Children's Waiver Eligibility **OHIP-0125 (rev. 04/19)**

Child's Name	Child's DOB	Child's CIN (If Known)	County of Residence

The above child has been assessed for services under the Children's Waiver using the Home and Community-Based Services (HCBS)/Level of Care (LOC) eligibility determination. Please take the appropriate action.

1. **Medicaid Status**
   - ☐ Child has active Medicaid.
   - ☐ Child does not have Medicaid (application is enclosed).

2. **Children's Waiver Status**
   - ☐ Child is approved for the Children's Waiver, and **waiver capacity is available.**
   - ☐ Child is approved for the Children's Waiver, but **waiver capacity is not available**.

3. **Change in Children's Waiver Status**
   - ☐ Child was previously approved for the Children's Waiver, and capacity is now available**.**
   - ☐ Child is disenrolled from the Children's Waiver effective _ _/_ _/_ _ _ _.
   - ☐ Child reassigned from _____ Diagnostic Group on _ _/_ _ /_ _ _ to _____ Diagnostic Group effective _ _ /_ _ /_ _ _ _.

4. **HCBS Waiver Diagnostic Group**
   - ☐K1: HCBS Level of Care
   - ☐K3: HCBS Diagnostic Group - Serious Emotional Disturbance
   - ☐K4: HCBS Diagnostic Group - Medically Fragile
   - ☐K5: HCBS Diagnostic Group - Developmentally Disabled and in Foster Care
   - ☐K6: HCBS Diagnostic Group - Developmentally Disabled and Medically Fragile

5. **Authorization**

Signature of Representative	Date
Printed Name	Telephone Number and E-Mail Address

☐ NYS DOH Capacity Management Team

☐ Children and Youth Evaluation Service (C-YES)