ALW Care Coordination Benefits

Care Coordination Agencies (CCA) assist participants in gaining access to needed waiver and other state plan services. This waiver benefit is designed to address the need for care coordination prior to the successful transition of an individual from a skilled nursing or institutional setting into an assisted living setting and to ensure that the participants care needs are continuously being met throughout their program enrollment.

In collaboration with participants and/or their families, the CCA will complete the assessment and reassessment of waiver participants using the ALW Assessment Tool, at least every six months, or more frequently if indicated by a change in the condition of the participant. CCAs must verify Medi-Cal eligibility and include the participants or their representative in the direct development and implementation of their Individual Service Plan (ISP).

Participants who are unable to direct the development of their own ISP and participate in the oversight of their own services may be assisted by a family member or other responsible party, such as a conservator. Persons responsible for a participant's health care decisions may fill the lead role in plan development and oversight in collaboration with the CCA as necessary.

Care coordination is on-going for the duration of time the participant is enrolled in the waiver. If a participant leaves the facility due to hospitalization, the CCA will continue to advocate for the participant for up to thirty days for the purpose of coordinating the participant returning to the assisted living setting.