Children's HCBS Authorization and Care Manager Notification Form

Updated February 2024

Instructions: The Children's Waiver Home and Community Based Services (HCBS) Provider must complete this Form for Children's Waiver HCBS provided at least 14 days prior to the initial service period of 24 hours/96 units/60 days (for new authorizations) or existing authorization period (for reauthorizations) expiring. **Providers should not wait until the initial/existing service amount/period has been exhausted before proceeding with this step.** Completion of this Form is not necessary for the initial service period of 24 hours/96 units/60 days. Submission of this Form does not replace the requirement for HCBS providers to notify Medicaid Managed Care Plans (MMCPs) of the first HCBS appointment date. Services must be provided in accordance with a person-centered Plan of Care (POC), the Children's Waiver, and the Children's HCBS Manual.

- For participants enrolled in MMCPs, the HCBS Provider completes Section 1 of this Form and submits it to the participant's MMCP for review according to the MMCP's authorization procedures. Following the review, the MMCP issues a service authorization determination to the enrollee and HCBS Provider. The HCBS Provider then completes Section 2 and sends this Form with a copy of the MMCP's service authorization determination to the participant's Health Home/C-YES care manager.
- For participants covered by fee-for-service Medicaid (i.e., not enrolled with a MMCP), the HCBS Provider completes Section 1 of the Form and sends it to the participant's Health Home/C-YES care manager, as applicable. Services provided are subject to State audit.

All fields must be completed unless listed as optional or as applicable.

Section 1 – Completed by HCBS Provider

Participant Information

Participant Legal Name: _____

Participant Preferred Name: _____

Participant DOB: _____ Gender Identity: _____ Pronouns: _____ Sex 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

Name of Foster Care Agency (if Foster Care box is checked) _____

Care Manager (CM) Name: _____ CM Phone: _____ CM Email: _____

Name of Health Home/C-YES: _____

Parent/Guardian/Legally Authorized Representative (P/G/LAR/OIP) Information

P/G/LAR # 1 – Please check one of the following

☐ **Parent** ☐ **Guardian** ☐ **Legally Authorized Representative** ☐ **Other Involved Person with whom the Participant Resides**

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 Participant: _____

P/G/LAR Address: _____

☐ Check this box if P/G/LAR is Local District of Social Services (LDSS) County Representative

P/G/LAR # 2 (Optional) – Please check one of the following

☐ **Parent** ☐ **Guardian** ☐ **Legally Authorized Representative** ☐ **Other Involved Person with whom the Participant Resides**

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 Participant: _____

P/G/LAR Address: _____

☐ Check this box if this is Local District of Social Services (LDSS) County Representative

P/G/LAR # 3 (Optional)– Please check one of the following

☐ **Parent** ☐ **Guardian** ☐ **Legally Authorized Representative** ☐ **Other Involved Person with whom the Participant Resides**

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 Participant: _____

P/G/LAR Address: _____

☐ Check this box if this is Local District of Social Services (LDSS) County Representative

Other Information

Please indicate how many siblings currently reside in the home: _____

Out of the current siblings who reside in the home, how many are also enrolled and receiving HCBS? _____

☐ Check this box if the participant attends school or other educational/vocational program

If applicable, please outline the participant'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.

Clinical Information

Participant Primary ICD-10 Diagnosis: _____

Participant K-Code(s): _____ Last Date of the HCBS LOC: _____

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

HCBS Provider Information

HCBS Provider Agency Name: _____ NPI/Tax ID #: _____

Provider Address: _____

Contact Person Name: _____ Contact Person Title: _____

Contact Person Phone: _____ Contact Person Email: _____

Secondary Contact Name: _____ Secondary Contact Title: _____

Secondary Contact Phone: _____ Secondary Contact Email: _____

Requested HCBS, Goals, and Objectives

Please note the first ever date of service, anticipated start date for this authorization period, frequency, scope, duration, and modality of each requested HCBS. Indicate the service date range being requested/included in this notice. Provide information related to the requested F/S/D in the box provided. Consider what the participant needs to reasonably achieve the goals/objectives listed in the following section. Duration cannot exceed 6 months. Supporting documentation must accompany this Form. Reference the Authorization Form Instructional Guide for information on completing this form and definitions of Frequency, Scope, Duration, and proper S.M.A.R.T. goals and interventions.

Please select the 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 Support Services, Expressive Therapy, and/or Pain and Symptom Management)

HCBS #1	Start date (1st service visit)	Start date for this authorization period	Frequency	Scope	Duration	Explanation of variation in schedule (if applicable)
Procedure Code						
Procedure Code						

Modality (Check all that apply): ☐ Individual _____

☐ Group _____

If requesting **both** modalities, please note which F/S/D is associated with each modality on the lines provided above.

Staff Assigned to Provide Service:

Staff #1 Name: _____ Staff # 2 Name: _____

Provide rationale (supporting documentation) for the need of the service and include why the amount is provided on a daily, weekly, biweekly, or monthly basis and accounting for the number of units.

Goals and Objectives

Clearly state S.M.A.R.T. goals the child's/youth's/family has identified and list specific objectives/interventions for the period of requested services. Goals must accurately reflect the participant'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 and delivered as allowable by the service definition in the HCBS manual.

Goal 1
Objective 1 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met
Objective 2 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met
Objective 3 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met
For re-authorization **Describe the status of the service goal/objective, including what has been accomplished, or what has been worked** **Outline what is still needed to be worked on with this goal/objective.**

Goal 2

Objective 1 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met

Objective 2 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met

Objective 3 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met

For re-authorization
Describe the status of the service goal/objective, including what has been accomplished, or what has been worked
Outline what is still needed to be worked on with this goal/objective.

Goal 3

Objective 1 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met

Objective 2 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met

Objective 3 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met

For re-authorization
Describe the status of the service goal/objective, including what has been accomplished, or what has been worked
Outline what is still needed to be worked on with this goal/objective.

Other services, outside of HCBS, participant is receiving related to this service (if applicable)

Please select the 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 Support Services, Expressive Therapy, and/or Pain and Symptom Management)

HCBS #2	Start date (1st service visit)	Start date for this authorization period	Frequency	Scope	Duration	Explanation of variation in schedule (if applicable)
Procedure Code						
Procedure Code						

Modality (Check all that apply): ☐ Individual _____

☐ Group _____

If requesting **both** modalities, please note which F/S/D is associated with each modality on the lines provided above.

Staff Assigned to Provide Service:

Staff #1 Name: _____ Staff # 2 Name: _____

Provide rationale (Medical Necessity with supporting documentation) for the need for the service and include why the amount is provided on a daily, weekly, biweekly, or monthly basis.

Goals and Objectives

Clearly state S.M.A.R.T. goals the child's/youth's/family has identified and list specific objectives/interventions for the period of requested services. Goals must accurately reflect the participant'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 and delivered as allowable by the service definition in the HCBS manual.

Goal 1
Objective 1 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met

Objective 2 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met

Objective 3 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met

For re-authorization
Describe the status of the service goal/objective, including what has been accomplished, or what has been worked
Outline what is still needed to be worked on with this goal/objective.

Goal 2

Objective 1 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met

Objective 2 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met

Objective 3 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met

For re-authorization
Describe the status of the service goal/objective, including what has been accomplished, or what has been worked
Outline what is still needed to be worked on with this goal/objective.

Goal 3

Objective 1 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met

Objective 2 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met
Objective 3 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met
For re-authorization **Describe the status of the service goal/objective, including what has been accomplished, or what has been worked** **Outline what is still needed to be worked on with this goal/objective.**

Other services, outside of HCBS, participant is receiving related to this service (if applicable)

Please select the 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 Support Services, Expressive Therapy, and/or Pain and Symptom Management)

HCBS #3	Start date (1st service visit)	Start date for this authorization period	Frequency	Scope	Duration	Explanation of variation in schedule (if applicable)
Procedure Code						
Procedure Code						

Modality (Check all that apply): ☐ Individual _____

☐ Group _____

If requesting **both** modalities, please note which F/S/D is associated with each modality on the lines provided above.

Staff Assigned to Provide Service:

Staff #1 Name: _____ Staff # 2 Name: _____

Please provide rationale (Medical Necessity with supporting documentation) for the need for the service and include why the amount is provided on a daily, weekly, biweekly, or monthly basis.

Goals and Objectives

Clearly state S.M.A.R.T. goals the child's/youth's/family has identified and list specific objectives/interventions for the period of requested services. Goals must accurately reflect the participant'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 and delivered as allowable by the service definition in the HCBS manual.

Goal 1
Objective 1 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met
Objective 2 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met
Objective 3 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met
For re-authorization **Describe the status of the service goal/objective, including what has been accomplished, or what has been worked** **Outline what is still needed to be worked on with this goal/objective.**

Goal 2
Objective 1 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met

Objective 2 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met

Objective 3 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met

For re-authorization
Describe the status of the service goal/objective, including what has been accomplished, or what has been worked
Outline what is still needed to be worked on with this goal/objective.

Goal 3

Objective 1 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met

Objective 2 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met

Objective 3 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met

For re-authorization
Describe the status of the service goal/objective, including what has been accomplished, or what has been worked
Outline what is still needed to be worked on with this goal/objective.

Other services, outside of HCBS, participant is receiving related to this service (if applicable)

Please select the 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 Support Services, Expressive Therapy, and/or Pain and Symptom Management)

HCBS #4	Start date (1st service visit)	Start Date for This Authorization Period	Frequency	Scope	Duration	Explanation of variation in schedule (if applicable)
Procedure Code						
Procedure Code						

Modality (Check all that apply): ☐ Individual _____

☐ Group _____

If requesting **both** modalities, please note which F/S/D is associated with each modality on the lines provided above.

Staff Assigned to Provide Service:

Staff #1 Name: _____ Staff # 2 Name: _____

Please provide rationale (Medical Necessity with supporting documentation) for the need for the service and include why the amount is provided on a daily, weekly, biweekly, or monthly basis.

Goals and Objectives

Clearly state S.M.A.R.T. goals the child's/youth's/family has identified and list specific objectives/interventions for the period of requested services. Goals must accurately reflect the participant'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 and delivered as allowable by the service definition in the HCBS manual.

Goal 1
Objective 1 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met

Objective 2 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met

Objective 3 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met

For re-authorization
Describe the status of the service goal/objective, including what has been accomplished, or what has been worked
Outline what is still needed to be worked on with this objective.

Goal 2

Objective 1 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met

Objective 2 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met

Objective 3 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met

For re-authorization
Describe the status of the service goal/objective, including what has been accomplished, or what has been worked
Outline what is still needed to be worked on with this goal/objective.

Goal 3

Objective 1 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met

Objective 2 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met
Objective 3 – Is this objective: ☐ New ☐ Partially Met ☐ Not Met ☐ Met
For re-authorization **Describe the status of the service goal/objective, including what has been accomplished, or what has been worked** **Outline what is still needed to be worked on with this goal/objective.**

Other services, outside of HCBS, participant is receiving related to this service (if applicable)

Describe any other barriers or obstacles to the participant's goals/objectives, and strategies to address these barriers. This box can be used for any applicable HCBS; please indicate the specific goal where these barriers are experienced.

I attest that the participant/family has elected to receive all HCBS requested above, with identified F/S/D, and for re-authorization. I attest that the services identified above can be provided and align with the service definitions and allowable interventions. I have provided supporting documentation regarding the identified F/S/D which will assist the participant to reach their goals.

_____

Signature of HCBS Provider

_____ _____ _____

Name (please print): Title: Date:

Submission of this 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 participants and to communicate with the Plan when changes occur with the participant/family and service delivery.

Section 2– Completed After Authorization Determination is received from Managed Care Plan (Enrolled Participant Only)

To Participant's Care Manager:

RE: Participant 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: _____