Children's Waiver Health Home Care Management (HHCM)/Child and Youth Evaluation Services (C-YES) Referral for Home and Community Based Services (HCBS) to HCBS Provider

Updated February 2024

Instructions:

All fields must be completed unless listed as 'optional' or 'as applicable.' Health Home and C-YES care managers ensure complete participant/family information is documented on this form to assist the HCBS provider in determining the service needs and Frequency, Scope, Duration (F/S/D). The participant's schedule for schooling, appointments, extra circular activities must be shared. HCBS cannot be provided during school hours and the participant's age, development, and condition must be considered for F/S/D. Care managers are responsible to ensure appropriate HCBS goals, interventions, and level / amount of HCBS provided to the participant by the HCBS provider.

Section 1 – Completed by HHCM/C-YES

Participant Information

Participant Legal Name: _____

Participant Preferred Name: _____

Participant DOB: _____ Gender Identity: _____ Gender Assigned at Birth: ☐ M ☐ F

Participant Phone: _____ Participant Email (optional): _____

Participant Address: _____

Participant CIN (if applicable): _____ ☐ Check this box if the Participant is in Foster Care

If selected 'Participant is in Foster Care' above, provide the following information, if known:

Name of Foster Care Agency: _____

County of Residence: _____

County of Fiscal Responsibility: _____

LDSS/HRA 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? _____

☐ **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 (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, in the box above, note how many hours a day, week, or month.

In the box below, please note the Summer Programming schedule if this schedule is different from what is noted in the box above.

Child Primary ICD-10 Diagnosis: _____

Child K-Code(s): _____

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

Enrollment Information

Care Manager Name: _____ Care Management Agency: _____

Care Manager Email: _____ Care Manager Phone #: _____

Care Manager Agency Address: _____

Name of Designated Lead Health Home Serving Children: _____

Name of Medicaid Managed Care Plan: _____

☐ LOC completed and verified in UAS? Last Date of Completed HCBS LOC: _____

☐ Capacity management approved by DOH? Date of slot approval: _____

HCBS Agency Information

HCBS Provider Name: _____ HCBS Provider Phone #: _____

HCBS Provider Address: _____

HCBS Provider Contact Name: _____

Has the family agreed to send a referral to this provider? ☐Yes ☐No

Requested HCBS, Goals, and Objectives

Through person-centered planning, the HH/C-YES care manager must identify the needs of the participant and refer the appropriate HCBS to address those needs. The participant/family has choice of services (only if the service can address the needs identified) and service provider. The care manager must ensure that the goals are clearly identified, strength-based, specific, and achievable. Care managers cannot request for the HCBS provider to determine the services and goals that are not already reflected on the HH/C-YES Plan of Care prior to the HCBS referral being made.

HCBS #1 Referral Request

Please select Children's Waiver HCBS being requested/included in this notice: (Pick one)

- ☐ 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)

Need identified to be addressed and Desired Goal for the identified HCBS:
Family Preferences (Staff Gender/Primary Language, Evening/Weekend Appointments, Time of Day, Group/individu services)

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)

Need identified to be addressed and Desired Goal for the identified HCBS:

Family Preferences (Staff Gender/Primary Language, Evening/Weekend Appointments, Time of Day, Group/individu services)

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)

Need identified to be addressed and Desired Goal for the identified HCBS:

Family Preferences (Staff Gender/Primary Language, Evening/Weekend Appointments, Time of Day, Group/individu services)

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)

Need identified to be addressed and Desired Goal for the identified HCBS:

Family Preferences (Staff Gender/Primary Language, Evening/Weekend Appointments, Time of Day, Group/individu services)

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

Describe any known barriers or obstacles to the member's goals, known strategies to address these barriers, and/or additional information/comments for the HCBS provider regarding the participant and their family and/or the service(s) requested.

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: