OCFS-8018 (1/2012)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

SERVICE SUMMARY FORM

BRIDGES TO HEALTH (B2H) HOME & COMMUNITY BASED SERVICES MEDICAID WAIVER PROGRAM

INSTRUCTION: To be completed by the Health Care Integrator (HCI) or Waiver Service Provider (WSP). Submit copy to Health Care Integration Agency (HCIA).

CHILD'S NAME, (*LAST, FIRST, MI,):*		
DATE OF BIRTH:	SEX: ☐ Male ☐ Female	MEDICAID CIN #:

B2H WAIVER TYPE *(Check one only)*

- ☐ B2H Serious Emotional Disturbance (SED) Waiver
- ☐ B2H Developmental Disabilities (DD) Waiver
- ☐ B2H Medically Fragile (MedF) Waiver

DATE OF SERVICE:	**START TIME:**	☐ AM ☐ PM	**END TIME:**	☐ AM ☐ PM	**TOTAL BILLABLE UNITS:**

Service Location:

A. Waiver Services (Check ONE Service Only)	**B. Individual**	**C. Group**	**D Services Planning (Max Billing per 6 mos.)**	**E. Billable Unit**
☐ Health Care Integration Location of Service: ☐ In Home ☐ Other				☐ Regular Full Month (Per one month) ☐ Enrollment Month (Per one month) ☐ HCIA transfer from original HCIA (Per half month) ☐ HCIA transfer to a New HCIA (Per half month) ☐ Hospitalization from 1-10 days (Per one month) ☐ Hospitalization from 11-30 days (Per one month)
☐ Family/Caregiver Supports & Services	☐	☐	☐ 1 Hour	Per 15 min. unit
☐ Skill Building	☐	☐	☐ 1 Hour	Per 15 min. unit
☐ Day Habilitation	☐	☐	☐ 2 Hours	Per 1 hour unit
☐ Special Needs Community Advocacy & Support	☐	☐	☐ 2 Hours	Per 15 min. unit
☐ Prevocational Services	☐	☐	☐ 2 Hours	Per 1 hour unit
☐ Supported Employment	☐		☐ 2 Hours	Per 1 hour unit
☐ Planned Respite	☐		☐ 1 Hour	☐ Full day respite rate (4 or more hours) ☐ Less than full day rate (if less than 4 hours)
☐ Crisis Avoidance, Management & Training	☐	☐	☐ 2 Hours	Per 15 min. unit
☐ Immediate Crisis Response Services	☐		☐ 2 Hours	Per 15 min. unit
☐ Intensive In-home Supports & Services	☐		☐ 2 Hours	Per 15 min. unit
☐ Crisis Respite	☐		☐ 1 Hour	☐ Full day respite rate (4 or more hours) ☐ Less than full day rate (if less than 4 hours)

Using the chart above, calculate your TOTAL BILLABLE UNITS based upon start and end times.
SEE B2H WAIVER RATE CODE MATRIX AND CHAPTER 13 OF THE B2H PROGRAM MANUAL FOR BILLING INFORMATION

Description of service provided:

Description of child's response to service. Include progress towards any identified goals or intervention strategies:

My signature verifies that the above service was provided.

HCI OR WSP NAME:	HCI OR WSP SIGNATURE: **X**	DATE:
HCI SUPERVISOR OR WSP SUPERVISOR NAME:	HCI SUPERVISOR OR WSP SUPERVISOR SIGNATURE: **X**	DATE:

HEALTH CARE INTEGRATION AGENCY(HCIA) / WSP AGENCY NAME:		PHONE #:	
ADDRESS:	CITY:	STATE:	ZIP CODE:

NOTE: FOR HEALTH CARE INTEGRATION ONLY. SEE ACCOMPANYING PROGRESS NOTES DATED FOR THE FOLLOWING CONTACTS:

CONTACT WITH WAIVER SERVICE PROVIDERS IN THE INDIVIDUALIZED HEALTH PLAN (IHP)

Date		Date	

CONTACT WITH CASE PLANNER/CASE MANAGER IF CHILD IS IN FOSTER CARE

Date		Date	