COVID Children's Waiver HCBS/LOC
Review Request Form

This form is utilized, during the State of Emergency, if an annual Children's Waiver HCBS/LOC re-assessment is due and is able to be completed; however, the child/youth is found HCBS/LOC ineligible **AND**

1. There is a concern of a potential risk of institutionalization (hospital/nursing home/residential) in absence of the waiver services during the State of Emergency, **OR**
2. The child/youth Medicaid eligibility was determined on Family of One budgeting and should not be disenrolled unless otherwise directed by the member/family

Today's Date: _____

Child/youth's name: _____

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

Date of Completed Re-Assessment: _____

Target Population chosen for HCBS/LOC redetermination:

- ☐ SED (Serious Emotional Disturbance)
- ☐ Medically Fragile (MF)
- ☐ Developmental Disability (DD) / MF
- ☐ MF/ Foster Care

Reason for Request:

- ☐ Member was ineligible at reassessment during State of Emergency risk of hospitalization
- ☐ The child/youth Medicaid eligibility was determined on Family of One budgeting
  - ☐ The HHCM/C-YES verified Medicaid by Family of One Budgeting

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

Name of Lead Health Home: _____ or ☐ C-YES

Name of CMA, if not C-YES: _____

C-YES Staff/HHCM Name: _____

Email: _____ Phone Number: _____

Signature_____ Date: _____

C-YES Staff/HHCM Supervisor Name: _____

Email: _____ Phone Number: _____

Signature: _____ Date: _____

Completed by Lead HH: HCBS/LOC Granted ☐ HCBS/LOC **not** Granted: ☐
(for CYES by the State)

Date of Review Completed: _____

HH/State Staff's Name: _____

HH/State Staff's Signature: _____