

## Licensed Practitioner of the Healing Arts (LPHA) Attestation Instructions

The Licensed Practitioner of the Healing Arts (LPHA) form is part of the enrollment application for HCBS for a Medicaid (or Medicaid eligible) member <21 years of age. To obtain HCBS, an eligibility determination is necessary. The HCBS Level of Care (LOC) Eligibility Determination is comprised of meeting three (3) 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 Child and Youth Evaluation Service (C-YES).

The LPHA attestation form is the required document to meet the Risk Factor for three of the Target Populations of Serious Emotional Disturbance (SED), Medically Fragile (MF) and Developmental Disability who are Medically Fragile (DD/MF). Functional Criteria will be completed by the HHCM or C-YES and be considered as part of the LOC determination prior to the Medicaid (or Medicaid eligible) member receiving HCBS services.

This Attestation form is to 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 (for a complete list of approved LPHA, see the Attestation form and the [HCBS manual](#)). The LPHA must attest that the member meets the target and risk eligibility requirements to receive HCBS. The LPHA must determine in writing **by the completion of this attestation** that the child, in the absence of HCBS, is at risk of institutionalization (i.e. hospitalization).

- **PLEASE NOTE:** In order to comply with conflict-free care management requirements, the attesting LPHA cannot be a supervisor/director associated with oversight of the HHCM program or C-YES (for additional guidance, please refer to the *Health Home Conflict Free Care Management Policy*).

The form should be completed by an allowable LPHA who has diagnosed or is actively treating the child. If the member is not receiving services already from an appropriate LPHA who is directly aware of the complex needs of the member, then it is the responsibility of the HHCM or C-YES to refer the member to an approved LPHA to assess the needs of the child in order to complete the attestation form. With consent, the HHCM or C-YES can provide supporting care management documentation for Target and Risk Factors to the LPHA., which may include IEP, RTF or RTC discharge paperwork, hospital discharge paperwork/plan, school reports, and/or diagnosis from another provider. The LPHA will review care management materials, verify the child meets the target population, assess their risk based on required risk factors for the target population, and complete this attestation form to support Target and Risk factors that contribute to the member's HCBS Level of Care (LOC) to determine HCBS eligibility. This form is to be completed annually (365 days).

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<b>Section A-</b>	<b>Demographic</b> <b>This section can be completed by HHCM, C-YES, or LPHA</b>
<b>Child/Youth Name</b>	The person's legal name: Last name, first name, and middle initial.
<b>Date of Birth</b>	The person's date of birth, in month, day, year (MM/DD/YYYY) format. (e.g. 04/03/1998)
<b>Biological Sex</b>	This is the sex the person was born with
<b>Gender Expression</b>	This is the sex the person identifies as
<b>CIN</b>	Client Identification Number
<b>Preferred Language</b>	Language the person understands
<b>Current/Primary Address</b>	The person's current home address. Include street/avenue, apartment number, city/town, state and zip code.
<b>Section B</b>	<b>Serious Emotional Disturbance Target Criteria</b>
<b>A. Ages 0 to their 21st birthday</b>	Child/youth is currently between the ages of 0 to their 21st birthday
<b>B. Child/youth meets any one of the DSM diagnoses listed on the form</b>	Serious Emotional Disturbance (SED) – the member has at least one of the Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis categories <b>AND</b> this diagnosis is determined to impact the members daily living functioning “ <i>over the past 12 months on a continuous or intermittent basis</i> ” in one of the 5 areas listed.  *A Licensed Professional who diagnosed the member must also determine impact on functioning and indicate that member has SED. The HHCM/C-YES cannot determine this through reviewing clinical information/assessments.  <b><i>Diagnosis/functioning/SED was determined by the appropriately qualified LPHA who may be the same or different LPHA completing this Attestation form</i></b>
<b>C. Diagnoses Name and Code</b>	This check box is attesting to the member having at least one of the DSM diagnoses categories listed in this section. The Diagnosis and code must be written out after checking the box that SED was determined.
<b>D. Diagnoses Category</b>	The diagnosis category. <b><i>*mental health diagnosis is only good for one year from the diagnosis date on level of care (LOC).</i></b>
<b>E. SED Risk Factors</b>	The check boxed listed under the SED risk factors, the LPHA needs to check <u>one</u> item 1-4 (defined below) based upon the supporting documentation obtained/reviewed <b>AND</b> check item 5.  Item 5 - This check box is attesting that the LPHA signing this form has determined that the child (in the absence of HCBS) is at risk of institutionalization (i.e., hospitalization or nursing facility placement)  <b><i>If <u>one</u> item in #1-4 AND item 5 is not checked by the LPHA, then the member will not be eligible regardless of meeting Target and Functional Criteria.</i></b>

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	<p><u>Definitions of Terms:</u></p> <p><b>Out-of-home placement: (Risk Factor #1–3):</b> RRSY, RTF, RTC, or other congregate care setting, such as SUD residential treatment facilities, group residences, institutions in the OCFS system or hospitalization.</p> <p><b>Applied for out-of-home placement (Risk Factor #3):</b> Any child who has been approved and placed on a waitlist for an out-of-home placement as defined below or a psychiatric hospital; or a child who has had one or more presentations at a CPEP or ER to be assessed for admission (“applied for”) to the hospital (medical or psychiatric) due to an acute need.</p> <p><b>Multi-system involved (Risk Factor #4):</b> means two or more child systems including: child welfare, juvenile justice, Department of Homeless Services, OASAS clinics or residential treatment facilities or institutions, OMH clinics or residential facilities or institutions, OPWDD services or residential facilities or institutions, or having an established IEP through the school district. Examples of system involvement can include, but are not limited to, the following:</p> <ul style="list-style-type: none"><li>• <b>Child welfare:</b> child protective services, preventive services, or foster care</li><li>• <b>Juvenile justice:</b> Arrest, PINS petition, Aftercare, Probation, or Parole</li><li>• <b>Department of Homeless Services:</b> preventative services, housing assistance services, or in a shelter</li><li>• <b>OASAS:</b> in receipt of a service(s) for a diagnosed substance use need by a certified OASAS provider/program</li><li>• <b>OMH:</b> in receipt of a service(s) for a diagnosed mental health need by a licensed OMH provider/program</li><li>• <b>OPWDD:</b> in receipt of a service(s) for diagnosed developmental disability by a licensed OPWDD provider/program</li><li>• <b>School:</b> Have an established IEP or 504 Plan to address an identified disability or impairment which is impacting the child’s success in the school environment</li><li>• <b>Clinical Services:</b> clinic and treatment services for behavioral health</li></ul> <p><b>Institutionalization (Risk Factor #5):</b> admission to a hospital (medical or psychiatric), ICF/IID, RTF or nursing facility</p>
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Section C	Medically Fragile (MF)
<b>A. Ages 0 to their 21st birthday*</b>	Child/youth is currently between the ages of 0 to their 21st birthday  <b>Note:</b> MF children may optionally transition to MLTC on their 18th birthday.
<b>B. Supporting documentation of physical disability</b>	Documents collected by HHCM or C-YES
<b>SSI Certification</b>	<i>For a child before the age of 18 it is every 3 years if the diagnosis may improve.</i>  <i>For adults it is every 3 years for diagnosis that may improve and every 7 years for long term diagnosis.</i>
<b>Disability Review Team Certificate: DOH-5144</b>	The length of disability coverage varies from case to case. For example, the minimum is usually 12 months and the maximum can be as long as 10 years.
<b>Childhood Medical Disability Report: DOH-5151</b>	To be completed by child's doctor
<b>Questionnaire School Performance: DOH-5152</b>	To be completed by the child's teacher or administrator, if the child is enrolled
<b>Description of Child Activities: DOH-5153</b>	To be completed by the parent/guardian/legally authorized representative
<b>C. Risk Factors</b>	This check box is attesting that the LPHA signing this form has determined that the child (in the absence of HCBS) is at risk of institutionalization (i.e., hospitalization or nursing facility placement). <b><i>*Institutionalization - admission to a hospital (medical or psychiatric), ICF/IID, RTF or nursing facility</i></b>
Section D	Developmental Disability (DD) and Medically Fragile (MF)
<b>A. Ages 0 to their 21st birthday</b>	Child/youth is currently between the ages of 0 to their 21st birthday
<b>B. Child/youth has Developmental Disability</b>	This MUST be determined by OPWDD and the HHCM/C-YES would provide verification that OPWDD has made this determination  If documentation is available from OPWDD/DDROs that the child was found DD eligible and/or meets LCED, this establishes that the child meets DD/MF Target Population.
<b>C. Risk Factors</b>	This check box is attesting that the LPHA signing this form has determined that the child (in the absence of HCBS) is at risk of institutionalization (i.e., hospitalization or nursing facility placement).  <b><i>*Institutionalization - admission to a hospital (medical or psychiatric), ICF/IID, RTF or nursing facility.</i></b>

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<b>Section E</b>	<b>LPHA information and Signature</b>
<b>Name:</b>	LPHA's full name
<b>License No.</b>	(Ex.-ML0000022222)
<b>Business St. Address</b>	Full business address with city, state, and zip code
<b>Signature</b>	LPHA's signature
<b>Date</b>	Date with month, day, and year
<b>Narrative</b>	The LPHA provides a short summary of the determination made regarding verification of target criteria and meeting of risk factors