



**State of Maine**  
**Department of Health and Human Services**  
**Assessment: DS SECT 21 COMPREHENSIVE WAIVER WAITING LIST JUSTIFICATION**  
**Fill out and send to: OACPDS – SHS 11 – 2<sup>nd</sup> Flr. Marquardt – Augusta - Attn: Charlene Plourde or**  
**E-mail to: OACPDS.DHHS@maine.gov**

<b>Does the person have a chronic illness that is not being managed safely at this time?</b>		
<b>Describe the illness and the level of care needed:</b>		
<b>Hospitalizations the last six months?</b>		Y/N
<b>CURRENT CARE PROVIDER</b>		
<b>Current care provider no longer has capacity to provide care due to:</b>	<b>Age of caregiver(s)</b>	<input type="checkbox"/>
	Physical/Medical Issues of the Caregiver	<input type="checkbox"/>
	Level of Stress in the Home Due to Care Being Provided	<input type="checkbox"/>
	Aging Out of Services	<input type="checkbox"/>
<b>Explain Care Provider Status:</b>		
<b>What other support services (paid or unpaid) is the person getting now?</b>		
<b>What has changed that does not allow the person to be supported where they are?</b>		
<b>What other options have been tried?</b>		
<b>What support is needed to alleviate the health and safety situation?</b>		
<b>What specific waiver services have been identified in the plan?</b>		
		Y/N
<b>If waiver funding was approved and an appropriate cost effective placement was available today would the person or family make the decision to move?</b>		
<b>Case Mgrs. Name</b>		<b>Agency</b>
<b>Date Form Completed:</b>		
<b>I signify the above information is current and accurately describes the person's current status and needs as of this date.</b>		
<b>Signature</b>		<b>Date</b>

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