

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
LOSS OF ELIGIBILITY RECOMMENDATION 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 by a Health Care Integration Agency (HCIA) Representative immediately upon receipt of information and forwarded to the Local Department of Social Services (LDSS) or Division of Juvenile Justice and Opportunities for Youth (DJJOY). Attach supporting documentation.

SECTION A This is to advise you that the above child may no longer be eligible for the B2H Medicaid Waiver Program. The loss of eligibility recommendation is based on the following reason(s):	
1.	The child is no longer Medicaid eligible. This was documented on: _____.
2.	The child no longer meets Level of Care Criteria (Form OCFS-8005 A, B or C). This was documented on _____.
3.	The child was admitted to a residence of 13 beds or more on _____, which is a non-qualified setting for B2H Medicaid Waiver Services.
4.	The child was admitted to institutional level of care, including hospitalization, incarceration, detention, or absent without consent on _____. It was determined on _____ that she/he has been/is expected to be in that setting for more than 30 consecutive days.
5.	The child has moved to a waiver ineligible setting, including any Medicaid funded settings, on _____.
6.	The B2H Medicaid Waiver Services are no longer appropriate for the child. This was documented on _____.
7.	The cost of serving this child in the B2H Medicaid Waiver Program is above the level necessary to meet the Federally mandated requirement that B2H Medicaid Waiver Service must be cost neutral in the aggregate when compared to statewide institutional costs, as determined by OCFS. This was documented on _____.
8.	The child/medical consenter no longer wants to receive B2H Medicaid Waiver Services. This was documented on _____.
9.	The child/medical consenter chooses to receive services from another Medicaid Waiver. This was documented on _____.
10.	The child turns 21 years of age on _____.
11.	The child moved: <input type="checkbox"/> a. out of state OR <input type="checkbox"/> b. to a non-participating county Effective _____.
12.	The child died on _____.
13.	Other Reason: _____ Effective _____.

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

SECTION B DECISION SECTION				
FOR <input type="checkbox"/> LOCAL DEPARTMENT OF SOCIAL SERVICES (LDSS) USE OR <input type="checkbox"/> DIVISION OF JUVENILE JUSTICE AND OPPORTUNITIES FOR YOUTH (DJJOY) USE ONLY – COMPLETE DECISION SECTION AND RETURN ORIGINAL TO HCIA				
Loss of Eligibility Decision: <input type="checkbox"/> Approved by LDSS or DJJOY, Complete Notice of Decision – Discontinuance from Waiver Program (OCFS-8011A). <input type="checkbox"/> Disapproved by LDSS or DJJOY Reason: _____				
CONTACT NAME:	CONTACT SIGNATURE: X	DATE:		
TITLE OF CONTACT:				
CONTACT ADDRESS:	CITY:	COUNTY:	STATE:	ZIP CODE: