HCBS/LOC Eligibility Determination Override Form

This form is utilized to request an override for HCBS/LOC Eligibility Redetermination under the Children's Waiver, for a transitioning child/youth from one of the previous six 1915 (c) HCBS waivers, to ensure continuity of services to enable the child/youth to remain safely in their home and community.

Child/youth's name: _____

Child/youth's CIN: _____ **Child/youth's DOB:** _____

Target Population chosen for HCBS/LOC redetermination:

- ☐ SED (Previous OMH Waiver)
- ☐ SED (Previous B2H Waiver)
- ☐ Medically Fragile (Previous CAH I/II)
- ☐ Medically Fragile (Previous B2H Waiver)

✸ *Developmentally Disabled (DD) and Foster Care target population cannot receive an override as ICF IDD and foster care status cannot be altered.*

Is the child/youth in Foster Care?

- ☐ Yes
- ☐ No

What component of the HCBS Eligibility Determination process did the child NOT meet?

- ☐ Target Population (Diagnoses/Conditions, SSI, Certificate Disability, LPHA Attestation)
- ☐ Functional Criteria (CANS-NY)
- ☐ Risk Factors (LPHA Attestation), if applicable

Check if the LPHA Attestation was completed and signed ☐ Date LPHA signed: _____

Who signed the LPHA Attestation and what is their role/relationship with the child/adolescent?

_____

_____

Outline why you and/or the treating LPHA, believe that without HCBS continued services, the child/youth is at risk of imminent hospitalization/institutionalization:

_____

_____

_____

_____

☐ C-YES Staff HHCM – Agency _____

C-YES Staff/HHCM Contact (Should follow-up be needed)

C-YES Staff/HHCM Name: _____

Email: _____ Phone Number: _____

Signature _____ Date: _____

Completed by the State: Override Granted: ☐ Override **not** Granted: ☐

State Agency: _____ Date of Review Completed: _____

State staff's name: _____

State staff's signature: _____