

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
SERVICE SUMMARY FORM

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

INSTRUCTION: To be completed by the Health Care Integrator (HCI) or Waiver Service Provider (WSP). Submit copy to Health Care Integration Agency (HCIA).

| | | |
|-----------------------------------|--|--|
| 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)

B2H Serious Emotional Disturbance (SED) Waiver
 B2H Developmental Disabilities (DD) Waiver
 B2H Medically Fragile (MedF) Waiver

| | | | | | |
|------------------|-------------|--|-----------|--|-----------------------|
| DATE OF SERVICE: | START TIME: | <input type="checkbox"/> AM <input type="checkbox"/> PM | END TIME: | <input type="checkbox"/> AM <input type="checkbox"/> PM | TOTAL BILLABLE UNITS: |
|------------------|-------------|--|-----------|--|-----------------------|

Service Location:

| A. Waiver Services (Check ONE Service Only) | B. Individual | C. Group | D Services Planning (Max Billing per 6 mos.) | E. Billable Unit |
|---|--------------------------|--------------------------|---|--|
| <input type="checkbox"/> Health Care Integration Location of Service: <input type="checkbox"/> In Home <input type="checkbox"/> Other | | | | <input type="checkbox"/> Regular Full Month (Per one month) <input type="checkbox"/> Enrollment Month (Per one month) <input type="checkbox"/> HCIA transfer from original HCIA (Per half month) <input type="checkbox"/> HCIA transfer to a New HCIA (Per half month) <input type="checkbox"/> Hospitalization from 1-10 days (Per one month) <input type="checkbox"/> Hospitalization from 11-30 days (Per one month) |
| <input type="checkbox"/> Family/Caregiver Supports & Services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> 1 Hour | Per 15 min. unit |
| <input type="checkbox"/> Skill Building | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> 1 Hour | Per 15 min. unit |
| <input type="checkbox"/> Day Habilitation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> 2 Hours | Per 1 hour unit |
| <input type="checkbox"/> Special Needs Community Advocacy & Support | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> 2 Hours | Per 15 min. unit |
| <input type="checkbox"/> Prevocational Services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> 2 Hours | Per 1 hour unit |
| <input type="checkbox"/> Supported Employment | <input type="checkbox"/> | | <input type="checkbox"/> 2 Hours | Per 1 hour unit |
| <input type="checkbox"/> Planned Respite | <input type="checkbox"/> | | <input type="checkbox"/> 1 Hour | <input type="checkbox"/> Full day respite rate (4 or more hours) <input type="checkbox"/> Less than full day rate (if less than 4 hours) |
| <input type="checkbox"/> Crisis Avoidance, Management & Training | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> 2 Hours | Per 15 min. unit |
| <input type="checkbox"/> Immediate Crisis Response Services | <input type="checkbox"/> | | <input type="checkbox"/> 2 Hours | Per 15 min. unit |
| <input type="checkbox"/> Intensive In-home Supports & Services | <input type="checkbox"/> | | <input type="checkbox"/> 2 Hours | Per 15 min. unit |
| <input type="checkbox"/> Crisis Respite | <input type="checkbox"/> | | <input type="checkbox"/> 1 Hour | <input type="checkbox"/> Full day respite rate (4 or more hours) <input type="checkbox"/> Less than full day rate (if less than 4 hours) |

*Using the chart above, calculate your TOTAL BILLABLE UNITS based upon start and end times.
SEE B2H WAIVER RATE CODE MATRIX AND CHAPTER 13 OF THE B2H PROGRAM MANUAL FOR BILLING INFORMATION*

Description of service provided:

Description of child's response to service. Include progress towards any identified goals or intervention strategies:

My signature verifies that the above service was provided.

| | | | | | |
|---|--|---|--|----------|-----------|
| HCI OR WSP NAME: | | HCI OR WSP SIGNATURE: X | | DATE: | |
| HCI SUPERVISOR OR WSP SUPERVISOR NAME: | | HCI SUPERVISOR OR WSP SUPERVISOR SIGNATURE: X | | DATE: | |
| HEALTH CARE INTEGRATION AGENCY(HCIA) / WSP AGENCY NAME: | | | | PHONE #: | |
| ADDRESS: | | CITY: | | STATE: | ZIP CODE: |

NOTE: FOR HEALTH CARE INTEGRATION ONLY. SEE ACCOMPANYING PROGRESS NOTES DATED FOR THE FOLLOWING CONTACTS:

CONTACT WITH WAIVER SERVICE PROVIDERS IN THE INDIVIDUALIZED HEALTH PLAN (IHP)

| | | | |
|------|--|------|--|
| Date | | Date | |
|------|--|------|--|

CONTACT WITH CASE PLANNER/CASE MANAGER IF CHILD IS IN FOSTER CARE

| | | | |
|------|--|------|--|
| Date | | Date | |
|------|--|------|--|