MEDICAID WAIVER - CARE AT HOME (CAH) I/II PROGRAM
For Physically Disabled Children
APPLICATION COVER SHEET
(To be completed for **ALL** applications)

Client Name: _____ **District:** _____ _____
County Contact Name/Number

SSN: _____ **CIN:** _____ **CAH I:** _____ **CAH II:** _____

Date Application is received by LDSS: ____/_____/____ **Child is already MA Eligible:** ___YES ___ NO

Date the LDSS is recommending for waiver eligibility ___/___/____

Early Intervention Service Coordination or Medicaid Service Coordination end date ___/___/_____

1. _____ Application Form Signed by Parent
2. _____ Choice of Care Form
3. _____ Proof of Age/Birth Certificate 3a. D.O.B.: ____/____/_____
4. _____ Proof of Physical Disability/ Documentation (i.e. SSI Letter or DSS-639)
   i. 4a. Expiration Date: ____/____/____ 4b. □ Group I □ Group II
   ii. 4c. Disability Listing(s): _____
      1. _____
5. _____ Proof of Medicaid Ineligibility/Eligibility
   i. □ Child is currently on Medicaid
   ii. □ If child is Medicaid ineligible or his/her status is pending, submit proof of Medicaid eligibility for child **AND/OR** parents ineligibility.

The following must be completed and signed by the assessing Nurse-from CASA, CHHA, Public Health or acceptable other. Visit to be completed by both a nurse and case manager, when possible.

6. _____ UAS-NY Form
6A._____ Pediatric Patient Review Instrument - (completed if child resides in SNF/Hospital or if unable to complete the UAS)-**NOTE**: UAS-NY **must** be completed within 90 days of waiver eligibility or the completed PPRI
7. _____ Home Assessment Abstract OR**;**
   _____ Path _____ Fastep 1 **OR;** _____ MAA-CN-1-8
8. _____ Case Management Selection
9. _____ M.D. Orders

Case Manager (10-13)

10. _____ Monthly Budget Sheet
11. _____ Case Management Plan of Services
12. _____ Palliative Care Waiver Service Selection (*Check the following that apply)*
    ___ Bereavement Services ___ Massage Therapy
    ___ Expressive Therapy ___ Family Palliative Care Education (Training)

13. Case Management Agency _____

14. Case Manager: _____ 14a. Tel:(____) _____
14b. E-Mail Address: _____ 14c. Fax:(____) _____
15. Prior Approval Nursing Obtained _____ Yes _____ No