FOSTER CARE STATUS
- ☐ In-Care
- ☐ Trial Discharge
- ☐ Discharged to Parent
- ☐ Discharged to Adoption
- ☐ Discharged to Permanent Resource

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUALIZED HEALTH PLAN (IHP)

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

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

NAME OF HEALTH CARE INTEGRATION AGENCY (HCIA):

REFERRAL SOURCE:
☐ Local Department of Social Services (LDSS) ☐ Division of Juvenile Justice and Opportunities for Youth (DJJOY)

CHILD'S NAME (*LAST, FIRST, MI,):*

DATE OF BIRTH:	SEX: ☐ Male ☐ Female	MEDICAID CIN #:

B2H WAIVER TYPE *(Check one only)*
- ☐ B2H Serious Emotional Disturbance (SED) Waiver
- ☐ B2H Developmental Disabilities (DD) Waiver
- ☐ 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).

TYPE OF IHP *(Check type and record the IHP due date):*

☐ **IHP (Preliminary):** within 60 days of receiving a Referral Packet. **Date IHP due:** ___/___/_____

☐ **IHP (Initial):** 30 days after enrollment. **Date IHP due:** ___/___/_____

☐ **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.

☐ **IHP (Annual Revised):** 30 days prior to annual reauthorization date. **Date IHP due:** ___/___/_____

DECISION SECTION: *(To be completed upon review of this IHP).* By ☐ **LDSS OR** ☐ **DJJOY**
COMPLETE DECISION SECTION AND RETURN ORIGINAL TO HCIA.

Date IHP received: ___/___/_____

Date of Decision: ___/___/_____ ☐ Approved ☐ Denied (Comments: Required for Denial)

Enrollment Date: ___/___/_____

CONTACT'S NAME:	CONTACT'S SIGNATURE: X	DATE:

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, review the most recent version of the CANS score sheet. State the reason for receiving service and intended goals using information from interviews and available documentation, including the CANS B2H assessment. Review the most recent CANS and use ratings of 2 or 3 in Needs and Risk Domains of the CANS to support selected B2H services. Use changes in these ratings between the last CANS and the current CANS to demonstrate changes in B2H service needs or goals.

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: For each service selected, review the most recent version of the CANS score sheet. State the reason for receiving service and intended goals using information from interviews and available documentation, including the CANS B2H assessment. Review the most recent CANS and use ratings of 2 or 3 in Needs and Risk Domains of the CANS to support selected B2H services. Use changes in these ratings between the last CANS and the current CANS to demonstrate changes in B2H service needs or goals.

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:

The B2H Waiver Services Projected Budget is part of the Individualized Health Plan (IHP) (OCFS-8017). The two page Excel document can be found by clicking the link below. Please include them in as pages 7 and 8 in your IHP Plan.

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 (as page 7 and 8) 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: