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 ____

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:

- ☐ Community Habilitation
- ☐ Day Habilitation
- ☐ Caregiver/Family Support and Services
- ☐ Community Self Advocacy Training Support
- ☐ Prevocational Services
- ☐ Supported Employment
- ☐ Respite Services
- ☐ Palliative Care (Specify below between: Massage, Bereavement, Expressive, Pain and Symptom)

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* (1st service visit)	Start Date for This Authorization Period	Frequency (# services per wk)	Scope (hrs per service)	Duration (e.g. 3 mos)
List:					

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

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

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

HCBS #3	Start Date* (1st service visit)	Start Date for This Authorization Period	Frequency (# services per wk)	Scope (hrs per service)	Duration (e.g. 3 mos)
List:					

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: __________