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: ☐ MALE ☐ FEMALE	PREFERRED METHOD OF CONTACT: ☐ EMAIL ☐ PHONE	PARENT/GUARDIAN EMAIL:
PARENT/GUARDIAN/LEGALLY AUTHORIZED REPRESENTATIVE NAME:			PARENT/GUARDIAN PHONE #:

TARGET POPULATION *(CHECK ONE ONLY)*	**REFERRAL TYPE *(CHECK ONE ONLY)***	**FINALIZED LEVEL OF CARE (LOC) STATUS**
☐ SERIOUS EMOTIONAL DISTURBANCE(SED) ☐ MEDICALLY FRAGILE (MEDF) ☐ DEVELOPMENTAL DISABILITIES (DD) AND MEDICALLY FRAGILE (MEDF) ☐ DEVELOPMENTAL DISABILITIES (DD) AND FOSTER CARE	☐ INITIAL REFERRAL ☐ SUBSEQUENT REFERRAL – REVISION / UPDATE TO THE EXISTING PLAN OF CARE ☐ ENROLLED IN MEDICAID MANAGED CARE PLAN NAME: _____	☐ LOC OBTAINED AND VERIFIED IN UAS _____DATE OF LOC CAPACITY MANAGEMENT APPROVED BY DOH 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):	
☐ COMMUNITY HABILITATION	☐ PREVOCATIONAL SERVICES
☐ DAY HABILITATION	☐ SUPPORTED EMPLOYMENT
☐ CAREGIVER/FAMILY SUPPORT AND SERVICES	☐ RESPITE SERVICE
☐ COMMUNITY SELF ADVOCACY TRAINING SUPPORT	**PALLIATIVE CARE:** ☐ MASSAGE ☐ BEREAVEMENT ☐ EXPRESSIVE ☐ 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.**