

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

REAUTHORIZATION 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 #:
B2H WAIVER TYPE (Check one only)		
<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 and submitted to the Local Department of Social Services (LDSS) or the Division of Juvenile Justice and Opportunities for Youth (DJJOY) within 30 days prior to the annual reauthorization date.

The identified child above meets all of the eligibility criteria for continued participation in the B2H Medicaid Waiver Program and the following documents are attached:

- Level of Care Form (OCFS-8005A, OCFS-8005B, or OCFS-8005C) completed and signed,
- Individualized Health Plan (IHP) (OCFS-8017) completed and signed
(If budget in IHP is over \$51,600, send a copy of IHP to OCFS Regional Office Quality Management Staff,
- Freedom of Choice Form (OCFS-8003) completed and signed,
- Waiver Participant's Rights Form (OCFS-8008) completed and signed.

Health Care Integration Agency Information (HCIA):

HCIA REPRESENTATIVE NAME:	HCIA REPRESENTATIVE SIGNATURE: X	DATE:
AGENCY NAME:	PHONE #:	
AGENCY STREET ADDRESS	CITY:	STATE: ZIP CODE:

DECISION SECTION

(CHECK ONE) FOR LOCAL DEPARTMENT OF SOCIAL SERVICES (LDSS) OR DIVISION OF JUVENILE JUSTICE AND OPPORTUNITIES FOR YOUTH (DJJOY) COMPLETE DECISION SECTION AND RETURN ORIGINAL TO HCIA.

Decision (Check one only):

1. **Request for B2H Medicaid Waiver Program Continuation Approved; effective** / / .

If the Request for B2H Medicaid Waiver Program is approved, **AND** there is a change in services;

Complete Notice of Decision – Denial of Waiver Service(s) (OCFS-8010B);

Complete Notice of Decision – Discontinuance of Service(s)/Service Provider(s) and/or Reduction of Service(s) (OCFS-8011B);

OR

2. **Request for B2H Medicaid Waiver Program Continuation Disapproved;**

Complete Notice of Decision – Discontinuance from Waiver Program. (OCFS-8011A)

Comments:

CONTACT'S NAME:	CONTACT'S SIGNATURE: X	DATE:
CONTACT'S TITLE :		
CONTACT'S ADDRESS:	CITY:	COUNTY: STATE: ZIP CODE:

Original – Health Care Integration Agency; **Copy of Completed 8014 Form Only** – Child/Medical Consenter, Case Planning Agency, Caregiver;

Copy of 8014 and Supporting Documentation – Local Department of Social Services or Division of Juvenile Justice and Opportunities for Youth