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DIVISION: Office of Long Term Care PAGE 1

GIS 08 OLTC/004

TO: All Local District Commissioners, Medicaid Directors, Care At Home

Coordinators

FROM: Mark Kissinger, Deputy Commissioner

Office of Long Term Care

SUBJECT: New CAH I/II Case Management Agency Selection Forms and Application

Cover Sheet Amendment (Attachments)

EFFECTIVE DATE: Immediate

CONTACT PERSON: Office of Long Term Care

Liz Morales (518)486-6562

eam04@health.state.ny.us by e-mail

The purpose of this GIS is to notify local department of social services (LDSS) staff of two new forms related to certification of participant provider choice for Care at Home I and II (CAH I/II) Medicaid waiver case management services: Case Management Agency Selection form and Change of Case Management Agency Request form. These forms are for immediate use. Other forms developed and utilized by Case Management agencies will no longer be accepted.

Completion of Case Management Agency Selection form will be required at the time of a child's enrollment in the waiver program. The form is to be signed by the participant's parent or guardian to certify choice in the selection of the participant's case manager. The case management agency and the LDSS CAH Coordinator must also sign the form and maintain a copy as part of the child's permanent CAH case record. The form must be submitted by the LDSS CAH Coordinator to the State Department of Health (NYSDOH) CAH program staff along with the CAH request for enrollment application documentation. The CAH I/II Application Cover Sheet was updated to reflect the new Case Management Selection Form.

The Change of Case Management Agency Request form is to be completed whenever there is a change in a child's case management agency. The change may occur when requested by a parent or guardian, the family is moving to a new county of residence and the current CAH case management agency does not have service locations in the new location, or the case management agency is no longer rendering services. This form is to be signed by the participant's parent or guardian, current and requested CAH case management agencies, and the LDSS CAH Coordinator. A copy is then forwarded to the NYSDOH Care At Home Program. It is the responsibility of the current case management agency to share the Plan of Care documents with the new case management agency.

CARE AT HOME CHANGE OF CASE MANAGEMENT AGENCY REQUEST

Care at Home I	Care at Home II
	am requesting to change his/her case
(Parent/Legal Guar management agency as follows:	an Name)
Current Case Management Agency _	
Requested Case Management Agency	
Parent/Legal Guardian Signature	
Current Case Management Agency	
Representative Signature	
To be completed by the Requested Case	anagement Agency:
	will provide Case Management to the above-named applicant
(Case Management Agency)	will not provide Case Management to the above-named applicant.
Explanation:	
	our responsibility to obtain all necessary medical tion from the previous case management agency.
Case Management Agency Representativ	Signature Date
LDSS CAH Coordinator Signature	Date

cc: Participant Family/Guardian
Case Management Agency
Requested Case Management Agency
New York State Department of Health – CAH Program

MEDICAID WAIVERS - CARE AT HOME PROGRAM For Physically Disabled Children APPLICATION COVER SHEET (To be completed for **new** applications only.)

Client	Name:	District:
SSN:	CIN:	CAH I: CAH II:
Date o	f Application:	
(1-5)	LDSS obtains (County CAH Coordinator or designate manager.	gnee). To be obtained and evaluated before involving
	 Application Form Signed by Parent Proof of Medicaid Ineligibility Proof of Age/Birth Certificate Proof of Physical Disability Case Management Selection Form 	D.O.B.:
	DSS-639 Expiration Date:	Group I Group II
	Disability Listing(s):	
		Stay (e.g., Inpatient Bill; Insurance Statement) from s from Insurance Company. Also, must list admission
(7 & 8)	Assessing Nurse-from CASA, CHHA, Public He case manager, when possible.	alth, VNA or acceptable other. Visit done by nurse and
	7 Pediatric Patient Review Instrument 8 Plan of Care (P.O.C.) Path Home Assessment Abstract Fastep MAA-CN-1-8	7A. For Private Duty Nursing has the following been identified: Nursing Provider(s) Prior Approval
(9,10 &	k 11) Case Manager	
	9 M.D. orders 10 Budget Sheet 11 Case Management Plan of Care	
(12) C	AH Coordinator, DDSO or Private CAH - CM	
	12 Case Manager:	/ () Telephone Number () Fax Number
	13 Other: Specify:	NYSDOH Revised 4/07

CARE AT HOME CASE MANAGEMENT AGENCY REQUEST

Care at Home I	Care at Home II
NOTE: This form must be submitted along with the app	plication to the Care at Home I/II waiver.
I understand that as a applicant for the Care at Home I/II Waive Management Agency from the attached list of approved Case Note to interview these providers prior to making my selection.	
I understand that this Case Management Agency will assist memy child's Plan of Care.	e in developing, implementing, and monitoring
I also understand that, at any time I may change my child's CAI will not affect his/her enrollment in Care at Home.	H Case Management Agency and this change
Child's Name	Date
Parent/Guardian Signature	Date
On behalf of my child, I have selected the following Case Mana	gement provider:
Case Management Agency	
To be completed by the Case Management Agency:	
(Case Management Agency)	will provide Case Management to the above-named applicant will not provide Case Management to the above-named applicant.
Case Management Agency Representative Signature	Date
LDSS CAH Coordinator Signature	Date

cc: Participant Family/Guardian
Case Management Agency
Requested Case Management Agency
New York State Department of Health – CAH Program