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

FROM: Mark L. Kissinger, Deputy Commissioner
Office of Long Term Care (OLTC)

SUBJECT: Care At Home (CAH) I/II Palliative Care Services

EFFECTIVE DATE: March 12, 2010

CONTACT PERSON: Office of Long Term Care
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The purpose of this GIS is to advise the LDSS that beginning February 25, 2010 the DOH will begin enrolling Pediatric Palliative Care Providers for CAH I/II.

Interested providers must be a Certified Home Health Agency (CHHA) or a Hospice, enrolled in NYS Medicaid, and may apply to provide one or more of the following services:

- Bereavement
- Expressive Therapy
- Family Palliative Care Education
- Massage Therapy
- Pain and Symptom Management

The Department of Health will review all applications and the LDSS CAH coordinator will be sent a copy of the letter of decision regarding the application. The LDSS CAH Coordinator will be responsible for maintaining a list of approved palliative care providers.

The provider application and description of the pediatric palliative care services is available on the Department of Health website located at: http://nyhealth.gov/facilities/long_term_care.

The CAH participant’s parent or guardian must select a provider for the pediatric palliative care service and the form must be completed, signed and dated by the service provider, the case manager and the CAH Coordinator. Copies of the forms are attached.

The pediatric palliative care service(s) must be deemed medically necessary and incorporated into the participant’s plan of care (assessment, physician orders, budget, case management plan of services).

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Long Term Care

CARE AT HOME I/II PALLIATIVE CARE

Bereavement Services Selection Form

_____Care at Home I _____Care at Home II

NOTE: Signed copies of this form must be supplied to the child's parent/guardian, case manager, Bereavement Agency and the LDSS.

I understand that in order for my child to receive Care at Home I/II Bereavement Waiver service, I must select a palliative care agency from the attached list of approved providers. I have been encouraged to interview these providers prior to making my selection.

I understand that the Bereavement palliative care agency I choose will assist me in developing, implementing and monitoring my child's plan of care regarding this service.

I may choose to discontinue this service or select a different palliative care agency for Bereavement services at any time. My child will still be eligible for the CAH I/II waiver if I choose to discontinue Bereavement services or change providers.

From the approved provider list, I have selected the following agency:

_____
Palliative Care Agency Telephone

_____
Agency Address

_____
Applicant (Child's) Name Date

_____
Parent/Guardian Signature Date

_____
Case Manager Signature Date

To be completed by the Palliative Care Agency:

_____
Palliative Care Agency

_____ **will** provide Bereavement Services to the above named applicant
_____ **will not** provide Bereavement Services to the above applicant.

_____
Explanation

_____
Palliative Care Agency Representative Signature (Include Title) Date

_____
LDSS CAH Coordinator Signature Date

NYSDOH FEB 2010

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Long Term Care

CARE AT HOME I/II PALLIATIVE CARE

Expressive Therapy Selection Form

_____Care at Home I _____Care at Home II

NOTE: Signed copies of this form must be supplied to the child's parent/guardian, case manager, Expressive Therapy Agency and the LDSS.

I understand that in order for my child to receive Care at Home I/II Expressive Therapy (art, music and/or play) Waiver service, I must select a palliative care agency from the attached list of approved providers. I have been encouraged to interview these providers prior to making my selection.

I understand that the Expressive Therapy palliative care agency I choose will assist me in developing, implementing and monitoring my child's plan of care regarding this service.

I may choose to discontinue this service or select a different palliative care agency for Expressive Therapy at any time. My child will still be eligible for the CAH I/II waiver if I choose to discontinue services or change providers.

From the approved provider list, I have selected the following agency:

_____
Palliative Care Agency Telephone

_____
Agency Address

_____
Applicant (Child's) Name Date

_____
Parent/Guardian Signature Date

_____
Case Manager Signature Date

To be completed by the Palliative Care Agency:

_____ will provide Family Education to the above named applicant
_____ will not provide Family Education to the above named applicant.

_____
Palliative Care Agency

_____
Explanation

_____
Palliative Care Agency Representative Signature (Include Title) Date

_____
LDSS CAH Coordinator Signature Date

NYSDOH FEB 2010

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Long Term Care

CARE AT HOME I/II PALLIATIVE CARE

Massage Services Selection Form

_____Care at Home I _____Care at Home II

NOTE: Signed copies of this form must be supplied to the child's parent/guardian, case manager, Massage Therapy Agency and the LDSS.

I understand that in order for my child to receive Care at Home I/II Massage Waiver service, I must select a palliative care agency from the attached list of approved providers. I have been encouraged to interview these providers prior to making my selection.

I understand that the Massage Therapy palliative care agency I choose will assist me in developing, implementing and monitoring my child's plan of care regarding this service.

I may choose to discontinue this service or select a different palliative care agency for Massage Therapy at any time. My child will still be eligible for the CAH I/II waiver if I choose to discontinue services or change providers.

From the approved provider list, I have selected the following agency:

_____
Palliative Care Agency Telephone

_____
Agency Address

_____
Applicant (Child's) Name Date

_____
Parent/Guardian Signature Date

_____
Case Manager Signature Date

To be completed by the Palliative Care Agency:

_____ **will** provide Bereavement Services to the above named applicant

_____ **will not** provide Bereavement Services to the above applicant.

_____
Palliative Care Agency

_____
Explanation

_____
Palliative Care Agency Representative Signature (Include Title) Date

_____
LDSS CAH Coordinator Signature Date

NYSDOH FEB 2010

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Long Term Care

CARE AT HOME I/II PALLIATIVE CARE

Pain and Symptom Management Selection Form

_____Care at Home I _____Care at Home II

NOTE: Signed copies of this form must be supplied to the child's parent/guardian, case manager, Family Pain & Symptom Management Agency and the LDSS.

I understand that in order for my child to receive Care at Home I/II Pain and Symptom Management Waiver service, I must select a palliative care agency from the attached list of approved providers. I have been encouraged to interview these providers prior to making my selection.

I understand that the Pain and Symptom Management palliative care agency will assist me in developing, implementing and monitoring my child's plan of care regarding Pain and Symptom Management.

I may choose to discontinue this service or select a different palliative care agency for Pain and Symptom management at any time. My child will still be eligible for the CAH I/II waiver if I choose to discontinue services or change providers.

From the approved provider list, I have selected the following agency:

_____
Palliative Care Agency Telephone

_____
Agency Address

_____
Applicant (Child's) Name Date

_____
Parent/Guardian Signature Date

_____
Case Manager Signature Date

To be completed by the Palliative Care Agency:

_____
Palliative Care Agency

_____ **will** provide Pain and Symptom management to the above named applicant

_____ **will not** provide Pain and Symptom Management to the above applicant.

_____
Explanation

_____
Palliative Care Agency Representative Signature (Include Title) Date

_____
LDSS CAH Coordinator Signature Date

NYSDOH FEB 2010

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Long Term Care

CARE AT HOME I/II PALLIATIVE CARE

Family Palliative Care Education (Training) Selection Form

_____Care at Home I _____Care at Home II

NOTE: Signed copies of this form must be supplied to the child's parent/guardian, case manager, Family Palliative Care Education Agency and the LDSS.

I understand that in order for my child to receive Care at Home I/II Family Palliative Care Education (Training) Waiver service, I must select a palliative care agency from the attached list of approved providers. I have been encouraged to interview these providers prior to making my selection.

I understand that the Family Palliative Care Education (Training) palliative care agency I choose will assist me in developing, implementing and monitoring my child's plan of care regarding this service.

I may choose to discontinue this service or select a different palliative care agency for Family Palliative Care Education at any time. My child will still be eligible for the CAH I/II waiver if I choose to discontinue services or change providers.

From the approved provider list, I have selected the following agency:

_____
Palliative Care Agency Telephone

_____
Agency Address

_____
Applicant (Child's) Name Date

_____
Parent/Guardian Signature Date

_____
Case Manager Signature Date

To be completed by the Palliative Care Agency:

_____ will provide Family Education to the above named applicant
_____ will not provide Family Education to the above named applicant.

_____
Palliative Care Agency

_____
Explanation

_____
Palliative Care Agency Representative Signature (Include Title) Date

_____
LDSS CAH Coordinator Signature Date

NYSDOH FEB 2010