

Children's HCBS Authorization and Care Manager Notification Form

Instructions: The Children's Waiver HCBS Provider must complete this form for Children's Waiver HCBS beyond the initial service period of 24 hours/96 units/60 days. Services must be provided in accordance with a person-centered plan of care, the Children's Waiver, HCBS Provider Manual, and the Children's Health and Behavioral Health Services – Children's Medicaid System Transformation Billing and Coding Manual.

- For Children enrolled in Medicaid managed care, the HCBS Provider completes Section 1 of this form and submits it to the child's Medicaid managed care plan for review according to the plan's authorization procedures. The Medicaid managed care plan issues a service authorization determination to the enrollee and HCBS Provider. The HCBS Provider completes Section 2 and sends this form with a copy of the service authorization determination to the child's Health Home care manager, if applicable.
- For Children covered by fee-for-service Medicaid (not enrolled in Medicaid managed care), 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.

Section 1 – COMPLETED BY HCBS PROVIDER

Child information

Child Name _____ Child DOB _____
 Child/Legal Representative Phone _____ Email (optional) _____
 Child Address _____
 Child CIN _____ Managed Care Plan ID _____
 Care Manager _____ CM Phone _____ Email _____
 Health Home _____ Diagnosis (Optional) _____

HCBS Provider information

HCBS Provider Name _____
 Provider Address _____ Tax ID # _____
 Contact person name _____ Title _____
 Phone _____ Email _____

HCBS requested

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

- | | |
|---|--|
| <input type="checkbox"/> Community Habilitation | <input type="checkbox"/> Supported Employment |
| <input type="checkbox"/> Day Habilitation | <input type="checkbox"/> Respite Services |
| <input type="checkbox"/> Caregiver/Family Support and Services | <input type="checkbox"/> Palliative Care (Specify below between:
Massage, Bereavement, Expressive, Pain
and Symptom) |
| <input type="checkbox"/> Community Self Advocacy Training Support | |
| <input type="checkbox"/> Prevocational Services | |

Please note the anticipated start date, frequency, scope, duration, and modality of each requested HCBS Indicate 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:

HCBS #1	Start Date* (1 st service visit)	Start Date for This Authorization Period	Frequency (# services per wk)	Scope (hrs per service)	Duration (e.g. 3 mos)
Procedure Code, if known					

Modality (check all that apply) _____. Individual Group On-site Off-site

HCBS #2	Start Date* (1 st service visit)	Start Date for This Authorization Period	Frequency (# services per wk)	Scope (hrs per service)	Duration (e.g. 3 mos)
Procedure Code, if known					

Modality (check all that apply) _____. Individual Group On-site Off-site

HCBS #3	Start Date* (1 st service visit)	Start Date for This Authorization Period	Frequency (# services per wk)	Scope (hrs per service)	Duration (e.g. 3 mos)
Procedure Code, if known					

Modality (check all that apply) _____. Individual Group On-site Off-site

Goals and Objectives

Clearly state the child's goal(s) and list specific objectives for the period of requested services. Goals must accurately reflect the member's approved Plan of Care. Objectives should be results-oriented, measurable steps towards the overall goal that can be achieved within the requested period of services.

Goal #1 _____

HCBS: _____

Objective #1 _____

Status: New Accomplished Existing (Partially met) Existing (Not met)

Justify continued/modified service for Existing (Partially met) or Existing (Not met) objectives:

Objective #2 _____

Status: New Accomplished Existing (Partially met) Existing (Not met)

Justify continued/modified service for Existing (Partially met) or Existing (Not met) objectives:

Objective #3 _____

Status: New Accomplished Existing (Partially met) Existing (Not met)

Justify continued/modified service for Existing (Partially met) or Existing (Not met) objectives:

Goal #2 _____

HCBS: _____

Objective #1 _____

Status: New Accomplished Existing (Partially met) Existing (Not met)

Justify continued/modified service for Existing (Partially met) or Existing (Not met) objectives:

Objective #2 _____

Status: New Accomplished Existing (Partially met) Existing (Not met)

Justify continued/modified service for Existing (Partially met) or Existing (Not met) objectives:

Objective #3 _____

Status: New Accomplished Existing (Partially met) Existing (Not met)

Justify continued/modified service for Existing (Partially met) or Existing (Not met) objectives:

Goal #3 _____

HCBS: _____

Objective #1 _____
Status: New Accomplished Existing (Partially met) Existing (Not met)

Justify continued/modified service for Existing (Partially met) or Existing (Not met) objectives:

Objective #2 _____
Status: New Accomplished Existing (Partially met) Existing (Not met)

Justify continued/modified service for Existing (Partially met) or Existing (Not met) objectives:

Objective #3 _____
Status: New Accomplished Existing (Partially met) Existing (Not met)

Justify continued/modified service for Existing (Partially met) or Existing (Not met) objectives:

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

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

Signature of HCBS Provider

Name (please print):

Title

Date

Submission of 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.

Section 2 – COMPLETED AFTER AUTHORIZATION RECEIVED FROM MANAGED CARE PLAN (Enrolled child only)
HCBS Determination

To Child's Care Manager:

RE: Child 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: _____