

To: _____
 Insert Local Social Services District Address
 City: _____
 State: _____ Zip Code: _____

From: _____
 Insert ICC Provider Agency Address
 City: _____
 State: _____ Zip Code: _____
 Date: _____
 Waiver Applicant: Name _____
 DOB: _____

Dear Medical Assistance Eligibility Worker:

On _____, the above referenced child has been conditionally accepted for inclusion in the Office of Mental Health Home and Community Based Services (OMH/HCBS) Waiver program for Children and Adolescents with Serious Emotional Disturbances. In order for the enrollment process to be completed, the child must be determined Medicaid eligible by your agency (LDSS). Under the terms of OMH Waivers, there is no parental deeming (i.e. the child is treated as a family of one). Therefore, please disregard the parent's income for this case.

Attached please find the following documents:

- Application for Medical Assistance for the Child Only
 (Note to LDSS: The ADC-Related budgeting category should be used in **all** cases; unless it is more advantageous to use the SSI-Related budgeting category (Disabled). Verification of resources is **not** required for children under 21 as per 10/OHIP/ADM-1. Waiver cases have already been determined to meet the SED requirement; therefore **no** further disability determination is needed for these children.
- Documentation
 - Proof of age Proof of legal residence Proof of health insurance coverage
 - Verification of income Proof of Social Security number

- Request to be considered for enrollment in a Medicaid Managed Care Plan
- Disability Documentation Package
 (Only needed if budgeting under the SSI-Related budgeting category)

If you need additional information or verification in order to process this application, please contact the undersigned at the above listed address / phone number.

Once Medicaid coverage has been established, the Operations Support Unit (OSU) will issue the Notice of Decision regarding Waiver enrollment to both the applicant and to your office. Additionally, OSU will enter the Exception Code "23" on this client's WMS-RE record.

Any questions regarding the Notice of Decision and / or activation of Exception Code 23 should be addressed to:

NYS Office of Mental Health, Operations Support Unit
 44 Holland Avenue, 1st Floor
 Albany, NY 12229
 Attention: Daniel Florek
 (518) 473 - 8234

Please refer any questions regarding the attached materials or this letter to my attention.

Respectfully,