NEW YORK CITY
ADMINISTRATION FOR CHILDREN'S SERVICES

Request For Services (R4S) Form

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

PLEASE TYPE OR PRINT NEATLY- Please submit TWO copies of the ENTIRE package by mail.

DATE OF REFERRAL: **9 / 3 / 2010**

CHILD'S NAME, (***LAST, FIRST, MI,***) *(Include any alias, nicknames or other names the child may be known by)*:
DOE, JANE M

CHILD'S CURRENT ADDRESS:
123 MAIN STREET #4A

CITY:	STATE:	ZIP:	COUNTY:	MEDICAID CIN #:
NEW YORK	**NY**	**10012**	**MANHATTAN**	**CV11412A**

DATE OF BIRTH:	SEX:	CASE NAME:	ACS CASE #:
8 / 15 / 2001	☐ Male ☒ Female	**LILY DOE**	**S5412326**

SOCIAL SECURITY #:	CASE PLANNING AGENCY NAME:
000-00-0000	**SESAME STREET FAMILY SERVICES INC.**
IS CHILD LEGALLY FREED? ☐ YES ☒ NO	IF NO, HAS PERMISSION TO OVERRIDE PARENTAL CONSENT BY ACS BEEN APPROVED? **N/A**

MEDICAL CONSENTER'S NAME:	RELATIONSHIP TO CHILD:	E-MAIL ADDRESS:
LILY DOE	**MOTHER**	**LILY.DOE@AOL.COM**

MEDICAL CONSENTER ADDRESS:	CITY:	STATE:	ZIP CODE:	PHONE #:
1515 ELMO STREET	**NEW YORK**	**NY**	**10031**	**347-555-1212**

IS CAREGIVER FLUENT IN ENGLISH? ☐ YES ☒ NO IF NOT, WHICH LANGUAGE? **Chinese**	IS CHILD FLUENT IN ENGLISH? ☒ YES ☐ NO IF NOT, WHICH LANGUAGE?	ARE THEIR ANY REASONABLE ACCOMMODATION AND/OR UNDUE HARDSHIP UNDER THE AMERICANS WITH DISABILITIES ACT TO BE CONSIDERED WHEN WORKING WITH THIS CHILD OR FAMILY? **MOTHER IS IN A WHEELCHAIR**

B2H WAIVER TYPE *(Check one only)*

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

REFERRAL TYPE *(Check one only)*

☒ Initial Referral
☐ Subsequent Referral: completed if child was Withdrawn or Denied previously.

SIBLING INFO *(Check ALL that Apply)*
☐ Sibling is enrolled in B2H-Name of Sibling(s): N/A
☐ A referral for another sibling is also being submitted- Name of Sibling(s): **N/A**

LEGAL STATUS OF CHILD: ☒ IN CARE ☐ ON TRIAL DISCHARGE ☐ PINS ☐ TPR PENDING ☐ CALENDARED FOR ADOPTION?

DATE OF PENDING ADOPTION: __/__/____ DATE OF ANTICIPATED FINAL DISCHARGE: __/__/____

NOTE: If child is discharged from care prior to being ENROLLED, they will NO longer be eligible for B2H.

IS CHILD CURRENTLY IN AN ELIGIBLE SETTING? (12 BEDS or LESS) ☐ YES ☒ NO
IF NO, HAS AN ELIGIBLE SETTING BEEN IDENTIFIED FOR CHILD? (FBH or SETTING OF 12 BEDS or LESS) ☒ YES ☐ NO
DATE OF INTENDED DISCHARGE or STEP DOWN DATE: 09 / 30 / 2010

IS CHILD RECEIVING SPECIAL EDUCATION? ☒ YES ☐ NO **IF YES PLEASE SUBMIT A CURRENT IEP WITHIN THE CURRENT YEAR.**

IS CHILD CURRENTLY RECEIVING ANY OTHER SUPPORTIVE SERVICES (i.e. OMH or CSPOA)? ☒ YES ☐ NO
IF YES PLEASE DESCRIBE: Child Receives Intensive Case management services through OMH

PLEASE CALL 212-646-6406 IF YOU NEED ASSISTANCE WITH THIS FORM

ORIGINAL MUST BE Mailed to- ACS 150 William Street, 4th Floor New York, NY 10038 **ATTENTION: (B2H) UNIT** - FAXES will **NOT** be accepted!

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The ***Freedom of Choice Act*** (H.R. 1964/S. 1173) Federal Law states that an individual have been informed that they may be eligible for services provided through either the B2H Medicaid Waiver Program or a medical institution It prohibits a federal, state, or local governmental entity from denying or interfering with a person's right to exercise such choices; or discriminating against the exercise of those rights in the regulation or provision of benefits, facilities, services, or information. Provides that such prohibition shall apply retroactively.

TO BE COMPLETED BY THE MEDICAL CONSENTER
I have chosen to ***(Check one only):***
☒ Apply for the B2H Medicaid Waiver
☐ **NOT** apply for services through the B2H Medicaid Waiver Program at this time.

A LIST AND BROCHURES OF HEALTH CARE INTEGRATION AGENCIES (HCIA) WAS PROVIDED TO THE CHILD/MEDICAL CONSENTER. THE CHILD/MEDICAL CONSENTER HAS SELECTED THE FOLLOWING HCIA**: (CHECK BOX BELOW)**

(CHECK ONE ONLY):

NYC (5 BOROUGHS)
- ❑ ABBOTT HOUSE
- ☒ CATHOLIC GUARDIAN SOCIETY AND HOME BUREAU
- ❑ CARDINAL MCCLOSKEY SERVICES (CMS)
- ❑ GRAHAM WINDHAM
- ❑ NEW ALTERNATIVES FOR CHILDREN (NAC)
- ❑ JEWISH CHILD CARE ASSOCIATION (JCCA)
- ❑ SCO FAMILY OF SERVICES

LOWER HUDSON VALLEY
- ❑ CHILDREN'S VILLAGE
- ❑ ASTOR SERVICES FOR CHILDREN AND FAMILIES

LONG ISLAND (NASSAU AND SUFFOLK COUNTY)
- ❑ LITTLE FLOWERS
- ❑ SCO

OTHER: _____
(TO BE COMPLETED ONLY IF HCIA IS NOT IN THESE THREE REGIONS**)**

My signature BELOW verifies that I have exercised my ***Freedom of Choice*** rights to choose my Health Care Integration Agency without any influences. I acknowledge that I understand that I have the right to change my HCIA at any time by contacting ACS at 212-676-6406 or my HCIA.

MEDICAL CONSENTER NAME:	MEDICAL CONSENTER SIGNATURE:	DATE:
LILY DOE	X *LILY DOE*	**9/3/2010**

FOSTER PARENT NAME:	FOSTER PARENT HOME PHONE:	FOSTER PARENT CELL PHONE:
MOMMA BIRD	**212-555-1212**	**917-987-2222**

FOSTER PARENT ADDRESS:	CITY:	COUNTY:	STATE:	ZIP CODE:
123 MAIN STREET #4A	**NEW YORK**	**Manhattan**	**NY**	**10012**

NAME OF RESIDENTIAL SETTING IF NOT IN A FOSTER HOME: (THIS INCLUDES HOSPITAL)	NAME OF CONTACT PERSON AT RESIDENTIAL SETTING IF NOT IN A FOSTER HOME: (THIS INCLUDES HOSPITAL)
N/A	**N/A**
PHONE # OF RESIDENTIAL SETTING IF NOT IN A FOSTER HOME: (THIS INCLUDES HOSPITAL)	E-MAIL ADDRESS OF RESIDENTIAL SETTING IF NOT IN A FOSTER HOME: (THIS INCLUDES HOSPITAL)
N/A	**N/A**

AGENCY REPRESENTATIVE NAME:	RELATIONSHIP TO CHILD: (e.g. Case Planner, Case Worker, Therapist)
MARY JANE	**CASE PLANNER**
AGENCY REPRESENTATIVE'S TITLE:	AGENCY REPRESENTATIVE'S E-MAIL ADDRESS:
CASE PLANNER	**MARY.JANE @SESAMESTREET.ORG**
AGENCY REPRESENTATIVE'S ADDRESS:	CITY: / COUNTY: / STATE: / ZIP CODE:
123 BERT STREET	**NEW YORK** / **MANHATTAN** / **NY** / **10038**
AGENCY **REPRESENTATIVE'S** OFFICE PHONE #:	AGENCY REPRESENTATIVE'S CELL PHONE #:
212-345-6789	**347-234-5678**
SUPERVISOR'S NAME:	SUPERVISOR'S E-MAIL ADDRESS:
MONROE STORY	**MONROE.STORY@SESAMESTREET.ORG**
SUPERVISOR'S OFFICE PHONE #:	SUPERVISOR'S CELL PHONE #:
212-963-3333	**212-567-2222**

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DIRECTOR'S NAME:	DIRECTOR'S E-MAIL ADDRESS:	
BUZZ LIGHTYEAR	**BUZZ.LIGHTYEAR@SESAMESTREET.ORG**	
DIRECTOR'S OFFICE PHONE #:	DIRECTOR'S CELL PHONE #:	
347-567-1234	N/A	
NAME OF PERSON COMPLETING THIS FORM:	SIGNATURE:	DATE:
MONROE STORY	X *MONROE STORY*	**9/3/2010**

CHECK THAT ALL DOCUMENTS ARE INCLUDED IN THIS PACKET BEFORE SUBMITTING TO ACS.
(Only completed packets will be reviewed for eligibility)

Please submit TWO copies of the ENTIRE package by mail.

✓	Document Type	SED	DD	MedF	Date Requirements/Directions
✓	Psychosocial	X	X	X	Evaluation must be completed within the past **(4) months** of date of referral
✓	Psychiatric	X			Evaluation must be completed within the past **(4) months** of date of referral
	Psychological		X		Evaluation must be completed within the past twelve **(12) months** of date of referral
	Adaptive Scales		X		Evaluation must be completed within the past twelve **(12) months** of date of referral
✓	Medical/Physical	X	X	X	Evaluation must be completed within the past twelve **(12) months** of date of referral
	IEP-Special Ed ONLY	X	X	X	Evaluation must be completed within the past twelve **(12) months** of date of referral-**Only if child is in Special Education.**
✓	Foster Parents Agreement to Accept Services	X	X	X	To be completed by the Foster Parent (when applicable)
✓	Authorization For Release of Health information (OCFS-8001)	X	X	X	To be completed by Biological Parent or medical Consenter if Permission for Override has been obtained or child is Legally Freed.

TO BE COMPLETED BY ACS STAFF ONLY

Date Medical Consenter contacted: 1st attempt __/__/____ **2nd attempt** __/__/____ **3rd attempt** __/__/____

Verification of Freedom of Choice: ☐ Confirmed (Medical Consenter exercised their Freedom of Choice willingly without any influences?) ☐ Yes ☐ No

Comments:

Date R4S Returned to Agency if incomplete: __/__/____

Date R4S sent to HCIA: __/__/____

Date R4S received (Time Stamp here)

ACS STAFF NAME:	**ACS STAFF** SIGNATURE:	DATE:
	X	

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