

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES

**CHANGE OF PROVIDER 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 #:
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**B2H WAIVER TYPE (Check one only)**

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

**INSTRUCTION:** This form must be completed when changing B2H Medicaid Waiver Program Provider(s) including: the Health Care Integration Agency (HCIA), the Health Care Integrator (HCI), or Waiver Service Provider (WSP). The HCIA representative must understand the reason for the change and identify appropriate and available provider(s).

The above child has changed to the following provider(s):

HCIA, HCI, or WSP REQUESTING TO BE CHANGED	CURRENT PROVIDER NAME AND PHONE NUMBER	NEW PROVIDER NAME AND PHONE NUMBER
<input type="checkbox"/> HCIA		
<input type="checkbox"/> HCI		
<input type="checkbox"/> WSP _____ SERVICE		

I understand that a change in B2H service provider(s) may necessitate a transfer of the child's B2H health information consistent with the regulations that govern such records, and I hereby consent to transfer of such records.

MEDICAL CONSENTER NAME:	MEDICAL CONSENTER SIGNATURE: <b>X</b>	DATE:
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HCIA REPRESENTATIVE NAME:	HCIA REPRESENTATIVE SIGNATURE: <b>X</b>	DATE:
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HCIA NAME:	PHONE #:
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HCIA ADDRESS:	CITY:	STATE:	ZIP CODE:
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