Health Home Care Management/C-YES Referral for Home and Community Based Services (HCBS) to HCBS Provider

Medicaid 1915(c) Children's Waiver Program

Instructions:

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

Section 1 – Completed by HHCM/C-YES

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

If selected 'Participant is in Foster Care' above, Name of 29-I Foster Care Agency_____

Residence County _____

Fiscal County _____

Fiscal County Representative _____

Medical Consenter _____

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 this is Local District of Social Services (LDSS) County Representative

P/G/LAR # 2 – 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 (If different from above) _____

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

P/G/LAR # 3– 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

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 explain 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 K-Code _____

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

Date LOC Eligibility Determination was Completed _____

Care Management, Care Management Agency, and Designated Lead Health Home Information

Contact's Name _____ Contact's Agency Name _____ Date _____

Contact's Title _____ Email _____ Phone # _____

Contact's Address _____

Name of Designated Lead Health Home Serving Children _____

Requested HCBS, Goals, and Objectives

HCBS #1 Referral Request

Please select 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 Supports Services, Expressive Therapy, or Pain and Symptom Management)

Modality (Check all that apply) ☐ Individual ☐ Group

Desired Goal or Need to be addressed
Family Preferences (Staff Gender/Age/Primary Language, Evening/Weekend Appointments, Time Of Day, Etc.)

Other services member is receiving related to this goal (if applicable)

HCBS # 2 Referral Request

Please select 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 Supports Services, Expressive Therapy, or Pain and Symptom Management)

Modality (Check all that apply) ☐ Individual ☐ Group

Desired Goal or Need to be addressed
Family Preferences (Staff Gender/Age/Primary Language, Evening/Weekend Appointments, Time Of Day, Etc.)

Other services member is receiving related to this goal (if applicable)

HCBS # 3 Referral Request

Please select 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 Supports Services, Expressive Therapy, or Pain and Symptom Management)

Modality (Check all that apply) ☐ Individual ☐ Group

Desired Goal or Need to be addressed
Family Preferences (Staff Gender/Age/Primary Language, Evening/Weekend Appointments, Time Of Day, Etc.)

Other services member is receiving related to this goal (if applicable)

HCBS # 4 Referral Request

Please select 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 Supports Services, Expressive Therapy, or Pain and Symptom Management)

Modality (Check all that apply) ☐ Individual ☐ Group

Desired Goal or Need to be addressed
Family Preferences (Staff Gender/Age/Primary Language, Evening/Weekend Appointments, Time Of Day, Etc.)

Other services 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.

HHCM/C-YES Signature

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

_____

Signature of HHCM/C-YES

_____ _____ _____

Name (please print): Title: Date: