TRANSFORMING YOUR LIFE
A RESOURCE GUIDE

Your Services

Your Supports

Your Choice

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PROLOGUE

Dear Reader,

We created this resource guide to assist you with navigating through the complexity of supports and services that you may choose to receive.

People and their families have voiced much frustration with the complexities of this changing system. Finding assistance and answers to their many questions has been an overwhelming task.

Whether it be starting out, transitioning or continuing with supports and services, we are hopeful that this guide will reduce some of the frustration related to the process and assist you with living the life you want to live or supporting a family member in this endeavor.

For those of you not aware, AHRC, Nassau has separated into four separate sister agencies (AHRC, Nassau, Citizens, Brookville Center for Children's Services and Advantage Care Diagnostic and Treatment Center/Fay J. Lindner Center) which work together, hand in hand, to provide supports and services through your life span and/or your family member's life span. By separating, it allowed the four agencies to specialize in the diverse needs of this population to provide quality supports and services. The four agencies are committed to working together to ensure that you live the life you want to live by receiving the supports needed to accomplish the goals you set out for yourself.

Your satisfaction is important to us so please contact us at (516)644-4800 with any questions, concerns or ideas. We are here to assist you in your journey.

Sincerely,

The Brookville Center for Children's Services, Citizens, AHRC Nassau and Advantage Care Diagnostic and Treatment Center/Fay J. Lindner Center

PROVIDER OVERVIEW

Brookville Center
for Children's Services

V.

Brookville Center is approved by the New York Stated Education Department and the Department of Health to provide educational and therapeutic services to children with developmental delays or disabilities.

Brookville Center provides a 12-month therapeutic program for children with developmental delays and developmental disabilities. The school age program serves students 5-21 years of age with intellectual disabilities, multiple disabilities traumatic brain injury and autism. Children are referred to this program from their local school district's committee on special education. Students in the program benefit from a high staff to student ratio, 12:1:4, 10:1:3 or 6:1:3.5. Students are grouped according to age and academic needs. Each class is a program to itself and curriculum is driven by the student's Individual Education Plan and New York State Education Departments' Standards for Education. Students may receive an array of services as mandated by their Individual Education Program (IEP).

Services include

- Day Care
- Pre-School Program
- School Age Program
- Children's Residential Program
- Children's Respite & Recreation Program

Citizens

Empower Enrich Elevate

Citizens provides quality supports and services to people with intellectual and developmental disabilities in the areas of Medicaid Service Coordination, residential opportunities, family support services and respite.

In May of 2011, the Office for People with Developmental Disabilities (OPWDD) recognized Citizens as a COMPASS agency; one of only eight agencies in New York State to achieve this title. This title was given based on the efforts made by Citizens to ensure supports and services are person directed and that those receiving services have a voice in agency decisions, policies and procedures and overall quality management and improvement initiatives. Citizens believes that when people come together and work as a team great things happen.

In September of 2012, Citizens began the process of CQL accreditation and began working toward person centered excellence. Citizens MSC department works closely with four personal outcome trainers to assist individuals with intellectual and other developmental disabilities in defining their personal goals and dreams and developing a life plan that includes natural supports, community supports and choice of service provision options. Since the start of this project great personal outcomes have been established by individuals with support networks working to assist them in the achievement of their goals. In February of 2014, Citizens became accredited in Person Centered Excellence by the Council on Quality and Leadership. This accreditation along with our Compass status makes Citizens one of the premier agencies in the field.

Citizens looks forward to working closely with you and your family members to assist in goal achievement and realization of dreams.

Services include:

- Medicaid Service Coordination
- Residential
- Self-Directed Services
- Crisis Respite
- Camp Loyaltown
- Family Support

AHRC Nassau is regarded as a respected and innovative leader in the field of developmental disabilities. For 65 years, AHRC's collective voice has enacted legislation, pioneered methods to promote community inclusion while continually seeking new ways to better support people with developmental disabilities. AHRC provides a wide array of quality supports including residential services, adult day habilitation and community-based services, vocational and employment services, guardianship, family support services and recreation opportunities, to more than 2,200 men and women throughout Nassau County.

The Office for People with Developmental Disabilities (OPWDD) recognized AHRC Nassau in 2004 as a COMPASS agency, making it one of only seven agencies in New York State to achieve this status. Recently, AHRC joined an elite group of agencies in the State to be accredited by the Council on Quality and Leadership (CQL) for its focus on person-centered excellence.

Services include:

- Residential
- Day Habilitation
- Employment Opportunities
- Respite & Recreation Program
- Community Habilitation

The Pearl & Jack Ain
AdvantageCare
DIAGNOSTIC AND TREATMENT CENTER
Comprehensive medical and dental services for children and adults with special needs

The mission of the Pearl & Jack Ain Advantage Care Diagnostic and Treatment Center is to provide the highest quality comprehensive medical services to children and adults with intellectual and other developmental disabilities in state-of-the-art facilities located in Brookville and Freeport, New York.

Advantage Care is a level III patient-centered medical home that meets standards consistent with those of the National Committee for Quality Assurance's (NCQA) Physician Practice Connections® Patient-Centered Medical Home Program (PPC-PCMH™). This is a model of care that seeks to strengthen the physician-patient relationship by promoting improved access, coordinated care, and enhanced patient/family involvement. Each patient has an ongoing relationship with a primary health care provider, who leads a team that takes collective responsibility for patient care. A medical home will focus on enhanced care through open scheduling, expanded hours, and communication among patients, providers and staff.

In cooperation with North Shore-LIJ Health System's Department of Dental Medicine, the Advantage Care Diagnostic and Treatment Center provides innovative dental care to children, adolescents and adults with intellectual and other developmental disabilities. Our dental services are customized to each individual's needs. Arrangements may also be made to provide specialty care in North Shore-LIJ Health System's dental clinic or under general anesthesia in their operating room.

Services include:

- Primary Medical Care for Adolescents (13 Years and Older) and Adults
- Dental Care for Children, Adolescents and Adults
- Women's Health including GYN exams and screenings
- Podiatry for Adults
- Psychiatry for Adults
- Lab Services for Adolescents and Adults

FAY J. Lindner Center
for autism & developmental disabilities

The Fay J. Lindner Center for Autism & Developmental Disabilities is a program of the Advantage Care Diagnostic & Treatment Center and is an affiliate of the North Shore-LIJ Health System. The Fay J. Lindner Center is a provider of services for children and adults with Autism Spectrum Disorder and other developmental disabilities. For over 10 years, the Lindner Center has been providing comprehensive diagnostic and neuropsychological assessments, outpatient psychological services, psychiatric care, including medication management, school consultation and advocacy and resource information, across the tri-state area.

Successful intervention requires the collaborative efforts of the concerned parents/caregivers, team of professionals and the schools, day-sites or jobs. The Lindner Center's team consists of highly trained and respected specialists in psychiatry, psychology, and speech/language pathology. Staff works closely with families to ensure a comprehensive and interdisciplinary approach to consultation, assessment and treatment. The Lindner Center's peer mentors are an essential part of the program. They provide social support and model age-appropriate interpersonal skills, encouraging group participants to make connections with one another.

Services include:

- Psychological and Neuropsychological Evaluations
- Psychological Services and Psychotherapy
- Psychiatry
- ➢ Speech and Language Evaluation and Services
- Social and Recreational Programming

A QUICK GUIDE TO

NAVIGATING SUPPORTS AND SERVICES

If you are looking for supports and services for the first time:

- Call Central Enrollment at (516) 644-4800
- Section 1: What's changing in New York
- Section 2: How to get started
- Section 3: How to link to supports and services

If you are transitioning from children's supports and services to adult supports and services:

- Call Central Enrollment at (516) 644-4800
- Section 7: Transitioning to adult supports and services
- Section 5: Self-directed supports and services
- Section 8: Adult supports and services
- Section 3: How to link to supports and services

If you are looking to change or enhance existing supports and services:

If you are a child or a family member of a child:

- Call Central Enrollment at (516) 644-4800
- Section 6: Children's supports and services
- Section 5: Self-directed supports and services
- Section 3: How to link to supports and services

If you are an adult or a family member of an adult:

- Call Central Enrollment at (516) 644-4800
- Section 8: Adult supports and services
- Section 5: Self-directed supports and services
- Section 3: How to link to supports and services

SECTION 1:

WHAT'S CHANGING IN NEW YORK STATE

"What's Changing in New York State?"

The Office for People with Developmental Disabilities (OPWDD) recently shared their vision and **Transformation Agreement** for the delivery of supports and services across New York State. Services and supports are changing from traditional program models (i.e., day habilitation and group home living) to **Consolidated Supports and Services (CSS) (now known as Self-Direction or Self-Directed Services)** with a focus on **self-determination** and **self-direction as a means for people to develop personalized services and supports to better meet their needs**. As part of this initiative, OPWDD's admission process has changed and now requires that people seeking services go through the **"Front Door"** to obtain authorization for service provisions. Our agencies are here to assist you as needed.

Four leading agencies supporting people with **intellectual and developmental disabilities (I/DD)** have partnered to provide a wide range of supports and services that meet the ever-changing needs of people with I/DD. With more than six decades of experience providing quality support services, AHRC Nassau, Citizens, Brookville Center for Children's Services and Advantage Care Diagnostic & Treatment Center are committed to a practical, individualized approach to supports and services.

We look forward to working closely with you and your family to assist you with acquiring any needed supports and services toward living a richer and fuller life of your choice.

CALL OUR CENTRAL ENROLLMENT DEPARTMENT TO GET STARTED (516) 644-4800

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To learn more about OPWDD's Transformation Agreement visit:
http://www.opwdd.ny.gov/transformation-agreement/home

CONTACT INFORMATION FOR THE LONG ISLAND DEVELOPMENTAL DISABILITIES REGIONAL OFFICE (DDRO)

(631)434-6000

SECTION 2:

HOW TO GET STARTED

CONTACTING CENTRAL ENROLLMENT

Whether you are just starting out, transition from children's services to adult services or interested in changing supports and services, knowing who to contact can be one of your most challenging tasks. Here are some simple steps to make the process easier and more successful:

- Call our **Central Enrollment department** at (516) 686-4888 and speak with one of our **Enrollment Coordinators** who will be happy to help you.
- Let them know if you are looking for supports and services for the first time, transitioning to adult supports and services or want to change existing supports and services. They will assist you accordingly.

CALL OUR CENTRAL ENROLLMENT DEPARTMENT TO GET STARTED (516) 644-4800

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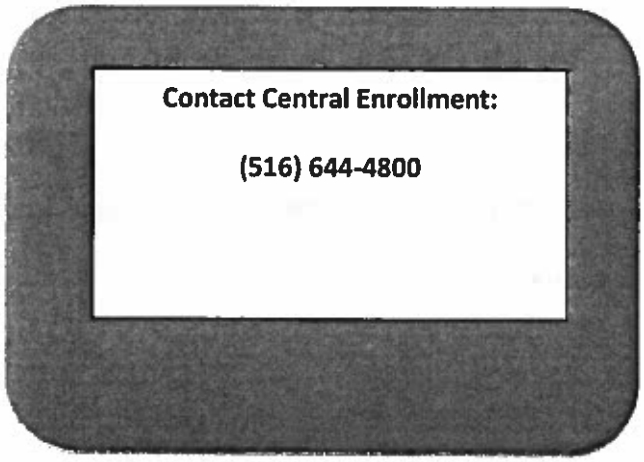
Overview of Central Enrollment

Our Enrollment Coordinators in the Central Enrollment Department are here to assist you with starting, transitioning and/or changing existing supports and services.

They will:

- Provide information on all available supports and services.
- Schedule a tour to visit programs of interest and/or a meeting with knowledgeable staff based on your interests or choices.
- Schedule a meeting with our **Entitlement Department** to determine your eligibility for these supports and services.
- Provide and assist you with completing any needed paperwork.
- Maintain ongoing communication with you until your supports and services have begun.
- Be your person of contact for any changes to existing supports and services.
- Maintain records of progress on obtaining and receiving supports and services.
- Ensure your satisfaction.



CALL OUR CENTRAL ENROLLMENT DEPARTMENT TO GET STARTED (516) 644-4800

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Overview of the Entitlement Department

Speaking with an Entitlement Coordinator:

An Entitlement Coordinator will speak with you and assist you with determining eligibility. Don't panic! Your Enrollment Coordinator will assist you with this process.

The Entitlement Department will also provide professional support to help you begin the process of applying for Federal entitlements you may be eligible to receive. Knowledgeable staff are available to answer your questions and concerns regarding:

- **Medicaid**
- **Medicare**
- **Social Security Disability Insurance (SSDI)**
- **Supplemental Security Income (SSI)**
- **SNAP(Food Stamps)**

Once a notice of decision indicating acceptance to one of our programs is sent to you from the **Developmental Disabilities Regional Office (DDRO)**, Medicaid representation is provided free of charge for the purpose of maintaining continued eligibility.

CALL OUR CENTRAL ENROLLMENT DEPARTMENT TO GET STARTED (516) 644-4800

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SECTION 3:

HOW TO LINK TO SUPPORTS AND SERVICES

What is Medicaid Service Coordination?

Think of **Medicaid Service Coordination (MSC)** as having your own personal guide as you navigate the supports and services available to people with **intellectual and/or developmental disabilities (I/DD).** Since the choice is yours, we encourage you to interview and hire the **Medicaid Service Coordinator (MSC)** of your choice.

By using a person centered planning approach, you and your Medicaid Service Coordinator creates an **Individualized Service Plan or "ISP"** which details the supports you choose to ensure your quality of life. Together with your Medicaid Service Coordinator you will review your ISP and update it when changes to your plan are needed. Your Medicaid Service Coordinator advocates for you and will maintain ongoing communication with all service providers and document all coordination activities.

Medicaid Service Coordinators ensure you are aware of your choices. You direct the planning process and decide the date and location of your ISP meetings, what is discussed, and who is invited. Thinking beyond the traditional models is encouraged.

Men and women receiving services meet a minimum of three times a year and as needed with their Medicaid Service Coordinator. This relationship is built on trust and understanding and ensures that all of your needs are considered when any life change occurs.

You work with your Medicaid Service Coordinator and your **Circle of Support (COS), now known as Planning Team,**to create an Individualized Service Plan (ISP). The ISP outlines in detail every support to be accessed by and for you. All aspects of your life, for which services and supports are needed are considered and a plan is created to address these items. We understand that as life changes, so may your plan for supports and services. Medicaid Service coordinators are trained in a **person-centered** planning method that enables them to place your needs and interests first in determining your future plans.

You and your Medicaid Service Coordinator update your ISP when changes are necessary that will better support your wants and needs. Your **Personal Outcome Measures (POM)** are reviewed at each ISP and include your current living situation, hobbies and interests, work/day aspirations, clinical services, health and safety, natural supports, and community resources.

Medicaid Service Coordinators monitor, assess, assist, and advocate for you in all the above areas. They are attentive to your wants and needs in order to provide you with links to supports and services that will benefit you. Together they evaluate a wide range of services including, Housing; Recreation; Respite; Physical Rehabilitative Therapies; Transportation Services; Competitive Employment; Clinical Services; Education; Community Habilitation; Day Habilitation; Residential Habilitation; and Supported Employment.

Day Habilitation, Residential Habilitation, and Supported Employment are examples of traditional Home and Community Based Services (HCBS) Waiver Services. HCBS Waiver is as funding source and Medicaid Service Coordination is a pre-requisite to enrolling into HCBS Waiver Services.

How Do I Get Started with Medicaid Service Coordination?

Our **Central Enrollment Department** works with you to obtain required documentation to enroll in Medicaid Service Coordination. Documents include:

- ☐ Copy of Medicaid Card
- ☐ Psychological Evaluation dated within three years and signed by a licensed psychologist (an Adaptive Behavior Scale must be included if IQ is over 60)
- ☐ Psychosocial dated within three years and signed by a licensed Social Worker
- ☐ Full Physical/Medical Exam signed by a Primary Care Physician (i.e., doctor) within past year
- ☐ Signed Individual Rights and Grievances (we provide this to you)

Once all the required documents have been received and processed, a complete packet is forwarded to Medicaid Service Coordination and you make your MSC selection. The MSC schedules a meeting with you in order to enroll you into Medicaid Service Coordination.

CALL OUR CENTRAL ENROLLMENT DEPARTMENT TO GET STARTED (516) 644-4800

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Preparing you to Enter OPWDD's "Front Door"

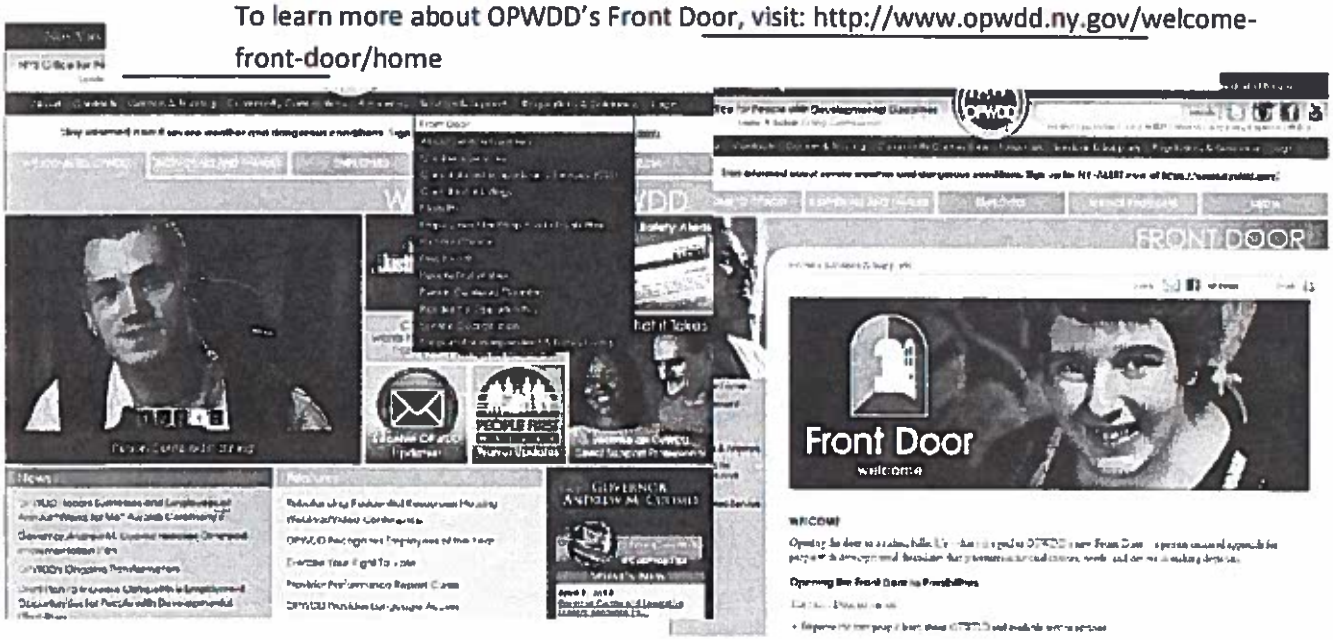
The Office for People With Developmental disabilities (OPWDD)'s **Front Door** is designed to improve the way people learn about and access available supports and services while giving people as many options as possible to direct their own lives. There is a Front Door team at each OPWDD Regional Office.

The Front Door applies to:

1. Anyone newly entering the system
2. A transitioning student entering the adult world;
3. Re-entering the system after a break in Waiver services of one year or more
4. Individuals transitioning into the community from Developmental Centers or other specialized settings (i.e. nursing home)

Your Medicaid Service Coordinator can assist you with OPWDD's Front Door process.

To learn more about OPWDD's Front Door, visit: http://www.opwdd.ny.gov/welcome-front-door/home



CALL OUR CENTRAL ENROLLMENT DEPARTMENT TO GET STARTED (516) 644-4800

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Your Front Door Key

- ☐ *Initiate:* Initiate contact with the Front Door Team by calling the Long Island **Developmental Disability Regional Office (DDRO)**: (631)434-6000. Be precise in documenting the name of the people you speak with and the information they provide.

- ☐ *Attend Information Session:* You will be given a date to attend an Information Session. At the end of the meeting you will have knowledge pertaining to service options and next steps.
- ☐ *Eligibility:* If Medicaid and OPWDD eligibility has not been established the process will begin at this point. Eligibility includes a review of current evaluations, specifically a psychological and a social history completed within the last three years.

- ☐ *Apply for Medicaid Service Coordination:* You may choose to apply for Medicaid Service Coordination by contacting our Central Enrollment Department at (516) 644-4800.

- ☐ *An Assessment is scheduled and completed*: At the end of the assessment you should have a better understanding of **self-determination** and options outside of traditional OPWDD services.

- ☐ *A Review of Strengths and Needs is Completed:* The Front Door Team reviews interests, strengths, and needs with the person.

- ☐ *Confirmation:* Request from the Front Door Team confirmation that you went through the Front Door. Ask for an effective date. Be precise in documenting the name of the people you speak with and the information they provide.

Note: The Front Door process isn't necessarily linear. These steps may occur simultaneously. Wherever you are in the process, contact our Central Enrollment Department at (516) 644-4800.

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SECTION 4:

PERSONAL OUTCOME MEASURES

Determining the Life You Want to Live

Achieving Your Personal Outcomes

Both AHRC and Citizens are accredited in person centered excellence by the **Council on Quality Leadership's (CQL).** They are among an elite group of agencies to receive this distinction. AHRC and Citizens are therefore committed to CQL's **Personal Outcome Measures®** as the starting point to assist you in setting your personal outcomes in order to have a richer and fuller life.

Each of the three words in Personal Outcome Measures® shows how this approach is different:

- **They're PERSONAL:** Each person's assessment for quality of life is unique to him or her. Each person defines their quality life on their own or if assistance with communication is desired, with the help of people who care about them and know them very well.
- **They're OUTCOME Based:** We are then guided by your expectations and what is important to you in your life. You experience real outcomes related to your personal expectations for a quality life defined by you.
- **They're MEASURED Differently:** We can't look at personal outcomes without measuring quality differently. Traditional systems measure how services are delivered or what the organization does. CQL's approach to measurement looks at personal quality of life and addresses questions of priority and relevance for the person based on their individual life priorities.

When you choose our partnered services, you will have a Personal Outcome Measures® discussion with one of our CQL trained &certified staff members who will prioritize your own personal/valued outcomes.

In order to attain your personal/valued outcomes, you will review your future plans with your **Planning Team** and set up your yearly plan with your **Medicaid Service Coordinator** (MSC).

We are confident your Personal Outcome Measures® will support you in living the life you choose with all the necessary supports.

To learn more about CQL and Personal Outcome Measures®, visit:
www.thecouncil.org

CALL OUR CENTRAL ENROLLMENT DEPARTMENT TO GET STARTED (516) 644-4800

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SUMMARY

At this point you should have successfully completed the following:

- **Eligibility for supports and services**
- **Enrollment and overview of supports and services of interest to you.**
- **Choosing your Medicaid Service Coordinator**
- **Having a personal outcome Interview to determine what matters most to you.**

The next step is to select the supports and services needed to live the life you want to live.

CALL OUR CENTRAL ENROLLMENT DEPARTMENT TO GET STARTED (516)644-4800

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Section 5:

SELF-DIRECTED SUPPORTS AND SERVICES

Self-directed Supports & Services

Now you can choose where you live, how you spend your day and how you participate in your community

The transformation in services means new and exciting changes for you as you get to decide what is important to you and who plays key roles in helping you choose the services you want and need.

Self-Determination is the philosophy that you self direct and have control over your life. With the assistance of your **Planning Team,** you will create an annual budget to develop and manage your life plan.

The Planning Team is the key decision making group that replaces other system structures. Your Planning Team are people chosen by you and will include your **Self-Direction broker** and **Medicaid Service Coordinator (MSC)** as well as your choice of both natural and professional supports.

Self-Direction and Independent Support Services (ISS) are tools used toassist people to lead the life they want to live. CSS and ISS are self-directed home and community based services.

Self-direction provides you with the opportunity to make decisions about what supports and services you need to ensure your quality of life. Self-direction means that you accept responsibility for managing or co-managing your supports and services. Self-direction of services includes you or your family advocate exercising your right to hire the staff of your choosing as well as manage your personal budget to meet your wants and needs. This includes opportunities to make decisions about:

- Having meaningful relationships with friends, family and others in your life
- Experiencing personal growth while maintaining your health and safety
- Living in the home and community you choose
- Working, volunteering and joining in leisure and community activities in your neighborhood
- Selecting how, when and by whom you are supported

There are two types of services which allow you to take responsibility and make choices:

1. *Self-Direction or Self-Directed Services*

   This model allows people to develop a self-directed plan which allows you to take responsibility to make choices. Some of the choices include where you wish to live, what you do during the day, who you want to spend your days with and how you participate in your community. This model also allows people to hire their own staff to provide services such as SEMP, Community Habilitation and Respite.

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Self-Direction allows you to control your own budget and hire your own staff with assistance from your Broker **and a Fiscal Intermediary (FI)**. A Broker provides technical assistance and may assist you and your Medicaid Service Coordinator with the development of a Planning Team, facilitate - connect to paragraph below.person centered planning, write the self-directed plan and budget. Your Broker will work with you and the FI to support you throughout this process. The Fiscal Intermediary is the financial management agency for services funded through a self-directed plan/budget. The FI assists you and your broker in managing your budget, employing and managing your staff. It is also the employer of record for the staff you hire.

The Seven Steps of Self-Direction include:

1. Determining if Self-Direction is appropriate for you.

2. Selecting a Broker and FI.

3. Forming a Planning Team.

4. Designing your person centered plan.

5. Working with a Broker and FI to create your self-directed plan and budget.

6. Submitting your plan and budget through your Broker to your local Developmental Disability Regional Office (DDRO) for approval.

7. Living the life you choose!

2. *Independent Support Services (ISS)*

ISS is a housing subsidy typically applied towards rent. It may also be applied to your mortgage, condo or co-op fees or other direct housing costs. As the person receiving the housing subsidy, you are expected to contribute 30% of your countable net income towards housing expenses.

A "transition" stipend is available and typically is used for the costs associated with establishing a residence (security deposit or first month's rent, furniture and moving expenses). The reimbursement will not exceed $3,000 and is a one-time allotment.

ISS can be used in conjunction with Self-Direction and will be part of your self-directed budget.. If pursuing ISS as a stand-alone service, additional guidance will be provided by your Medicaid Service Coordinator.

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SECTION 6:

CHILDREN'S SUPPORTS

AND

SERVICES

Supports & Services for Children

CHILDCARE

Day Care Services are provided to infants, toddlers and preschoolers at four locations in Nassau County and the program is licensed and approved by the **Office of Children and Family Services (OCFS).** Children are afforded an enriching experience and adhere to the New York State standards of early childhood learning. Activities such as music, arts and crafts, language, motor skills, pre-academic activities and computers are taught by appropriately credentialed staff.

EDUCATIONAL PROGRAMS

Preschool

Our Preschool Program offers educational and therapeutic supports and services, at four locations in Nassau County, to children 3-5 years of age with developmental delays and/or developmental disabilities. The Program offers integrated class settings and self-contained classes and is approved by the New York State Education Department and the Department of Health.

School Age

The School Age Program is a 12 month therapeutic program for children with developmental delays and developmental disabilities. It serves children, 5-21 years of age with intellectual disabilities, multiple disabilities, traumatic brain injury and autism. Children are referred to this program from their local school district's **Committee on Special Education (CSE)**. Children in the program benefit from a high staff to student ratio, 12 students:1 teacher:4assistants/aides, 10 students:1teacher:3assistant/aides or 6students:1teacher:3.5assistants/aides and are matched according to age and academic needs. Each class is a program unto itself and curriculum is driven by the student's **Individual Education Plan (IEP)** and New York State Education Departments' Standards for Education. Students may receive an array of services as mandated by their (IEP).

CALL OUR CENTRAL ENROLLMENT DEPARTMENT TO GET STARTED (516) 644-4800

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Children's Residential Program

Children with autism and their families can turn to The Brookville Center for Children's Services (BCCS) when searching for a structured educational and residential program. This program was created in 2009 in an effort to assist with bringing children home to New York who needed to move out of state to get their educational and residential needs met. Our **Children's Residential Program (CRP)** serves children with autism who live in one of four houses located in Lido Beach and in Wantagh.

The residential program is based on a collaborative approach with Brookville Center for Children's Services educational program. Therapeutic interventions include speech therapy including **Picture Exchange Communication Systems (PECS)** and augmentative communication devices, occupational therapy and positive behavioral supports. An **Interdisciplinary team (IDT)** approach provides comprehensive services that teach life skills (i.e. laundry, cooking, and prevocational skills). This holistic approach fosters family involvement and promotes community integrated recreation based on individual preferences.

CALL OUR CENTRAL ENROLLMENT DEPARTMENT TO GET STARTED (516) 644-4800

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Children's Respite Programs

Crisis Respite Home

Citizens offers a comfortable place for your child to stay. Caring and dedicated professionals provide a safe and friendly environment which gives families peace of mind. Our community-based respite home can support a full range of medical and behavioral supports for children and adults with **intellectual and developmental disabilities(I/DD).** Options for respite services can include overnight stays for up to six people at any one time, 7 days a week, 24 hours a day for children and adults who are **Medicaid** waiver eligible. House is handicapped accessible. Professional staff in the home are trained in positive behavioral supports and behavior management strategies and are certified in medication administration, CPR, G-tube feedings and insulin administration.

CALL OUR CENTRAL ENROLLMENT DEPARTMENT TO GET STARTED (516) 644-4800

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Children's Recreation and Respite Programs

Saturday Recreation and Vacation Respite

To be considered for the recreation programs and vacation respite, children must have a Medicaid waiver or be eligible to receive Medicaid waiver services. If you are unsure if your child meets this criteria, please contact our Central Enrollment Department today at (516) 644-4800.

Two Saturday recreation programs are available, one with a focus on recreation for children with varying disabilities and the other with a focus on social skills for children with autism. Additionally, a vacation respite recreation program is offered for children with developmental disabilities in April, August and December.

All programs include a wide range of skill enhancement for children through music, arts and crafts, cooking, movement dance and indoor and outdoor play. Swimming in the outdoor pool is available during the summer months.

Summer Camp Respite

A unique respite opportunity is available in the summer months at Camp Loyaltown located in Hunter Mountain, New York.

Camp Loyaltown is a summer sleep-away camp that offers respite for family members while providing a rewarding opportunity for children and adults with I/DD. Campers experience independence in this safe, supportive and fun setting while developing new friendships and participating in engaging activities. There are several sessions to choose from and scholarships are available based on financial need.

A state-of-the-art health and wellness center is equipped to handle campers' medical needs and is staffed by RN's and LPN's.

CALL OUR CENTRAL ENROLLMENT DEPARTMENT TO GET STARTED (516) 644-4800

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Medical, Dental and Clinical Services for Children

The Advantage Care Diagnostic and Treatment Center provides medical and dental services for children and adolescents. Our Center provides personalized desensitization programs which reduce fear and anxiety some patients experience prior to and during medical and dental appointments. These programs are intended to assist patients in feeling comfortable when seeing providers, which enables them to cooperate with treatment and recommendations for improving their overall health and wellbeing.

Choose from our services:

PRIMARY MEDICAL CARE FOR ADOLESCENTS 13 YEARS AND OLDER

- Comprehensive interview and evaluation of medical history
- Examination and treatment of acute and chronic medical conditions
- Well visits, school and camp physicals
- Physician on call
- Review of laboratory data, including genetic testing that is ordered and received
- Venipuncture (blood work)
- Immunizations
- EKG
- Coordination of care with other physicians and professionals

DENTAL CARE FOR CHILDREN, ADOLESCENTS AND ADULTS

- Initial dental assessment
- Bi-annual examinations
- Dental hygiene services (cleanings, x-rays, fluoride treatment)
- Restorative dental services (fillings)
- Prosthodontic services (crowns)
- Endodontic services (root canal treatment)
- Periodontal services (treatment of gums)
- Ambulatory surgery services
- Cosmetic procedures

Diagnostic Testing at the Fay J. Linder Center

The first step in obtaining services for I/DD is obtaining a correct diagnosis. If you are searching for a provider who can accurately diagnose an intellectual or developmental disability, we can help.

The Fay J. Lindner Center for Autism & Developmental Disabilities provides comprehensive diagnostic and neuropsychological assessments, outpatient psychological services, psychiatric care, including medication management, school consultation and advocacy and resource information, across the tri-state area are also available.

Successful intervention requires the collaborative efforts of the person with I/DD and their circle of support. Lindner Center's team consists of highly trained and respected specialists in psychiatry, psychology, and speech/language pathology. The staff works closely with families to insure a comprehensive and interdisciplinary approach to consultation, assessment and treatment. The Lindner Center's peer mentors are an essential part of the program. They provide social support and model age-appropriate interpersonal skills, encouraging group participants to make connections with one another.

Children and adults with **Autism Spectrum Disorder(ASD)** and other developmental disabilities experience impairments across a range of areas including: cognitive, social, communication, adaptive, affective/emotional and behavioral. The Lindner Center's team creates an individualized, effective assessment plan that is unique for each person depending on the referral questions and presenting symptoms. The Lindner Center conducts psychological evaluations for children as young as 18 months and people through adulthood.

Psychological evaluations include testing in the following areas:

- Diagnostics
- Social-Emotional (to rule out a co-existing mental health diagnosis)
- Neuropsychological/Executive Functioning
- Psycho-educational
- Eligibility (for programs and entitlement services)

CALL OUR CENTRAL ENROLLMENT DEPARTMENT TO GET STARTED (516) 644-4800

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SECTION 7:

TRANSITIONING

TO

ADULT SERVICES

Transitioning to Adult Services

Begin Planning for the Future

It is never too early to start planning for the future. As early as possible, encourage your child to develop their independence by teaching them to be responsible. Allow them to do as much as possible for themselves. This includes simple household chores such as placing their plate in the sink after meals, sorting their laundry, etc. Encourage them to engage in adolescent activities such as visits with peers or overnight respite. Additionally, begin to assist with supportive decision making by having them make decisions on things important to them (i.e., the color of their room, etc.).

Many children with developmental disabilities and their families have questions about what kinds of supports are available when school ends and life as an adult begins. We strongly recommend that transition planning for students begin at age 14.

Parent Guidelines- Planning for Your Child's Transition to Adult Services

Transition Process:

Ages 14 – 21

1. Save **all** information regarding your child's diagnosis including physical exams, social histories/psychosocial and psychological evaluations and other related service evaluations.
2. If your family member currently lives in a **children's residential program (CRP)**, at age 14 you must contact the **Developmental Disabilities Regional Office (DDRO)** and place your family member's name on the aging out roster. This will allow them to be considered for adult residential placement.
3. Contact our **Central Enrollment Department** at (516)644-4800 to:
    - Assist you with registering your child, determining eligibility, and scheduling time to attend a **Front Door** Access to Services Information Session for Individuals and Families.
    - Explore supports and services that will help you family member live the life they want to live (i.e., **Self-Directed Services,** Community Habilitation, day options, living options, etc.).
    - Obtain **Social Security Income (SSI)** and **Medicaid.**
    - Obtain a **Medicaid Service Coordinator (MSC)** of your family member's choice.

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People with Developmental Disabilities' (OPWDD) Guide for Transitioning:

Transition from Local Schools:

OPWDD's Transition Coordinators can help students at local schools plan for OPWDD supports they may need as adults. Our **Central Enrollment Department** can assist and link you to your local Transition Coordinator. Just call (516)644-4800.

Transition from Residential Schools:

Students at residential schools are entitled to remain at school until they complete their educational requirements or until the end of a school year in which they turn 21. Once students complete their schooling, OPWDD is responsible for their adult services, and students can only remain at school until OPWDD offers appropriate adult services. OPWDD is committed to helping students at residential schools transition to adult life by ensuring needed supports are in place when students age out of school. Age Out Coordinators can help students and families learn about residential support options, as well as employment and other day supports. Our Central Enrollment Department can assist and link you to your local Aging Out Coordinator. Just call (516)644-4800.

Consent Form for Transition Planning:

Student records, such as student's **Individual Education Plan (IEP)** and reports from assessments can help with OPWDD eligibility determination and planning for adult services. In order for schools to share information about a student, OPWDD must have a signed consent form from the student's parent or guardian on file. Our Central Enrollment Department can assist you in obtaining the needed consent form and getting it over to OPWDD. Just call (516)644-4800.

There are many supports and services available for young adults with developmental disabilities. However, unlike public education, students and families must apply for these supports. There are people to help you learn about what options are available and how to apply for services. A strong **Planning Team** can assist in the transition process. A planning team is a group of people which can include family members, friends, community members and support staff who have been freely chosen by you and who have come together to assist you to visualize, express and accomplish your dreams. With your interests and goals in mind, a COS can assist you to make choices/decisions that enable you to take charge of your life.

In addition to the information you receive from the school, you may find the following websites helpful:

Q&A for parents: www.p12nysed.gov/specialized/publications/transition/parents.htm

Q&A for Students: www.p12nysed.gov/specialized/publications/transition/students.htm

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State Education Department Transition Planning:
www.p12.nysed.gov/specialized/publications/transitionplanning-2011.htm

Transition Planning Timeline: www.p12.nysed.gov/specialized/publications/plantimeline.htm

A good tool to use is the transition planning self-assessment inventory. This guide will help walk you through important questions about your future goals and prepare you to work with your school to plan for adult life: www.p12.nysed.gov/specialized/transition/t4trans.htm

Remember:

Tips for Students:

- Ask questions
- Talk to your teachers
- Talk to your parents
- Talk to a job developer at school
- Talk to fellow students
- Form a Planning Team to assist you with this process

Tips for Parents/Families/Guardians:

- Start early; it is never too early to investigate the possibilities.
- Ask questions; find out what options exist in your community and how to apply for them.
- Learn about the eligibility process for obtaining supports; find out what documentation needs to be pulled together so that supports are ready when you need them.

Remember:

1. ALL 18-year-olds can and should register to vote.
2. ALL 18-year-old males must register for selective service, even if disabled (see information from the Selective Service website at **http://www.sss.gov**).
3. Rights change as you progress from child to adult. Know your rights and/or teach your family member about their rights and how to protect their rights.

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SECTION 8: ADULT SUPPORTS AND SERVICES

Supports and Services for Adults

Day Options:

In addition to the non-traditional supports and services mentioned earlier such as **Self-Direction** or **Individualized Supports and Services (ISS),** traditional supports and services are still available for those that require a highly supervised, more structured and clinically supported model. All traditional models of supports and services require a demonstration of need as well as **Developmental Disabilities Regional Office (DDRO)**approval.

AHRC, Nassau's Adult Day Habilitation Program:

If you meet the criteria described above and are ready to take an active role in the community, the day habilitation's community hubsite program may be the right choice for you.

Community volunteerism is the provision of volunteer services within surrounding communities. Volunteers are provided with ample, meaningful and productive jobs in the community and/or on site. All jobs, whether they occur in the community, or at the hub site are to provide opportunities for volunteers to be as independent as they can and participate, as much as possible in their own lives. Volunteers will learn vocational and socialization skills through this community volunteerism and skills-building program. Each day, at over 30 locations throughout Nassau County, volunteers with **intellectual and developmental disabilities (I/DD)** provide a variety of community volunteer opportunities to include assisting the elderly by shopping for groceries, delivering meals on wheels and helping their neighbors with various jobs. Clinical support is provided on site and a small staff ratio is provided. Additionally, when volunteers return to their sites they also work on other tasks such as mailings, assembling donation items and other tasks that contribute to a productive and meaningful day. Volunteers can also work on personal goal plans toward becoming more productive.

There are also numerous volunteer opportunities at various organizations in the community such as senior centers, houses of worship, museums, libraries, and hospitals. More than 1200 volunteers with I/DD are making a meaningful impact on the communities.

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EMPLOYMENT - How Can You Join the Workforce?

AHRC can offer opportunities to assist you in joining the workforce. If you need to develop certain skills before entering the workforce, AHRC Nassau is there to help you reach your goal of becoming employed.

Currently, people with I/DD are receiving Pre-Vocational Services and Work Readiness training. If you are joining our workforce for the first time, the focus has shifted to assist you in being well prepared for future employment. For those referred and determined eligible by the Vocational Rehabilitation professionals of the Office of **Adult Career & Continuing Education Services (ACCES-VR)**, a variety of options and services may be authorized as part of your **Individualized Service Plan (ISP),** ultimately preparing you for competitive community based employment. These services may include:

- Level I Assessment- Diagnostic Vocational Evaluation(DVE) / Community Based Situational Assessment
- Work Readiness Service - Soft Skills Training
- Benefits Advisement

If you are interested in future employment opportunities we expect to offer ***Pathways to Employment*** which will be an option to best prepare people for an employment based outcome. *Pathways* will be offered in conjunction with other **Office of People With Developmental Disabilities (OPWDD)** funded supports and services for those determined eligible. This option will be time limited and is expected to be delivered in small group settings within the local community. Through *Pathways*, you will be able to discover your strengths and capabilities by learning work concepts such as job focus, problem solving and task completion. At the conclusion of the *Pathways* process, successful candidates are expected to be referred for Supported Employment Services with a clear Vocational and/or Employment related goal.

Supported Employment(SEMP)

We are dedicated to helping you find competitively paid community-based employment opportunities. Our services include a thorough screening process that will help our Employment Training Specialists to find an employment opportunity that best suits your skills and interests, as well as one-on-one training to ensure you are capable of meeting and exceeding the expectations of any employer. Our Employment Training Specialists will work to insure that any and all reasonable accommodations are made to ensure your success in the job.

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Residential Options

In line with OPWDD's transformation agreement, residential opportunities are limited to those aging out of children's residential programs and those deemed "at risk" by the DDRO.

If you currently have a Medicaid Service Coordinator, they can assist you with pursuing residential options. If you do not have a Medicaid Service Coordinator, please contact our **Central Enrollment Department** at (516)644-4800 who can also assist you with this process.

All residential placements must be approved by the DDRO's Residential Placement Committee.

Traditional Living options:

Intermediate Care Facilities (ICFs):

- **Citizens' Helen Kaplan Intermediate Care Facility (ICF)** provides supports and services for people with I/DD who have multiple cognitive, medical and/or physical disabilities requiring 24-hour support and supervision. Currently the program includes three homes and supports a total of 48 men and women. In addition to the extensive clinical and medical supports, the program provides ongoing active treatment. Services include habilitative services, psychology, physical therapy, speech therapy, occupational therapy, nursing, nutrition and recreation. Increased independence, inclusion, individualization and productivity are the hallmarks of this program.
- **Citizens' Medically Frail Intermediate Care Facility (ICF)** provides enhanced medical support to those in need of 24- hour nursing services along with habilitative services, psychology, physical therapy, speech therapy, occupational therapy, nursing, nutrition and recreation services. The home supports a maximum of eight people. Residents with chronic medical conditions are able to remain in the community while receiving enhanced medical supports and reduce disruptive and restrictive hospital stays.

Regulatory oversight is provided to all ICF programs by New York State on an annual basis and by AHRC's Regulatory Affairs Department.

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Individualized Residential Alternatives (IRAs):
IRAs are homes or apartments throughout our local communities.

IRA's come in the following forms:

- **Supervised IRA's**
- **Supervised Apartments**
- **Supportive Apartments**

Supervised IRA's:

These homes typically provide 24-hour supports and services based on the needs of the men and women living there. Each person is supported with 24 hour oversight by trained direct support professionals. Additional clinical supports and services are also provided and may include nursing, nutrition, physical therapy, psychology, speech and sexuality services. Both Citizens and AHRC, Nassau provide residential opportunities for those aging out of children's residential programs and for those deemed at risk by the DDRO.

Supervised Apartments:

These apartments typically provide 24-hour supports and services available at the location of the apartment. Specific support is based on the needs of the men and women living there. Additional clinical supports and services are also provided and may include nursing, nutrition, physical therapy, psychology, speech and sexuality services. AHRC, Nassau provides supervised apartments for those deemed at risk by the DDRO.

Supportive Apartments/Homes:

These apartments/homes typically provide minimal supports and services based on the needs of the men and women living there. Direct support staff may stop by during the week to assist you as needed. Additional clinical supports and services are also provided and may include nursing, nutrition, physical therapy, psychology, speech and sexuality services. AHRC, Nassau provides residential opportunities for those deemed at risk by the DDRO.

To discuss residential options, please call our Central Enrollment Department at (516) 644-4800.

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Non-traditional Living Options:

Non-traditional Living Options are also available and include living at home with your family; family care; **Individual and community supports (ICS)** and buying your own home. If you are interested in any of these non-traditional living options, call our Central Enrollment Department at (516) 644-4800.

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Respite

Spending time away from a loved one with I/DD is not easy, but it is possible to do so safely and with peace of mind. Two community based homes provide residential respite for people with I/DD and their families. Respite can support a full range of medical and behavioral needs. The professional staff at each home are trained in positive behavioral supports and behavior management strategies and are certified in medication administration, CPR, G-tube feedings, and insulin administration.

Options for respite services include:

AHRC's Respite:

Overnight stays for adults who are waiver eligible for up to five people at any one time, 7 days per week, 24 hours a day in Levittown.

Citizens' Crisis Respite:

Crisis respite services are available for up to six people at any one time, 7 days per week, 24 hours a day at our Seaford location. Citizens' respite can accommodate people with challenging behaviors and/or medical needs and is handicapped accessible.

Citizens' Camp Loyaltown:

A unique respite opportunity is available in the summer months at Camp Loyaltown located in Hunter Mountain, New York.

Camp Loyaltown is a summer sleep-away camp that offers respite for family members while providing a rewarding opportunity for children and adults with I/DD. Campers experience independence in this safe, supportive and fun setting while developing new friendships and participating in engaging activities. There are several sessions to choose from and scholarships are available based on financial need.

A state-of-the-art health and wellness center is equipped to handle campers' medical needs and is staffed by RN's and LPN's.

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Living at Home – Supports and Services

COMMUNITY HABILITATION:

A person with I/DD who lives independently in the community or with family members and is Medicaid Waiver Enrolled can benefit from AHRC, Nassau's Community Habilitation Program. A Community Habilitation Professional can be assigned with you one-on-one or in a small group setting on a regularly scheduled program for the life skills of your choice. This life-skills training program takes place in your home or in your local community.

FAMILY REIMBUSEMENT:

Both AHRC, Nassau and Citizens offer a reimbursement program which provides goods and services to people or families with financial hardships related to the care of a family member with a disability. To qualify for this funding, you must live on your own or with family and the goods or services requested cannot be reimbursable by any other funding source. Applications and guidelines for this program are distributed at the beginning of each calendar year.

RECREATION PROGRAMS:

Citizens' Family Support Services recreation program has many unique opportunities for adults to participate in. There's a seasonal program of recreation, The STARZ Special Olympics Training Clubs and a Trip Program that consists of 5 day trips and one overnight stay in the Catskills.

Our seasonal program of weekly recreational activities run September through June like the school year. Every August, members send in a completed registration form, photo and payment to join. That program includes: Tuesday & Thursday evening recreation where guests can choose from basketball, making a craft or playing bingo; eight weekly bowling groups in seven different alleys; Friday night and Sunday afternoon D.J. Dances; three nights of Yoga Classes, two classes offered each night; a bimonthly Friday Social Group for peers to discuss common challenges and solutions; and a Saturday morning Walking Club at Cantiague Park in Hicksville.

The Starz Special Olympic Training Clubs practice and compete in local, regional and state competitions in various sports. Currently we offer opportunities in track and field, basketball, bocce, softball, bowling, equestrian sports, alpine skiing and aquatics. This program runs with the help of many dedicated Agency and Special Olympic volunteers. We celebrate everyone's accomplishments with a dinner at the end of the season.

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The Trip Program consists of a Party Cruise on the Miss Freeport V in September; a one night overnight stay at Villa Roma Resort in Callicoon, NY; and 4 summer trips designed to appeal to our guests and their families to popular New York attractions like the Bronx Zoo, Intrepid Sea, Air and Space Museum, Long Island Ducks baseball games, Riverhead Aquarium, and local theatres. We invite 30-40 guests on our day trips to encourage socialization.

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Diagnostic, Medical, Dental, and Clinical Supports and Services for Adults:

Diagnostic Testing at the Fay J. Linder Center

The first step in obtaining services for I/DD is obtaining a correct diagnosis. If you are searching for a provider who can accurately diagnose an intellectual or developmental disability, we can help.

The Fay J. Lindner Center for Autism & Developmental Disabilities provides comprehensive diagnostic and neuropsychological assessments, outpatient psychological services, psychiatric care, including medication management, school consultation and advocacy and resource information, across the tri-state area are also available.

Successful intervention requires the collaborative efforts of the person with I/DD and their circle of support. Lindner Center's team consists of highly trained and respected specialists in psychiatry, psychology, and speech/language pathology. The staff works closely with families to insure a comprehensive and interdisciplinary approach to consultation, assessment and treatment. The Lindner Center's peer mentors are an essential part of the program. They provide social support and model age-appropriate interpersonal skills, encouraging group participants to make connections with one another.

Children and adults with **Autism Spectrum Disorder (ASD)** and other developmental disabilities experience impairments across a range of areas including: cognitive, social, communication, adaptive, affective/emotional and behavioral. The Lindner Center's team creates an individualized, effective assessment plan that is unique for each person depending on the referral questions and presenting symptoms. The Lindner Center conducts psychological evaluations for children as young as 18 months and people through adulthood.

Psychological evaluations include testing in the following areas:

- Diagnostics
- Social-Emotional (to rule out a co-existing mental health diagnosis)
- Neuropsychological/Executive Functioning
- Psycho-educational
- Eligibility (for programs and entitlement services)

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Advantage Care Diagnostic & Treatment Center:

Advantage Care Diagnostic & Treatment Center is a level III patient-centered medical home that meets standards consistent with those of the National Committee for Quality Assurance's (NCQA) Physician Practice Connections® Patient-Centered Medical Home Program (PPC-PCMH™). This model of care strengthens the physician-patient relationship by promoting improved access, coordinated care, and enhanced patient/family involvement. Each patient has an ongoing relationship with a primary health care provider, who leads a team that takes collective responsibility for patient care. A medical home focuses on enhanced care through open scheduling, expanded hours, and communication among patients, providers and staff.

Advantage Care provides personalized desensitization programs and are utilized to reduce fear and anxiety patients experience prior to and during medical and dental appointments. They are intended to assist patients in feeling comfortable when seeing providers, so they may be cooperative with treatment and recommendations for improving their overall health and wellbeing.

Choose from our services:

PRIMARY MEDICAL CARE FOR ADULTS

- Comprehensive interview and evaluation of medical history
- Examination and treatment of acute and chronic medical conditions
- Review of laboratory testing
- Immunizations
- EKG
- Coordination of care with other physicians and/or service providers concerning medical status of patients.
- Hospitalist to admit and track an individual during a hospitalization.

WOMEN'S HEALTH

- Comprehensive medical history
- Routine exams addressing signs and symptoms of gynecologic origin
- Diagnostic testing – may include phlebotomy, cultures and pap smears, as indicated
- Instruction on self-breast exam and women's health issues

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DENTAL CARE FOR ADULTS

- Initial dental assessment
- Bi-annual examinations
- Dental hygiene services (cleanings, x-rays, fluoride treatment)
- Restorative dental services (fillings)
- Prosthodontic services (crowns)
- Endodontic services (root canal treatment)
- Periodontal services (treatment of gums)
- Ambulatory surgery services
- Cosmetic procedures

PODIATRY FOR ADULTS

- Initial podiatric assessment of patients
- Biomechanical foot orthotics
- Preventative diabetic foot care – LOPS testing
- Evaluation and management of ulcers or infections
- Treatment of fungal infection, nail removal
- Evaluation and treatment of foot and or ankle pain
- Treatment of neuroma, bunion, and hammertoe
- Removal of corns, calluses

PSYCHIATRY FOR ADULTS

- Comprehensive psychiatric assessment of patients to evaluate current behavior or mental health concerns
- Identification of psychiatric disorders
- Assessment of psychiatric disorders and pharmacologic medication management
- Continuous monitoring of the efficacy of medication, dosage and toxicity, adverse reactions
- Monitoring autonomic involuntary movement disorders (AIMS testing)
- Monitoring extra-pyramidal symptoms (EPS testing)
- Educating patients, families and caregivers about risks and benefits of medication

LAB SERVICES FOR ADOLESCENTS AND ADULTS

- Laboratory services are provided according to current standards of practice in health care and following Department of Health Infection Control guidelines.
- Through the use of a qualified commercial and/or hospital based clinical laboratory licensed in New York State.
- Provide all necessary laboratory services.

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The Future of Services

As we move towards the future, the fiscal reality is that traditional HCBS Waiver services such as Day Habilitation and Residential Habilitation are becoming more limited. OPWDD is fully supporting a shift towards Self-Direction which allows each individual to control their own portable budget with assistance from a **fiscal intermediary (FI)**. Self-Direction gives you the authority to create the support and services you receive and hire the staff that delivers these services. Therefore each CSS plan is as unique as the person who designs it. Self-Directed plans and budgets allow individuals to access the supports needed to:

- Live at home or in a home of their own
- Pursue interesting and meaningful employment, volunteer, or other community activities
- Engage in satisfying, productive relationships with family, friends, and community members
- Maintain a healthy lifestyle

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SECTION 9:

COMMONLY ASKED QUESTIONS AND ANSWERS

Frequently Asked Questions

Below, is a list of frequently asked questions. Some of these questions may be the same ones you have.

1. **Q: What will people using the front door experience that is different from the old way of doing things?**

   A: The wants and needs of the individual will come first when mapping out a service plan. People with developmental disabilities will be guided in the exploration of options from the array of services offered in the OPWDD service delivery system. The service plan will be tailored to the individual with supports that offer full integration in the community.

2. **Q: What is the Front Door?**

   A: OPWDD's Front Door is designed to improve the way people learn about and access available service options while giving individuals as many opportunities as possible to direct their own service plans. There is a Front Door Team at each OPWDD Regional Office. The Front Door supports a person-centered approach for people with developmental disabilities that prioritizes individual choices, needs and desires in making decisions and provides a statewide approach to how we offer services to people in order to promote the awareness of choice of service options for individuals and families with a particular emphasis on self-direction, employment and community inclusion.

3. **Q: What is the intent of the Front Door?**

   A: The Front Door strives to create a standardized, statewide process for people to learn about OPWDD and available service options, better connect individuals to services and supports based on their assessed needs and give individuals and families as many opportunities as possible for self-direction. The Front Door is also built on the philosophy of self-determination and the idea that people with developmental disabilities have the right to enjoy more meaningful relationships with family, friends and others in their lives, experience personal growth, fully participate in their communities and live in the home of their choice.

4. **Q: What are the key components of the Front Door?**

   A: Key components include initial contact for those who are new or seeking to modify existing services, determining eligibility for services, assessment of strengths, identifying needs and needed supports and plan authorization and implementation.

5. **Q: How can individuals and families contact the Front Door Team?**

   A: Front Door contact information can be found on OPWDD's website at http://www.opwdd.ny.gov/welcome-front=door/Front Door contact Numbers

6. **Q: If I select a support or service and do not like it, can I change it?**

   A: Yes. This is your life. You can change supports and services at any time.

7. **Q: What is the difference between supports and services for children and those for adults?**

   A: Supports and services for children mainly focus on education and socialization. Supports and services for adults mainly focus on life skill enhancement and career opportunities. There are however, similarities as both children and adult supports and services provide for any needed clinical and medical interventions and/or training.

8. **Q. If my family member requires traditional supports and services, can he/she still get them?**

   A: Yes. Although there is currently a transition in the types of supports and services available, traditional supports and services such as day and residential opportunities will still be available for those in need of them.

9. **Q: Who can I speak to if I have questions about my Medicaid?**

   A: You can contact our Central Enrollment Department with any questions related to Medicaid and other benefits at (516)644-4800.

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10. Q: It took me over three months to get the supports and services I needed due to a delay with getting through the Front Door. Is there anything being done about this?

A: The DDRO has made a commitment to people receiving supports and services and their families to increase the manpower needed to handle calls regarding the Front Door in a timely manner. Their goal is to get people through within a few weeks.

11. Q: Where can I find a list of agencies that provide Medicaid Service Coordination?

A: You can contact our Central Enrollment Department at (516)644-4800 and obtain a list of agencies that provide Medicaid Service Coordination.

12. Q: Who is eligible for Medicaid?

A: Individuals with disabilities age 18 years or older are eligible for Medicaid if their income and resources (bank accounts, life insurance, etc.) are listed below a certain amount. Programs like the Medicaid Buy-In Program for working People with disabilities can help working adults keep more of their income and still get Medicaid.

Children with developmental disabilities under the age of 18 who live at home with their families may be eligible for the Medicaid HCBS Waiver based on their own income and resources. Their family income and resources are not looked at when applying for the Medicaid HCBS Waiver.

If an individual has too much income or resources, he or she can spend that money on medical expenses to qualify for Medicaid. This is called a spend down. In most cases, any money spent out of pocket on medical needs can be used to meet a spend down. There are also other ways to keep an individual's resources, such as setting up a Medicaid qualifying trust. This is a specific type of trust that must be set up by a lawyer.

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13. Q: What is self-direction/self-directed services?

A: Self-direction provides people the opportunity to make decisions about what supports and services they need to help themselves. Self-direction means that an individual accepts responsibility for helping to manage (co-manage) their supports and services. Self-direction of services includes the individual or their family/advocate exercising either employer authority, budget authority or both. This includes decisions about having meaningful relationships with friends, family and others in your life, experiencing personal growth while maintaining your health and safety, living in the home or community of your choice, working, volunteering and joining in leisure and community activities in your neighborhood and selecting how, when and by whom you are supported.

14. Q: Is self-direction of community habilitation the same if the person participates in consolidated supports and services (CSS)?

A: Self-direction of community habilitation is different from consolidated supports and services (CSS). In self-directed community habilitation, the individual does not manage a personal individualized budget. In CSS, the individual has a budget that they are responsible for managing.

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SECTION 10:

GLOSSARY

OF

TERMS

Glossary of Terms

ACCES-VR: Adult Career and Continuing Education Services – Vocation

ACCES-VR offers access to a full range of services that may be needed by person with disabilities. ACCES-VR coordinates policy and services relating to special education, transition services, and vocational rehabilitation.

AMAP: Approved Medical Administration Personnel

ASD: Autism Spectrum Disorders

BROKER: The title of the person that assists you with starting Self-Direction and who helps you create a budget with the assistance of a fiscal intermediary.

CENTRAL ENROLLMENT DEPARTMENT:

The department responsible for providing information on all available supports and services, scheduling tours to visit programs of interest/or meeting with knowledgeable staff based on your interests or choices, scheduling meetings with our Entitlement Department to determine eligibility, providing and assisting you with completing any needed paperwork, maintaining ongoing communication with you until your supports and services have begun, being your person of contact for any changes to existing supports and services, maintaining records of progress on obtaining and receiving supports and services and ensuring your satisfaction.

COS: Circle of Support (now known as Planning Team). A circle of support is a group of people consisting of family, friends, community members and support staff who have come together to assist a person to visualize, express and accomplish his/her life interests and goals resulting in a more self- directed life. A circle of support is the key decision making group and members of the circle of support are freely chosen by the individual to help him/her achieve his/her valued outcomes/goals.

CQL: The Council on Quality and Leadership

CRP: Children's Residential Program

CSE: The Committee on Special Education

CALL OUR CENTRAL ENROLLMENT DEPARTMENT TO GET STARTED (516) 644-4800

(Add holding hands icon)

CSS: Consolidated Supports and Services (now known as Self-Direction or Self-Directed Services) is a Home and Community Based Services (HCBS) waiver service option that has been approved by the federal Centers for Medicaid/Medicare Services (CMS). In New York State, it is one of the major components for implementation of self-determination. All people who are eligible to receive OPWDD services are eligible for self-determination. Federal Medicaid pays for the cost of Self-Directed services for persons who are Medicaid/HCBS waiver eligible.

DDRO: The Developmental Disabilities Regional Office. OPWDD operates through 5 regional offices that are responsible for: heightening the agency's focus on service delivery and quality improvement; providing for enhanced oversight of the existing network of nonprofit providers; and helping to ensure accountability statewide.

DSP: Direct support Professional. The staff that assists and supports your family member as needed.

DVE: Diagnostic Vocational Evaluation

ENROLLMENT COORDINATOR:

The person in the Central Enrollment Department responsible for assisting people and/or their families with starting, transitioning and/or changing existing supports and services.

ENTITLEMENT DEPARTMENT:

The department responsible for assisting you and/or your family member with determining eligibility and applying for federal entitlements you may be eligible to receive (i.e., Medicaid, Medicare, SSDI, SSI and/or feed stamps).

ETP: Employment Training Program. The employment training program offers people an opportunity to work in an internship that will lead to permanent employment in a community business. During the internship, wages will be paid through ETP while the person learns the skills needed for the job. EPT participants also attend job readiness classes that present topics such as conflict resolution and how to dress for work. EPT services include increased job development and job coaching as well as assistance with other employability skills.

FI: Fiscal Intermediary. A fiscal intermediary sets up an individual financial account for each person based on the approved Self-Directed plan and budget.

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(Add holding hands icon)

FRONT DOOR: The mechanism established by OPWDD to assess and provide service provision.

HCBS Waiver: Home and Community Based Services waiver. To be eligible for waiver services, a person must otherwise need Intermediate Care Facilities' (ICF) level services. The waiver allows OPWDD to purchase services in a much more flexible manner than would otherwise be possible under the state plan. It also allows NYS to purchase Medicaid services for children under the age of 18 without "deeming" or taking into account their parent's income. Currently, services available include Residential Habilitation, In-Home Residential Habilitation, Day Habilitation, Supported Employment, Prevocational Services, Respite, environmental Modifications (E-Mods), Adaptive Devices, Self-Directed Services, Live-In Caregiver, fiscal intermediary, Plan of Care Supports and Services, and Family Education and training.

I/DD: Intellectual/Developmental Disabilities

ICF: Intermediate Care Facilities. ICF's are designed for those individuals whose disabilities limit them from living independently. Services may be provided in an institutional or community setting. For the most part, ICF's support people who are unable to care for their own basic needs, require heightened supervision and the structure, support and resources that define this program type. ICF's provide 24-hour staffing supports for people with specific adaptive, medical and/or behavioral needs and includes intensive clinical and direct support services, professionally developed and supervised activities and a variety of therapies as required by the person's needs.

ICS: Individual and Community Supports. This is a platform designed to provide more flexibility and authority for individuals and families in choosing the supports and services that best meet their needs.

IDT: Interdisciplinary team

IEP: Individualized Education Plan. An IEP is the tool to document how one student's special needs relates to his/her disability will be met within the context of the educational environment.

ISP: Individualized Service Plan. An ISP is a written personal plan, or blueprint, for a person with developmental disabilities that summarizes the help he or she wants and needs to achieve his or her own aspirations in life. The document is required of the HCBS Waiver and must be created, reviewed and updated at least twice annually by the Medicaid Service Coordinator (MSC).

ISS: Individualized Supports and Services

MEDICAID: Medicaid is a joint federal-state health insurance program providing medical assistance primarily to low-income Americans. It is also available to people under 65 years of age if they are blind or disabled.

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MEDICARE: Medicare is a federal health insurance program providing health care benefits to Americans age 65 and over, as well as some disabled people under age 65. Eligibility for Medicare is linked to Social Security and railroad retirement benefits.

MSC: Medicaid Service Coordination and Medicaid Service Coordinator. Medicaid Service Coordination is a Medicaid State Plan service provided by OPWDD, which assists persons with developmental disabilities in gaining access to necessary services and supports appropriate to the needs of the person. MSC is provided by qualified Medicaid service coordinators (MSC's) and uses a person centered planning process in developing, implementing and maintaining an individualized service plan (ISP) with and for a person with developmental disabilities. MSC promotes the concepts of choice, individualized services and supports and person satisfaction.

NATURAL SUPPORTS:

Natural supports are friends, family members, co-workers, community members and other non-paid and naturally occurring relationships that support and assist an individual in an integrated and community based setting.

NOD: Notice of Decision. After an application is made for a benefit or service, the applicant will receive, in response, a notice indicating whether the request is denied or approved/authorized.

OCFS: Office of Children and Family Services

OPWDD: The Office for People with Developmental Disabilities

PATHWAYS TO EMPLOYMENT:

It is an option to best prepare people for an employment based outcome. Through Pathways, you will be able to discover your strengths and capabilities by learning work concepts such as job focus, problem solving and task completion. At the conclusion of Pathways, successful candidates are expected to be referred for Supportive employment services with a clear vocational and/or employment related goal.

PECS: Picture Exchange Communication System

PERSON-CENTERED PLANNING:

A person centered planning approach centers around the capabilities and strengths of a person in order to create a vision for a desirable future. It focuses on each person's gifts, talents, and skills, not on deficits and deficiencies. It is an ongoing process of social change wherein the service coordinator works with the person with disabilities and people who pledge their support to that person to identify the individual's vision on their best life and to pursue that vision in their community. All OPWDD supported MSCs are expected to employ person centered planning practices for people receiving MSC.

CALL OUR CENTRAL ENROLLMENT DEPARTMENT TO GET STARTED (516) 644-4800

PHASE 1: Presently the Front Door is focused on people who are new to OPWDD. In Phase 1, you must go through the Front Door if eligibility has not been established, eligibility has been established but the person is not receiving services, an eligible person is not receiving MSC and is now requesting MSC, an eligible person is not receiving any HCBS Waiver services and is now requesting one or more services, there has been a significant break (1 year or more) in services, young adults who are transitioning from public or residential schools into the OPWDD adult service system or any person who is transitioning into the community from Developmental Centers or Intermediate Care Facilities.

PHASE 2: Terminology used regarding the front door process. Phase 2 applies to you if you are anyone currently receiving adult supports and services. A target date for Phase 2 has not yet been identified which will require anyone who wants a "change" in their services to also go through the Front Door. OPWDD is working to ensure that statewide practices are in place and DDRO resources are available to effectively and efficiently meet the anticipated demands on the Front Door in Phase 2.

PLANNING TEAM:

A Planning Team (formerly known as Circle of Support) is a group of people consisting of family, friends, community members and support staff who have come together to assist a person to visualize, express and accomplish his/her life interests and goals resulting in a more self-directed life. The Planning Team is the key decision making group and members of the team are freely chosen by the individual to help him/her achieve his/her valued outcomes/goals.

POM: Personal Outcome Measures

PROFESSIONAL SUPPORTS:

Support provided by paid staff.

RESPITE: Is the provision of short-term, temporary relief to those who are caring for family members who might otherwise require permanent placement in a facility outside the home. Respite programs provide planned short-term and time limited breaks for families and other unpaid care givers of people with intellectual and/or developmental disabilities in order to support and maintain the primary care giving relationship.

SELF-DETERMINATION:

The philosophy that people supported have a free choice of services, supports and method of service delivery, that they may design their own service plan and manage their own self-directed budget. With the assistance of your planning team, you will create an annual budget to develop and manage your life plan. There are five primary principles of the self-determination philosophy, which are freedom, authority or control, support, responsibility and self-advocacy.

SELF-DIRECTION:

Provides you with the opportunity to make decisions about what supports and services you need to ensure your quality of life. Self-direction means that you accept responsibility for managing or co-managing your supports and services. Self-direction of services includes you or your family advocate exercising your right to hire the staff of your choosing as well as manage your personal budget to meet your wants and needs. This includes decisions about having meaningful relationships with friends, family and others in your life, experiencing personal growth while maintaining your health and safety, living in the home or community of your choice, working, volunteering and joining in leisure and community activities in your neighborhood and selecting how, when and by whom you are supported.

SEMP: Supportive Employment. SEMP provides the supports people need to obtain and maintain paid, competitive jobs in the community. Individuals with developmental disabilities will typically transition to SEMP after they have received supportive employment services funded by the NYS Adult Career and Continuing Education Services – Vocational Rehabilitation (ACCES-VR) and require limited job coaching to successfully maintain their employment. People also come to supportive employment from programs that offer intensive training such as ESEMP and ETP.

SNAP (Food Stamps):

Administered by the US Department of Agriculture (USDA), the New York State Supplemental Nutrition Assistance Program (SNAP), the new name for the food stamp program, issues monthly electronic benefits that can be used like cash at authorized retail food stores. Eligibility and benefit levels are based on household size, income, assets and other factors.

SSDI: Social Security Disability Insurance

SSI: Supplemental Security Income

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TRANSFORMATION AGREEMENT:

New York State and the Federal Centers for Medicare and Medicaid (CMS) have identified a series of shared goals that will improve opportunities for individuals with developmental disabilities in the areas of employment, integrated living and self-direction of services. These goals are captured in a transformation agreement. In it, OPWDD has committed to offering opportunities for individuals moving from OPWDD campus based institutions to live in smaller, more personalized settings, establishing a strategy for increasing supportive housing options and a timeline for offering people of intermediate care facilities opportunities for services that are fully integrated into the community, increasing the number of individuals in competitive employment by 700 in one year and educating more than 6,000 stakeholders in order to increase the number of individuals who are self-directing their services in part or whole from 850 to over 2,000 in this fiscal year.

CALL OUR CENTRAL ENROLLMENT DEPARTMENT TO GET STARTED (516) 644-4800

(Add holding hands icon)

APPENDIX

ITEMS INCLUDED IN THE APPENDIX

- Medical Evaluation
- Psychological Assessment/Evaluation
- Psychosocial Evaluation
- Application for Participation in the OPWDD Home and Community Based Services Waiver
- Notice of Decision regarding Home and Community Based Services Enrollment Application
- Instructions for Completing the Transmittal Form for Determination of Developmental Disability.
- Transmittal Form for Determination of Developmental Disability
- Application for Participation in Medicaid Service Coordination
- Medicaid Service Coordination Agreement Statement of rights and Responsibilities

MEDICAL EVALUATION

Patient:_____ DOB:_____ ☐ Male ☐ Female ☐Initial ☐Annual

Address:	Evaluation Date:
	Home Phone #:
Escorted By:	Patient's Language:

PAST MEDICAL HISTORY

Medical:

Surgical:

Psychiatric:

Allergies:

FAMILY MEDICAL / SOCIAL HISTORY

Tobacco: ☐NO ☐YES If "YES" Packs Per Day:_____ Tobacco Exposure: ☐NO ☐YES

Alcohol: ☐NO ☐YES If "YES" Amount:_____

Drugs: ☐NO ☐YES If "YES" Type/Amount:_____

CURRENT DIET AND CONSISTENCY

Present diet (including calories, consistency and restrictions, if applicable):

MEDICATION

Name	Dosage/Frequency	Reason

IMMUNIZATIONS

MEDICAL EVALUATION

Patient:_____ DOB:_____ ☐ Male ☐ Female ☐Initial ☐Annual

Tetanus: Date of last vaccine:	Other:

REVIEW OF SYSTEMS

General Condition:	Eyes:
ENT:	Cardiovascular:
Respiratory:	GI:
Genitourinary:	Skin:
Musculoskeletal:	Neurological:
Psychiatric:	Hematologic/Lymph
Comments:	

CURRENT LIMITATIONS/RESTRICTIONS/PRECAUTIONS

Are there currently any limitations and/or restrictions in activity? ☐NO ☐YES
If "YES", describe any limitations on activity including adaptive equipment:

PHYSICAL EXAM

Height:_____ Weight:_____ BP:_____ Pulse:_____ Resp:_____

Temp:_____ BMI:_____ Waist Circumference:_____

Skin:	Breast Exam:
Head & Neck:	Heart:
Eyes/Vision:	Abdomen:
Corrective Lenses:	Recto/Procto:
Ears/Hearing:	Back/Spine:
Nose:	Extremities:
Mouth:	Lymphatic System:
Throat:	Genitalia/GYN:
Dentition:	Urinary:
Chest/Lungs:	Neurological:
Other:	
Ambulation Status:	
Comments:	

List any changes in treatment plan:
☐Diet change requested, specify:

☐Changes in limitations and restrictions, specify:

MEDICAL EVALUATION

Patient:_____ DOB:_____ ☐ Male ☐ Female ☐Initial ☐Annual

RECOMMENDED SCREENINGS *(attach script and/or check appropriate box(es)*				
Diagnostic Study	**Age/Sex**	**Frequency**	**Script Given**	**Performed Today**
Cervical Spine X-ray	Down Syndrome/Baseline Age 21	As Indicated		
Colonoscopy	Age 50/Men & Women	As per GI		
EKG	Baseline – Age 40/Men & Women	Annually		
Mammography	Baseline – Age 40/Women	Annually or As Indicated by Physician		
GYN (PAP/Breast Exam)	Women	As per GYN		
Routine Labs, CMP, CBC w/Diff, UA, Lipid Profile	All	Annually		
Medication Blood Levels	Men & Women	As Indicated		

Diagnosis & Problems	**Plan**

	Return to Clinic (*date*):
Physician's Signature:	Date:
Physician's Name: (*print or stamp*)	Physician's Phone #:

NASSAU COUNTY AHRC
PSYCHOLOGICAL ASSESSMENT
Privileged and Confidential

Name: Date of Evaluation:

Date of Birth: Age:

Reason for Referral:

Background Information:

Prior Evaluations:

Tests Administered:

Wechsler Adult Intelligence Scale-4th Edition (WAIS IV):
Verbal Comprehension Index:
Perceptual Reasoning Index:
Working Memory Index:
Processing Speed Index:
Full Scale IQ:

Vineland II Adaptive Behavior Scales- Survey Interview Form:

Adaptive Behavior Composite:
Adaptive Level:

		Age Equivalent:
Communication Domain:	Receptive	years, months
Standard Score:	Expressive	years, months
Percentile:	Written	years, month
Adaptive Level:		
Daily Living Skills Domain:	Personal	years, months
Standard Score:	Domestic	years, months
Percentile:	Community	years, months
Adaptive Level:		

Socialization:		Interpersonal	years, months
Standard Score:		Play and Leisure	years, months
Percentile:		Coping Skills	years, months
Adaptive Level:			

Maladaptive Behavior Index:
Internalizing:
Externalizing:

Behavioral Observations:

Analysis of Test Data:

The Wechsler Adult Intelligence Scale-Fourth Edition (WAIS IV) is an individually administered clinical instrument for assessing the cognitive ability of individuals aged 16 years, 0 months through 90 years, 11 months. The WAIS IV consists of four index scales which are used to derive the Full Scale IQ score.

The Vineland II Adaptive Behavior Scales measures the personal and social skills of individuals from birth to adulthood. It assesses adaptive behavior in four domains: Communication, Daily Living Skills, Socialization and Motor Skills, as well as providing a composite score that summarizes the individual's performance across all four domains.

DSM-5 Diagnosis:

Recommendations:

Joanne Downes, M.A. LMHC
N.Y.S. Licensed School Psychologist
N.Y.S. Licensed Mental Health Counselor

NASSAU COUNTY AHRC CLINIC
PSYCHOSOCIAL ASSESSMENT

Individual:	**Date:**
Date of Birth:	
Referred by:	
Individuals seen during Interview:	
Nature of Disability:	
Additional Disabilities:	
Clinician:	

I. PRESENTING PROBLEM\REASON for REFERRAL:

II. DESCRIPTION /APPEARANCE:

III. FAMILY COMPOSITION\HISTORY:

Name	Relationship	Date of Birth	Occupation

IV. DEVELOPMENTAL HISTORY:

V. EDUCATIONAL HISTORY:

VI DAILY LIVING SKILLS:

VII. RESIDENTIAL HISTORY\CURRENT LIVING SITUATION:

VIII. WORK HISTORY:

IX. MEDICAL HISTORY:

X. PSYCHIATRIC HISTORY:

X. SUMMARY:

XII. AGENCY INVOLVEMENT:

Indicate all agency programs, AHRC or others in which the individual was and or is currently involved (check):

- ☐ Community Residence
- ☐ Apartment Program
- ☐ Day Habilitation
- ☐ Day Treatment
- ☐ Medicaid Waiver
- ☐ Recreation
- ☐ Workshop
- ☐ Other-specify:_____

_____ _____

SOCIAL WORKER DATE

_____ _____

SOCIAL WORKER DATE

HCBS Form 02.01.97 (3/97, 7/12)

APPLICATION FOR PARTICIPATION IN THE OPWDD HOME AND COMMUNITY BASED SERVICES WAIVER

Name of Applicant: _____

Current Address: _____

_____

Social Security #: _____ Date of Birth: _____

Medicaid #: _____ County: _____

☐ Check here if not currently enrolled in Medicaid.

I am requesting participation in the Home and Community Based Services Waiver administered by the New York State Office for People With Developmental Disabilities. I understand that approval will be based on my choice of Home and Community based services in preference to care in an Intermediate Care Facility and on evidence of:

- developmental disability;
- eligibility for admission to an Intermediate Care Facility;
- eligibility for Medicaid enrollment;
- availability of appropriate community based services; and
- appropriate living arrangement

Date of stated intent to apply for HCBS waiver services: _____

Applicant Signature: _____

Applicant Name (Print): _____

Assisted by (Signature): _____

Assisted by (Print): _____

Address: _____

_____

Telephone Number: _____ Date: _____

HCBS Form 02 21 Rev 11/94

NOTICE OF DECISION
HOME AND COMMUNITY BASED SERVICES ENROLLMENT APPLICATION

Date: _____

Dear _____
(Applicant's Name)

This is to inform you that the following action has been taken on your application to participate in the OPWDD Home and Community Based Services (HCBS) waiver. Please read this notice carefully.

☒ AUTHORIZED

Your participation in the OPWDD Home and Community Based Services (HCBS) waiver has been authorized, beginning on _____
(Enrollment Date)

☐ DENIED

Your participation in the OPWDD Home and Community Based Services (HCBS) waiver has been denied for the following reason(s):

_____

_____

_____

IF YOU DO NOT AGREE WITH THE ABOVE DECISION, YOU HAVE THE RIGHT TO AN ADMINISTRATIVE REVIEW. PLEASE CONTACT THE DDSO FOR MORE INFORMATION.

Sincerely,

_____
Director

LONG ISLAND DDSO

45 MALL DRIVE

COMMACK, NY 11725
Name/Address of DDSO

cc: Advocate
Case Manager
DDSO Waiver TABS Data Entry
FOR VOLUNTARY AGENCIES ONLY-Bureau of Community Funding, 30 Russell Road, Albany, NY 12206
Social Services District Office (district with fiscal responsibility)
DSS Office in County of Residence (if different from county of fiscal responsibility)

PLEASE BE SURE TO READ THE BACK OF THIS NOTICE

HCBS Form 02.21.Rev. 11/94

Applicant Name (Last,First, M.I.): _____

Current Address: _____

_____

_____

Type of Current Residence (check one):

[ ] ICF [ ] DC [ ] CR [ ] Own Home

[ ] Family Care [ ] Other _____

SS# _____

TABS# _____

CIN# _____

CASE# _____

EXPECTED District of MA Fiscal Responsibility (check one)

[ ] County _____

[ ] State - District 98

Chapter 621 Eligible: [ ]Yes [ ] No

Type of ISE Residence (check one)

[ ] IRA

[ ] Family Care

[ ] Own Home

[ ] Community Residence

ISE Address (if known)

_____

_____

_____

_____

MA RESTRICTION/EXCEPTION CODES

DDSO staff check appropriate boxes.

Local DSS staff date enter appropriate exception code(s) in WMA.

EFFECTIVE DATE OF CODES = DATE OF ENROLLMENT IN WAIVER

HCBS WAIVER CODES

[ ] 46 HCBS Waiver participants living in IRAs, FC or AT Home.

[ ] 47 HCBS Waiver participants living in CRs and eligible for Sub Chapter A Day Treatment funding *

[ ] 48 HCBS Waiver participants living in CRs.

* Individuals in day treatment are eligible for Sub Chapter A funding if they are not Chapter 621 eligible, and if they are not in Family Care.

Instructions for Completing Transmittal form

Please type or clearly print all information

General Instructions:

Complete this form and send it to your local DDRO with copies of records. Copies of records that prove disability prior to the age of 22 must be attached to the transmittal. These will be used for the OPWDD eligibility review. If you have questions about the kinds of records needed for the eligibility review, see ***ELIGIBILITY FOR OPWDD SERVICES*** **Important Facts.** The Facts sheet can be found on the OPWDD website [http://www.opwdd.ny.gov] or requested from your local DDRO.

Detailed Instructions:

This Transmittal form can be completed by: the person who wants to know if they are eligible for OPWDD services, their parent or advocate, or an agency staff person who is helping the person.

Section 1 **Person's Information**

Name: The person's legal name: Last name, first name, and middle initial.

TABS ID: The person's TABS identification number. If not registered, leave blank.

SS#: The person's 9 digit Social Security Number.

Date of Birth: The person's date of birth, in month, day, year (MM/DD/YYYY) format. (e.g. 04/03/1998)

Medicaid #: The person's Medicaid number.

County of Residence: The individual's county of residence, (for example, Kings, Essex.)

Sex: Put an **X** in the **M** box for a boy/man or in the **F** box for girl/woman.

Home Address: The person's current home address.
Include street/avenue, apartment number, city/town, state and zip code.

Mailing Address: The address where the person receives mail, if different from the home address.
Include the PO box/street/avenue, apartment number, city/town, state, and zip code.

Phone: The person's phone number including area code.

Also Known as: List all names (other than legal name) the person is known by.
Include nicknames, maiden name, etc.

Send Information to: Put an X next to the box indicating where the information about the eligibility decision should be sent. **If a parent or advocate (other than the Agency in Section 3) is to be sent information from the DDRO, check box 3 and/or 4 and fill in the Parent/Advocate parts of Section 2.** Any agency in Section 3 will automatically receive information concerning the eligibility determination.

Section 2 **Involved Parents or Advocates** – This section is optional unless box 3 or 4 of Send Information To is checked. If **only one** Parent/Advocate is needed, use **P/A1** Name and Address.

Name: The parent or advocate's name: Last name, first name, and middle initial.

Home Address: The current home address of the parent or advocate.
Include street/avenue, apartment number, city/town, state and zip code.

Mailing Address: The address where the parent or advocate *receives mail*, **if different** from the home address.
Include the PO box or street/avenue address, apt. #, city/town, state, and zip code.

Phone: The parent or advocate's phone number, including area code.

Section 3 **Referring Agency Information (if applicable)**

Agency Name: The agency's complete name.

Agency Code: The agency's OPWDD agency code, if known.

Agency Contact: Name of the agency staff person to be contacted about the eligibility determination.

Street Address: Fill in the address where the agency contact receives mail. Include the PO box or street, address, city/town, and zip code.

Phone: The agency contact's phone number including area code and any extension.

Section 4 Place an X in box 1 for a determination of developmental disability only. Or, place an X in the box next to each service the person is interested in receiving **IF** he/she is determined to be eligible for OPWDD services.
NOTE: The Transmittal is **not** an application for services.

Completed by: Legibly PRINT the name of the person who completed the form and the date when the form is completed.

Form Completed by: Put an X in the correct box to indicate who completed the form (the person/SELF, Parent or Advocate, Agency staff, or PASRR Coordinator).

Submit the completed form and required records to your local DDRO.

NYS Office For People With Developmental Disabilities *Form # ELI (9/2012)*

Transmittal Form for Determination of Developmental Disability

Proof of a person's qualifying developmental disability is required in order to determine eligibility for OPWDD services. Complete this form and send it to your local Developmental Disabilities Regional Office. (See Instructions on page 2)

ATTACH: Copies of Records that are evidence of a disability prior to age 22

Contact your local DDRO if you have questions or need help to fill out this form.

Please Type or Print a Readable Copy. An * indicates required information.

***Section 1. Person's Information**

*Name:			TABS ID (if known):	*SS#:	
*Date of Birth:	Medicaid #:		* County of Residence:	*Sex: ☐ M ☐ F	
*Home Address:			Mailing Address (if different):		
*City:	*State:	*Zip:	City:	State:	Zip:
*Phone:			*Also Known As:		

*Send information to (Check as many as desired):

1. ☐ Self -Home
2. ☐ Self - Mailing Address
3. ☐ Parent/Advocate 1 (Complete Section 2 P/A1 Name & Address)
4. ☐ Parent/Advocate 2 (Complete Section 2 P/A2 Name & Address)
5. ☐ PASRR Coordinator

Note: Do not check 3 or 4 if the Advocate is the Agency listed in Section 3.

Section 2: Involved Parents or Advocates – Use address where mail is received. Optional unless 3 or 4 is checked above.

P/A1 Name:			P/A2 Name:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Phone:	Country:		Phone:	Country:	

Section 3: Referring Agency Information (if applicable) – Automatically receives information if completed.

Agency Name:			
Agency Code (if known):	Street Address:		
Agency Contact:			
Phone:	City:	State:	Zip:

***Section 4: Check the services you are interested in receiving if determined eligible**

☐ 1. Developmental Disability Determination only – No services requested at this time.

☐ 2. Individualized Support Services (ISS) ☐ 3. Respite Center ☐ 4. Residential Habilitation – IRA

☐ 5. Community Habilitation ☐ 6. Intermediate Care Facility (ICF) ☐ 7. Day Habilitation

☐ 8. Day Treatment ☐ 9. Pre-Vocational services ☐ 10. Supported Work (SEMP) ☐ 11. Care at Home

☐ 12. FET – Family Education & Training ☐ 13. CSS – Consolidated Supports & Services

☐ 14. Case Management, e.g. MSC ☐ 15. Environmental Modifications/Adaptive Devices

☐ 16. Art. 16 Clinic Family Support Services: ☐ 17. Respite ☐ 18. Other Family Supports

☐ 19. PASRR Level II Assessment ☐ 20. Other (specify):

***Completed By (Name):** _____ ***Date:** _____

Print Legibly

***Form Completed by:** 1. ☐ Self 2. ☐ Parent/Advocate 3. ☐ Agency 4. ☐ PASRR Coordinator

Following to be completed by DDRO Staff Only:

Date Received by DDRO:	**Intake Staff Name:**	
Person's TABS ID #:	**Date entered in TABS:**	**By (initials):**

STATE OF NEW YORK
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

MSC1-APPL

Individual Application for Participation in Medicaid Service Coordination

Section I. Individual Information

Name: Last First MI	TABS ID# (if known)	Social Security Number:
Address: Street	Date of Birth:	Medicaid Number:
City: State: ZIP Code:	Phone:	DDSO: Long Island

Section II. MSC Vendor/DDSO Information

Vendor/DDSO Name:

Vendor address:

City:	State:	ZIP Code:

TABS Program Code:

Section III. Individual Signature

I am requesting participation in MSC effective (date)

I have chosen the MSC Vendor/DDSO identified above to provide the MSC services I want and need.

Individual's Signature	Phone:	Date:

Family Member or Advocate's Signature (if appropriate)

Phone:	Date:

Family Member of Advocate's Address (if different from individual):

Section IV. Vendor Signatures

The individual identified above has indicated a need for an MSC service coordinator. To the best of my knowledge, this individual meets all of the eligibility criteria necessary for participation in MSC.

MSC Vendor/DDSO Contact's Name (print)

MSC Vendor/DDSO Contact's Signature

Phone Number:	Date:

Section V. To be completed by the DDSO MSC Coordinator

Date Application Received:

- ☐ Request for MSC **APPROVED** for TABS processing
- ☐ Request for MSC **WITHDRAWN** by individual
- ☐ Request for MSC **DENIED**

Reason for Denial:

- ☐ Individual is not enrolled in Medicaid.
- ☐ Individual does not have a diagnosis of a developmental disability.
- ☐ Individual is permanently enrolled in another comprehensive Medicaid long term care service coordination program.
- ☐ Individual currently resides in an ICF/MR, ICF/DD or in another Medicaid facility that provides service coordination.
- ☐ Individual did not respond to request for information.
- ☐ Individual does not meet the need for ongoing and comprehensive service coordination.

Signature of DDSO MSC Coordinator:	Date:
Data Entry Person's Initials:	Date:

STATE OF NEW YORK
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

MSC1 -APPL

Instructions for Completion of the
Individual Application for Participation in Medicaid Service Coordination (MSC1-APPL)

Please clearly print (or type) all information

Section I *Individual Information*: This section should be completed by the MSC vendor, or DDSO for state delivered MSC, selected by the individual.

Section II *MSC Vendor/DDSO Information*: This section should be completed by MSC vendor, or DDSO for state delivered MSC, selected by the Individual.

Section III The individual and MSC vendor, or DDSO for state delivered MSC, must agree upon an effective date. The effective date should be the date on which the individual needs MSC to begin, if all eligibility factors are met.

This section must be signed by the individual, or individual's family or advocate, if appropriate. The signatures verify that the individual has chosen the agency identified above to provide him or her with MSC.

The family member or advocate's address must be included if different from the individual's address.

Section IV This section is signed by a staff person representing the MSC vendor, or the DDSO for state delivered MSC. The signature verifies that the individual has indicated a need for MSC and, in the best judgment of the vendor or DDSO, the individual meets all of the eligibility criteria required to receive MSC.

Once Sections I, II, III, and IV have been completed, this form should be sent to the DDSO's MSC Coordinator.

Section V This section is to be completed by the DDSO's MSC Coordinator. Please refer to MSC Manual section, *Individual Enrollment in MSC*, for additional information.

Date Application Request Received: DDSO date stamps application upon receipt.

Request APPROVED for TABS Processing: If application form is complete and DD diagnosis verified: DDSO checks this item, signs and dates this section, and then forwards application to data entry person for TABS processing and eligibility determination.

Request for MSC WITHDRAWN by Individual: At any point in the process, the individual may voluntarily withdraw his or her application. This decision should be documented, If application is withdrawn: DDSO checks this item, signs and dates this section, and forwards application to data entry person so individual can be removed from the pended file.

Reason for MSC DENIED: When it has been determined that the individual will not meet the MSC eligibility criteria, or the individual hasn't send in the required documents within the allotted time frames: DDSO checks this item, checks the specific reason for denial, signs and dates this section, and forwards a copy to the data entry person so the individual can be removed from pended file.

Data entry person initials and dates the form after completing the data entry.
The form is then returned to the DDSO's MSC coordinator.

STATE OF NEW YORK
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

MSC5 – MSCA
October 1, 2012

Medicaid Service Coordination Agreement
Statement of Rights and Responsibilities

Name of the Person:

Medicaid Number (CIN#):

The purpose of this document is to outline your rights and responsibilities under the Medicaid Service Coordination (MSC) program and what your service coordinator will do for you. This document must be reviewed with you at the time of enrollment in MSC and signed. It only needs to be signed once but must be reviewed once a year with your service coordinator. This document should be forwarded to the chosen provider whenever you change MSC vendors.

Rights and Responsibilities

Informed Choice

You and your service coordinator will talk about Informed Choice. Your service coordinator will help you make informed choices.

Informed Choice

The service coordinator assists individuals on his/her caseload to understand and make informed choices.

A person has made an informed choice when he or she has made a decision based on a good understanding of the options available and a good understanding of how that choice may affect his or her life.

A person can make an informed choice on his/her own or may ask family members, friends, or others for assistance if the individual needs help making a good decision. Informed choices can be about everyday things, like what to wear, or big life changing things like where to live, what kind of work to do, or who to be friends with. These decisions can also be about what kinds of services or supports someone wants or needs, and where and how to get them.

When making an informed choice a person should understand the possible risks involved and what can be done to reduce the risks. A person should also realize that his/her ability or desire to make choices may change over time, or may be different for different kinds of decisions.

Personal choices should be respected and supported by others involved in the person's life.

Free choice of MSC vendor and service coordinator:

You have the right to make an informed choice about your service coordination vendor and service coordinator.

If you think you can be better served by another service coordination vendor, you can request information from your service coordinator or the OPWDD Regional Office about other service coordination vendors that may be available.

If you think you can be better served by another service coordinator, you can request information from your current service coordinator about other service coordinators within the agency or be referred to the OPWDD Regional Office for information about the availability of other service coordinators.

Free choice of HCB Waiver Service providers:

You have the right to select any available qualified provider for HCB Waiver Services. You may request a change in service providers if you think you can be better served by another available qualified Waiver provider.

Comprehensive Assessment

You and your service coordinator will use a person-centered planning process to identify your personal valued outcomes and necessary supports and services.

Development of a Specific Care Plan and Periodic Review

You and your service coordinator will develop an Individualized Service Plan (ISP) and periodically reassess your ISP to make sure that it is correct and addresses your valued outcomes and supports and services as identified.

The ISP must be reviewed at least semi-annually (twice per year) by the service coordinator with you and others as necessary or as agreed upon. At least once a year, the ISP review must be a face-to-face meeting with the service coordinator and you, your advocate (as appropriate), and all major service providers and others as necessary or agreed upon.

Advocacy, Linkage, Referral and Related Activities

You and your service coordinator will work together along with others to determine the services and natural supports that you need and desire to achieve your valued outcomes.

Your service coordinator will assist you to complete all necessary forms to make referrals to services identified.

You and your service coordinator will develop an Activity Plan if you choose to have an Activity Plan. An Activity Plan describes the short-term service coordination activities that are most important to you. An Activity Plan will help you meet specific valued outcomes as described in your ISP. An Activity Plan lists tasks you would like to complete and the person responsible for completing each task. It is your service coordinator's responsibility to help you get the services you want and need. Your service coordinator will work to get you these services whether or not you choose to have an Activity Plan. **Note: an Activity Plan is required for all Willowbrook Class Members.**

Your service coordinator will complete the MSC withdrawal form with you if you no longer want or need service coordination. If you are enrolled in the HCBS Waiver and choose to discontinue MSC, you will be immediately enrolled in Plan of Care Support Services (PCSS). You can continue to get PCSS from your current service coordinator if feasible.

Your service coordinator will provide you with information about other service coordinators or other service coordination agencies if you would like to make a change. Your service coordinator will refer you to the OPWDD Regional Office if you want to change your service coordination vendor.

You agree to notify the service coordinator of personal changes (such as changes in health, Medicaid status, address, telephone number), program or service changes (such as new service needs or a desire to switch programs or agencies) and when there is an emergency to report.

Monitoring and Follow-Up

- You and your service coordinator will stay in contact to talk about what is happening in your life.
- You and your service coordinator will meet in your home to identify and help with any health and safety problems or concerns.
- Your service coordinator will do his or her best to contact the right people, programs and providers to make sure that your service plan is followed.
- Your service coordinator will talk with you about the supports and services you are getting and make sure the people working with you are helping with what you need and want.
- Your service coordinator will ask if you are happy and satisfied with the supports and services listed in your ISP and with the supports and services you are getting from these providers.
- You and your service coordinator will work together to identify any new needs and make changes to your service plan as necessary.
- Your service coordinator will provide you with a 24-hour emergency telephone number and will inform you and your advocate(s) of any changes to the emergency number. This is a responsibility of your MSC agency.

Signatures - By signing this form you, your family member or advocate (as necessary), service coordinator and service coordination supervisor affirm that MSC rights and responsibilities were discussed, that you made informed choices and that all parties understand and agree to the conditions specified.

Person Receiving MSC _____ **Date** _____

Family Member/Advocate _____ **Date** _____

MSC Vendor _____ **Date** _____

Service Coordinator _____ **Date** _____

Service Coordinator Supervisor _____ **Date** _____