



**New York City Administration
for Children's Services**



IS OFFERING

FREE MR/DD EVALUATIONS

The New York City Administration for Children's Services is proud to offer this valuable evaluation service to all foster care children Five (5) years old and up, identified or suspected of having a developmental disability.

These Psychological and Psychosocial Evaluations are an essential part of the OPWDD eligibility Process

To make a referral for an evaluation please contact:

**ACS Developmental Disabilities Unit
NYC Administration for Children's Services
150 William Street, 8th Floor 8-J3
New York, NY 10038**

212.676.9072

Nicole.Hechme@dfa.state.ny.us





New York City Children's Services

Division of Family Support Services
150 William Street, 14th Floor
New York, NY 10038
212 341 4132 Office
212 227-4010 Fax

Ronald E. Richter
Commissioner

Charles Barrios
Deputy Commissioner

Angel Mendoza, M.D.
Assistant Commissioner
Office of Child and Family Health

ACS/AHRC Evaluation Project Referral Checklist

The following is a list of required materials for an ACS/AHRC Psychological referral: Please submit a complete packet of required documentation as specified below. Please check off **all completed items** on the blanks provided before each item on the checklist below. **Incomplete packets can NOT be processed.**

_____ **ACS-AHRC Referral Form:** two pages.

_____ **AHRC Authorization for Release of Information:** (*Note: The original copy of the signed consent form is required by AHRC and must accompany the child at the time of evaluation.)

_____ **AHRC Assignment of Insurance Benefits**

_____ **Clinical Documentation:** That describes why there is a reasonable suspicion of mental retardation and/or developmental disability

_____ **IEP Report From School:** (classification of MR, multiply handicap, or MR/ED are seen as appropriate)

_____ **Previous Psychological Evaluations:** Any previous psychological evaluation that shows intelligence testing and levels of adaptive functioning

_____ **Psycho-Social History:** include relevant details about the child's history and functioning.

_____ **Psychiatric Evaluation:** if the child is dually diagnosed, exhibits severe behavioral challenges and/or is prescribed psychotropic medications.

_____ **5 Years old and older:** The child must be at least 5 years old to participate

_____ **Supervisor Sign-off:** Initial here that the packet is complete and has been reviewed by a supervisor/director within your organization: **DO NOT INITIAL UNLESS ALL THE ITEMS ABOVE ARE PRESENT IN THE PACKET.**

Please fax/mail the completed package to:

Nicole Hechme
ACS/AHRC Evaluation Project
ACS Developmental Disabilities Unit
150 William Street, 8th Floor, 8-J3
New York, N.Y. 10038
(212) 676-9072
(212) 676-0176 – Fax



ACS MRDD
EVALUATION PROJECT

AHRC FAMILY & CLINICAL SERVICE REQUEST

Date: / /

Client Name _____ ID# 0 0 _____
Last name First name

ACS Case # _____ Case Name _____

Date of Birth ____/____/____ SSN _____ - - _____ Gender () Male () Female

Address _____ Apt _____ City _____ State _____ Zip Code _____

Home Phone (____) _____ Work Phone (____) _____ Ext _____

Do you receive services from other agencies? () YES () NO If yes, list services _____
 List Article 16 services received from other agencies _____

Is the consumer in Foster Care? (X) YES () NO Who is the Legal Guardian? _____

Language: () English () Cantonese () Russian () Spanish () Mandarin () Other
 Ethnicity: () African American () Asian () Caucasian () Hispanic / Latino () Pacific Islander () Other () Unknown

Referral Source

Referral made by _____ Title _____

Agency _____ Dept _____

Address _____ City _____ State _____ Zip Code _____

Phone (____) _____ Ext. _____

Send copy of report to: Nicole Hechme Agency ACS Developmental Disabilities Unit
 Address 150 William Street, 8th Fl 8-J3 City New York State NY Zip Code 10038 Tel (212) 676-9072

Service requested: () Psychological Evaluation () *Psychosocial History

***Please include a copy of any previous psychological report and the original Authorization for Release of Information and Insurance Benefits form.**

Reason requested: Eligibility Determination for OPWDD Residential Services and/or OCFS Bridges 2 Health (B2H) Waiver: developmental disabilities category due to reasonable suspicion of Mental Retardation and/or Developmental Disability

Please specify purpose of evaluation (check one): () Bridges to Health Unit Attn: Jodi Saitowitz
 () ACS Developmental Disabilities Unit Attn: Robin Epstein
 () Other: Please specify _____

Preferred location of service (circle one): MANHATTAN **OR** BRONX **Language Preferred:** _____

Insurance Information

Other Insurance _____ ACS Contract ID# CT 20070006058 Effective Date ____/____/____

Consumer Name: _____

CONTACT INFORMATION

Appointment Confirmation (This is the foster care agency representative who is facilitating)

Last Name _____	First Name _____	Relationship _____
Address _____	Apt _____	City _____ State _____ Zip Code _____
Home Phone () _____	Emergency Phone () _____	
Business Phone () _____	Ext _____	Co. Name _____ Dept _____

Caregiver / Family (Please specify if this person has *lived with and cared for* the client and will be available to serve as "respondent" for the evaluation of level of functioning)

Last Name _____	First Name _____	Relationship _____
Address _____	Apt _____	City _____ State _____ Zip Code _____
Home Phone () _____	Emergency Phone () _____	
Business Phone () _____	Ext _____	Co. Name _____ Dept _____

Legal Guardian

Last Name _____	First Name _____
Address _____	City _____ State _____ Zip Code _____
Home Phone () _____	Emergency Phone () _____
Business Phone () _____	Ext _____ Co. Name _____ Dept _____

ACS Case Manager

Last Name _____	First Name _____
Address _____	City _____ State _____ Zip Code _____
Business Phone () _____	Emergency Phone () _____

Primary Care Physician

Facility Name _____	Dept _____
Physician's Last Name _____	First Name _____
Address _____	City _____ State _____ Zip Code _____
Business Phone () _____	Ext _____ Emergency Phone () _____

Non AHRC Medicaid Service Coordinator (Medicaid Service Coordinator, if applicable)

Name _____	Agency Name _____
Address _____	City _____ State _____ Zip Code _____
Service Coordinator's Last Name _____	First Name _____
Business Phone () _____	Ext _____ Emergency Phone () _____



Department of Family and Clinical Services

Authorization for Release of Information
For Children in Foster Care

AHRC Client #

I hereby authorize the Department of Family and Clinical Services of AHRC to:

- Disclose information to: Obtain information from: Exchange information on an Ongoing basis with:

NAME/AGENCY

ADDRESS

REGARDING

Client Name

DOB

The name to be disclosed is:

- Summary of treatment
Other (specify):

Please indicate which of the following apply:

- Parental rights have been terminated. Undersigned is authorized to allow release of information.
Parental rights have not been terminated. Parents have given permission to release information.
Parental rights have not been terminated. No response from parent regarding this release.

I understand that I may revoke this authorization at any time. I also understand that any authorization which was made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of this child's confidentiality. Unless I revoke this authorization prior to such time, this authorization shall expire when the desired information is released by AHRC or when treatment is terminated.

This consent shall remain effective for the duration of treatment or for the purposes or periods indicated. If no specific date, event, or condition is indicated, this consent will last no longer than reasonably necessary to serve the purpose for which it is given.

Date, event or condition at which authorization expires:

Foster Care Caseworker (Signature)

Today's Date

Foster Care Caseworker (please print)

Agency

AHRC Client # _____

A16 Department of Family and Clinical Services

ASSOCIATION FOR THE HELP OF RETARDED CHILDREN

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize my insurance company ACS CT 20070006058
(name of company)
to pay the AHRC Department of Family and Clinical Services, 83 Maiden Lane,
New York, NY 10038 directly for services provided to members of my family. If
payments are made directly to me, such payments shall not exceed the Department of
Family and Clinical Service charges for those services.

Client's Name: _____

Authorized Signature: _____

Date: _____



New York City Children's Services

Division of Family Support Services
150 William Street, 18th Floor
New York, NY 10038
212 341 8934 Office
212 341 0946 Fax

Ronald E. Richter
Commissioner

Charles Barrios
Deputy Commissioner

Angel Mendoza, M.D.
Assistant Commissioner
Office of Child and Family Health

ACS MRDD EVALUATION PROJECT Information Guide

PURPOSE: To provide psychological evaluations for *MRDD eligibility determination* to children and teens in foster care (ages 5 and up).

A specialized MRDD psychological evaluation is the first important step in determining whether a foster child or teen is eligible for **OCFS Bridges to Health (B2H)** services and/or OPWDD services

These evaluations are available for any foster children for whom:

- ⌘ there is a *reasonable suspicion of Mental Retardation (MR) and/or Developmental Disability (DD)* but formal required testing has not been completed, or
- ⌘ for whom *prior MR/DD evaluations* produced vague or ambiguous results and there is strong justification for further assessment

Bridges to Health eligibility determination is based on the same 3 essential factors as **OPWDD eligibility determination:**

- ⌘ Low IQ (<70) or higher with another qualifying developmental disability
- ⌘ Low level of adaptive functioning (<70 in 2 areas on a standardized test for adaptive functioning)
- ⌘ Documented history of disability during an earlier stage of development.

REQUIRED for REFERRAL: Foster Care case planners must submit

- ⌘ **ACS-AHRC Referral Form:** two pages
- ⌘ **AHRC authorization for release of information** (*)
- ⌘ **AHRC authorization for insurance payment**
- ⌘ **Clinical documentation:** that describes why there is a strong suspicion of Mental Retardation and/or Developmental Disability that was first observed during early childhood.
WE WILL NOT BE ABLE TO ACCEPT REFERRALS WITHOUT SUPPORTING CLINICAL DOCUMENTS.
- ⌘ **Name of the respondent:** *Someone who has lived with and cared for the child/teen* for at least the last **Six (6)** months and is available to provide information to the evaluator.

All referral materials must be sent to:

Nicole Hechme
ACS Developmental Disabilities Unit
150 William Street, 8th Floor 8-J3, New York, NY 10038
Email: nicole.hechme@dfa.state.ny.us
Phone: (212) 676-9072
Fax: (212) 676-0176

(*) Note: The original copy of the signed consent form is required by AHRC and must accompany the child at the time of the evaluation.

Completing the AHRC Referral Form:

- ⌘ All referrals must specify the *Reason for Referral* – indicating why there is reasonable suspicion of Mental Retardation and/or Developmental Disability.
- ⌘ The vendor has locations in **Manhattan** and the **Bronx**.
- ⌘ The AHRC Referral Form must specify *Appointment Confirmation Contact Information* – The name of the primary contact person at the foster care agency who will facilitate the scheduling of the appointment and who will receive the report when completed.
- ⌘ The AHRC Referral Form must also specify the name of the *Caregiver/Family Member* who will accompany the foster child to the evaluation and serve as the **“RESPONDENT”** for the evaluation. An evaluation will usually take about 2 hours.

Important Note: OPWDD eligibility criteria requires the **“Respondent”** to be *someone who has lived with and cared for the child*. Therefore the foster care caseworker **cannot** serve this function, nor can a teacher or other social service worker-- *Except* in cases in which a teen is in congregate care and there is a consistent house parent who knows the teen’s functional capacities well.

- ⌘ **Background clinical documentation is required for all referrals.** This can include psychosocial, prior psychiatric reports, prior psychological reports and school reports (such as IEPs).

Important note: Evaluations to support OPWDD eligibility cannot be completed without background developmental history – especially for teens undergoing evaluations. The clinical reports must give special attention to the age at which the signs of Mental Retardation or Developmental Delay were first noted. OPWDD will not certify any child or teen for whom there is no evidence of delay that appeared during early childhood. *The foster care case planner is responsible to provide a psychosocial summary*, which should indicate evidence of disability from the point it was first noted in the child’s developmental history.

MRDD evaluations are provided **free of charge** at AHRC as part of this special ACS-funded project. The child’s insurance will not be charged.

How does a foster child benefit from being certified as OPWDD eligible? Foster children and teens with developmental disabilities who live in the community are now eligible for a broad array of specialized treatment and support services through the OCFS Bridges to Health Waiver. Clients who need a higher level of care can be placed in OPWDD residential care when they age-out of foster care. This process is facilitated by the ACS Developmental Disabilities Unit.

If you have any questions or require additional assistance, please contact us at:

Nicole Hechme
ACS Developmental Disabilities Unit
150 William Street, 8th Floor 8-J3, New York, NY 10038
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