

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES

**HEALTH CARE INTEGRATOR SELECTION FORM**

*BRIDGES TO HEALTH (B2H) HOME & COMMUNITY BASED SERVICES MEDICAID WAIVER PROGRAM*

CHILD'S NAME, (LAST, FIRST, MI.):		
DATE OF BIRTH:	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	MEDICAID CIN #:
<b>B2H WAIVER TYPE (Check one only)</b> <input type="checkbox"/> B2H Serious Emotional Disturbance (SED) Waiver <input type="checkbox"/> B2H Developmental Disabilities (DD) Waiver <input type="checkbox"/> B2H Medically Fragile (MedF) Waiver		

**INSTRUCTION:** To be completed by the Health Care Integration Agency (HCIA) Representative.

<p>I understand that as an applicant for the Bridges to Health (B2H) Medicaid Waiver Program, I may select a Health Care Integrator (HCI) from the list provided to me by my chosen Health Care Integration Agency (HCIA):</p>
NAME OF HCIA
<p>I have been encouraged to interview these HCIs prior to making my selection. I understand that if I do not select a HCI, one will be chosen for me.</p> <p>I understand that this HCI will assist me in selecting B2H Services from the above HCIA's Waiver Service Providers to develop, implement, and monitor my Individualized Health Plan (IHP) (OCFS-8017).</p> <p>I also understand that at any time I may change my HCI or the HCIA and still be eligible for the B2H Medicaid Waiver Program by completing the Change of Provider Form (OCFS-8006).</p>

**The HCI that has been selected is:**

HCI NAME:		PHONE #:	
MEDICAL CONSENTER NAME:	MEDICAL CONSENTER SIGNATURE: <b>X</b>	DATE:	
HCIA REPRESENTATIVE NAME:	HCIA REPRESENTATIVE SIGNATURE: <b>X</b>	DATE:	
HCIA NAME:		PHONE #:	
HCIA ADDRESS:	CITY:	STATE:	ZIP CODE: