Children's HCBS Authorization and Care Manager Notification Form

Instructions: The Children's Waiver Home and Community Based Services (HCBS) Provider must complete this Form for Children's Waiver HCBS provided at least 14 days prior to the initial service period of 24 hours/96 units/60 days (for new authorizations) or existing authorization period (for reauthorizations) expiring. **Providers should not wait until the initial/existing service amount/period has been exhausted before proceeding with this step.** Completion of this Form is not necessary for the initial service period of 24 hours/96 units/60 days. Submission of this Form does not replace the requirement for HCBS providers to notify Medicaid Managed Care Plans (MMCPs) of the first HCBS appointment date. Services must be provided in accordance with a person-centered Plan of Care (POC), the Children's Waiver, and the Children's HCBS Manual.

- For children enrolled in Medicaid Managed Care, the HCBS Provider completes Section 1 of this Form and submits it to the child's MMCP for review according to the MMCP's authorization procedures. Following the review, the MMCP issues a service authorization determination to the enrollee and HCBS Provider. The HCBS Provider then completes Section 2 and sends this Form with a copy of the service authorization determination to the child's Health Home/C-YES care manager.
- For children covered by fee-for-service Medicaid (i.e., not enrolled with a MMCP), the HCBS Provider completes Section 1 of the Form and sends it to the child's Health Home/C-YES care manager, as applicable. Services provided are subject to State audit.

All fields must be completed unless listed as optional or as applicable.

Section 1 – Completed by HCBS Provider

Participant Information

Participant Name ____ Participant DOB ___________________________

Participant Phone ____________________ Participant Email (optional) ______________________

Participant Address

____

Participant CIN ________________ ☐ Check this box if the participant is in Foster Care

Name of 29-I Foster Care Agency (if Foster Care box is checked) ______________________________

Care Manager (CM) Name________________________ CM Phone_______________ CM Email __________

Name of Health Home/C-YES __________________________________

Parent/Guardian/Legally Authorized Representative (P/G/LAR) Information

P/G/LAR # 1 – Please check one of the following

☐ **Parent** ☐ **Guardian** ☐ **Legally Authorized Representative**

P/G/LAR Name _____________________________________ P/G/LAR Email (Optional) _________________________

P/G/LAR Phone _____________________________________ ☐ Check this box if the child and P/G/LAR live together

P/G/LAR Relationship to Child ___________________________

P/G/LAR Address ____

☐ Check this box if P/G/LAR is Local District of Social Services (LDSS) County Representative

P/G/LAR # 2 (Optional) – Please check one of the following

☐ **Parent** ☐ **Guardian** ☐ **Legally Authorized Representative**

P/G/LAR Name ____________________________ P/G/LAR Email (Optional) ______________

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P/G/LAR Phone ______________________________ ☐ Check this box if the child and P/G/LAR live together

P/G/LAR Relationship to Child _______________________

P/G/LAR Address ____

☐Check this box if this is Local District of Social Services (LDSS) County Representative

P/G/LAR # 3 (Optional)– Please check one of the following

☐ **Parent** ☐ **Guardian** ☐ **Legally Authorized Representative**

P/G/LAR Name ____ P/G/LAR Email (Optional) ____________________________

P/G/LAR Phone ____ ☐ Check this box if the child and P/G/LAR live together

P/G/LAR Relationship to Child ______________________________

P/G/LAR Address ____

☐ Check this box if this is Local District of Social Services (LDSS) County Representative

County Representative's Name and Email (if known)____

Please indicate how many siblings currently reside in the home_______

Out of the current siblings who reside in the home, how many are receiving HCBS? _______

Out of the current siblings who reside in the home, how many are receiving Health Home Care Management? _______

☐ Check this box if the child attends school or other educational/vocational program

If applicable, please outline the child's school or educational/vocational program schedule below, including how many hours a week they attend the program in question (i.e., Mon-Fri 8am-1pm, etc.). Please also include other standing appointments, e.g., therapy, medical appointments, OT/PT/ST, CFTSS, PDN/PCA/CDPAS, Hospice, etc.

School/Education Regular Appointments/Programs Extracurricular/Community Activities Other Programming/Services/Activities

For extracurricular or community activities, note how many hours a day, week, or month.

Summer Programming Schedule

Clinical Information

Child Primary ICD-10 Diagnosis ____

Child/youth K-Code _______

Target Population ☐ SED ☐ Medically Fragile ☐ DD and Medically Fragile ☐ DD and Foster Care

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Administrative Information (If applicable)

Date of First Appointment _______________

Date HCBS Provider Notified the Plan of First Appointment___________________

☐ By checking this box, I attest that the above appointment took place
Note: Notification can occur via email or phone

HCBS Provider Information

HCBS Provider Agency Name ____________________________________ NPI/Tax ID # ________________________________

Provider Address ____

Contact Person Name ____________________________________ Contact Person Title ________________________________

Contact Person Phone ___________________________________ Contact Person Email ________________________________

Secondary Contact Name_______________________________ Secondary Contact Title _________________________

Secondary Contact Phone ___________________________________ Secondary Contact Email _________________________

Requested HCBS, Goals, and Objectives

Please note the anticipated start date, frequency, scope, duration, and modality of each requested HCBS. Indicate the service date range being requested/included in this notice. Please consider what the member needs to reasonably achieve the objectives listed in the following section. Duration cannot exceed 6 months. Medical Necessity documentation must accompany this Form.

Frequency: Is defined as how often the service will be offered to the participant and/or family/caregiver. Services may be delivered on a weekly, biweekly, or monthly basis according to the needs of the participant and family. Providers must specify the type of frequency referenced in the "frequency" space provided below (e.g., 2x/week, 4x/month, etc.).

Scope: Is defined as the service components and interventions being provided and utilized to address the identified needs of the participant and/or family/caregiver. A time allotment for how long each service will be delivered per occurrence should be included in the "scope" space provided below (e.g., 2 hours, 1.5 hours, etc.). The scope of the service should correspond to the abilities of the participant and/or family/caregiver and be reflective of the billing unit identified by service. If the scope varies based off the day of the week, please provide relevant context and information in the box below. Additionally, please denote the scope for individual services vs. group services.

Duration: Is defined as the length in time that the service will be delivered to the participant and/or family/caregiver (i.e., 3 months, 6 months, etc.).

Please select the Children's Waiver HCBS being requested/included in this notice

☐ Community Habilitation
☐ Day Habilitation
☐ Caregiver/Family Advocacy and Supports Services (CFASS)
☐ Prevocational Services
☐ Supported Employment
☐ Respite Services (Specify below between Planned and/or Crisis)
☐ Palliative Care (Specify below between Massage Therapy, Counseling and Support Services, Expressive Therapy, and/or Pain and Symptom Management)

HCBS #1	Start Date (1st service visit)	Start Date for This Authorization Period	Frequency	Scope	Duration	Explanation of variation in schedule (if applicable)

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Procedure Code						
Procedure Code						

Multiple Procedure Codes are reported for Caregiver/Family Advocacy and Support Services (CFASS) only.

Modality (Check all that apply) ☐ Individual ☐ Group

Please provide rationale (Medical Necessity with supporting documentation) for the need for the service.

Each Goal should be written to be measurable or that is demonstrated as achievable by the specific HCBS, in accordance with the HCBS Manual. Each Goal must have at least one specific objective – what will the HCBS provider do or how the HCBS provider will work with the member to accomplish the Goal.

Goal 1
Objective 1
For re-authorization **Describe the status of the service goal/objective, including what has been accomplished, or what has been worked on.** **Outline what is still needed to be worked on with this objective.**
Objective 2

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For re-authorization **Describe the status of the service goal/objective, including what has been accomplished, or what has been worked on. Outline what is still needed to be worked on with this objective.**
Objective 3
For re-authorization **Describe the status of the service goal/objective, including what has been accomplished, or what has been worked on. Outline what is still needed to be worked on with this objective.**

Other services, outside of HCBS, member is receiving related to this goal (if applicable)

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Please select the Children's Waiver HCBS being requested/included in this notice

- ☐ Community Habilitation
- ☐ Day Habilitation
- ☐ Caregiver/Family Advocacy and Supports Services (CFASS)
- ☐ Prevocational Services
- ☐ Supported Employment
- ☐ Respite Services (Specify below between Planned and/or Crisis)
- ☐ Palliative Care (Specify below between: Massage Therapy, Counseling and Support Services, Expressive Therapy, and/or Pain and Symptom Management)

HCBS #2	Start Date (1st service visit)	Start Date for This Authorization Period	Frequency	Scope	Duration	Explanation of variation in schedule (if applicable)
Procedure Code						

Modality (Check all that apply) ☐Individual ☐Group

Please provide rationale (Medical Necessity with supporting documentation) for the need for the service.

Goal 1
Objective 1
For re-authorization **Describe the status of the service goal/objective, including what has been accomplished, or what has been worked on. Outline what is still needed to be worked on with this objective.**
Objective 2
For re-authorization **Describe the status of the service goal/objective, including what has been accomplished, or what has been worked on. Outline what is still needed to be worked on with this objective.**
Objective 3
For re-authorization **Describe the status of the service goal/objective, including what has been accomplished, or what has been worked on. Outline what is still needed to be worked on with this objective.**

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Other services, outside of HCBS, member is receiving related to this goal (if applicable)

Please select the Children's Waiver HCBS being requested/included in this notice

- ☐ Community Habilitation
- ☐ Day Habilitation
- ☐ Caregiver/Family Advocacy and Supports Services
- ☐ Prevocational Services
- ☐ Supported Employment
- ☐ Respite Services (Specify below between Planned and/or Crisis)
- ☐ Palliative Care (Specify below between: Massage Therapy, Counseling and Support Services, Expressive Therapy, and/or Pain and Symptom Management)

HCBS #3	Start Date (1st service visit)	Start Date for This Authorization Period	Frequency	Scope	Duration	Explanation of variation in schedule (if applicable)
Procedure Code						

Modality (Check all that apply) ☐ Individual ☐ Group

Please provide rationale (Medical Necessity with supporting documentation) for the need for the service.

Goal 1
Objective 1

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For re-authorization **Describe the status of the service goal/objective, including what has been accomplished, or what has been worked on. Outline what is still needed to be worked on with this objective.**
Objective 2
For re-authorization **Describe the status of the service goal/objective, including what has been accomplished, or what has been worked on. Outline what is still needed to be worked on with this objective.**
Objective 3
For re-authorization **Describe the status of the service goal/objective, including what has been accomplished, or what has been worked on. Outline what is still needed to be worked on with this objective.**

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Other services, outside of HCBS, member is receiving related to this goal (if applicable)

Please select the Children's Waiver HCBS being requested/included in this notice

- ☐ Community Habilitation
- ☐ Day Habilitation
- ☐ Caregiver/Family Advocacy and Supports Services
- ☐ Prevocational Services
- ☐ Supported Employment
- ☐ Respite Services (Specify below between Planned and/or Crisis)
- ☐ Palliative Care (Specify below between: Massage Therapy, Counseling and Support Services, Expressive Therapy, and/or Pain and Symptom Management)

HCBS #4	Start Date (1st service visit)	Start Date for This Authorization Period	Frequency	Scope	Duration	Explanation of variation in schedule (if applicable)
Procedure Code						

Modality (Check all that apply) ☐ Individual ☐ Group

Please provide rationale (Medical Necessity with supporting documentation) for the need for the service.

Goal 1
Objective 1
For re-authorization **Describe the status of the service goal/objective, including what has been accomplished, or what has been worked on. Outline what is still needed to be worked on with this objective.**
Objective 2
For re-authorization **Describe the status of the service goal/objective, including what has been accomplished, or what has been worked on. Outline what is still needed to be worked on with this objective.**
Objective 3

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For re-authorization **Describe the status of the service goal/objective, including what has been accomplished, or what has been worked on. Outline what is still needed to be worked on with this objective.**

Other services, outside of HCBS, member is receiving related to this goal (if applicable)

Describe any other barriers or obstacles to the member's goals/objectives, and strategies to address these barriers.

I attest that the member has elected to receive all HCBS requested above.

____

Signature of HCBS Provider

____ ____________________ ____________

Name (please print): Title: Date:

Submission of this Authorization Form does not preclude telephonic review, which may be required by the Medicaid Managed Care Plan. NYS encourages providers to reach out to the Plan regarding authorization protocol to ensure timely delivery of services for members.

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Section 2– Completed After Authorization received from Managed Care Plan (Enrolled Participant Only)

To Participant's Care Manager:

RE: Participant CIN_________________________

☐ The HCBS requested was approved.

☐ The HCBS requested was partially approved.

☐ The HCBS requested was denied.

☐ The Medicaid Managed Care Plan authorization determination is attached.

Provider's Initials _______________ Date: _______________

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