HCS Program

Waiting List

MARY LEE FOUNDATION

Date of Received HCS Program Waiting List: _____

Currently have HCS waiver: ☐ Yes ☐ No ☐ Enrollment in Process

Type of HCS services looking to receive: _____

Name: _____ Nick Name: _____

Medicaid ID #: _____ Level of Need (LON): _____

Qualifying Diagnosis: _____

Current Provider: _____ Phone #: _____

Email: _____

Current Case Manager/: _____ Phone #: _____
Family Member

Email: _____

Current Address: _____

Primary contact: _____ Phone #: _____

Email: _____

Physician's name: _____ Telephone #: _____

Address: _____

Age: _____ Date of birth: _____ Sex: ☐ Male ☐ Female Weight: _____ Height: _____
Month/Day/Year

Are they currently under Guardianship? ☐ Yes ☐ No If yes, list type of Guardianship and Name of Guardian(s)

_____

Known Allergies: ☐ Yes ☐ No (If yes, please explain in detail allergy and reaction): _____

_____

_____

History of seizures? ☐ Yes ☐ No (If yes, please explain in detail how often, date of last seizure, how long the seizure lasted and what type of seizures, any triggers) _____

_____

_____

Any dietary restrictions? ☐ Yes ☐ No (If yes, please explain.) _____

_____

Is any assistance needed for eating/drinking? ☐ Yes ☐ No (If yes, please explain.) _____

_____

_____

Any behavior problems? ☐ Yes ☐ No (If yes, please explain in detail.) _____

_____

_____

Is this person on a behavior plan? ☐ Yes ☐ No (If yes, please provide us with a copy)

Does he/she need assistance toileting? ☐ Yes ☐ No (If yes, please explain in detail.)

_____

_____

Does he/she need assistance bathing? ☐ Yes ☐ No (If yes, please explain in detail.)

_____

_____

History of wandering from assigned area without informing staff? ☐ Yes ☐ No (If yes, please explain in detail.)

_____

_____

_____

Does he/she need assistance walking or ambulating? Is he/she a fall risk? ☐ Yes ☐ No (If yes, please explain.)

_____

_____

_____

Medical History: (If yes, please explain.)

☐ Yes ☐ No Heart Disease: _____

☐ Yes ☐ No High Blood Pressure: _____

☐ Yes ☐ No Chronic Lung Disease: _____

☐ Yes ☐ No Asthma: _____

☐ Yes ☐ No Kidney Disease: _____

☐ Yes ☐ No Diabetes: _____

☐ Yes ☐ No Cancer: _____

☐ Yes ☐ No Hearing Problems: _____

☐ Yes ☐ No Visual Problems: _____

☐ Yes ☐ No Problems with Bowel or Bladder Functions: _____

☐ Yes ☐ No Stroke or TIA's: _____

☐ Yes ☐ No Recent Surgeries: _____

☐ Yes ☐ No Orthopedic Problems: _____

☐ Yes ☐ No Other: _____

Vaccines: ☐ Yes ☐ No Pneumonia Date received: _____

☐ Yes ☐ No Influenza Date received: _____

☐ Yes ☐ No Chicken Pox Date received: _____

☐ Yes ☐ No Tetanus Date received: _____

☐ Yes ☐ No COVID Date received: _____

☐ Yes ☐ No Shingles Date received: _____

Medications and times: _____

_____

_____

Level of Supervision required:

☐ No special supervision away from facility (is able to walk away, ride the bus/STS and travel around town without staff assistance).

☐ No special supervision within facility but has the following restrictions when traveling away from the facility:_____

_____

_____

_____

☐ Within eyesight

☐ Within hearing

☐ Within arm's length

☐ Other supervision restrictions: _____

_____

_____

_____

Name of person completing application: _____

Signature: _____ Date: _____

- Please submit the ICAP booklet/Score sheet and DID (Determination of Intellectual Disability) documents to Mary Lee Foundation, HCS Department, with this completed form. Thank you!

Supplementary documents received by: _____ Date:_____