New York State Office of Mental Health
Home and Community-Based Services
Application for Participation and Freedom of Choice

Name of Child

Current Address

Street

City | Zip | County

Social Security # | Date of Birth

Name of HCBS Program for Which Applying

I am requesting participation in the HCBS Waiver for Children and Adolescents with Serious Emotional Disturbance. I understand that approval will be based on my choice of home and community based services in preference to care in psychiatric inpatient services for children under 21 and on evidence of my child's:

- ❒ being between 5 and 18 years of age;
- ❒ meeting definition of serious emotional disturbance;
- ❒ requiring, or at imminent risk of needing, psychiatric institutional level of care;
- ❒ having complex health or mental health care needs;
- ❒ having service and support needs that cannot be met by just one agency/system;
- ❒ capable of being cared for in the community if provided access to HCBS Waiver services;
- ❒ being eligible for Medicaid under the HCBS Waiver;
- ❒ being capable of being served in the community within the federally approved yearly cost;
- ❒ viable and consistent living environment and parent/guardian willingness to participate in the HCBS Waiver and support child in the home and community.

I/we have been informed that _____(name of child/adolescent)_____ may be eligible for care and treatment in a hospital or through Home and Community Based Services (HCBS). I/we have also been informed that, if the child/adolescent is eligible, he/she has a choice between hospital care and HCBS and also a choice of feasible alternatives available under HCBS.

Child/Adolescent's Signature (As appropriate)

Name of Parent/Guardian

Signature of Parent/Guardian

Signature of Witness | Date