NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

INDIVIDUAL'S NAME: **DOB:** **TABS ID#:**

SERVICE AMENDMENT REQUEST FORM

BEFORE USING THIS FORM, READ INFORMATION STARTING ON PAGE 8.

This form should be submitted ONLY for one of the following (for more information, see pages 8 & 9 of this form):

- ✓ **Adding an additional HCBS waiver service:** Individual is requesting to add a new HCBS waiver service. **Do not use this form for service(s) previously authorized.**
- ✓ **Increasing service amount:** Individual requesting an increase in service amount for an existing HCBS waiver service
- ✓ **Changing provider:** Individual is notifying DDRO of a change in provider

INSTRUCTIONS: Please provide all information requested below. If you have any questions or need assistance, contact your DDRO office. Submission of incomplete forms and/or forms with incorrect information may cause delays or may result in the request being returned, requiring resubmission.

☐ **This request is a resubmission, and replaces a previous form submitted on**

INDIVIDUAL'S NAME:	**DOB:**	**TABS ID#:**
ADDRESS:	**COUNTY:**	**MEDICAID #:**
	PHONE:	
	EMAIL:	
CURRENT LIVING SITUATION (e.g., at home, IRA):		
PRIMARY CONTACT PERSON:	**RELATIONSHIP:**	
ADDRESS (if different from applicant)**:**	**PHONE:**	
	EMAIL:	

CARE MANAGER COMPLETING THIS FORM:	**TITLE:**
CCO NAME:	**PHONE:**
CCO ADDRESS:	**EMAIL:**
	SUPERVISOR NAME:
BROKER NAME (when applicable)**:**	**SUPERVISOR'S EMAIL:**

DEVELOPMENTAL DISABILITY
DIAGNOSIS (LIST ALL CURRENT):
DESCRIBE AMBULATION STATUS:
LIST ANY OTHER RELEVANT CONDITIONS (when present)**:**

ISPM OVERALL SCORE:		**DATE OF DDP2:**	
DOMAIN SCORES	**HEALTH:**	**BEHAVIORAL:**	**ADAPTIVE:**

EDUCATION INFORMATION

Is the individual currently attending school? ◯ Yes ◯ No 10 Month Student ◯ 12 Month Student ◯

If you answered "yes" to the above question, the following questions below are required. If you answered "no," skip this section.

Name of School: _____ School Type: ◯ Day ◯ In-State Residential ◯ Out-of-State Residential ◯ Other, specify: _____

Projected Graduation Date: _____ (If unsure of the exact date, enter June 1st & year of anticipated graduation, e.g., 06/01/2019).

DDRO Staff Only: If the individual is in school, please forward contact information and Education Information to Local School Transition Coordinator or Residential School Transition Coordinator as appropriate.

NEW YORK STATE OF OPPORTUNITY. Office for People With Developmental Disabilities

INDIVIDUAL'S NAME: **DOB:** **TABS ID#:**

CURRENT OPWDD SERVICES

List all services currently received through OPWDD. Please include the provider name and service amount.

SERVICE TYPE	ANNUAL NUMBER OF AUTHORIZED UNITS OF SERVICES	ANNUAL NUMBER OF UNITS OF SERVICES RECEIVED	PROVIDER NAME

NON-OPWDD SERVICES & NATURAL SUPPORTS

List all current non-OPWDD services. These include formal services provided by another state agency, county, and/or another service system. Please also list any natural supports the individual has in their life, including those provided by family, friends, neighbors and community. Note: in some cases, a daily schedule may be requested.

SERVICE OR SUPPORT TYPE	DESCRIPTION AND ANNUAL AMOUNT OF SERVICES, INCLUDING **PROVIDER NAME** (WHEN APPLICABLE)

OPWDD SERVICES TO BE DROPPED OR REDUCED

If the service(s) requested on this form are intended to replace existing service(s) or result in reduction in service amount, list the service(s) being dropped or reduced below (include service amount when applicable.)

NOTE: WHEN APPLICABLE, A DDP1 TO DROP MUST BE SUBMITTED BY PROVIDER AGENCY PRIOR TO ENROLLMENT IN THE NEW AUTHORIZED SERVICES.

SERVICE TYPE (to be DROPPED or REDUCED)			ANNUAL NUMBER OF UNITS OF SERVICES RECEIVED	PROVIDER NAME
	Drop	Reduce		
	○	○		
	○	○		
	○	○		
	○	○		
	○	○		

NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

INDIVIDUAL'S NAME: **DOB:** **TABS ID#:**

SERVICES REQUESTED

INSTRUCTIONS: Please provide the required information below. If you have any questions or need assistance, contact your DDRO office. Submission of incomplete forms and/or forms with incorrect information may cause delays or may result in the request being returned, requiring resubmission.

COMMUNITY HABILITATION (CH)

Request Type (check all that apply):

☐ **This request is to ADD this as a new service** (i.e., individual does not receive any CH currently)

☐ **This request is to INCREASE units** (i.e., individual currently receives CH and needs an increase in the number of units to be received)

☐ **This is a change of provider only** (i.e., individual is switching from one provider to another with same number of units)

☐ **This is to add a new/additional provider only** (i.e., individual is adding another provider that is different from the existing provider)

Service Type:

☐ **Direct Provider-Purchased** (if individual is Self-Directed, check this box only if this service is not already included in an approved Self-Directed Budget)

☐ **Agency Supported Self-Directed** with Memorandum of Understanding (MOU)

Billing Units/Service Units Calculators (Choose one):

Annual Billing Units Requested (1 unit = 1/4 hour): _____ ***Calculates to*** **Annual Service Units Requested** (1 unit = 1 hour): 0.00

OR

Annual Service Units Requested (1 unit = 1 hour): ___ ***Calculates to*** **Annual Billing Units Requested** (1 unit = 1/4 hour): 0.00

Provider Information (Include if a provider has been identified and agreed to provide this service)

Provider Agency Name: _____ Agency Contact Name: _____

Agency Email: _____ Projected Start Date: _____

When individual has selected multiple providers for this service, list additional agency names here:

_____

Justification for service and description of how it supports the individual's goals (please provide specific details):

_____

Additional Information that may be useful to the DDRO in consideration of this service request (optional):

_____

COMMUNITY TRANSITION SERVICES

(Used for individuals moving out of certified residential settings to live independently)

Request Type (check all that apply): ☐ **check here if requesting this service**	*Note: Fiscal Intermediary required, 1-time expenditure, up to $3000. Allowable expenses can be reimbursed if the expense was incurred no more than ninety days before or after the individual's move to the new residence.*
Fiscal Intermediary (FI) Provider (if known): Agency Name: _____	**Date of expected move:**
Brief explanation of plan for move: _____	

NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

INDIVIDUAL'S NAME: **DOB:** **TABS ID#:**

DAY HABILITATION

Request Type (check all that apply):

☐ **This request is to ADD this as a new service**

☐ **This request is to INCREASE units (e.g., individual currently receives DH and needs an increase in amount)**

☐ **This is change of provider only**

☐ **This is to add a new/additional provider only**

GROUP DAY HABILITATION INFORMATION

Group Day Habilitation Units Requested (annual amount):

Requesting: ☐ **Without Walls** _____

☐ **Site-Based (in a certified setting)** _____

(1 unit = minimum of 4 hours or more per day,
½ unit = minimum of 2 and less than 4 hours per day)

- 5 days/week = 215 units
- 4 days = 172 units
- 3 days = 129 units
- 2 days = 86 units
- 1 day = 43 units
- ½ day = 21 units

☐ Check if requested increase is with existing provider

Provider Information

Provider Agency Name: _____ Agency Contact Name: _____

Agency Email: _____ Projected Start Date: _____

When individual has selected multiple providers for this service, list additional agency names here:

_____

Justification for service and description of how it supports the individual's goals:

_____

Additional Information that may be useful to the DDRO in consideration of this service request (optional):

_____

SUPPLEMENTAL GROUP DAY HABILITATION INFORMATION –

Service provided Saturday, Sunday or Monday-Friday starting at 3pm or later

Supplemental Day Habilitation Units Requested (annual amount):

Requesting: ☐ **Without Walls** _____

☐ **Site-Based (in a certified setting)** _____

1 unit = minimum of 4 hours or more per day,
½ unit = minimum of 2 and less than 4 hours per day

- Full = 100 units
- Half = 50 units

☐ Check if requested increase is with existing provider

Provider Information

Provider Agency Name: _____ Agency Contact Name: _____

Agency Email: _____ Projected Start Date: _____

When individual has selected multiple providers for this service, list additional agency names here:

_____

Justification for service and description of how it supports the individual's goals:

_____

Additional Information that may be useful to the DDRO in consideration of this service request (optional):

_____

NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

INDIVIDUAL'S NAME: **DOB:** **TABS ID#:**

FAMILY EDUCATION and TRAINING (FET)

Request Type (check all that apply):

☐ **This request is to ADD this as a new service**

☐ **This is a change of provider only**

☐ **This is to add a new/additional provider only**

Annual Units Requested: _____
(up to 2 units per year; a unit of service can be up to 2 hours)

Provider Information

Provider Agency Name: _____ Agency Contact Name: _____

Agency Email: _____ Projected Start Date: _____

When individual has selected multiple providers for this service, list additional agency names here: _____

Justification for service and description of how it supports the individual's goals:

_____

Additional Information that may be useful to the DDRO in consideration of this service request (optional):

_____

PATHWAY TO EMPLOYMENT

Request Type (check all that apply):

☐ **This request is to ADD this as a new service**

☐ **This is a change of provider only**

Has the individual participated in Pathway to Employment previously? ◯ Yes ◯ No

If yes, which agency provided the service? _____

If yes, have the 278 hours or 365 days been used yet? ◯ Yes ◯ No

If yes, enter *Request to Bill Additional Pathway to Employment Services:*

Approval Number _____ Date Sent _____ Pathway Agency _____

Unit of Service = 278 hours

Provider Information

Provider Agency Name: _____ Agency Contact Name: _____

Agency Email: _____ Projected Start Date: _____

Justification for service and amount requested:

_____

PREVOCATIONAL SERVICES – Community Based (CBPV)

Request Type (check all that apply):

☐ **This request is to ADD this as a new service**

☐ **This request is to INCREASE units (i.e., individual currently receives PreVoc and needs an increase in amount)**

☐ **This is a change of provider only**

Choose a calculator:

Annual Billing Units Requested
(1 unit = 1/4 hour): _____ → **Annual Service Units Calculation** (1 unit = 1 hour): 0.00

OR

Annual Service Units Requested
(1 unit = 1 hour): _____ → **Annual Billing Units Calculation** (1 unit = 1/4 hour): 0.00

Provider Information if Identified (Include if a provider has been identified and agreed to provide this service)

Provider Agency Name: _____ Agency Contact Name: _____

Agency Email: _____ Projected Start Date: _____

Will the individual earn wages? (Prevoc wages are at or below 50% of prevailing wage) ◯ Yes ◯ No

Justification for service and amount requested:

_____

NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

INDIVIDUAL'S NAME: **DOB:** **TABS ID#:**

PREVOCATIONAL SERVICES – Site Based (SBPV)

(Only for providers with locations that are already approved by OPWDD)

The agency identified has OPWDD Central Office approval for new enrollments in Site Based Prevocational Service. ◯ Yes ◯ No

Request Type (check all that apply):

☐ **This request is to ADD this as a new service**

☐ **This request is to INCREASE units (i.e., individual currently receives PreVoc and needs an increase in amount)**

☐ **This is a change of provider only**

☐ **This is to add a new/additional provider only**

Is this a student leaving high school requesting Site Based Prevocational Services? ◯ Yes ◯ No

If Yes, did the person complete an ACCES-VR assessment as required by the Workforce Innovations Opportunity Act (WIOA)? ◯ Yes ◯ No

Units Requested (annual amount):

_____ ☐ **Site-based**
(1 unit = minimum of 4 hours or more per day, ½ unit = minimum of 2 and less than 4 hours per day)

Projected Start Date: _____

Provider Information if Identified:

Provider Agency Name: _____ Agency Contact Name: _____

Agency Email: _____ Site Program Code: _____

When individual has selected multiple providers for this service, list additional agency names here:

_____

Will the individual earn wages? (Prevoc wages are at or below 50% of prevailing wage) ◯ Yes ◯ No

Justification for service and amount requested:

_____

RESPITE - (HCBS Waiver Respite)

Request Type (check all that apply):

☐ **This request is to ADD this as a new service**

☐ **This request is to INCREASE units (e.g., individual currently receives respite and needs an increase in amount)**

☐ **This is a change of provider only**

☐ **This is to add a new/additional provider only**

Annual Respite Billing Units Requested: _____ → **Annual Respite Service Units Calculation=** 0.00
(1 unit = 1/4 hour) (1 unit = 1 hour)

OR

Annual Respite Service Units Requested: _____ → **Annual Respite Billing Units Calculation=** 0.00

☐ **Direct Provider-Purchased** (if individual is Self-Directed, check this box only if this service is not already included in an approved Self-Directed Budget)

☐ **Agency Supported Self-Directed** with MOU

Provider Information

Provider Agency Name: _____ Agency Contact Name: _____

Agency Email: _____ Projected Start Date: _____

Additional Information that may be useful to the DDRO in consideration of this service request (optional):

_____

When individual has selected multiple providers for this service, list additional agency name here:

_____

Justification for service and amount requested:

_____

NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

INDIVIDUAL'S NAME: **DOB:** **TABS ID#:**

SELF-DIRECTED BUDGET AUTHORITY (Budget to be developed, request falls within Personal Resource Account (PRA))

☐ **NEW request for Self-Direction (SD) Fiscal Intermediary (FI) & Broker (i.e., individual is new to self-direction)**
Note: all participants and/or their families interested in Self-Direction are expected to attend a required two-hour Self-Direction orientation. Please contact the Self-Direction Liaison at your Regional Office for orientation session dates and times.

Proposed Fiscal Intermediary Provider (if known): _____
Proposed Broker (if known): _____
Proposed Budget Type (if known): Residential Only ◯ Other Than Residential Only ◯ Both ◯
Comments: _____

Note: *This form **is not required** when requesting a change in FI or amending the following services within the SD Budget: self-hired staff, Individual Directed Goods and Services (IDGS), brokerage, Live-In Caregiver (LIC), Other Than Personal Services (OTPS), Family Reimbursed Respite (FRR) and Housing Subsidy. These changes should be processed directly between the Broker and the DDRO Self-Direction Liaison.*

This form may not be required in your Region when requesting a change in Agency Supported Self-Directed with MOU Community Habilitation, SEMP, and Respite. For questions, check with the Self-Direction Liaison in your region.

This form ***is required*** when *adding or increasing Direct Provider-Purchased services. For these requests, please follow the usual Service Amendment Request Form process for the service being requested.*

SUPPORTED EMPLOYMENT (OPWDD HCBS waiver SEMP)

Request Type (check all that apply):
☐ **This request is to ADD this as a new service**
☐ **This is a change of provider only**

Service Type:
☐ **Direct Provider-Purchased** (not Self-Directed)
☐ **Self-Directed** ◯ Yes ◯ No
If Yes, which type of self-directed service? (check all that apply)
☐ Self-Directed Direct Provider-Purchased ☐ Agency Supported Self-Directed with MOU ☐ Self-Hired Staff

Employment status: Is the individual currently employed?
◯ **Yes** (if yes, complete **EXTENDED SEMP SECTION** below)
◯ **No** (if no, complete **INTENSIVE SEMP SECTION** below)

Provider Information (SEMP Provider or Fiscal Intermediary):
Provider Agency Name: _____ Agency Contact Name: _____
Agency Email: _____

EXTENDED SEMP

Projected EXTENDED SEMP service enrollment date:
Name of business where individual is employed: _____
Does the individual earn a wage that is at or above the applicable federal/state/county minimum wage? ◯ Yes ◯ No
Is this job in an integrated setting in the community? ◯ Yes ◯ No
Justification for service and amount requested:
_____

INTENSIVE SEMP (includes ETP)

Individual enrolling in Intensive SEMP *does not have a job, has completed Discovery, has participated in ACCES-VR or ETP (or is applying for ETP), and has addressed identified challenges to employment.*
Is the individual currently receiving ACCES-VR services? ◯ Yes ◯ No **If Yes, anticipated completion date:** _____
Projected INTENSIVE SEMP services enrollment date:
Select one (one of the following is required for enrollment in Intensive SEMP):
◯ A ***Request to Bill OPWDD SEMP Intensive Services*** form has been approved:
Approval Number: _____ **Date Sent:** _____ **Intensive SEMP Agency:** _____
◯ The individual is applying for ETP and ETP has been approved to start by the ETP Supervisor? ◯ Yes ◯ No
Justification for service and amount requested:
_____

NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

INDIVIDUAL'S NAME: **DOB:** **TABS ID#:**

CARE MANAGER SIGNATURE

☐ **Required** - Please attest by checking this box that a person-centered conversation with the individual about their needs has occurred and that you are requesting a service that the individual wants, that promotes community integration and is being provided in the least restrictive environment.

Date of person-centered discussion:

Signature – Care Manager signature is required: • **Signature confirms that the individual or their designated legal representative has agreed to the requested changes.** • Electronic signature is preferred and electronic submission is required. • You may also sign the document by hand, scan the signed document and submit it electronically.	
Electronic Signature	**Date of Signature:**
Hand-signed Signature	**Date of Signature:**

SERVICE AMENDMENT REQUEST FORM SUBMISSION INSTRUCTIONS

This form is used by care managers to request amendments to services for those individuals who are not required to go through the Front Door. In order for the DDRO to consider the service request, please follow instructions below:

1. **Please check below on page 9 for information about <u>those services that do not require</u> submission of this form.**
2. As part of the process, the care manager completes and submits the Service Amendment Request Form (SARF) electronically via the region specific CCO Alert email box. **Supporting documents for the SARF form should be submitted in CHOICES** using the Documentation Submission Form.
   - The reason chosen for submission on the Documentation Submission should be "Service Authorization."
   - If uploading SARF supporting documents, they must adhere to the naming convention:

     Naming Convention: Last name_first name_TABS ID_YYYY_MM_DD_Document Name

WHO SHOULD <u>NOT</u> USE THIS FORM?

INDIVIDUALS WHO ARE REQUIRED TO ACCESS SERVICES THROUGH THE FRONT DOOR PROCESS SHOULD <u>NOT</u> USE THIS FORM OR THE SERVICE AMENDMENT PROCESS.

THE FOLLOWING INDIVIDUALS MUST USE THE FRONT DOOR PROCESS:

- Individuals for whom OPWDD eligibility has not been established.
- An OPWDD eligible person not currently receiving Health Home Care Management Services or Basic HCBS Plan Support from a CCO.
- An OPWDD eligible person receiving Health Home Care Management Services or Basic HCBS Plan Support but **not** receiving other services who is now requesting an HCBS Waiver service.
- An OPWDD eligible person who is not receiving any HCBS Waiver services and is now requesting HCBS services.
- Individuals transitioning into the community from specialized settings such as nursing homes, prisons or intermediate care facilities (ICFs).

NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

INDIVIDUAL'S NAME: **DOB:** **TABS ID#:**

SERVICES FOR WHICH COMPLETING A SERVICE AMENDMENT FORM IS *NOT REQUIRED*	
SERVICE TYPE:	**HOW TO APPLY FOR SERVICE:**
RESIDENTIAL SERVICES IN FACILITIES CERTIFIED OR OPERATED BY OPWDD	Follow Certified Residential Opportunities Protocol: Care manager contacts DDRO for assistance.
ENVIRONMENTAL MODIFICATIONS (EMODS) AND/OR ASSISTIVE TECHNOLOGY	Follow the established application process, submitting all required application materials to the DDRO.
FAMILY SUPPORT SERVICES (FSS) - NON-WAIVER SERVICES	Includes Family Reimbursed Respite, Family Reimbursement, Recreation, Service Access Assistance, Educational Advocacy. Individual/family works directly with provider agency and FSS liaison at the DDRO to apply for available services. When the individual has a care manager, the care manager helps to facilitate this process between the provider agency and the FSS liaison.
HOUSING SUBSIDY	Care manager contacts Housing Subsidy providers directly. If unable to locate an Housing Subsidy provider agency with available funding, care manager contacts DDRO Certified Housing Team for assistance.
INTENSIVE BEHAVIORAL (IB) SERVICES	Follow the established application process, submitting all required application materials to the DDRO.
INTENSIVE WAIVER RESPITE	After units are approved, the respite provider agency submits "Intensive Respite Approval Form" as directed.
SELF-DIRECTION	This form is not required when requesting a change in Fiscal Intermediary (FI) or amending the following services within the Self-Direction Budget: self-hired staff, IDGS, brokerage, Live-In Caregiver (LIC), Other Than Personal Services (OTPS), Family Reimbursed Respite (FRR), and Housing Subsidy. Changes to these services should be processed directly between the Broker and Self-Direction Liaison. This form may not be required in your Region when requesting a change in Agency Supported Self-Directed with MOU Community Habilitation, SEMP, and Respite. For questions, check with the Self-Direction Liaison in your region.