NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Functional Assessment Consent

Instructions: This form must be completed by the individual being assessed if they are 18 years of age or older, or by the child's parent, guardian, or legally authorized representative or by a voluntary foster care agency caring for such child if the child is under 18 years of age and does not meet the circumstances below*. Legally authorized representative is defined as "a person or agency authorized by state, tribal, military or other applicable law, court order or consent to act on behalf of a person for the release of medical information". A voluntary foster care agency means "an agency under contract with NYC Administration for Children's Services to provide foster care."

*[Please note, children who are parents, pregnant, and/or married, and who are otherwise capable of consenting, should also use and complete this form.]

NAME OF INDIVIDUAL BEING ASSESSED

NAME OF HEALTH HOME - ADULT OR CHILDREN (CIRCLE ONE)

INDIVIDUAL'S DATE OF BIRTH

A Functional Assessment (FA):

- ☐ Determines eligibility for Behavioral Health, Home and Community Based Services (BH HCBS) for individuals 21 years and older
- ☐ Determines eligibility for Health and Behavioral Health, Home and Community Based Services (HBH HCBS) for individuals up to the age of 21
- ☐ Identifies strengths and needs for HBH HCBS and Children's Health Home
- ☐ Identifies Children's Health Home assessment results

The FA is used to gather information for a Plan of Care, which must be developed for anyone who qualifies for HCBS and/or is enrolled in a Health Home. The FA will be completed in the Uniform Assessment System-NY (UAS-NY), a secure statewide database that captures and stores identifying information and completed assessments for each individual that receives services. Stringent security controls protect the information and restrict access to only those persons authorized as needed to inform services delivery. If an FA has been received in the past, that FA will also be reviewed in order to ensure the best services are provided. As the payor of Medicaid services on your behalf, New York State will also have access to your health information.

For individuals 21 years and older in need of services, the FA determines eligibility for BH HCBS and is used to gather information to develop a Plan of Care.

For individuals up to the age of 21 in need of services, a FA is required to document the individual's functional limitations in order to determine eligibility for HBH HCBS. The FA is also used to determine the Children's Health Home assessment results for individuals enrolled in a Children's Health Home and is used to gather information to develop a Plan of Care.

In order to best serve you or your child, we need to conduct a functional assessment. The FA will be completed annually for individuals 21 and older, every 6 months for individuals under 21, or sooner if a significant life event occurs.

Please sign below to indicate whether or not you give consent for a FA to be completed on you or your child.

☐ I understand the purpose of the Functional Assessment and give consent for a Functional Assessment to be completed by

NAME OF PROVIDER

on me or my child (circle one). I further understand that my consent is voluntary and can be withdrawn at any time.

☐ I do not give consent for a Functional Assessment to be completed on me or my child (circle one). I understand by not giving consent for a Functional Assessment, I may not have access to Home and Community Based Services.

PRINT NAME OF INDIVIDUAL/PARENT/GUARDIAN/LEGALLY AUTHORIZED REPRESENTATIVE/VOLUNTARY FOSTER CARE AGENCY

SIGNATURE OF INDIVIDUAL/PARENT/GUARDIAN/LEGALLY AUTHORIZED REPRESENTATIVE/VOLUNTARY FOSTER CARE AGENCY

DATE

We greatly appreciate your involvement in this process. If you have any questions regarding this process please call

at

☐ By checking this box, I am withdrawing my consent to have a functional assessment conducted.

PRINT NAME OF INDIVIDUAL/PARENT/GUARDIAN/LEGALLY AUTHORIZED REPRESENTATIVE/VOLUNTARY FOSTER CARE AGENCY

INDIVIDUAL'S DATE OF BIRTH

SIGNATURE OF INDIVIDUAL/PARENT/GUARDIAN/LEGALLY AUTHORIZED REPRESENTATIVE/VOLUNTARY FOSTER CARE AGENCY

DATE