Children's Waiver
Home and Community Based Services (HCBS)
Authorization and Care Manager Notification Form Instructional Guide

February 2024

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Background

To be eligible for HCBS, children/youth must have a medical condition, developmental disability, and/or serious mental health diagnosis that is impacting their daily functioning and that places them at risk of hospitalization or institutionalization, or results in the need for supports to return safely home and to their community after discharge from an institutional level of care.

The participant's HCBS eligibility is determined by the Health Home (HH) or Children and Youth Evaluation Services (C-YES) care manager. The HHCM/C-YES establishes the needs, goals, and the HCBS of the participant/family based upon a person-centered plan of care and referral to the HCBS provider. The Children's Waiver HCBS provider determines the Frequency, Scope, Duration (F/S/D) for each service to be provided with supporting documentation based upon the needs and goals of the participant/family. HCBS cannot be provided during school hours and the participant's other appointments and activities as well as the participant's age, development, and condition must be considered when determining F/S/D. If the participant is enrolled with a Medicaid Managed Care Plan (MMCP), authorization is needed to provide and bill for these services based upon the *Children's Waiver (HCBS) Authorization and Care Manager Notification Form*.

Purpose

This Guidance outlines how the HCBS Provider completes and requests authorization for Children's Waiver HCBS via the *Children's HCBS Authorization and Care Manager Notification Form* and the required timeframes associated with this process.

Who completes this form?

The *Children's HCBS Authorization and Care Manager Notification Form* must be completed by the HCBS Provider that was selected by the HHCM/C-YES following the Referral Process. The HHCM/C-YES HCBS Referral Form must be utilized when completing and requesting authorization, as the HCBS provider's identified service and goals to address the participants identified needs must be consistent with the care manager's Plan of Care and the referral that was made to the HCBS provider.

When is this form completed?

Upon the HCBS provider's acceptance of a referral from the HHCM/C-YES care manager, the HCBS provider will schedule a first appointment with the participant/family and **MUST** notify the MMCP upon the first appointment being scheduled no later than 1 business day after the first appointment. Upon receipt of notification of the first appointment, the MMCP will establish the provider in their claim systems to authorize payment for the initial service period up to 60 days, 96 units, or 24 hours. HCBS provided beyond the initial service period must receive authorization from the participant's Medicaid Managed Care Plan (MMCP). Please reference the *Utilization Management and Other Requirements for 1915(c) Children's Waiver Services* guidance (Updated May 2023) for more information on notification timelines.

The HCBS provider must request authorization by submitting the *Children's HCBS Authorization and Care Manager Notification Form*, at least 14 days prior to exhausting the initial or approved service period. Providers should not wait until the initial/existing service amount/period has been exhausted. 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. Changes needed to services and goals must be communicated to the care manager.

- For participants enrolled in Medicaid Managed Care, 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 along with a copy of the 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.

If the initial service period is not exceeded, either due to the participant not needing additional units of service or the participant/family choosing not to continue with additional service units, then the participant would be discharged from the HCBS provider/service and the *Children's HCBS Authorization and Care Manager Notification Form* is not required to be sent to the MMCP. However, the HCBS provider must notify the MMCP and the care manager of the participant's discharge.

The *Children's HCBS Authorization and Care Manager Notification Form* must be completed, or the information verified if auto-populated through the Referral Portal of IRAMS, by the HCBS provider.

Participant Information:

Section 1	Participant Information
Participant Legal Name	The legal name of the participant: First Name, Middle Initial (if applicable), and Last Name.
Participant Preferred Name	The name the participant prefers to be called (if different from their legal name).
Participant DOB	The participant's date of birth, in month, day, year (MM/DD/YYYY) format. (e.g., 04/03/1998).
Gender Identity	How the participant identifies themselves.
Pronouns	The preferred pronouns the participant uses.
Sex Assigned at Birth	The sex that the participant was assigned at birth (which would be identified in EMedNY).
Participant Phone	The Participant's Phone number if the participant is over the age of 18. (###) ###-###
Participant Email (optional)	The Participant's email is an optional field but should be provided if the HCBS Provider has it on file and if the participant/family communicate in this manner.
Participant Address	The Participant's residential address.
CIN	Participant's Medicaid Client Identification Number.
Foster Care	Check the box **ONLY** if the participant is <u>currently</u> in Foster Care.
	If checked provide the name of the Foster Care Agency.

Care Manager (CM) Name	Care Manager name: First Name, Last Name.
CM Phone	Care Manager phone number (###) ###-###
CM Email	Care Manager agency email address.
Name of Health Home/C-YES	Name of Health Home or C-YES that is working with the participant.

Parent/Guardian/Legally Authorized Representative Information:

Section 1	**Parent/Guardian/Legally Authorized Representative (P/G/LAR) Information** For each parent/guardian/legally authorized representative, the HCBS Provider must fill out **ALL** of the information below (unless specified as optional). The HCBS provider must include P/G/LAR information for all applicable individuals. Add additional pages if necessary.
P/G/LAR	P/G/LAR #1 – Is the **primary** P/G/LAR of the participant and with whom the participant resides. If the participant does not reside with the primary P/G/LAR, then that should be noted.
	Check the box that represents the role of the P/G/LAR in relation to the participant.
	The P/G/LAR #2 and #3 is utilized if the participant has multiple P/G/LAR (i.e., two parents who reside at different addresses) or other adults the participant resides with.
	Other Involved Person with whom the Participant Resides is checked for foster parents or others with whom the participant resides but does not have custody of the participant (i.e., grandparent, uncle, aunt, etc.).
P/G/LAR Name	First Name, Last Name.
P/G/LAR Email (optional)	Optional field, complete if the HCBS provider has it or complete if means of communication with the P/G/LAR.
P/G/LAR Phone	Format: (###) ###-####
If the P/G/LAR lives with the Participant	Check the associated box if yes.
P/G/LAR Relationship to Participant	Note the P/G/LAR's exact relation to the participant (i.e., father, grandmother, etc.)
P/G/LAR Address	The P/G/LAR's residential address.
If the P/G/LAR is a LDSS Representative	Check the associated box if yes.
Section 1	**Other Information**
Indicate how many siblings reside in the home	Number of siblings residing in the home with the participant.

Out of the current siblings who reside in the home, how many are also enrolled and receiving HCBS	Number of siblings residing in the home with the participant who are enrolled in the Children's Waiver.
If the participant attends school or other educational/ vocational program	Check the associated box if yes.
School/Education	If applicable, outline the participant's school or educational/vocational program schedule in this box. This includes the number of hours per week the participant attends the program (i.e., Mon-Fri 8am-1pm, etc.).
Regular Appointments/ Programs	Please include other standing appointments (e.g., therapy, medical appointments, OT/PT/ST, CFTSS, PDN/PCA, Hospice, etc.). Example: Mental health counseling each Thursday 4-5pm.
Extracurricular/ Community Activities	Please include information on the participant's known other regularly scheduled activities (e.g., extracurriculars, community activities, outside programming, services). For extracurricular or community activities, note how many hours per day, week, or month. Example: Soccer each Saturday (Aug-Nov) 9-11am.
Other Programming/ Services/Activities	Please include information regarding any other programming, services, or activities that the participant is involved in that are not included in the fields above.
Summer Programing Schedule	If the authorization period will include summer months, note the participant's schedule for programming over the summer, if different from the rest of the year. Note the number of hours per week the participant attends a program and what days of the week a participant attends the program (i.e., Summer School Mon, Wed, Fri 8am-2pm).

Clinical Information:

Section 1	**Clinical Information - This section must be Completed by HCBS Provider**
Participant Primary ICD-10 Diagnosis	Note the participant's primary ICD-10 diagnosis used for billing.
Participant K-Code(s)	Note the participant's K-codes viewable in EMedNY. All participants must have a K1 code to demonstrate HCBS eligibility and a Target Population K-code of K3 – K6.
Last Date of the HCBS Level of Care (LOC) Determination	The date the last HCBS LOC was conducted by the Health Home/C-YES care manager.
Target Population	Check the box for the Target Population per the K-code and completed HCBS LOC of the participant at the time of completing this authorization.

HCBS Provider Information:

Section 1	HCBS Provider Information
HCBS Provider Agency Name	Note the name of the Designated HCBS Provider agency, include any relevant DBAs.
NPI/Tax ID #	The 10-digit NPI/Tax ID number for the designated provider agency.
Provider Address	The address of the designated provider agency.
Contact Person Name	The primary contact name at the provider agency in relation to this Form.
Contact Person Title	The primary contact's title.
Contact Person Phone	The primary contact's phone number.
Contact Person Email	The primary contact's email.
Secondary Contact Name	The secondary contact's name at the provider agency in relation to this Form.
Secondary Contact Title	The secondary contact's title.
Secondary Contact Phone	The secondary contact's phone number.
Secondary Contact Email	The secondary contact's email.

Requested HCBS, Goals, and Objectives

During the first appointment, the HCBS provider will conduct an intake assessment based upon the HCBS Referral sent by the care manager, to determine the needs, goals, and strengths of the participant/family. Once it is determined that the HCBS provider can provide the requested service and the participant/family consent to receive the referred HCBS, then the HCBS provider, in collaboration with the participant/family, care manager, and other involved parties as appropriate, will develop goals and determine the F/S/D for each provided HCBS during the service period. HCBS goals should be strengths-based and must be **Specific, Measurable, Achievable, Relevant, and Time-bound (i.e., SMART goals)**. Requests for services should also be accompanied by supporting documentation from other involved professional(s) that outlines the needs of the participant directly linked to the F/S/D.

HCBS Providers are required to fill out sections for EACH HCBS they will be providing for the participant as well as the accompanying goals and objectives for each HCBS.

Section 1	Requested HCBS, Goals, and Objectives ***Each HCBS MUST have its own section to outline the goals and objectives for that HCBS.***
Select the Children's Waiver HCBS being requested/ included in this notice	Under each HCBS (#1, #2, #3….) only one HCBS can be checked to correspond with the information that will follow. The check box indicates what HCBS the HCBS provider will

	be providing information about. The service selected must be able to address the participant needs according to the service definition and service components outlined in the HCBS manual.
Procedure Code	Per the selected HCBS, enter all procedure code(s) for the service that will be provided and billed.
Start date (1st service visit)	Note the first ever date of service for this HCBS by this provider (i.e., if requesting re-authorization, the date would be before this period of time for service).
Start date for this authorization period	Anticipated start date for this authorization period being requested.
Frequency	How often the service will be offered to the participant, i.e., weekly, biweekly, or monthly basis.
Scope	The time allotment for how long each service will be delivered per the Frequency, i.e., 1 hour, 30 minutes, etc.
Duration	Duration cannot exceed 6 months.
Explanation of variation in schedule (if applicable)	To be utilized if a consistent schedule is not utilized, i.e., Frequency is weekly, every other week is an hour of scope and the opposite week is an hour and half.
Modality	Using the check boxes to indicate if the HCBS will be provided in an individual AND/OR a group setting. **IF** selecting both options, HCBS providers must note which F/S/D is associated with each modality on the lines.
Staff #1 Name	The name of the primary staff member assigned to provide the HCBS service listed above.
Staff #2 Name	The name of the second staff member to provide the HCBS service listed above (i.e., if two procedure codes or additional staff level servicing the participant); add additional line or pages as needed.
Provide Rationale	The HCBS Provider must include the rationale/need for the number of services as determined by the participant/family, HCBS provider, care manager, and other involved professionals. Documentation from a third-party (i.e., the care manager and other involved professionals) must be submitted with this form to support the F/S/D.
Goal	HCBS Providers must complete this section with the goal(s) that the participant will be working towards during service delivery. Goals are informed by the care manager's referral, HCBS provider's assessment of the participant, and are developed in partnership between the HCBS provider, the participant/ family, care manager, and other involved professionals. The HCBS goals should be strengths-based, meet an identified need of the participant, and must be Specific, Measurable, Achievable, Relevant, and Time-bound (i.e., SMART goals). **See Appendix B for examples.**
Objective	HCBS Providers must complete this section with the objectives (interventions) that will be provided to and with the participant, to reach the established service goals. Objectives must be provided based upon the service definitions. Objectives should be results-oriented, measurable steps towards the overall goal that can be achieved within the

	requested period of services. **See Appendix B for examples.** For initial and re-authorization requests: Participant's objectives should be marked as either new, partially met, not met, or met depending on the progress of the participant in meeting their goals through that objective. <u>Key for the objective checkboxes</u>: **New**: This objective/intervention has just been established for the period of requested services. **Partially Met**: This objective was established as part of a previous authorization. While some progress has been made, this objective has not been fully completed. The need for additional intervention continues (details provided in the re-authorization section below). **Not Met**: This objective was established as part of a previous authorization and has not been pursued nor met. The need for this intervention continues (details provided in the re-authorization section below). **Met:** This objective is complete and met. Other objectives for this goal may be pursued or the goal may be closed (details provided in the re-authorization section below).
For Re-Authorization: **Describe the status of the service goal/objective, including what has been accomplished, or what has been worked on.** **Outline what is still needed to be worked on with this goal/objective.**	This section is **ONLY** for HCBS providers submitting a reauthorization form. Providers must describe the status of each service objective/goal. This should include information on what objectives have been accomplished, what has been worked on, and what is still needed to be worked on. Clearly outline if the objective will continue and how. If the objective is met, indicate if the goal be closed or if other objectives for the goal are continuing.
Other services, outside of HCBS, member is receiving related to this service (if applicable)	If applicable, fill in any services the member is receiving related to the HCBS (i.e., counseling, peer support, CFTSS)
Any other barriers or obstacles to the member's goals/objectives and strategies to address these barriers	HCBS providers must note any obstacles or barriers that a participant may face relating to any HCBS goals or objectives listed above and indicate the specific goal where the barriers are experienced. The HCBS providers must also note any known strategies to address these obstacles or barriers.
Section 1	**Signature** *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	Staff member's signature completing the form on behalf of the designated HCBS agency with credentials, if applicable.
Name (please print)	Printed name of staff member completing the form on behalf of the designated HCBS Provider agency.
Title	Agency title of the staff member completing the form.
Date	Date of HCBS provider staff signature.

Completed After Authorization Determination is Received from Managed Care Plan

Section 2	This section is completed by the HCBS provider and sent to the HHCM/C-YES. For participants enrolled in Managed Care, this section is sent to the HHCM/C-YES **AFTER** Authorization is Received from the MMCP, accompanied by the MMCP authorization determination letter. For participants not enrolled in Managed Care, this section is completed immediately after completing Section 1 and sent to the HHCM/C-YES.
Participant's CIN	The participant's Medicaid Client Identification Number.
Was the HCBS requested approved?	If the participant is enrolled in Managed Care, the HCBS provider must check the box to indicate whether the requested HCBS was approved, partially approved, or denied by the participant's Managed Care Plan. The authorization determination from the Managed Care Plan must be attached to this form and the box must be checked to indicate it has been attached. If the participant is not enrolled in Managed Care, these boxes can be left unchecked.
Provider's Initials	First and Last initials of the staff member from the designated HCBS provider agency who is submitting the form to the HHCM/C-YES (FirstLast) (i.e., JD).
Date	The date the HCBS Provider staff initials were added to the form.

Appendix A

Please consider what the participant needs to reasonably achieve the goals/objectives listed in the following section. Supporting documentation must accompany this Form when submitting to the MMCP or placed in the participant's record for Fee for Service.

Frequency Scope and Duration:

Definitions:

Frequency: Is defined as how often the service will be offered to the participant and/or family/caregiver. Services may be delivered on a **weekly, biweekly, or monthly basis** according to the needs and availability of the participant and family. Providers must specify the type of frequency referenced in the "frequency" space provided.

For example:

- Every week
- Every 2 weeks
- Every 3 weeks
- Every month

Scope: Is defined as the service components and interventions being provided and utilized to address the identified needs of the participant/family. A time allotment for how long each service will be delivered per occurrence should be included in the "scope" space provided. The scope of the service should correspond to the abilities, availability, and developmental age of the participant/family, cannot be provided during school hours (to school-aged youth), and be reflective of the billing unit identified by service. If the scope varies based of the day of the week/month, please provide relevant context and information in the "Explanation of variation of schedule" box. Additionally, please denote the scope for individual services vs. group services. This can be presented as decimals rounded to the nearest quarter hour (e.g., 1.25 hours, 3.75 hours, 2 hours, etc.).

Duration: Is defined as the length in time that the service will be delivered to the participant/family to reach their goals. Duration cannot be longer than six months at a time.

Frequency, Scope, and Duration Examples:

[Example 1]

After the first appointment, it has been determined that Drew requires two and a half hours of Day Habilitation every week for the next six months.
Frequency: Weekly
Scope: 2.5 hours
Duration: 6 months

[Example 2]

Miranda is being reauthorized for prevocational services and her HCBS provider has determined that she now needs to receive services for four hours every month for the next six months.
Frequency: Monthly
Scope: 4 hours
Duration: 6 months

Appendix B
SMART Goals and Objectives:

Developing HCBS Person-Centered Goals and Objectives
During the first appointment with the participant/family, the HCBS provider will conduct an intake assessment to determine the needs, goals, and strengths of the participant/family, based upon the referral from the care manager. ***The HCBS provider MUST ensure that the services identified to be provided meet the service definition and purpose of the service.***

Each defined goal should be accompanied with a minimum of one objective in the *Children's HCBS Authorization and Care Manager Notification Form*. The goals to be achieved should be reflective of the developmental and physical needs of the participant. The objectives/interventions are the activities and tasks the HCBS provider will do when working with the participant to reach their goals. Furthermore, the goals and objectives should be strengths-based, measurable, and directly linked to the service that is being provided. To help facilitate goal and objective setting with the participant and their family, the HCBS provider should utilize the SMART Goal framework.

SMART Goals- What are they?
The SMART Goal framework was designed to help guide goal setting. The acronym SMART stands for Specific, Measurable, Achievable, Relevant, and Time-bound. The components of the five aspects of S.M.A.R.T goals are:

Specific- The goal should be clearly defined and focused. When setting a specific goal, it is important to answer who, what, when, where, and why?

Measurable- A goal should be measurable to track progress and determine when it is to be achieved.

Achievable- The goal should be realistic and attainable, given the resources and constraints available. Breaking the goal into smaller, actionable steps can help the participant/family to achieve it.

Relevant- The goal should be aligned and reflect what's important to the participant/family and their needs.

Time-bound- The goal should have a specific deadline or timeline for completion. Define the period in which the goal is to be attained and agree when to check progress.

Defining Goal vs. Objective (intervention)
A goal is a longer-term outcome that the participant/family strives to achieve, while an objective defines the exact actions and steps an HCBS provider and participant/family will take to reach the goals. Objectives should be results-oriented, measurable steps towards the overall goal that can be achieved within the requested period. Objectives should not span over multiple authorization periods. If this occurs, then the objective should be broken down into smaller achievable activities and learning. ***The level of intervention (number of units/hours) must be directly related to the objective to be achieved.***

HCBS SMART Goal & Objective Examples
[Example 1]

Goal: In the next six months, Drew will increase his independence by learning to safely navigate his

community. Drew will display evidence of meeting this goal by displaying appropriate interactions with community members (i.e., asking for directions, saying “thank you” to store clerks, etc.), utilizing public transportation, and safely crossing streets.

Objective #1: At least three times per month for two hours, HCBS provider will facilitate opportunities for Drew to interact with and/or ask at least one person for assistance in the community (e.g., asking a store clerk which aisle a desired item is located; holding a door open for someone; saying “thank you” to the cashier who gives him change).

Objective #2: Drew will practice safely crossing the street (i.e., looking both ways before crossing, using crosswalks, etc.) at least once per week for half hour with his HCBS provider.

Objective #3: Drew will practice taking public transportation with HCBS provider at least once every two weeks for two hours. Utilizing the transportation map, determining where he wants to go and what transportation is needed to get him there.

[Example 2]

Goal: Madison will secure a 15-20 hours/week paid work/job within the next six months.

Objective #1: Madison will practice resume writing with HCBS provider to create her resume and practice answering interview questions two times a week for an hour.

Objective #2: Madison will role play with HCBS provider to practice acceptable job behaviors in the workplace three times a month for an hour.

Objective #3: Madison will explore various career options to decide what she is interested in by attending job fairs, completing skills assessment tests, completing personalized career research, and responding to job advertisements five times a month for two hours.

[Example 3]

Goal: Mariah will be enrolled as a full-time student in local community college in Fall 2024.

Objective #1: Within the next three months, Mariah will work with HCBS provider to complete applications to school one hour each week.

Objective #2: Within the next three months, Mariah will work with HCBS provider to find and apply for financial aid and academic scholarships two hours a week.

[Example 4]

Goal: Jose will display socially appropriate behaviors during times of heightened emotion at school 2 out of 3 times over the next six months.

Objective #1: Jose will practice coping skills with his HCBS provider two times a week for two hours to help with managing his emotions. The HCBS provider will include Jose’s parents and siblings, when appropriate, to help prompt Jose when he needs to utilize these coping skills. The HCBS provider will partner with Jose’s teacher and Jose to practice these coping skills at school.

Objective #2: Jose will role-play pro-social behaviors with his HCBS provider each week for one hour.

Appendix C
Authorizations for Caregiver Family Advocacy and Support Services (CFASS):

CFASS should be requested on the *Children's HCBS Authorization and Care Manager Notification Form* by service level (e.g., Level 1, Level 2, or a mix of both), if required to meet Plan configuration needs. HCBS providers should connect with MMCPs to determine if this level of detail is required for the Plan from whom they are seeking authorization.

In the case where a Level 1 and Level 2 staff will be utilized together because of workforce issues, then the updated Authorization Form will allow for this (extra line for the additional procedure code). In these situations, F/S/D should be based on the needs of the participant and the total Frequency units should be made and separated by the two staffing levels.

It is not allowed that two staff persons would be providing CFASS with the different staff levels, at the same time. CFASS purpose is to provide training, education, and support to the caregiver and other care taking adults (i.e., relative, neighbor, etc.) that is directly related to the needs and services provided to the participant.

Process When CFASS Staffing Changes Occur

- If a **permanent** staff change results in a different level of CFASS, then:
    - a new Authorization Form should be completed and submitted to the Plan at least 14 days prior to submitting a claim for the service at a different level than what is currently authorized.
- If a staff change occurs that is **not permanent**, then:
    - the HCBS provider must notify the MMCP of this change at least 14 days prior to submitting a claim for the service.
    - The notification will take place outside of the HCBS Authorization and Care Manager Notification Form, and can be via email, phone, or some other agreed upon mechanism between the MMCP and the provider, and should include the following information:
        - Participant Name
        - Participant CIN
        - HCBS Provider Agency Name
        - F/S/D of currently approved CFASS (including service level)
        - Newly requested CFASS level
        - Date(s) service has been/will be rendered by staff at a different service level

If the notification follows the requirements above, and the participant has an active authorization in place for CFASS, then the MMCP must approve the request and update their system accordingly to pay the relevant claims. MMCPs and HCBS providers must maintain documentation to support the request and approval of the request in their records.

HCBS providers should connect with the participant's MMCP to determine if authorizations for CFASS need to take place at the Procedure Code level to comply with Plan configuration needs.

This guidance does not apply to MMCPs who have configured their systems to allow for combinations of Level 1 and Level 2 service delivery.