Children's HCBS Authorization and Care Manager Notification Form

Instructions: The Children's Waiver Home and Community Based Services (HCBS) Provider must complete this form for Children's Waiver HCBS provided beyond the initial service period of 24 hours/96 units/60 days. **Providers should not wait until this initial service amount/ period has been exhausted before proceeding with this step.** Services must be provided in accordance with a person-centered plan of care, the Children's Waiver, and the Children's HCBS 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 (MMCP) for review according to the Plan's authorization procedures. The MMCP 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/C-YES care manager.
- For children covered by fee-for-service Medicaid (not enrolled in MMCP), 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) _____ 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:

- ☐ Community Habilitation
- ☐ Day Habilitation
- ☐ Caregiver/Family Advocacy and Support Services
- ☐ Prevocational Services
- ☐ Supported Employment
- ☐ Respite Services (Specify below among Planned and Crisis)
- ☐ Palliative Care (Specify below among: Massage Therapy, Counseling and Support Services, Expressive Therapy, or Pain and Symptom Management)

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. Duration cannot exceed 6 months:

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

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/ month)	Scope (hrs per service)	Duration (e.g., 3 mos)
Procedure Code(s)					

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/ month)	Scope (hrs per service)	Duration (e.g., 3 mos)
Procedure Code(s)					

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: _____