FORM 5

HCBS TRANSFER - LETTER TO LDSS CONFIRMING CLINICAL ELIGIBILITY FOR WAIVER

TO: ____
Name/Address of Local Social Services County

____

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FROM: ____
Name/Address Receiving ICC Agency

____

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DATE:________________________________

RE: ________________________________
Waiver Child's Name (LN, FN, MI)

____
SSN

____
DOB

Dear Medical Assistance Eligibility Examiner:

We have been advised that the above referenced child recently moved to your county and has filed a Medicaid application with your office. This letter is to let you know that while residing in _______________ county this child was determined to be clinically eligible for and enrolled in the Office of Mental Health (OMH) Home and Community Based Services (HCBS) Waiver for Children and Adolescents with Serious Emotional Disturbance. In order to continue to be eligible/enrolled in this Waiver, s/he must be found Medicaid eligible in your county.

When determining this child's continued Medicaid eligibility, please remember to apply the Medicaid procedures/policies that are applicable to OMH 1915(c) Waiver cases, specifically, no parental deeming (i.e. the child is treated as a family of one) and no income or resource spenddown (i.e. application of excess income and/or resource policy is not applicable under the provisions of the OMH Waiver).

Once Medicaid eligibility has been determined, we ask that you send a copy of the Medicaid Notice of Decision to the following OMH Unit:

NYS Office of Mental Health
Operations Support Unit
Finance, First Floor
44 Holland Avenue
Albany, NY 12229
Attention: HCBS Waiver

Please refer any questions regarding this letter to my attention.

Respectfully,

____
(Individualized Care Coordinator)

cc. OMH Operations Support Unit

c/mmf/wp8.0/projects/hcbs/forms/Form 5 - HCBS Transfer Letter to LDSS Confirming Clinical Eligibility for Waiver.wpd

Draft Date: September 25, 2006