



GRACE ADULT DAY HEALTH CARE
Community-Based Adult Services
Participant Information

Dear Applicant,

Thank you for your interest in Grace Adult Day Health Care. This package is your application. If you have any questions, or would like help completing it, please call our Social Work Department at (408) 727-6280.

WHO QUALIFIES

CBAS is a Medi-Cal benefit for adults who have an ongoing health, memory or mental health condition, need supervision or skilled care during the day, and would be at risk of hospital or nursing facility care without it.

Your Medi-Cal health plan decides whether CBAS is authorized, based on your physician's request and our assessment. Grace also reviews each application to make sure we can meet the applicant's needs safely. Our Social Work Department can answer questions about the program and the application.

HOW TO APPLY

Your application is complete when we have received all of the following:

- the Participant Information form on the following pages;
- the Grace Physician Health Assessment form, completed by your doctor;
- TB clearance; and
- if you are a Santa Clara Family Health Plan member, your plan's Health Risk Assessment (HRA).

Return the package by fax, mail or in person, or complete and sign it through the secure link we send you. Please do not send it by ordinary email — email is not a secure way to send health information.

Fax	(408) 516-9527
Mail or deliver	Grace Adult Day Health Care, 3010 Olcott Street, Santa Clara, CA 95054
Questions	Social Work Department, (408) 727-6280

Our Intake Coordinator will contact you once the complete application has been received. If you have not heard from us within a week, please call us.

COST

If you qualify, your Medi-Cal health plan, the VA, or long-term care insurance may cover the full cost. If you are paying privately, call the Center for our rates.

MEALS AND TRANSPORTATION

Breakfast, a hot lunch and snacks are provided every day. Door-to-door transportation is available in most of Santa Clara County and in Fremont.

If you live outside our routes, we will help you apply for transportation through VTA ACCESS paratransit.

IF YOU ARE NOT YET IN A MEDI-CAL HEALTH PLAN

Call Health Care Options at 1-844-580-7272 to enroll. The plans available depend on where you live:

Santa Clara County	Anthem Blue Cross • Santa Clara Family Health Plan • Kaiser
Alameda County	Anthem Blue Cross • Alameda Alliance

Health Care Options in your language:

Farsi	Mandarin	Vietnamese	Spanish
1-800-840-5034	1-800-576-6885	1-800-430-8008	1-800-430-3003

WHAT HAPPENS NEXT

1. Once your complete package has arrived, we review it and our Intake Coordinator contacts you.
2. Your assessment takes place over your first three days at the Center. Our nurse, social worker and therapists meet you on each of those days. Plan to stay at least four hours each day, and bring your medications in their original containers. Your social worker also visits your home during these days — a home assessment is required before you can start.
3. Your Grace team prepares your plan of care — the services you will receive and the days you will attend — and sends it to your physician for signature.
4. Once the plan is signed and your health plan approves the services, we confirm your first day and arrange your transportation.

A family member or caregiver is welcome at any part of the assessment.

PARTICIPANT

Last name _____ First name _____
Date of birth ____/____/____ Sex ☐ M ☐ F
Address _____
City _____ ZIP _____
Telephone _____ Email _____

LANGUAGE

Primary language _____
Speaks English ☐ Fluently ☐ Some ☐ Not at all

COVERAGE

Medi-Cal # _____ Issue date ____/____/____
Medicare # _____
SSN _____ - _____ - _____
Health plan ☐ SCFHP ☐ Anthem ☐ Kaiser ☐ Alameda Alliance ☐ HPSM ☐ VA
Share of cost ☐ No ☐ Yes — \$ _____ per month
Private pay ☐ No ☐ Yes

HOME AND SUPPORT

Residence ☐ House ☐ Apartment ☐ ICF/DD-H ☐ Other ☐ Residential care facility
Lives with ☐ Alone ☐ Spouse ☐ Adult child ☐ Other relative ☐ Other
Hours alone ☐ None ☐ Under 4 ☐ 4 to 8 ☐ Over 8
Receives IHSS ☐ No ☐ Yes

CONTACTS

FIRST CAREGIVER OR EMERGENCY CONTACT

Name _____ Relationship _____
Phone _____ Email _____
Address _____

SECOND CAREGIVER

Name _____ Relationship _____
Phone _____ Email _____
Address _____

HEALTH

Hospital stay ☐ None ____/____/____ Reason _____
Last ER visit ☐ None ____/____/____ Reason _____
Last fall ☐ None ____/____/____ Falls in the past 6 months ☐ None ☐ One ☐ Two or more
Equipment ☐ None ☐ Cane ☐ Walker ☐ Wheelchair ☐ Oxygen ☐ Catheter
Memory concerns ☐ No ☐ Yes — _____



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SAFETY

	Yes	No	If yes, explain
Wanders or leaves without telling anyone	☐	☐	
Physical aggression in the last 6 months	☐	☐	
Needs two people to transfer	☐	☐	

HELP NEEDED EACH DAY

Activity	Independent	Supervision	Assistance	Dependent	Notes
Walking	☐	☐	☐	☐	
Getting in and out of bed or a chair	☐	☐	☐	☐	
Bathing	☐	☐	☐	☐	
Dressing	☐	☐	☐	☐	
Eating	☐	☐	☐	☐	
Toileting	☐	☐	☐	☐	
Grooming	☐	☐	☐	☐	
Taking medications	☐	☐	☐	☐	
Preparing meals	☐	☐	☐	☐	
Housework	☐	☐	☐	☐	
Shopping	☐	☐	☐	☐	
Managing money	☐	☐	☐	☐	
Using the telephone	☐	☐	☐	☐	
Getting to appointments	☐	☐	☐	☐	

PHYSICIANS

	Name	Address	Phone	Fax
Primary care				
Specialist				
Other provider				

ADDITIONAL INFORMATION

SIGNATURE

I confirm that the information above is accurate to the best of my knowledge.

Signature of participant _____ Date ____/____/____

Signature of family or caregiver _____ Date ____/____/____

