Provider Attestation Form
New York State (NYS) Social Care Networks (SCN)

CONTEXT: Healthcare providers (HCPs) use this form for a Medicaid Managed Care member under their care who may have unmet health-related social needs. The purpose of this form is to document medical eligibility requirements to receive appropriate health-related social needs services that are funded by New York State Medicaid. Available services include housing, nutrition, transportation, and case management (e.g., home remediation services for individuals with asthma, medically tailored meals for individuals with chronic conditions).

Services have multiple, distinct eligibility requirements. **It is essential for HCPs to review and select ALL criteria that apply to the individual to ensure they are able to receive all services for which they could be eligible.** For a full list of eligibility criteria, see the final page of this form. For a list of eligibility criteria for each service, see here: https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/

HCPs WHO MAY COMPLETE THIS FORM:

- New York State (NYS) Licensed Healthcare Providers that accept Medicaid Members
- Other Healthcare Providers that are part of programs within larger agencies that accept Medicaid Members (e.g., Health Home, School-Based Health Center) and have access to necessary clinical information (e.g., medical records)

INSTRUCTIONS TO HCP FOR FILLING OUT FORM:

STEP 1 **Medicaid member information:** HCP to fill out information for the Member.

STEP 2 **Eligibility criteria for health-relates social need services:** HCP to review the eligibility criteria definitions at the end of the form and check the boxes for **ALL** criteria that apply to member.

STEP 3 **HCP information:** HCP must fill out their information and sign the form. Information includes their full name and credentials, provider Individual NPI, Medical Provider ID (MMIS Number), facility name, telephone number, and fax number.

SUBMISSION:

HCPs should send completed forms to the **Social Care Network via email or fax** or any HIPAA complaint method, or share directly with the member; the member will need to then share the completed form with the Social Care Network.

STEP 1: MEMBER INFORMATION

Member Name: _____ Member DOB: _____/_____/_____

Client Identification Number (CIN) (*optional*): _____

STEP 2: ELIGIBILITY CRITERIA FOR HEALTH-RELATED SOCIAL NEED SERVICES

SCN program eligibility criteria (see detailed definitions at end of form)

It is essential for HCPs to review and select ALL criteria that apply to the individual to ensure they are able to receive all services for which they could be eligible

Behavioral and Developmental Health Needs

- ☐ Substance Use Disorder (SUD) or Severe Mental Illness (SMI) or Intellectual and/or Developmental Disability ***(see appendix for definition)***

Maternal and Child Health *(see attestation below if any of the following are checked)*

- ☐ Pregnant or up to 12 months postpartum ***(see appendix for definition)***
- ☐ Pregnant or up to 12 months postpartum who require refrigeration for breast milk
- ☐ High-risk child under the age of 18 ***(see appendix for definition)***
- ☐ Children under 18 that are obese, underweight, or overweight or with malnutrition or complications from malnutrition ***(see appendix for definition)***

Special Medical Care Needs for Adults (Medical Respite)

- ☐ Requirement for pre-surgical or procedure care
- ☐ At risk for inpatient hospitalization or emergency department visits, AND requiring recuperation and care for an illness or injury
- ☐ Admission or discharge from an Acute Care hospitalization related to a health condition or illness

Nutritional and Home Modification Needs

- ☐ Receiving enteral or parenteral nutritional therapy
- ☐ Need for medically necessary home modifications (e.g., ramps, handrails, grab bars, etc.)
- ☐ A health condition or is at risk for a health condition that is exacerbated by the moisture, mold, pests or indoor air quality in the home (e.g., asthma, COPD, environmental allergies, atopic dermatitis)
- ☐ Need for medical necessity of home remediation service, including mold or pest remediation

Environmental and Temperature-Related Health Needs

- ☐ A medical condition or regularly taking medications that significantly interferes with their body's ability to regulate temperature (daily thermoregulation); this may include dependence on others to regulate the temperature in their environment due to severe behavioral or physical disability
- ☐ Previous heat-related illness requiring emergency room or urgent care visit within the last 12 months
- ☐ Previous cold-related illness requiring emergency room or urgent care visit within last 12 months

Chronic Health Conditions

- ☐ Chronic condition **(*see appendix for definition*)** (e.g., diabetes, chronic Hepatitis-C, congestive heart failure, asthma, HIV/don')
- ☐ Requires medications requiring refrigeration for the management of a chronic condition

Asthma

- ☐ 1 or more hospital inpatient stays(s) related to asthma within the last 12 months
- ☐ 2 or more Emergency Department (ED) visits related to asthma within last 12 months
- ☐ 2 or more urgent care visits related to asthma within the last 12 months
- ☐ 2 or more prescribing events for oral steroid use related to an asthma diagnosis within the last 12 months
- ☐ 3 to 11 prescribing events for rescue inhaler, including albuterol within the last 12 months

Other

- ☐ Medicaid high utilizer (***see appendix for definition***)
- ☐ Enrolled in NYS Health Home
- ☐ Homeless **(*see appendix for definition*)**
- ☐ Transitioned out of institutional care / congregate settings, such as nursing facilities, large group homes, congregate residential settings, institutions for mental disease, correctional facilities, State Psychiatric, State or Voluntary Community Residence, Single Room Occupancy (SRO), and acute care hospitals within the past 90 days

STEP 3: PROVIDER INFORMATION

The **Healthcare Provider** completing this form must attest to the following statement:

"I, _____[print full name], with credentials (e.g., MD, DO, NP, PA, LCSW): _____, hereby attest that I am a Medicaid-enrolled provider OR employed by a healthcare provider that is part of a program within a larger agency that accepts Medicaid members _____[print Employer name]) with sufficient access to relevant member information to identify the criteria selected above."

Provider Individual NPI: _____Medicaid Provider ID (MMIS Number), if no NPI *(OPT):* _____

Facility Name: _____Telephone: _____ Fax: _____

HIPAA complaint email address (if applicable): _____

"I hereby attest that the information contained herein is current, complete, and accurate to the best of my knowledge and belief. I understand that my attestation may result in the provision of services which are paid for by state and federal funds and I also understand that whoever knowingly and willfully makes or causes to be made a false statement, or representation may be prosecuted under the applicable federal and state laws."

Provider Signature: _____ Date: _____

Appendix: Provider Attestation Form – Provider Guide
New York State (NYS) Social Care Network (SCN)

Definitions of Eligibility Criteria

Categories	Population	Definition
Behavioral and Develop-mental Health Needs	Individuals with Substance Use Disorder (SUD)	Individuals diagnosed with a substance use disorder. As defined by CMS[1], SUD can result from all types of substance use—alcohol, marijuana, opioids, heroine, etc.—that interferes with being able to meet life's responsibilities, interferes with physical health, or is in an illegal substance.
	Individuals with Severe Mental Illness (SMI)	Individuals with persistent, disabling, progressive or life-threatening mental health condition that requires treatment and/or supports in order to be stabilized, prevent the condition from worsening, or maintain health goals. It includes those with a mental health diagnosis, such as schizophrenia, bipolar disorder, as well as those at risk of suicide.
	Individuals with an Intellectual or Developmental Disability (I/DD)	Individuals with an Intellectual Disability or Developmental Disability that requires services or supports to achieve and maintain care goals. Includes a diagnosis of an intellectual or developmental disability, such as Autism Spectrum Disorder, Cerebral Palsy, Epilepsy, Prader-Willi syndrome, a genetic disorder that results in I/DD, Fetal Alcohol Syndrome, untreated inherited metabolic disorders, familial dysautonomia, and chronic neurological disorders.
Maternal and Child Health	Pregnant or postpartum persons	Pregnant and up to 12 months postpartum from the date of delivery, miscarriage, or termination
	High-risk children under the age of 18	Individuals under 18 who have one of the following: • A chronic condition (e.g., behavioral health condition, developmental delay, chronic life-threatening allergies, physical disability, and asthma); a full list of chronic conditions can be found here: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_chronic_condition_update_dd_conditions.htm • Child maltreatment (CM). As defined by the CDC[2], CM includes physical, sexual, and emotional abuse and neglect of a child under the age of 18 by a parent, caregiver, or another person in a custodial role (e.g., clergy, coach, teacher); • Special healthcare need (CYSHCN). As defined by HRSA[3], CYSHCH includes those who have or are at increased risk for chronic physical, developmental, behavioral, or emotional condition (e.g., asthma, sickle cell disease, epilepsy, anxiety, autism, and learning disorders) and who also require health and related services of a type or amount beyond that required by children generally; • Low birth weight of <2500 grams; • A health condition, including behavioral health and developmental syndromes, stemming from trauma, child abuse, and neglect
	Children under 18 that are obese, underweight, or overweight or with malnutrition or complications from malnutrition	Individuals under 18 who meets one of the following criteria: • Overweight, obese, or underweight • Malnutrition or at risk of developmental or growth delay or impairment as a result of insufficient nutrition
Chronic conditions	Chronic condition	Members with specific chronic conditions listed on the DOH website, such as, pre-diabetes, diabetes, chronic Hepatitis-C, congestive heart failure, chronic kidney disease, chronic obstructive pulmonary disease, obesity, hypertension, malignancies (active cancer or cancer in remission), asthma, sickle cell disease, or HIV/AIDS A full list of chronic conditions can be found here: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_chronic_condition_update_dd_conditions.htm
Other	Medicaid High Utilizers	• Five or more Emergency Department visits within the last 12 months; or • Four or more Emergency Department visits and one or more Hospital Inpatient stays within the last 12 months; or • Two or more Hospital Inpatient stays within the last 12 months;
	Homelessness	As defined by U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5, 4 categories of homelessness: • Literally homeless • Imminent risk of homelessness • Homelessness under other Federal regulations • Fleeing / attempting to flee domestic violence See https://www.hudexchange.info/homelessness-assistance/coc-esg-virtual-binders/coc-esg-homeless-eligibility/four-categories/ for more details

[1] CMS – Substance Use Disorder: https://www.cms.gov/training-education/partner-outreach-resources/american-indian/alaska-native/behavioral-health/substance-use-disorders

[2] CMS – Child Maltreatment: https://cdpsdocs.state.co.us/safeschools/Resources/CDC%20Centers%20for%20Disease%20Control%20Prevention/CDC%20Understanding%20Child%20Maltreatment%20Fact%20Sheet%202013.pdf

[3] HRSA Children and Youth with Special Health Care Needs (CYSHCN): https://mchb.hrsa.gov/programs-impact/focus-areas/children-youth-special-health-care-needs-cyshcn, https://mchb.hrsa.gov/sites/default/files/mchb/programs-impact/nsch-data-brief-children-youth-special-health-care-needs.pdf

Enhanced Health-Related Social Need Services that are provided to eligible Members through the SCN Program

Services	Description
Housing	• Home Accessibility and Safety Modifications • Home Remediation • Asthma Remediation • Recuperative Care (Medical Respite) • Rent / Temporary Housing • Utility Setup / Assistance • Pre-tenancy Services • Tenancy Sustaining Services • Community Transitional Supports (CTS) • Housing Transition and Navigation Services
Nutrition	• Nutrition Counseling and Education • Medically Tailored or Clinically Appropriate Home Delivered Meals • Medically Tailored or Nutritionally Appropriate Food Prescriptions • Fresh Produce and Non-perishable Groceries (Pantry Stocking) • Cooking Supplies
Transportation	• Transportation services for public and private transport to connect to HRSN services and HRSN case management activities
Case Management	• Case management and support to help Members access appropriate HRSN resources

If the HCP is checking any "Maternal and Child Health" criteria, the SCN should attest to the following:

"I attest that the use or disclosure of PHI that I am requesting is not for a purpose prohibited by the HIPAA Privacy Rule at 45 CFR 164.502(a)(5)(iii) because the purpose of the use or disclosure of protected health information is not to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care or to identify any person for such purposes.

I understand that I may be subject to criminal penalties pursuant to 42 U.S.C. 1320d-6 if I knowingly and in violation of HIPAA obtain individually identifiable health information relating to an individual or disclose individually identifiable health information to another person."

SCN Representative signature: _____ Date:_____

Description of the SCN Representative's Role: _____