

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

TRANSITION PLAN

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

INSTRUCTION: To be completed by the Health Care Integration Agency (HCIA) 18 months prior to the child's 21st birthday (for children aging out of the B2H Medicaid Waiver program), a minimum of three (3) months prior to an anticipated discontinuance date for all other children OR within 30 days of an unanticipated discontinuance from the B2H Waiver Program.

CHILD'S NAME (LAST, FIRST, MI.):			
DATE OF BIRTH:	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	MEDICAID CIN #:	ANTICIPATED DATE OF TRANSITION: / /

B2H WAIVER TYPE: (Check one only)

B2H Serious Emotional Disturbance (SED) Waiver

B2H Developmental Disabilities (DD) Waiver

B2H Medically Fragile (MedF) Waiver

SERVICE NEEDS FOR TRANSITION: List the services to be provided, include Medicaid State Plan and any other appropriate services such as services from another Home and Community Based Waiver.

Service Type	Agency Name	Contact Person	Phone

	Describe the following action steps necessary to access services	Person Responsible
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

The HCIA must provide its most current eligibility and/or assessment information to the LDSS or DJJOY, so that the LDSS/DJJOY can evaluate the child's eligibility for adult services.

SPECIFIC INSTRUCTIONS:

Include any additional recommendations for future services planning, if applicable.

The signatures below provide verification that this information is current and accurate.

MEDICAL CONSENTER NAME:	MEDICAL CONSENTER SIGNATURE: X	DATE:	
HEALTH CARE INTEGRATOR NAME:	HEALTH CARE INTEGRATOR SIGNATURE: X	DATE:	
HCIA SUPERVISOR NAME:	HCIA SUPERVISOR SIGNATURE: X	DATE:	
HCIA NAME:		HCIA PHONE #:	
HCIA ADDRESS:	CITY:	STATE:	ZIP CODE:

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

CONTACT NAME:	CONTACT SIGNATURE: X	DATE:
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