

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
INDIVIDUALIZED HEALTH PLAN (IHP)
BRIDGES TO HEALTH (B2H) HOME & COMMUNITY BASED SERVICES
MEDICAID WAIVER PROGRAM

FOSTER CARE STATUS
<input type="checkbox"/> In-Care
<input type="checkbox"/> Trial Discharge
<input type="checkbox"/> Discharged to Parent
<input type="checkbox"/> Discharged to Adoption
<input type="checkbox"/> Discharged to Permanent Resource

INSTRUCTION: To be completed by Health Care Integrator (HCI).

NAME OF HEALTH CARE INTEGRATION AGENCY (HCIA):		
REFERRAL SOURCE: <input type="checkbox"/> Local Department of Social Services (LDSS) <input type="checkbox"/> Division of Juvenile Justice and Opportunities for Youth (DJJOY)		
CHILD'S NAME (LAST, FIRST, MI.):		
DATE OF BIRTH:	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	MEDICAID CIN #:

B2H WAIVER TYPE (Check one only) <input type="checkbox"/> B2H Serious Emotional Disturbance (SED) Waiver <input type="checkbox"/> B2H Developmental Disabilities (DD) Waiver <input type="checkbox"/> B2H Medically Fragile (MedF) Waiver	IHP DEVELOPMENT Attach minutes of Team Meetings convened to develop this IHP. Minutes must include individuals who participated and the date of meeting(s).
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TYPE OF IHP (Check type and record the IHP due date):		
<input type="checkbox"/> IHP (Preliminary): within 60 days of receiving a Referral Packet. Date IHP due: ___ / ___ / ___		
<input type="checkbox"/> IHP (Initial): 30 days after enrollment. Date IHP due: ___ / ___ / ___		
<input type="checkbox"/> IHP (Revised): to be completed when there is a need for significant change in the level or amount of service(s). Complete the following:		
B2H Service	Type of Change (increase*, decrease, addition, or discontinuance)	Brief description of reason for change
* Note: for already authorized services, an increase up to \$5,000 does not require LDSS or DJJOY sign-off.		
<input type="checkbox"/> IHP (Annual Revised): 30 days prior to annual reauthorization date. Date IHP due: ___ / ___ / ___		

DECISION SECTION: (To be completed upon review of this IHP). By <input type="checkbox"/> LDSS OR <input type="checkbox"/> DJJOY COMPLETE DECISION SECTION AND RETURN ORIGINAL TO HCIA.			
Date IHP received: ___ / ___ / ___			
Date of Decision: ___ / ___ / ___ <input type="checkbox"/> Approved <input type="checkbox"/> Denied (Comments: <u>Required</u> for Denial)			
Enrollment Date: ___ / ___ / ___			
CONTACT'S NAME:		CONTACT'S SIGNATURE:	DATE:
		X	
CONTACT'S TITLE :			
CONTACT'S ADDRESS:	CITY:	COUNTY:	STATE: ZIP CODE:

1. CHILD ASSESSMENT

Based upon interviews and available documentation, including the Child and Adolescent Needs & Strengths Assessment (CANS) B2H assessment, provide information related to: **(1) History and Risk Factors, (2) Needs, (3) Strengths,** and **(4) Preferences,** for all categories (A-N), as required. *Attach additional sheets if needed.*

A. Family/Caregiver

B. Permanency Goal

C. Living Situation

D. Physical Health

E. Developmental Health

F. Mental Health

G. Alcohol and Substance Abuse

1. CHILD ASSESSMENT - CONTINUED

Based upon interviews and available documentation, including CANS B2H assessment, provide information related to: **(1) History and Risk Factors, (2) Needs, (3) Strengths, and (4) Preferences**, for all categories (A-N), as required. *Attach additional sheets if needed.*

H. Community Service

I. Recreation or Leisure Time

J. Spirituality

K. Criminal Background

L. Education/School

M. Vocation or Job *(over 14 years of age)*

N. Budgeting/Money Management *(over 14 years of age)*

2. MEDICAID STATE PLAN SERVICES

Type of Medicaid State Plan Service (i.e. primary care physician, psychologist)	Provider Name, Address, and Phone #

3. NON-MEDICAID STATE PLAN SERVICES

Type of Service (i.e. foster care, preventive service)	Provider Name, Address, and Phone #

4. TRANSITION PLANNING

Target Date for Waiver Transition:

Describe circumstances/services needed to transition from the B2H Waiver Program:

6. B2H WAIVER SERVICES: For each service selected, state the reason for receiving service and intended goals using information from interviews and available documentation, including the CANS B2H assessment.

1. Health Care Integration:

2. Family/Caregiver Supports and Services:

3. Skill Building:

4. Day Habilitation:

5. Special Needs Community Advocacy and Support:

6. Prevocational Services:

7. Supported Employment Services:

6. B2H WAIVER SERVICES (CONTINUED): For each service selected, state the reason for receiving service and intended goals using information from interviews and available documentation, including the CANS B2H assessment.

8. Planned Respite:

For B2H MedF: define specific training required of respite worker based upon the child's needs:

9. Crisis Avoidance, Management, and Training:

10. Immediate Crisis Response Services:

11. Intensive In-Home Supports and Services:

12. Crisis Respite:

For B2H MedF: define specific training required of respite worker based upon the child's needs:

13. Adaptive and Assistive Equipment:

14. Accessibility Modifications:

Pages 8 and 9 (B2H Waiver Services Projected Budget) of the Individualized Health Plan (IHP) (OCFS-8017) are Excel documents and can be found by clicking the link below.

Internet: [B2H WAIVER SERVICES PROJECTED BUDGET](#)

Please complete the Excel template, save it with a new name to your desktop, then print a copy and attach it to the IHP.

REVIEW OF THE FOLLOWING IS REQUIRED FOR CHILDREN RESIDING IN GROUP HOMES OR AGENCY OPERATED BOARDING HOMES ONLY (Check When Completed):

Medication Administration Record Individual Medication Plan

CAREGIVER - Person responsible for assisting the child with daily activities, medication management, and financial transactions.

NAME OF CAREGIVER:		RELATIONSHIP TO CHILD:	
CURRENT ADDRESS OF CAREGIVER:	CELL PHONE #:	PHONE #:	

EMERGENCY CONTACT - In case of an emergency, such as a fire, health and safety issue, natural disaster or other public emergency, first call the responsible Caregiver. If the Caregiver is not available, please call the Emergency Contact.

EMERGENCY CONTACT:		RELATIONSHIP TO CHILD:	
EMERGENCY CONTACT ADDRESS	CELL PHONE #:	PHONE #:	

The required signatures below signify agreement that waiver services have been verified to appropriately meet the child's health and welfare, and are cost effective.

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

The signatures below acknowledge support of the IHP.

CHILD'S NAME:	CHILD'S SIGNATURE (If appropriate): X	DATE:
VOLUNTARY AGENCY CASE PLANNER NAME (If Applicable):	VOLUNTARY AGENCY CASE PLANNER SIGNATURE: X	DATE:
VOLUNTARY AGENCY NAME:		
VOLUNTARY AGENCY ADDRESS:	PHONE #:	

Use this area for any additional writing space needed: