Children's Waiver HCBS Reassessment Eligibility Extension Request Form

This form is utilized if an annual (365-days) Children's Waiver HCBS Eligibility Determination reassessment is due but is unable to be completed for extenuating circumstances whereas the care manager cannot complete the reassessment. Prior to making an approval decision, the HCBS Reassessment Eligibility Extension Guidance HCBS LOC Reassessment Eligibility Extension Guidance (ny.gov) should be reviewed. Please pick one reason and add a justification/explanation.

☐ Hospitalization/Institutionalization ☐ Out of state/country

☐ Public Health Emergency (PHE) ☐ Other: must specify the reason

Reason for Other and Justification/Explanation for all above:

This module cannot be utilized for late reassessments. Late reassessments must be documented within the member's case record why the reassessment could not be accomplished by the required 365-days and will impact the HH/C-YES audit compliance.

Today's Date: _____

Child/youth's name: _____

Child/youth's CIN: _____ Child/youth's DOB: _____

Date Re-Assessment is Due: _____ Requested New Due Date: _____

The extension allows for the member to remain enrolled within the Children's Waiver for no longer than 90 days, without an assessment/service. The child/youth's circumstances should dictate the extension timeframe requested. No more than one extension can be requested for the same assessment. Example: 30-day extension requested, the assessment could not be completed, another 30-day extension cannot be requested. The assessment can still be completed however, it would be considered late and out of compliance, if the child/youth was still enrolled).

Target Population chosen for HCBS reassessment:

☐ Serious Emotional Disturbance ☐ Medically Fragile (MF)

☐ Developmental Disability (DD)/MF ☐ DD/Foster Care

Name of Lead Health Home: _____ or C-YES ☐

Name of CMA, if not C-YES: _____

C-YES Staff/HHCM Name: _____

Email: _____ Phone Number:_____

Signature_____ Date: _____

C-YES Staff/HHCM Supervisor Name: _____

Email: _____ Phone Number: _____

Signature: _____ Date: _____

Completed by Lead HH: ☐ HCBS Extension Granted ☐ HCBS Extension not Granted

(For C-YES the State Staff will determine if an extension will be granted)

Date of Review Completed: _____

HH/State Staff's Name: _____

HH/State Staff's Signature: _____