This checklist should only be submitted when a rights modification is needed due to documented wandering or exit seeking behaviors that have proven impossible to successfully manage in a less restrictive setting. Evidence must be provided.

NCW Individual’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicaid ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pega: \_PRG - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. This request is for: [ ]  A new applicant, not yet enrolled in NCW

Anticipated NCW enrollment date: \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was he/she in a memory care/secured unit at the time of application? [ ]  Yes [ ]  No

[ ]  An enrolled individual moving to memory care/secured unit from another setting

What type of setting have they been living in before now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specify the timing: [ ]  Mid-care plan [ ]  Annual review

[ ]  Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does this individual have sufficient mental capacity to make an informed decision to agree to memory care/secured unit placement? [ ]  Yes [ ]  No (If no, a representative must be identified in #4)
2. Does this individual’s physician believe mental capacity will decrease over time?

 [ ]  No [ ]  Yes (If yes, a representative must be identified in #4)

1. If the answer to #2 is “No” and/or the answer to #3 is “Yes,” a representative who is willing to approve this placement is required. What is the name & relationship of representative? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. If question #4 is required and the answer is “Yes,” does the representative plan to remain involved throughout the duration of NCW enrollment to continue to make decisions on behalf of this individual? (Obtain a statement confirming their intent to remain involved.) [ ]  Yes [ ]  No (If no, request will be denied.)
3. Attach all of the following records/items and submit them together with this completed form to the NCW program office:

[ ]  A LOC Determination completed in the last 365 days which indicates disorientation to person, place and/or time.

[ ]  A narrative description of the specific wandering, exit seeking, and other behaviors exhibited by this individual that have endangered the NCW individual or others, records of incidents that have occurred, clinical diagnoses, and any other justification to support the restrictive placement.

[ ]  A narrative description or written documentation of less restrictive interventions tried and how these interventions failed which led to necessitating restrictive placement. (Examples may include attempts to redirect, use of a prescribed WanderGuard, door alarms, constant supervision, a less restrictive setting, etc.) **OR** an explanation describing long-term placement in this setting already and a detailed description of how moving would be detrimental to health and safety.

[ ]  A narrative description of the NCW individual’s stated goals/wishes for community integration and a written plan for how to achieve their stated goals/wishes. Include the frequency and who will be responsible to assist with accessing the greater community **OR** an explanation for why community access will not occur (Examples may include the Individual’s preferences, extreme disorientation causing health decline if they exit their “home” environment, etc.)

[ ]  When a representative is listed in question #4, obtain a signed statement from the representative stating, “I explicitly approve the restrictive placement of [NCW Participant] and affirm my intent to remain involved with [NCW Participant] throughout New Choices Waiver enrollment in order to make decisions on their behalf.”

CMA Case Manager or CMA RN Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CMA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CMA Case Manager or CMA RN Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NCW Program Office Approval Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_