Licensed Practitioner of the Healing Arts (LPHA) Attestation
Serious Emotional Disturbance (SED) Form

Serious Emotional Disturbance (SED) Attestation INSTRUCTIONS

PURPOSE:
The Licensed Practitioner of the Healing Arts (LPHA) Attestation Form is part of the enrollment application for the Children's Waiver Home and Community Based Services (HCBS) for a Medicaid (or Medicaid eligible) member <21 years of age for children/youth enrolled in Health Homes Serving Children or referred to the Child and Youth Evaluation Services (C-YES). To obtain HCBS, an eligibility determination is necessary. The HCBS Level of Care (LOC) Eligibility Determination is comprised of meeting three factors: Target Population, Risk Factors, and Functional Criteria. Each of the three (3) factors require collection of supporting documentation and materials by the Health Home Care Manager (HHCM) or C-YES.

The goal of HCBS is to provide community-based services to children/youth to prevent institutional level of care such as psychiatric hospitalization, residential treatment, nursing home, or for HCBS to be in place to assist the child/youth to return to their community from an institutional level of care. This Attestation Form **MUST** be filled-out by a Licensed Practitioner of the Healing Arts (LPHA) who has the ability to diagnose within their scope of practice under NY State law **OR** to be filled-out by a Licensed Practitioner who is under the supervision of a LPHA who has the ability to diagnose within their scope of practice under NY State law as outlined on the last page of this form.

<u>REQUIREMENTS of the LPHA Completing this Form</u>

The LPHA completing and signing this form must:

- Be actively working with, or
- Have previously worked with the member in a clinical capacity within the last year (12 months), or
- Have completed a comprehensive evaluation to verify diagnoses and determine the child/youth meets SED criteria

The LPHA must attest that the member meets the SED Target Population and Risk eligibility requirements as outlined in the sections below **AND** must provide clinical documentation to the care manager to receive HCBS. The LPHA must determine in writing by the completion of this Attestation Form that the child/youth, in the absence of HCBS, is at risk of institutionalization (i.e., hospitalization) due to their mental health needs **OR** unable to return to their community due to their mental health needs. The HHCM/C-YES is required to retain supporting documentation with the LPHA Form in the member's case record to demonstrate HCBS eligibility. **Note: The completed LPHA Form alone will not be sufficient for HCBS eligibility without the supporting documentation.*

Prior to the Children's HCBS Level of Care Determination being completed and this LPHA Form being signed and attested, the potential HCBS member must first be determined to meet the SED determination criteria as outlined by the Office of Mental Health (OMH) requirements. Documentation of such needs and diagnosis(es) are to be provided with this LPHA Form. The LPHA Attestation Form is the required document to verify the child/youth meets criteria for SED and the Risk Factors for the Target Population. The HHCM/C-YES are responsible for the completion of the Child and Adolescent Needs and Strengths (CANS-NY), which includes functional criteria, and is also part of the HCBS Level of Care determination process prior to the Medicaid (or Medicaid eligible) member receiving HCBS.

To assist the LPHA to complete the Attestation, the HHCM/C-YES can provide supporting care management documentation, with consent, for Target and Risk Factors to the LPHA. This may include Individualized Education Program (IEP), Residential Treatment Facility (RTF), or Residential Treatment Center (RTC) discharge paperwork, hospital discharge paperwork/plan, school reports, and/or diagnosis from another provider to inform the determination of whether the child meets the required risk factors.

PLEASE NOTE:

- In order to comply with conflict-free care management requirements, the attesting LPHA cannot be any staff for the Health Home program or C-YES, inclusive of a supervisor / director or leadership position associated with oversight of the HHCM or C-YES or a designated HCBS provider agency/staff who is also affiliated with the HHCM agency completing the HCBS eligibility determination (for additional guidance, please refer to the Health Home Conflict Free Care Management Policy). Definitions of terms used in this form can be referenced in the Appendix on page 6.

Section A - Please Complete

Demographics

Child/Youth First Name ________________________ Middle Initial _____ Last Name ____________________________

Date of Birth _____________________________ Biological Sex Male Female

Preferred Language _____________________ Current/Primary Address ______________________________________

Gender Expression ____________________ Client Identification Number CIN# (if available) _____________________

Serious Emotional Disturbance (SED) Target Criteria

If the HHCM already had the Health Home SED determination form completed within the last year by an LPHA for Health Home enrollment, this should be shared with the LPHA (if different) completing this Attestation Form to assist and share information.

Serious Emotional Disturbance means a child or adolescent has a designated mental illness diagnosis according to the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) **AND** has experienced functional limitations due to emotional disturbance over the past 12 months on a continuous or intermittent basis. Therefore, the child must meet all three (3) of the following:

1. The child/youth is currently between the ages of 0 to their 21st birthday

AND

2. Child/youth has a designated mental illness diagnosis according to the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) in one of the following diagnostic categories:
   - Schizophrenia Spectrum and Other Psychotic Disorders
   - Bipolar and Related Disorders
   - Depressive Disorders
   - Anxiety Disorders
   - Obsessive-Compulsive and Related Disorders
   - Trauma-and Stressor-Related Disorders
   - Dissociative Disorders
   - Somatic Symptom and Related Disorders
   - Feeding and Eating Disorders
   - Disruptive, Impulse-Control, and Conduct Disorders
   - Personality Disorders
   - Paraphilic Disorders
   - Gender Dysphoria
   - Elimination Disorders
   - Sleep-Wake Disorders
   - Sexual Dysfunctions
   - Medication-Induced Movement Disorders
   - Attention Deficit/Hyperactivity Disorders
   - Tic Disorders

Diagnoses Name ____ Code # ________________

Diagnoses Cluster ____

AND

3. The Medicaid member has experienced functional limitations due to serious emotional disturbance over the past 12 months on a continuous or intermittent basis. The functional limitations must be moderate in at least two of the following areas or severe in at least one of the following areas:
    - ability to care for self (e.g., personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
    - family life (e.g., capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or
    - social relationships (e.g., establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or
    - self-direction/self-control (e.g., ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or ability to learn (e.g., school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).

Serious Emotional Disturbance (SED) Risk Factors

The child/youth must meet **one** of the following factors 1–4 **AND** must also meet factor 5.

1. The child/youth is currently in an out-of-home placement, including psychiatric hospital (supporting documentation is needed to support this choice, i.e., admission paperwork, letter form the institution signed and with credentials, discharge paperwork within the last 3 months, PSYCKES record of inpatient stay), **or**
2. The child/youth has been in an out-of-home placement, including psychiatric hospital within the past six months (supporting documentation is needed to support this choice, i.e., discharge paperwork, letter form the institution signed and with credentials, letter from the SPOA of confirmation of out-of-home placement, PSYCKES record of inpatient stay), **or**
3. The child/youth has applied for an out-of-home placement, including placement in psychiatric hospital, within the past six months (supporting documentation is needed to support this choice, i.e., Letter from the SPOA that an application/discussion/review occurred for an out-of-home placement), **or**
4. The child/youth currently is multi-systems involved (i.e., two or more systems) and needs complex services/supports to remain successful in the community (supporting documentation is needed to support this choice, i.e., paperwork from each multi-systems that identify the specific needs of the member for their involvement and meeting the definitions below. Health Home enrollment, involvement with C-YES or Medicaid managed care plan, and enrolled in school does not meet multi-systems involvement),
   AND
5. The child/youth must be SED as determined by a Licensed Practitioner of the Healing Arts (LPHA) who has the ability to diagnose within their scope of practice under NY state law **OR** to be filled-out by a Licensed Practitioner who is under the supervision of a LPHA who has the ability to diagnose within their scope of practice under NY State law. The LPHA completing and signing this form must also be actively working with, has previously worked with the member in a clinical capacity within the last year (12 months), or who has completed a comprehensive evaluation in order to verify diagnoses and determine the child meets SED criteria. The LPHA, or Licensed Practitioner under the supervision of a LPHA, signing this form has determined that the child/youth (in the absence of HCBS) is at risk of institutionalization (i.e., hospitalization or nursing facility placement) due to their mental health needs **OR** is unable to return to their community due to their mental health needs.

Institutionalization – admission to an inpatient psychiatric hospital or other out of home treatment setting such as Residential Treatment Facility (RTF)/Center (QRTP) or Community Residence for the purposes of mental health treatment.

Multi-systems involvement - is defined as two or more child-serving systems, one of which must be involvement in the children's mental health system and at least one other system, as outlined below. If the member is receiving more than one mental health service (CFTSS, clinic, etc.), this would only count as one system involvement, inclusive of school-based behavioral health services.

Other systems can include child welfare (e.g., CPS, Foster care), juvenile justice (e.g., Probation), Department of Homeless Services, OASAS clinics or residential treatment facilities or institutions*, OPWDD services or residential facilities or institutions*, or having an established school IEP, 504 plan, and in receipt of services through the school district. However, multi-systems involvement does not include systems/services that all children should receive, such as school or primary care services.

Enrollment in a Medicaid managed care plan, Health Homes/C-YES, HCBS, or other care coordination services also does **not** count toward multi-systems involvement.
For additional examples of multi-systems involvement, please refer to the LPHA section of the Waiver Enrollment Policy.

***Note:* Documentation of multi-systems involvement must be submitted along with the LPHA form to meet the risk factor eligibility portion of the HCBS eligibility determination)**

**Please note that children/youth with an I/DD or SUD diagnosis must have a co-occurring qualifying mental health diagnosis, meet the SED criteria, and be at risk of hospitalization/out of home placement due to their mental health needs, in order to be enrolled in HCBS under the SED Target Population.*

Serious Emotional Disturbance (SED) LPHA Information and Signature

I do hereby attest that this information is true, accurate, and complete to the best of my knowledge and that this form was completed based on my ongoing treatment and/or clinical evaluation of the child noted above and supported by accompanying materials.

Name of LPHA: ________________________________

License No. (Ex.-ML0000022222): ____

Business Street Address: ________________________________

City, State, and Zip code: ____

Signature: ________________________________

Date: _______________________

Affiliated Organization:_____________________________

Are you under the supervision of an LPHA?

Yes

No

If yes, provide your supervisor's name. ________________________________ License No. __________________

Which of the following best describes the type of clinician you are:

I, the clinician, am actively serving the member for _________ (indicate for how long), or

I, have previously worked with the member in a clinical capacity within the last year (12 months), or

I, the clinician, was referred for the purpose of completing the comprehensive evaluation in order to verify diagnoses and determine the child meets SED criteria.*

*For this response, please attach any relevant supporting document.

Date of evaluation: ____________________________

Please provide a narrative explanation of how the determination that the child/youth is at risk if not for HCBS was made and what supporting documentation has been provided to verify the child has met target and risk factors (REQUIRED):

In order to comply with conflict-free care management requirements, the attesting LPHA may not be a supervisor / director or leadership position associated with oversight of the HHCM or C-YES or a designated HCBS provider agency/staff who is also affiliated with the HHCM agency who is completing the HCBS Eligibility Determination (for additional guidance, please refer to the Health Home Conflict Free Care Management Policy).
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If the child is identified as having significant needs by the HHCM/C-YES, and they have been unsuccessful in getting a treating clinician to complete the form, HHCM/C-YES may contact the county Children’s Single Point of Access (C-SPOA) for assistance. The C-SPOA can work with the HHCM/C-YES to collect required information to complete/sign the form. (Documentation will be required to demonstrate efforts the member/family and care manager has attempted to obtain treatment)

This form was completed by the county C-SPOA based on documentation review and information gathering by the HHCM/provided by the treating LPHA.

County: ____

Name of LPHA Designee: ____

LPHA Signature: ____

LPHA License #: ____

APPENDIX A

Licensed Professional of the Healing Arts (LPHA)

Licensed Practitioner of the Healing Arts: An individual professional who is a Licensed Psychiatrist, Licensed Clinical Social Worker, Nurse Practitioner, Physician, Physician Assistant or Licensed Psychologist and practicing within the scope of their State license.

a. **Psychiatrist** is an individual who is licensed and currently registered to practice medicine in New York State, who (i) is a diplomat of the American Board of Psychiatry and Neurology or is eligible to be certified by that Board, or (ii) is certified by the American Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by that Board.
b. **Licensed Clinical Social Worker (LCSW)** is an individual who is currently licensed and registered as a Clinical Social Worker by the New York State Education Department.
c. **Nurse Practitioner** is an individual who is currently certified and currently registered as a nurse practitioner by the New York State Education Department.
d. **Physician** is an individual who is licensed and currently registered as a physician by the New York State Education Department.
e. **Physician Assistant** is an individual who is currently licensed and registered as a physician assistant by the New York State Education Department.
f. **Licensed Psychologist** is an individual who is currently licensed and currently registered as a psychologist by the New York State Education Department from the New York State Education Department and who possesses a doctoral degree in psychology.

Licensed Practitioner who is under the supervision of a LPHA:

a. **Licensed Psychoanalyst** is an individual who is currently licensed and currently registered as a psychoanalyst by the New York State Education Department.
b. **Licensed Marriage & Family Therapist (LMFT) i**s an individual who is licensed and currently registered as a marriage and family therapist by the New York State Education Department.
c. **Licensed Mental Health Counselor (LMHC) i**s an individual who is licensed and currently registered as a mental health counselor by the New York State Education Department.
d. **Licensed Creative Arts Therapist (LCAT)** is an individual who is licensed and currently registered as a Creative Arts Therapist by the New York State Education Department possesses a creative arts therapist permit from the New York State Education Department.
e. **Registered Professional Nurse** is an individual who is licensed and currently registered as a registered professional nurse by the New York State Education Department.
f. **Licensed Master Social Worker (LMSW)** is an individual who is either currently registered as a Licensed Master Social Worker (LMSW) by the New York State Education Department.