

New York State Department of Health
**Health Home Care Management/C-YES Referral for
Home and Community Based Services (HCBS) to HCBS Provider**
Medicaid 1915(c) Children's Waiver Program

SECTION I: To be completed by the HHCM/C-YES. Complete one form per HCBS provider. One form may include all HCBS to be provided by the HCBS provider.

CHILD'S NAME (LAST, FIRST, MI):		MEDICAID CIN #:	
CHILD'S ADDRESS (#, STREET):		CHILD'S ADDRESS (CITY, STATE):	CHILD'S ZIP CODE
DATE OF BIRTH:	SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	PREFERRED METHOD OF CONTACT: <input type="checkbox"/> EMAIL <input type="checkbox"/> PHONE	PARENT/GUARDIAN EMAIL:
PARENT/GUARDIAN/LEGALLY AUTHORIZED REPRESENTATIVE NAME:			PARENT/GUARDIAN PHONE #:
TARGET POPULATION (CHECK ONE ONLY)		REFERRAL TYPE (CHECK ONE ONLY)	
<input type="checkbox"/> SERIOUS EMOTIONAL DISTURBANCE(SD) <input type="checkbox"/> MEDICALLY FRAGILE (MEDF) <input type="checkbox"/> DEVELOPMENTAL DISABILITIES (DD) AND MEDICALLY FRAGILE (MEDF) <input type="checkbox"/> DEVELOPMENTAL DISABILITIES (DD) AND FOSTER CARE		<input type="checkbox"/> INITIAL REFERRAL <input type="checkbox"/> SUBSEQUENT REFERRAL – REVISION / UPDATE TO THE EXISTING PLAN OF CARE <input type="checkbox"/> ENROLLED IN MEDICAID MANAGED CARE <input type="checkbox"/> PLAN NAME: _____	
FINALIZED LEVEL OF CARE (LOC) STATUS			
<input type="checkbox"/> LOC OBTAINED AND VERIFIED IN UAS <input type="checkbox"/> _____ DATE OF LOC <input type="checkbox"/> CAPACITY MANAGEMENT APPROVED BY DOH <input type="checkbox"/> DATE OF SLOT APPROVED _____			

Name of Care Manager, Care Management Agency and Designated Lead Health Home:

CONTACT'S NAME:		CONTACT'S AGENCY NAME:			DATE:	
CONTACT'S TITLE:		EMAIL ADDRESS:			PHONE #:	
CONTACT'S ADDRESS:			CITY:	COUNTY:	STATE:	ZIP CODE:
NAME OF DESIGNATED LEAD HEALTH HOME SERVING CHILDREN:						

A list of Home and Community Based Service Providers was provided to the child/parent/guardian/legally authorized representative. The child/parent/guardian/legally authorized representative has selected the following agency. The child/parent/guardian/legally authorized representative has chosen the provider below.

HOME AND COMMUNITY BASED SERVICE PROVIDER:			PHONE #:			
HOME AND COMMUNITY BASED SERVICE PROVIDER ADDRESS:		CITY:	STATE:		ZIP CODE:	
HOME AND COMMUNITY BASED SERVICE PROVIDER STAFF CONTACT NAME:						

PLEASE CHECK SERVICE BEING REQUESTED AND DESIRED GOAL TO BE ADDRESSED FOR EACH SERVICE:

REFERRED HCBS SERVICE(S):	
<input type="checkbox"/> COMMUNITY HABILITATION	<input type="checkbox"/> PREVOCAATIONAL SERVICES
<input type="checkbox"/> DAY HABILITATION	<input type="checkbox"/> SUPPORTED EMPLOYMENT
<input type="checkbox"/> CAREGIVER/FAMILY SUPPORT AND SERVICES	<input type="checkbox"/> RESPITE SERVICE
<input type="checkbox"/> COMMUNITY SELF ADVOCACY TRAINING SUPPORT	PALLIATIVE CARE: <input type="checkbox"/> MASSAGE <input type="checkbox"/> BEREAVEMENT <input type="checkbox"/> EXPRESSIVE <input type="checkbox"/> PAIN AND SYMPTOM MANAGEMENT
DESIRED GOAL OR NEED TO BE ADDRESSED:	
FAMILY PREFERENCES: (MALE/FEMALE STAFF, EVENING HOURS, ETC.)	

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ADDITIONAL INFORMATION OR COMMENTS FOR THE HCBS PROVIDER:

❖ If additional HCBS are requested for a referral, add another sheet.