NEW YORK STATE DEPARTMENT OF HEALTH
Office of Long Term Care

CARE AT HOME I/II PALLIATIVE CARE

Massage Services Selection Form

_____Care at Home I _____Care at Home II

NOTE: Signed copies of this form must be supplied to the child's parent/guardian, case manager, Massage Therapy Agency and the LDSS.

I understand that in order for my child to receive Care at Home I/II Massage Waiver service, I must select a palliative care agency from the attached list of approved providers. I have been encouraged to interview these providers prior to making my selection.

I understand that the Massage Therapy palliative care agency I choose will assist me in developing, implementing and monitoring my child's plan of care regarding this service.

I may choose to discontinue this service or select a different palliative care agency for Massage Therapy at any time. My child will still be eligible for the CAH I/II waiver if I choose to discontinue services or change providers.

From the approved provider list, I have selected the following agency:

____

Palliative Care Agency Telephone

____

Agency Address

____

Applicant (Child's) Name Date

____

Parent/Guardian Signature Date

____

Case Manager Signature Date

To be completed by the Palliative Care Agency:

____

Palliative Care Agency

______ **will** provide Bereavement Services to the above named applicant

______ **will not** provide Bereavement Services to the above applicant.

____

Explanation

____

Palliative Care Agency Representative Signature (Include Title) Date

____

LDSS CAH Coordinator Signature Date

NYSDOH FEB 2010