **Mailing Address:** | |
| **Legal Guardian (s):** | **Guardian Email Address:** |
| **Guardian Address:** | **Guardian Phone #:** |
| **Case Manager:** | **Case Mgr. Email address:** |
| **CM Agency** | **Case Mgr. Phone #:** |
| **Person Completing Form:** | **Date Form Completed:** |

1. Is the member receiving any services? ☐ Yes ☐ No

   If yes, please check all that apply:

   ☐ Mental Health Community Supports(S17) ☐Brain Injury Waiver(S18) ☐Adults with Disability Waiver(S19) ☐Other related Conditions Waiver (19) ☐Rehabilitation and Community Supports for Childrein(S28) ☐ ICF/IDD(S50) ☐Private Non-medication Institution Services(S96) ☐Behavioral Health Services(S65) ☐Behavioral health homes(S92) ☐State Contact ☐Other

   If other, please explain: _____

   _____

   _____

   _____

   _____

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

☐ Home Supports – Shared Living ☐ Home Supports – 24/7 Residential ☐ Home Supports - In-Home Supports ☐ Community ☐ Work ☐ Respite ☐ Assisted Technology ☐ Crisis services ☐ Behavioral Consultation ☐ Communication Devices/Assessments ☐ Other Consultation Services/Assessments ☐ Other

Please explain:_____

3. Do you want to remain on the waiting list? ☐ Yes ☐ No

This form must be completed and returned to the Office of Aging & Disability Services (OADS) for Annual Waiting List Confirmation Review as outlined in MaineCare Benefits Manual Chapter II §21.03-6d. **If we do not receive this form you may be removed from the waiting list.**

**Please Send Completed Forms to:**

**Waiver Assistant**
**c/o DHHS/OADS**
**41 Anthony Ave State House Station 11**
**Augusta Maine 04333-0011**

**For an initial application or reconsideration of priority, please complete entire form.**

☐ **Initial Application** / ☐ **Reconsideration of Priority**

## II. Living Situation

1. Where is the member currently living? _____

_____

_____

2. Have the member's living arrangements changed in the past few years? ☐ Yes ☐ No

   If yes, please explain: _____

_____

_____

_____

_____

_____

3. Is the member living in unhealthy or unsafe circumstances? ☐ Yes ☐ No

   If yes, please explain: _____

_____

_____

_____

_____

_____

## III. CAREGIVER INFORMATION:

| **Primary Caregiver's name (s):** | **Date of Birth:** |
|---|---|
| **Relationship to Member:** | |

1. Is the caregiver having difficulty caring for the member? ☐ Yes ☐ No

   If yes, please explain: _____

_____

_____

_____

_____

2. Does primary caregiver have a terminal illness? ☐ Yes ☐ No

   If yes, is another responsible or willing caregiver available? ☐ Yes ☐ No

   Who/Relationship to Member? _____

   _____

   _____

   _____

   _____

   _____

## IV. Health and Safety:

1. In the past 12 months, has a report been filed with DHHS on behalf of the member, due to abuse, neglect and/or exploitation? ☐ Yes ☐ No

   If yes, please specify date of most recent report and a brief explanation. _____

   _____

   _____

   _____

   _____

   _____

2. Is the health, safety or welfare of the member in danger? ☐ Yes ☐ No

   If yes, please explain._____

   _____

   _____

   _____

   _____

3. Is the health, safety or welfare of others in danger, due to the member's needs? ☐ Yes ☐ No

   If yes, please explain. _____

   _____

   _____

   _____

   _____

4. Within the last 12 months, has the member (check all that apply and explain):

☐ Increased functional needs and required supports, as a result of a mental health or medical condition. Please list all current diagnosis. _____

_____

_____

_____

☐ Criminal behavior resulting in involvement with the Criminal Justice System (not dependent upon conviction) that impacts or results in the harm or threat to others.

☐ Three or more hospital admissions over the last 12 months due to a medical or behavioral decline that is expected to continue.

☐ Prolonged and unresolved Crisis Involvement resulting in high-risk for institutionalization

Please explain: _____

_____

_____

_____

_____

5. Is the member at risk for abuse, neglect, and/or exploitation in the absence of, the provision of benefit services, identified in the service plan? ☐ Yes ☐ No

   If yes, please explain: _____

_____

_____

_____

_____

_____

_____

_____

Please include in this Application:

1. A signed current Person-Centered Plan Face Sheet (both pages) or Personal Plan (**MH or Children's Case Management**)
2. A completed **DS Comprehensive HCB Waiver Assessment** (commonly referred to as a BMS-99) saved in **EIS** and **not locked** or a completed assessment at: http://www.maine.gov/dhhs/oads/docs/ICF.doc **(MH or Children's Case Management)**
3. A completed Annual Cost of Care Estimate at: http://www.maine.gov/dhhs/oads/docs/calculator.xsl
4. Provide all relevant/current documents that will support eligibility and priority determination

**Please Send Completed Application To:**

**Waiver Assistant**
**c/o DHHS/OADS**
**41 Anthony Ave State House Station 11**
**Augusta Maine 04333-0011**