HCBS Service Level Request

Client Name: **Client CIN #:** **Gender:** Address Phone Number	**Assessor Name**: **Agency:** Venture Forthe Inc. **Assessor Phone Number:** **Assessor Email:**
	Managed Care Organization (MCO):
	1.) **Date of NYS Eligibility Assessment**:
	2.) **Eligibility Determination:**

3**.) Housing Verification**

A.) Is the address listed above, a setting chosen by the individual (does the individual want to live in the above listed setting?

☐ Yes

☐ No- Housing Questionnaire is optional but may be completed at this time.

B.) This address is 1.) Nursing home;2.) An institution for mental diseases; 3.) An intermediate care facility for individuals with developmental disabilities;4.) A hospital;5.) an OMH licensed Congregate Treatment Site (community residence); or 6.) Any other location that has qualities of an institution, as determined by New York State.

☐Yes- Stop HCBS Services unless client is eligible to complete the risk assessment.

☐No

4.) **Which HCBS services would your client benefit from access to in the future?**

Tier 1and 2

Service Categories	Client Requested	Eligibility Indicated	N/A
Transitional Employment	☐	☐	☐
Educational Support Services	☐	☐	☐
Pre-Vocational Services	☐	☐	☐

What is needed?

Problems addressed:

Past Efforts:

Preferences & Strengths:

Outcomes I want to achieve:

Barriers to achieving the outcomes:

Service Categories	Client Requested	Eligibility Indicated	N/A
Empowerment Services-Peer Supports	☐	☐	☐

What is needed?

Problems addressed:

Past Efforts

Preferences & Strengths:

Outcomes I want to achieve:

Barriers to achieving the outcomes:

Service Categories	Client Requested	Eligibility Indicated	N/A
Ongoing Supported Employment	☐	☐	☐
Intensive Supported Employment	☐	☐	☐
Non-Medical Transportation	☐	☐	☐
Psychosocial Rehabilitation	☐	☐	☐

What is needed?

Problems addressed:

Past Efforts:

Preferences & Strengths:

Outcomes I want to achieve:

Barriers to achieving the outcomes:

Service Categories	Client Requested	Eligibility Indicated	N/A
Community Psychiatric Support and Treatment Habilitation	☐	☐	☐
Family Support and Training	☐	☐	☐

What is needed:

Problems addressed:

Past Efforts:

Preferences & Strengths:

Outcomes I want to achieve:

Barriers to achieving the outcomes:

Service Categories	Client Requested	Eligibility Indicated	N/A
Short-term Crisis Respite	☐	☐	☐
Intensive Crisis Respite	☐	☐	☐
Habilitation	☐	☐	☐

What is needed:

Problems addressed:

Past Efforts:

Preferences & Strengths:

Outcomes I want to achieve:

Barriers to achieving the outcomes:

5.) I**f Education support services, Pre-vocational Services, and/or intensive Supported Employment or Ongoing Supported Employment are selected above, please complete the follow:**

The Health Home Care Manager (HHCM) is responsible for facilitating the Member's informed choice in education and/or employment support services. The following section should be made by the Member, based on an informed choice, if any education and/or employment support services were selected. Based on the information provided to me by my Care Manager, I have chosen to:

☐Receive services through the Home and Community Based Services (HCBS) Waiver designated agency. The Behavioral Health Home and Community Based Services identified in this Plan of Care are note available to this individual under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.) (i.e. ACCESS-VR).

☐Pursue support from ACCESS-VR

☐Receive services through the BH HCBS Waiver AND pursue separate and non-duplicative services through ACCESS-VR. The Behavioral Health Home and Community Based Services identified in this Plan of Care are not available to this individual under Section 110 of the Rehabilitation Act 1973 or the IDEA (20 U.S.C 1401et seq.) (i.e. ACCESS-VR).

☐N/A

6.**) Goal Statement**

What does your client hope to achieve or gain through the program:

7.) **Current Services Summary**

(Disorder/Diagnosis being treated for)

Service Category: Service Paid? ☐ Yes ☐ No Service Type/Specialty:

Provider Name/Organization:

Provider Address: Provider Phone:

Services Provided Description: Service Frequency: Last Visit Date:

(Disorder/Diagnosis being treated for)

Service Category: Service Paid? ☐ Yes ☐ No Service Type/Specialty:

Provider Name/Organization:

Provider Address: Provider Phone:

Services Provided Description: Service Frequency: Last Visit Date:

(Disorder/Diagnosis being treated for)
Service Category: Service Paid? ☐ Yes ☐ No Service Type/Specialty:
Provider Name/Organization:
Provider Address: Provider Phone:
Services Provided Description: Service Frequency: Last Visit Date:

(Disorder/Diagnosis being treated for)
Service Category: Service Paid? ☐ Yes ☐ No Service Type/Specialty:
Provider Name/Organization:
Provider Address: Provider Phone:
Services Provided Description: Service Frequency: Last Visit Date:

(Disorder/Diagnosis being treated for)
Service Category: Service Paid? ☐ Yes ☐ No Service Type/Specialty:
Provider Name/Organization:
Provider Address: Provider Phone:
Services Provided Description: Service Frequency: Last Visit Date:

(Disorder/Diagnosis being treated for)
Service Category: Service Paid? ☐ Yes ☐ No Service Type/Specialty:
Provider Name/Organization:
Provider Address: Provider Phone:
Services Provided Description: Service Frequency: Last Visit Date: