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:	GENDER IDENTITY:	PREFERRED CONTACT METHOD: ☐ EMAIL ☐ PHONE	PARENT/GUARDIAN EMAIL:	PARENT/GUARDIAN PHONE #:
PARENT/GUARDIAN/LEGALLY AUTHORIZED REPRESENTATIVE NAME:		PRIMARY LANGUAGE:		SECONDARY LANGUAGE (IF APPLICABLE):

TARGET POPULATION *(CHECK ONE ONLY)*

- ☐ SERIOUS EMOTIONAL DISTURBANCE(SED)
- ☐ MEDICALLY FRAGILE (MEDF)
- ☐ DEVELOPMENTAL DISABILITIES (DD) AND MEDICALLY FRAGILE (MEDF)
- ☐ DEVELOPMENTAL DISABILITIES (DD) AND FOSTER CARE

REFERRAL TYPE *(CHECK ONE ONLY)*

- ☐ INITIAL REFERRAL

(OR)

- ☐ SUBSEQUENT REFERRAL – REVISION / UPDATE TO THE EXISTING PLAN OF CARE

ENROLLMENT

NAME OF MEDICAID MANAGED CARE PLAN:

_____

FINALIZED LEVEL OF CARE (LOC) STATUS (CHECK COMPLETED STEPS)

LOC OBTAINED AND VERIFIED IN UAS

_____ DATE OF LOC, IF APPLICABLE

CAPACITY MANAGEMENT APPROVED BY DOH

DATE OF SLOT APPROVED_____, IF APPLICABLE

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:			

ADDITIONAL INFORMATION OR COMMENTS REGARDING THE PARTICIPANT AND/OR THEIR FAMILY:

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

REFERRED HCB SERVICE(S):	
☐ COMMUNITY HABILITATION	☐ PREVOCATIONAL SERVICES
☐ DAY HABILITATION	☐ SUPPORTED EMPLOYMENT
☐ CAREGIVER/FAMILY ADVOCACY AND SUPPORT SERVICES	☐ RESPITE SERVICE
PALLIATIVE CARE: ☐ MASSAGE ☐ COUNSELING AND SUPPORT SERVICES ☐ EXPRESSIVE ☐ PAIN AND SYMPTOM MANAGEMENT	
DESIRED GOAL OR NEED TO BE ADDRESSED:	
FAMILY PREFERENCES: (STAFF GENDER/AGE/PRIMARY LANGUAGE, EVENING/WEEKEND APPOINTMENTS, TIME OF DAY, ETC.)	

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ADDITIONAL INFORMATION OR COMMENTS FOR THE HCBS PROVIDER REGARDING THE SERVICE(S) REQUESTED:

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