

Living Resources Corporation  
**Carriage House Arts Center**



**Referral Packet**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone: Home: \_\_\_\_\_

Cell: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Parent: \_\_\_\_\_

Address: (if different) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Phone (home): \_\_\_\_\_

Cell: \_\_\_\_\_

Parent listed above is the Court Appointed Legal Guardian (if applicant is older than 18) - **Yes No**

If "No" indicate guardian: \_\_\_\_\_

Referred by: \_\_\_\_\_

Diagnosis: \_\_\_\_\_  
 \_\_\_\_\_

Ethnicity / Race (please check one)

- White                       Asian or Pacific Islander  
 Black                         American Indian / Alaskan  
 Hispanic                     Other

SS #: \_\_\_\_\_

Medicaid #: \_\_\_\_\_

Tab #: \_\_\_\_\_

Type of Residence: (Circle one)

*IRA ICF Supported/Supervised Apt.*

*Family Care With Family Independent*

Residential Provider: \_\_\_\_\_

Service Coordinator: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_

E-Mail: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Other Medicaid Services Received \_\_\_\_\_  
 \_\_\_\_\_

Special Needs: \_\_\_\_\_  
 \_\_\_\_\_

To help cut down the time needed for the intake process,  
 Please return referral packet with:  
 1) Most current ISP                      4) Level of Care Document (LOCD)  
 2) Proof of Eligibility  
 3) Notice of Decision

Living Resources Corporation  
Carriage House Arts Center  
Referral Form – Art Experience

Please complete the following:

*Current or Past Art classes:*

*Areas of Interest:*

*Availability: Please check-off the days and hours you would like to attend the program*

**Weekdays** - Monday Tuesday Wednesday Thursday Friday  
Hours - 9:30am – 11:30am 12:00pm – 2:00pm 3:00pm – 5:00pm  
5:30pm – 7:30pm

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**Weekends** – Saturday Sunday  
Hours - 10:00am – 12:00pm 1:00pm – 3:00pm

*What do you hope to gain from attending the Carriage House Arts Center?*

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*Is there anything else you would like us to know?*

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Living Resources Corporation  
Carriage House Arts Center  
"Ability to be Alone" Form

Please be advised that the CHAC does not provide transportation home. In any unforeseen emergency cases where a CHAC staff would have to transport a participant home, it is possible that supervision may not be available at the time of drop off. Please check off and sign the following to indicate whether the participant can be dropped off at home under those circumstances.

\_\_\_\_\_  may /  may NOT be dropped off at home when no one is there.  
(Printed Name)

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date

Additional Notes (optional)

\*This form must be updated annually\*

Created on 12/4/2008 10:00 AM

## EMERGENCY CONTACTS

Please list primary, secondary and physician contacts to be notified in case of a medical emergency.

Primary Contact Name:	Address:	Phone: Home: Work: Cell:
Relationship:	E-Mail:	
Secondary Contact Name:	Address:	Phone: Home: Work: Cell:
Relationship:	E-Mail:	
Primary Physician:	Address:	Phone:
Specialty (if applicable):		
Other Doctor:	Address:	Phone:
Specialty:		
Other Doctor:	Address:	Phone:
Specialty:		
Dentist:	Address:	Phone:

## OTHER CONTACTS

Use this section to list other individuals involved with this applicant. (adult siblings, advocates, employment or residential program contacts, etc.)

Name	Relationship	Mailing Address / E-mail	Phone:
			Home: Work: Cell:
			Home: Work: Cell:
			Home: Work: Cell:
			Home: Work: Cell:
			Home: Work: Cell:

## SERVICE COORDINATION INFORMATION

Medicaid Service Coordinator	Agency Affiliation	Agency Address	Phone:
		:	Work: ext: Cell: E-mail -

Date Completed: \_\_\_\_\_

*\*Always inform the program coordinator of any changes in contacts as soon as possible.*

## MEDICATION INFORMATION

***IMPORTANT!*** Please attach most recent PPD results and a copy of immunization records.

Please list all medications currently prescribed, including vitamins or other supplements

Medication	Dose/when taken	Prescribing Physician	Reason

Note allergies or special instructions: ("needs to avoid the sun, cannot eat dairy products, allergic to cats", etc)

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Today's date: \_\_\_\_\_

***\*Always notify the program coordinator of any medication changes as soon as possible.***

Please be advised that \_\_\_\_\_ is capable of carrying and administering the following medications at the following times and in the following doses. He/She may need reminders from staff.

Medication (including mg)

Time

Dose

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\_\_\_\_\_  
Consumer Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\*Medications will be reviewed annually. Please notify the program of any changes that occur before the time of review.

**ADMISSION CRITERIA**

**Carriage House Arts Center**

**Group Day Habilitation / Supplemental Group Day Habilitation / 100% State Funded**

1. Applicant must have a documented diagnosis of a developmental disability.
2. Applicant must have Medicaid and be enrolled in the waiver.
3. Applicant must want to become more independent in art expression.
4. Applicant must be willing to participate in the planning and implementation of programs which will assist him/her in becoming more independent.
5. Applicant must not have evidenced instances or threats of a severe behavior problem within the last year which has threatened the physical or mental/emotional health of themselves or others in the community.
6. All plans – behavior, ISP, needed medical, etc. – must be disclosed by applicant and/or service provider prior to admission; failure to do so may result in discharge from the program.
7. Applicant must disclose all medication information, including name, time taken, dosage and purpose.
8. Applicant, through his/her own choice, must desire to be enrolled in the Carriage House Arts Center (CHAC) of Living Resources Corporation.
9. Applicant must follow the rules and regulations of the Living Resources Corporation.
10. Applicant must be actively involved in the activities offered by the CHAC.
11. Med. certification is not a requirement of CHAC staff and therefore, any administration of meds, including standing orders, will need to be given outside of program. CHAC is not responsible for seeing that medication is taken by self-administering consumers.
12. Applicant must be independent in all areas of personal hygiene or accompanied by a person to assist applicant.

**Applicant:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Service Coordinator:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Guardian:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Authorization/Consent for Use or Disclosure of Information  
for Publication Purposes**

Living Resources Corporation, on its own, and working with others, often develops, videos, brochures, slide shows, photo displays, websites and other publicity materials to explain Living Resources and to encourage people to support Living Resources. These materials are often used within Living Resources and distributed to the public for promotion, fund raising and advertising. Sometimes, television, radio and newspaper reporters will be at Living Resources events.

I, \_\_\_\_\_, authorize Living Resources Corporation or the Living Resources Corporation Foundation to use or disclose the following information about me for promotion, fund raising and advertising:

***Check all that apply***

- Photographs or other likenesses of me
- My name
- My residence or program attended
- Other (please describe):

For the publication purposes described below:

***Check all that apply***

- Posting on the Living Resources Website
- Publication in a Living Resources Newsletter, Brochure, Annual Report, or other format for public distribution
- Release to Media
- Training materials, including video recordings
- Posting to Living Resources-related Social Media sites (i.e. Living Resources Facebook page)
- Other (please describe):

I agree that I do not have to inspect or approve the use or disclosure of any photographs or likenesses of me or any other information about me, or be given a copy. I agree that I will not be paid.

I understand that I may revoke this authorization, in writing, at any time by notifying Living Resources' Public Affairs Department. I understand that a revocation is not effective against actions taken by Living Resources personnel before they received such revocation and to the extent that they have already relied upon this authorization for publicity purposes (brochures, newsletters, annual reports, video recordings, etc.).

I understand that my name, likeness or image may constitute personal health information under the Health Insurance Portability and Accountability Act ("HIPAA"). I understand that if this Consent and Release allows my name, likeness or image to be disclosed to a person or entity that is not a health care provider or health plan, or other covered entity, my name, likeness or image may no longer be protected under the HIPAA privacy rules by those entities.

I hereby release Living Resources Corporation and Living Resources Foundation, and their directors, officers, employees, contractors and affiliates, from any liability arising out of the use of my name, likeness or image for promotion and advertising, including, but not limited to, liability for invasion of privacy, right of publicity, defamation, or copyright infringement. I agree that this Consent and Release satisfies the requirements of the New York Civil Rights Law.

I understand that I do not have to sign this authorization form, and that Living Resources will still provide services to me.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Consumer/Self





Meeting Life's Challenges

**Carriage House Arts Center  
Supplemental Group Day Habilitation and Group Day Habilitation  
Attendance/Discontinuation Policy**

Upon applying for enrollment into Living Resources Carriage House Arts Center Program, it is important to make you aware that there are large numbers of candidates who share an interest in our program. Our hope is to provide art instruction to all who desire that service however our capacity is limited. In consideration of these limitations, please be aware of our "Discontinuation Policy" in regards to attendance.

The key to effectively providing services is communication and we would ask that you provide advance notice of any anticipated absences or extended leave from the Carriage House Art Center. This would enable the art teachers to better plan for their upcoming classes.

It is important that you understand that when current Art Students are exhibiting excessive absenteeism and/or otherwise demonstrating a continued disinterest in receiving art instruction, the agency must presume that the Student/Family desires temporary or permanent disengagement from those services. As always it is best if we are alerted to your intents, planned interruptions' or barriers to receiving art services so we can work in partnership to plan for or address those circumstances.

***Policy Timeline:***

After two (2) months with no advance notice of absences, we will discuss your interest in continuing enrollment in the art program and work with you to address any barriers to your attendance.

After an absence of three (3) months, we will offer the opportunity to another individual and those "Supplemental Group Day Habilitation" or "Group Day Habilitation" units will no longer be available to you. These units will be reinvested to allow another individual waiting for these services to enter our program.

If less than six (6) months has elapsed from your last attended class and units are still available, you may return to the Carriage House Arts Center. If more than six (6) months have elapsed, you will need to repeat the intake process which may lead to being placed on a waiting list until units become available.

***Acknowledgement Statement:***

I have received this copy of the *Supplemental Group Day Habilitation and Group Day Habilitation Discontinuation Policy* and provide my signature of understanding to this policy directive.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Printed Name*

\_\_\_\_\_  
*Relationship to Student*

## Rights & Objection Statement

On \_\_\_\_\_, \_\_\_\_\_ was provided with instruction, explanation  
(Date) (Person's Name)  
 and discussion around Individual Rights and Objection procedures by Living Resources'  
 representative, \_\_\_\_\_. These rights and objection procedures are  
(Staff Member's Name)  
 documented in the policy and procedure manual, which is located at each program  
 site/office for future on-going reference. \_\_\_\_\_ has received a  
(Person's Name)  
 copy of the rights and objection procedures for his/her own personal keeping. In addition  
 to the individual's personal copy, the entire listing of rights will be posted at the program  
 site so that full access is available at all times.

### Statement of Agreement/Understanding

I, \_\_\_\_\_ have been given instruction by Living Resources' representative  
(Person's Name)  
 \_\_\_\_\_ on all the rights granted to me by the State of New York  
(Staff Member's Name)  
 and the objection procedures available to me through agency and State policy. I have full  
 understanding of the objection process and my rights and feel free to exercise such rights  
 whenever I believe the need arises.

\_\_\_\_\_  
 Individual's Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Witness

\_\_\_\_\_  
 Date

## RIGHTS & RESPONSIBILITIES

Reviewed 3/98

The following section of this policy and procedure manual applies to The Carriage House Arts Center operated by the Living Resources Corporation.

No residents will be deprived of any civil or legal right guaranteed to all citizens solely because of a diagnosis of developmental disability. All residents will be given the respect and dignity that is extended to every person regardless of race, religion, national origin, creed, age, gender, ethnic background, sexual orientation, developmental disability or other handicap, or health condition such as one tested for or diagnosed as having HIV infection. In addition, there will be no discrimination for these or any other reason.

The rights set forth in this guideline are intended to establish the living and/or program environment in keeping with the community at large, to the extent possible, given the degree of the disabilities of the residents. Rights that are self-initiated or involve privacy or sexual issues may need to be adapted to meet the needs of the residents with the most severe handicaps and/or residents whose need for protection, safety, and health care will justify such adaptation.

It is the responsibility of Living Resources to ensure that rights are not arbitrarily denied. Limitations of resident rights will be on an individual basis and for clinical purposes. The clinical justification and specific period of time the limitation is to remain in effect will be contained in the individual's plan of service record.

Upon admission and as changes occur thereafter, each Resident will be informed of his/her rights which include, but are not limited to:

- 1) The right to a safe and sanitary environment.
- 2) The right to be free from physical or psychological abuse.
- 3) The freedom from corporal punishment.
- 4) The right to freedom from unnecessary use of mechanical restraining devices and/or excessive medication.
- 5) The right to be protected from commercial or other exploitation.

- 6) The right to confidentiality with regard to all information contained in the resident record, and access to such information subject to provisions of Article 33 of the Mental Hygiene Law and the commissioner's regulations. In addition, confidentiality with regard to HIV-related information will be maintained in accordance with article 27-F of the Public Health Law, 10 NYCRR Part 63 and the provisions of section 633.19 of this part.
- 7) The right to a written individualized plan of services which has as its goal the maximization of the resident's abilities to cope with his/her environment, fosters social competency, which includes meaningful recreation and community programs and contact with non-handicapped persons; and which enables the resident to live as independently as possible.

Such right includes:

- a) The opportunity to participate in the development and modification of an individualized plan of services, unless constrained by the resident's ability to do so.
  - b) The opportunity to object to any provision within a plan of service, and the opportunity to appeal any decision with which the resident disagrees, made in relation to his/her objection to the plan.
  - c) The right to meaningful and productive activities within the resident's capacity although some risk may be involved, and which take into account his/her interests.
- 8) The right to receive services, including assistance and guidance from staff who are trained to administer services adequately, skillfully, safely, and humanely, with full respect for the resident's dignity and personal integrity.
  - 9) The right to appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent/guardian/correspondent, to participate in the choice of physician and dentist, or the opportunity to obtain a second medical opinion.

- 10) The right to clinically sound instructions on the topic of sexuality and family planning services and information about the existence of these services, including access to medication or devices to regulate conception, when clinically indicated.

This right includes:

- (a) freedom to express sexuality as limited by one's consensual ability to do so, provided such expressions do not infringe on the rights of others.
  - (b) the right to make decisions regarding contraception and pregnancy pursuant to the mandates of applicable State and Federal law.
  - (c) the right of Living Resources to reasonably limit the expression of sexuality including time and location thereof, in accordance with a plan for effective program management.
- 11) The right to observance and participation in the religion of his/her choice, through the means of his/her choice, including the right of choice not to participate.
  - 12) The opportunity to register and vote, and the opportunity to participate in activities that educate him/her in civic responsibilities.
  - 13) The right to be free from discrimination, abuse or any adverse action based on his/her status as one who is the subject of an HIV related test or who has been diagnosed as having HIV infection, AIDS, or HIV related illness.
  - 14) The right to receive information upon admission, regarding the supplies and services that the agency will provide or for which additional charges will be made, and timely notification of any changes thereafter.
  - 15) The right to use of his/her personal money and property, including regular notice of his/her financial status and to be provided assistance in the use of his/her resources, as appropriate.
  - 16) The right to a balanced and nutritious diet, served at appropriate times and in as normal a manner as possible, and which is not altered or totally denied for behavior management or disciplinary purposes.

- 17) The right to individually owned clothing which fits properly, is maintained properly, and is appropriate for the age, season, activity, and the opportunity to be involved in the selection.
- 18) The right to adequate & individually owned grooming and personal hygiene supplies.
- 19) The right to a reasonable degree of privacy in sleeping, bathing and toileting areas.
- 20) The right to a reasonable amount of safe, individual, accessible, storage space for clothing and other personal belongings used on a day-to-day basis.
- 21) The opportunity to request an alternate residential setting whether a new residence or a change of room, and involvement in decisions regarding such change.
- 22) The right and opportunity, either personally or through parent(s), guardian(s), or correspondent, to express without fear of reprisal grievances, concerns, and suggestions to the Executive Director, the Commissioner of OMRDD, and/or the Commission on Quality Care. For person's on conditional release from a Developmental Center, this will also include: the Mental Hygiene Legal Service and the board of visitors.
- 23) The right to receive visitors at reasonable times, to have privacy when visited, provided such visits avoid infringement on the rights of others, and to communicate freely with persons within or outside the program site.
- 24) The opportunity to make, or have made on his/her behalf, an informed decision regarding cardiopulmonary resuscitation, in accordance with the provisions of Article 29-B of the Public Health Law, and any other applicable law or regulation.
- 25) The right to a normalized life style.
- 26) The right to assistance to Mental Health Information Services.
- 27) The freedom to make decisions.
- 28) The freedom of speech.
- 29) The right to be gainfully employed.
- 30) The right to respect for his/her cultural identity.
- 31) The right to continuity of treatment.

- 32) The right to due process of law.
- 33) The right to access meaningful recreation and community programs, and the right to participate in the planning of such activities.
- 34) The right to participate with staff in the establishment of house rules.
- 35) The right of the resident's, their parents/guardians and/or correspondent to express grievances, concerns and suggestions to the Executive Director, and/or the Commission on Quality Care without fear of reprisal.
- 36) The right of the residents, parents and correspondents, to be informed of the residents rights under law and regulation and the guarantee that such rights shall be abridged. A statement of the rights included in this section and any others established by policy shall be maintained in each program site and transmitted to each resident's parent and/or correspondent.
- 37) The opportunity to create a health care proxy in accordance with regulation, Part 633.20.

Implementation of the above rights entails inherent risks to the resident. To the extent reasonable, foreseeable, and appropriate, under the circumstances, such rights will be described to the resident and/or their family, guardian or correspondent. However, residents assume responsibility for those risks typically associated with participation in normal activities, to the extent the resident's abilities permit such participation.

None of the foregoing rights will be limited for disciplinary purposes, retribution or for the convenience of staff.

All staff members and volunteers are advised of the previously listed rights during the orientation training provided previous to their assignment in any program.

Resident Rights and rules of conduct will be conveyed in the parent's, guardian's or correspondent's primary language as necessary to facilitate comprehension. Normally this information is provided in writing previous to or upon the admission date of the individual and as changes occur thereafter. If another language other than English is required for comprehension purposes, the agency will make arrangements to present this information in the appropriate primary language used by that individual and his/her parent, guardian, or correspondent.

Notification to the parent, guardian or correspondent will not be conducted if the resident is a capable adult and expresses his/her objection.

At the admission meeting, the Day Community Opportunities Program Coordinator will present and discuss how such rights may be exercised and the obligations incurred upon admission to and participation in the day program.

Living Resources has developed and implemented a process by which admitted residents are made aware of and understand the rights to which they are entitled, how such rights might be exercised and the obligations they incur upon admission to and participation in the day program. This process is one of which involves an annual review conducted between the resident and a program staff member. The staff member ascertains the resident's understanding and agreement and/or denial of said rights. After an agreement has been incurred, the resident verifies that understanding by signature, and is placed in the resident's file. If the resident is incapable of such understanding, all staff working at the program site will sign an agreement stating their understanding and their agreement to implement resident rights as a routine service within the program.

Should denial or objection occur, Living Resources will proceed through documented policy & procedure regarding "Objections and Appeal Process." (See policy in the P&P Manual).





*Meeting Life's Challenges*

300 Washington Ave Ext.

Albany, New York 12203

Phone: 518 218-0000

Fax: 518 867 8708

## *Notice of Privacy Practices*

*Established 04-14-03*

*Updated 03-09-2011*

THIS NOTICE DESCRIBES HOW IDENTIFIABLE HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At Living Resources, we understand that information about you and your family is personal. We are committed to protecting your privacy and sharing information only with those persons who need to know and are allowed to see the information. This notice tells you how Living Resources uses and discloses information about you. It describes your rights and what our responsibilities are concerning information about you.

If you have any questions about this notice, please contact Christine Hough at 218-0000 extension #4309.

### **1. *Who will follow this notice?***

All people who work for Living Resources in our residences, in our non-residential service programs and in our administrative offices will follow this notice. This includes **employees** and **contractors** who are authorized to enter information in your clinical record or need to review your record in order to provide services to you, and **volunteers** or **interns** that we allow to assist you.

### **2. *What information is protected?***

All information that we create or keep that relates to your health or care and treatment, including your name, address, birth date, social security number, your medical information, your individualized service plan and other information about your care in our programs.

### **Your Clinical Information Rights**

You have the following rights concerning your clinical information. When we use the word “you” in this notice we also mean your personal representative. Depending on your circumstances and in accordance with state law, this may be your guardian, your health care proxy, or your involved parent, spouse or adult child.

- ❖ You have a right to see or inspect your clinical information and obtain a copy. Some exceptions apply, such as records regarding incident reports and investigations, and information compiled for use in court or administration proceedings. NOTE: Living Resources may require you to make your request for records in writing.
- ❖ If we deny your request to see your clinical information, you have the right to request a review of that denial. Professionals chosen by Living Resources who were not involved in denying your request will review the record and decide if you may have access to the record.
- ❖ You have the right to ask Living Resources to change or amend clinical information that you believe is incorrect or incomplete. We may deny your request in some cases, for example, if the record was not created by Living Resources or if after reviewing your request, we believe the record is accurate and complete.
- ❖ You have a right to request a list of disclosures that Living Resources has made of your clinical information. The list, however, does not include certain disclosures such as those made to you or made to others with your permission.
- ❖ You have the right to request a restriction on uses or disclosures of your health information related to treatment, payment, health care operations and disclosures to involved family. Living Resources, however, is not required to agree to your request.
- ❖ You have the right to request that Living Resources communicates with you in a way that will help keep your information confidential.
- ❖ You have the right to receive a paper copy of this notice. You may ask Living Resources staff to give you another copy or you may obtain one from our website at [www.livingresources.org](http://www.livingresources.org)
- ❖ To request access to your clinical information or to request any of the rights listed here, you may contact Chris Hough at 218-0000 ext. #4309

### **Living Resources Responsibilities for Your Clinical Information:**

Living Resources is required to:

- ❖ Maintain the privacy of your information in accordance with federal and state laws.
- ❖ Give you this notice of our legal duties and practices concerning the clinical information we have about you.
- ❖ Follow the rules in this notice. Living Resources will use or share information about you only with your permission except for the reasons explained in this notice.
- ❖ Tell you if we make changes to our privacy practices in the future. If changes are made that affect the use and disclosure of your protected health information, your rights, our duties, or our privacy practices, Living Resources will notify you and post a new notice on our website at [www.livingresources.org](http://www.livingresources.org)

## ***How Living Resources Uses & Discloses Clinical Information***

Living Resources may use and disclose clinical information without your permission for the purposes described below. For each of the categories of uses and disclosures, we explain what we mean and offer an example. Not every use or disclosure is described, but all of the ways we will use or disclose information will fall within these categories.

- ❖ ***Treatment:*** Living Resources will use your clinical information to provide you with treatment and services. We may disclose clinical information to doctors, nurses, psychologists, social workers, qualified mental retardation professionals (QMRP), developmental specialist, and other Living Resources personnel, volunteers or interns who are involved in providing your care. For example, involved staff may discuss your clinical information to develop and carry out your individualized service plan (ISP). Other agency staff may share your clinical information to coordinate different services you need, such as medical tests, respite care, transportation, etc. We may also need to disclose your clinical information to your service coordinator and other providers outside of Living Resources who are responsible for providing you with the services identified in your ISP or to obtain new services for you.
  
- ❖ ***Payment:*** Living Resources will use your clinical information so that we can bill and collect payment from you, a third party, an insurance company, Medicare or Medicaid or other government agencies. For example, we may need to provide the NYS Department of Health (Medicaid) with information about the services you received in our facility or through one of our HCBS waiver programs so they will pay us for the services. In addition, we may disclose your clinical information to receive prior approval for payment for services you may need. Also, we may disclose your clinical information to the US Social Security Administration, or the department of health to determine your eligibility for coverage or your ability to pay for services.
  
- ❖ ***Health Care Operations:*** Living Resources will use clinical information for health care operations. These uses and disclosures are necessary to operate agency programs and residences and to make sure all consumers receive appropriate, quality care. For example, we may use clinical information for quality improvement to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also disclose information to clinicians and other personnel for on-the-job training. We will share your clinical information with other Living Resources staff for the purposes of obtaining legal services through our Counsel's office, conducting fiscal audits, and for fraud and abuse detection and compliance through our department of Quality Assurance. We will also share your clinical information with Living Resources staff to resolve complaints or objections to your services. We may also disclose clinical information to our business associates who need access to the information in order to perform administrative or professional services on our behalf. (example: agency attorney or independent auditors)

### *Other Uses and Disclosures that Do Not Require Your Permission*

In addition to treatment, payment and health care operations, Living Resources may use your clinical information without your permission for the following reasons:

- ❖ To tell you directly about possible alternatives or health-related benefits or services that may be of interest to you.
- ❖ When we are required to do so by *federal or state law*.
- ❖ For *public health reasons*, including prevention and control of disease, injury or disability, reporting births and deaths, reporting child abuse or neglect, reporting reactions to medication or problems with medical devices or products, and to notify people who may have been exposed to a disease or are at risk of spreading the disease.
- ❖ To report *domestic violence and adult abuse* or neglect to government authorities if you agree or if necessary to prevent serious harm in accordance with the law.
- ❖ For *health oversight activities*, including audits, investigations, surveys and inspections, and licensure. These activities are necessary for government to monitor the health care system, government programs, and compliance with civil rights laws. Health oversight activities do not include investigations that are not related to the receipt of health care or receipt of government benefits in which you are the subject.
- ❖ For *judicial and administrative proceedings*, including hearings and disputes. If you are involved in a court or administrative proceeding we will disclose clinical information if the judge or presiding officer orders us to share the information.
- ❖ For *law enforcement* purposes, in response to a court order or subpoena, to report a possible crime, to identify a suspect or witness or missing person, to provide identifying data in connection with a criminal investigation and to the district attorney in furtherance of a criminal investigation of client abuse.
- ❖ In the event of your death, to *coroners or medical examiners* for identification purposes or to determine cause of death, and to funeral directors to allow them to carry out their duties.
- ❖ To organ procurement organizations to accomplish cadaver, eye, tissue, or *organ donations* in compliance with state law.
- ❖ For *research* purposes when you have agreed to participate in the research an Institutional Review Board or Privacy Committee has approved the use of the clinical information for the research purposes.
- ❖ To *prevent or lessen a serious imminent threat* to your health and safety or someone else's where permitted by law.
- ❖ To authorized federal officials for intelligence and other *national security* activities authorized by law or to provide protective services to the president and other officials.
- ❖ To *correctional institutions or law enforcement officials* if you are an inmate and the information is necessary to provide you with health care, protect your health and safety or that of others, or for the safety of the correctional institution.
- ❖ To *government agencies* that administer public benefits if necessary to coordinate the covered functions of the programs.
- ❖ Fundraising. We may use your name and address, or the name of your involved family members, in order to make contact as part of a fund-raising effort. We may also share this information with only our Living Resources Foundation that will contact you to raise money on our behalf. *If you do not want to be contacted for these fundraising efforts, please write to: Ms. Joan Meyer, Director of Public Affairs at 300 Washington Ave Ext., Albany, New York 12203 or call at (518) 218-0000 extension #5330.*
- ❖ Appointment reminders and follow-up calls. We may use and disclose protected health information to contact you with a reminder that you have an appointment for treatment or medical care. We may also call to follow-up on care you received with us, to tell you of test results, or to confirm an appointment with us or another health care provider.

### Uses and Disclosures that Require Your Agreement:

Living Resources may disclose clinical information to the following persons if we tell you we are going to use or disclose it and you agree or do not object:

- ❖ To *family members and personal representatives* who are involved in your care if the information is relevant to their involvement and to notify them of your condition and location; or
- ❖ To *disaster relief organizations* that need to notify your family about your condition and location should a disaster occur.

### Authorization Required For All Other Uses and Disclosures:

For all other types of uses and disclosures not described in this notice, Living Resources will use or disclose clinical information only with a written authorization signed by you that states who may receive the information, what information is to be shared, the purpose of the use or disclosure and an expiration for the authorization. Written authorizations are always required for use and disclosure of psychotherapy notes and for certain marketing purposes.

**NOTE:** If you cannot give permission due to an emergency, Living Resources may release clinical information in your best interest. We must tell you as soon as possible after releasing the information.

You may revoke your authorization at any time. If you revoke your authorization in writing, we will no longer use or disclose your clinical information for the reasons stated in your authorization. We cannot, however, take back disclosures we made before you revoked and we must retain clinical information that indicates the services we have provided to you.

### Changes to this Notice:

We reserve the right to change this notice. We reserve the right to make changes to terms described in this notice and to make the new notice terms effective to all clinical information that Living Resources maintains. We will post the new notice with the effective date on our website at [www.livingresources.org](http://www.livingresources.org) and will also have a copy at each program site immediately available. In addition, we will offer you a copy of the revised notice at your next scheduled service planning meeting.

### Complaints:

If you believe your privacy rights have been violated:

- ❖ You may file a complaint with the agency's Privacy Officer at 300 Washington Avenue Extension, Albany, New York 12203 (518) 218-0000 ext. #4309. Or,
- ❖ You may contact the Secretary of the Department of Health and Human Services. You may call them at (202) 690-7000 or write them at 200 Independence Ave S.W., HHH Building, Room 509H, Washington DC, 20201.
- ❖ You may file a grievance with the Office of Civil Rights by calling 866-OCR-PRIV or (202) 619-0403 or by e-mail at [www.hhs.gov/ocr/hipaa](http://www.hhs.gov/ocr/hipaa)

All complaints must be submitted in writing. ***You will not be penalized for filing a complaint.***



*Meeting Life's Challenges*

300 Washington Ave Ext.

Albany, New York 12203

Phone: 518 218-0000

Fax: 518 867 8708

### *Acknowledgement Statement*

I acknowledge that I have received the Living Resources' Notice of Privacy Practices. I am aware that I may contact the agency's Privacy Officer should I have any questions or concerns regarding this document.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



Meeting Life's Challenges

300 Washington Ave Ext.  
Albany, New York 12203  
Phone: 518 218-0000  
Fax: 518 867 8708

**AUTHORIZATION FOR THE RELEASE OF INFORMATION**

**I hereby authorize the use or disclosure of my health information as described below.**

**Individual's Name:** \_\_\_\_\_

**Person(s)/organization(s) providing the information:**

**Person(s)/organization(s) receiving the information:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Specific description of information (including dates):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**What is the purpose of the use or disclosure:**

\_\_\_\_\_  
\_\_\_\_\_

(Note: "at the request of the individual" is sufficient description of the purpose when the individual initiates the authorization and elects not to provide a statement of the purpose)

**Expiration:**

I understand that this authorization will expire on the following date \_\_\_/\_\_\_/\_\_\_ or with the following event: \_\_\_\_\_

**Acknowledgement:**

This Authorization may be revoked in writing at any time, except to the extent that the entity disclosing the information has already relied upon it. Signing this Authorization is not a condition for treatment, payment, enrollment or eligibility for benefits. Information disclosed in reliance upon this Authorization may not be re-disclosed by the recipient except in accordance with law or as otherwise authorized. In the event of such re-disclosure, the information may no longer be protected under the HIPAA Privacy Rule.

\_\_\_\_\_  
**Signature of Individual or Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed name of Individual's Representative:**

\_\_\_\_\_  
**Relationship to the consumer:**

If this authorization is signed by a personal representative of the individual, the representative's authority to act on behalf of the individual is a designation by the Chief Executive Officer of Living Resources, Fredrick W. Erlich.

## ***OBJECTION & APPEAL PROCEDURES***

The following guidelines have been established as a mechanism available for resolution between the objecting party:

The individual receiving services and his/her parent, guardian, or correspondent will be advised of the process for initiating an objection. This advisement will occur upon initiation of any services by this agency to an individual and ongoing in the future as changes occur.

If resolution can not be reached on an informal basis, the objecting party will be given the opportunity to submit a formal written objection requesting a hearing to the CEO. Within five working days of receipt of formal written objection, a hearing will be scheduled before the CEO with no less than 10 days notice. A written decision by the CEO will be sent to the involved parties within 10 working days of that conference.

### **Responsibility**

### **Procedure**

- |                     |   |
|---------------------|---|
| Service Coordinator | 1. Ensures that when an individual's program plan or QMRP is periodically reviewed or when changes are proposed to the program plan, the individual and his/her correspondent are advised of the review and of their right to participate in the planning process and of their right to object to the plan, proposed changes or agency initiated discharge. Provides such notification in writing (ensuring comprehension). As part of this notification: <ul style="list-style-type: none"><li>(a) Provides the name, office, address, and telephone number of the local DSO Director to whom formal written objections are to be addressed.</li><li>(b) Describes the role of MHLS as an advocate for persons with developmental disabilities.</li><li>(c) For Willowbrook Class members, states availability of the Willowbrook Consumer Advisory Board to act on a person's behalf when designated by the correspondent, if the correspondent cannot exercise this right (e.g. because of age, illness, out-of-state residence, etc.)</li></ul> |
| CEO                 | 2. Attempts to resolve objections on an informal basis. Notes objections and strategies for resolution in the individual's program plan.<br><br>3. Sends letter of confirmation to objecting party with results of attempts to resolve objections on an informal basis. If unable to resolve objections, explains to the individual, correspondent or MHLS the right to invoke the formal written objection and appeal procedures set forth below.  |



If the first available party on this list objects to the proposed service plan, or if no party is available or is willing to give consent, application may be made to a court of competent jurisdiction.

If application is made to a court by the agency subsequent to the objection of one of the above parties because such action is considered in the best interest of the individual, notice of such application will be given to the objecting party.

- |  |  |
|--|--|
| Individual<br>Or Other<br>Objecting<br>Party | 4. Conveys objection(s) and request for a hearing in writing to the DDSO Director.   |
| DDSO<br>Director                             | 5. Within five days, arranges a hearing to be held before a hearing officer, with at least ten days advance notice of the hearing date to those entitled to be involved. The notice is to be sent by certified mail, return receipt requested, to the correspondent and MHLS. The individual and his/her coordinator are to receive copies of the same notice. All parties are to receive copies of the written notice.  |
| Individual,<br>Correspondent,                | 6. All entitled to appear at the scheduled hearing and present oral or written statements, documents, or testimony in support of their position relative to the objection. In accordance with agency policy, the coordinator or other designated staff person makes appropriate arrangements for appropriate staff to attend and participate in the hearing.   |
| Hearing<br>Officer                           | 7. Conducts the hearing and ensures receipt of all material and relevant statements, documents and testimony.<br>8. Ensures that testimony and statements are recorded, either by a stenographer or electronically.<br>9. Determines, from everything submitted by the parties at the hearing, if the objection is sustainable. In making this determination, considers among other things, the individual's program and service needs; whether services and programs currently received by the individual meet those needs; whether other programs and services more appropriate to meet the individual's needs are available within existing resources; and the efforts by staff to plan for and implement the provision of more appropriate programs & services within the current location and/or elsewhere. |

- |                                 |   |
|---------------------------------|---|
| Hearing<br>Officer              | 10. Sustains the objection if, after weighing the above factor and any other relevant considerations advanced by the parties, he/she finds that the plan or proposed changes thereto, including agency initiated proposals to discharge, are not reasonable under the circumstances.  |
|                                 | 11. Prepares a written decision within fourteen days of the hearing, setting forth findings made and reasons that support said findings. Where an objection is sustained, recommends resolution to the dispute. Forwards decision to the local DSO Director.  |
| DDSO<br>Director                | 12. Sends the hearing officer's written decision by certified mail, return receipt requested, to the CEO, correspondent and MHLS. Includes a cover letter which explains that any party dissatisfied with the decision can appeal, within ten days of receipt of the decision, to the Commissioner. Sends a copy of the decision to the individual and his/her coordinator. |
| CEO                             | 13. Where the hearing officer's decision sustains the objecting party's objection and recommends a resolution to the dispute, and no appeal is taken, attempts to carry out the recommended resolution in a timely fashion and within available resources.  |
| Parties<br>to the<br>Proceeding | 14. May appeal the hearing officer's decision by sending a written letter of appeal to the Commissioner within ten days of receipt of the decision.   |
| Commissioner                    | 15. May at his/her discretion, send the matter back to the hearing officer for further review.  |
|                                 | 16. Upon receipt of letter of appeal, reviews evidence presented at hearing and based on such review, renders a written decision on issues presented within fourteen days of receipt of letter of appeal.   |
|                                 | 17. Sends written decision to all parties involved in the proceedings by certified mail, return receipt requested.  |
| Objecting<br>Party              | 18. May seek judicial review as provided by the laws of New York State Article 78.  |



Meeting Life's Challenges

300 Washington Ave Ext.  
Albany, New York 12203  
Phone: 518 218-0000  
Fax: 518 867 8708

Dear Applicant,

The New York State Office for People with Developmental Disabilities (OPWDD) has adopted regulations titled *Liability for Services* (14 NYCRR Subpart 635-12). These regulations require all provider agencies, including Living Resources to submit notification to you regarding your liability for payment of Home & Community Based Services (HCBS) Waiver, which your family member may receive through our agency.

Please read through the enclosed Liability Notice (form LIAB-05). This notice, from OPWDD identifies the current type(s) of services being requested and some of the responsibilities involved on your behalf as well as ours at Living Resources.

Also enclosed is a fact sheet developed by OPWDD which we found helpful to understand the details concerning this Liability directive. Please read the enclosed fact sheet titled "What Families Should Know."

Certainly there is a great deal of information presented in this letter. If you need further information or wish to discuss this topic in more detail, please do not hesitate to contact the Director of services or myself at (518) 218-0000 extension #4309.

We look forward to working with you as best we can to ensure that the OPWDD Liability requirements are adhered to.

Sincerely,

Christine Hough  
Director for Corporate Compliance

*Acknowledgement of Receipt:*

I have received the Liability Packet as referred to in this letter.

Signature \_\_\_\_\_

Date: \_\_\_\_\_

Living Resources  
 300 Washington Avenue Extension  
 Albany, New York 12203  
 Phone: 515-218-0000  
 Fax: 518-862-2175

### LIABILITY NOTICE FOR PERSONS APPLYING FOR SERVICES

Individual asking for services: \_\_\_\_\_ Date: \_\_\_\_\_

Fee(s) for requested services: \$ 84.52 per 2 hour class (\$150.44 per 4 hour class)

**You got this notice because** you are the individual named above asking for the services for yourself (or you are assisting the individual), you have to pay for the services for the individual named above with your own money, or because you are responsible for the money of the individual named above. If you are the individual named above, any time you read the individual's or "you" in this notice, it means you.

Someone asked for one or more of the services checked off below for the individual. These are services that the New York State Office for People with Developmental Disabilities (OPWDD) oversees.

- |   |  |
|---|--|
| <input type="checkbox"/> Residential Habilitation in an IRA | <input type="checkbox"/> Prevocational services              |
| <input type="checkbox"/> At-Home Residential Habilitation   | <input type="checkbox"/> Respite                             |
| <input type="checkbox"/> Intermediate Care Facility         | <input type="checkbox"/> Supported Employment Services       |
| <input checked="" type="checkbox"/> Day Habilitation        | <input type="checkbox"/> OPTS Program Blended Services       |
| <input type="checkbox"/> Community Habilitation             | <input type="checkbox"/> OPTS program comprehensive services |
| <input type="checkbox"/> Medicaid Service Coordination      |  |

Anyone getting these services must have the kind of Medicaid that pays for the services or must pay for the services. Fee waivers or reductions are available in unusual circumstances.

#### Giving Us Information

**Before we start the services** you must give us the information we ask for. We need to see if Medicaid or someone else will pay for the services. Even if you agree to pay for the services, we can ask for information so we can see who has to pay for the services, if anyone who has to pay can afford it and if Medicaid will pay.

**While we are providing the services, you must tell us about:**

- Any notice from a Medicaid district about the individual losing Medicaid. You have to tell us about the notice no later than 5 days after you get it or learn about it.
- Any changes in the type of Medicaid coverage the individual has
- Any changes in income, savings or other assets, living situation, immigration status or any other change that affects the individual's Medicaid eligibility
- If you think you no longer have to pay for the services, if you think someone else has to pay, or if you or someone else can no longer afford to pay

***We must protect the privacy of information we get.*** Only certain people working for us are allowed to ask for and see this information. We can only give this information to New York State and others to apply for benefits such as Medicaid, Medicare, Social Security and food stamps.

### **Paying for the services**

***If the individual already has the right kind of Medicaid,*** you must give us the individual's Medicaid Client Identification Number (or something else that proves he or she has Medicaid) and the individual must keep Medicaid in the future.

### ***If the individual does not already has the right kind of Medicaid:***

***You will have to apply for Medicaid*** if no one pays us for the services and we do not waive the fee. If you have to apply for Medicaid, you must do everything that is legal that will qualify the individual for the right kind of Medicaid and that will keep the right kind of Medicaid for the individual. You can also give us information and let us do the application ourselves or help you apply.

### **OR**

***You will have to pay for the services*** if no one else pays for them and we do not waive the fee. If you are responsible for the individual's money, you only have to use the individual's money, not your own money, to pay for the services.

***The right kind of Medicaid*** is the kind that will pay for the services you are requesting.

***You must do what is needed to enroll the individual in the Home and Community Based Services (HCBS) Waiver,*** unless the individual is not asking for HCBS Waiver services. Services that are not HCBS Waiver services are 1CF/DD, day treatment and/or MSC.

***The full fee*** we will charge for the services is on the front of this notice or on a sheet attached to this notice. If we reduce the fee, you must pay the reduced fee. If we reduce or waive the fee, and it turns out you can pay the full fee, you will have to pay the full fee. We will give you 30 days' written notice if we change any reduced or waived fees. You will still be liable for fees, and we will still bill you, even if the State pays us for the services, even if the law requires us to serve you and even if there are legal proceedings to stop services.

***We will send you bills*** if you are paying for the services. We will send you a bill for a month by the 10<sup>th</sup> of the following month. For example, we will send you a bill for April services by May 30. If you do not pay the bills, we will try to collect from you. We cannot interfere with the services or harass or threaten you or anyone else about your bills. If you still do not pay the bills, we may assign our claim for payment to New York State.

***We can deny or stop services.*** We can deny your request for services for financial reasons if Medicaid will not pay, if we do not have reasonable assurance that you or someone else will pay and if we have not waived the fee. If we begin services because you have Medicaid or you or someone else agrees to pay, we can stop services if you lose Medicaid or if you or the person paying us stops. We have to follow normal rules about stopping services. We cannot deny or stop services if the law forbids it.

### **The limited exception**

If you are only receiving supported employment OR respite services you may be eligible for the limited exception. This means that you could continue to receive supported employment or respite services (but not both) without applying for Medicaid and the HCBS Waiver and without being billed for the service. To learn more about the limited exception, ask for the publication "Information About the Limited Exception".



# Putting People First

## Services for Individuals with Developmental Disabilities



At OMRDD our motto is "putting people first." With that in mind we are committed to providing top-quality services for the people with developmental disabilities we support. This brochure explains what you need to know to apply for services from OMRDD. It outlines, step by step, how to get these services paid for. I encourage you to read through it. If you need help, representatives from our Revenue Support Field Offices can assist you. Their phone numbers and locations are printed at the end of this information.

*Diana Jones Ritter, Commissioner*

### What Families Need to Know About Payment for Services

Many services for people with developmental disabilities are available from the New York State Office of Mental Retardation and Developmental Disabilities (OMRDD) and agencies in the OMRDD system. Starting February 15, 2009 there will be a change in how some of these services must be paid for. Payment rules for other services are expected to change at a later date in 2009. This booklet explains what steps must be taken to be sure services are paid for.

#### Individuals who get these Medicaid-funded OMRDD services must apply for Medicaid.\*

Most OMRDD services are funded through Medicaid and the Medicaid Home and Community Based Services (HCBS) waiver. OMRDD requires individuals to enroll in the right type of Medicaid coverage for the services they need. In most cases individuals will need to enroll in both Medicaid and the Medicaid HCBS waiver. The HCBS waiver covers special services that are generally not covered by other types of health insurance.

Once an individual is enrolled in Medicaid and (if needed) the HCBS waiver, Medicaid will pay for the services. The individual or the family will not be asked to pay. Talk to the agency you want services from to be sure you apply for the right programs to get the services you want. If a person does not enroll in the correct Medicaid coverage, in most cases, the individual or the family will have to pay for the desired services.

#### Medicaid-funded services:

- **Intermediate Care Facilities (ICF)** – Residential treatment program with 24-hour care for individuals who need extra help with their daily activities.

#### Medicaid-funded HCBS waiver services:

- **Residential habilitation provided in:**
  - **Individualized Residential Alternatives (IRA)** – Certified homes which provide room, board and individualized service options.
  - **Community Residences (CR)** – Homes that provide semi-independent living.
  - **Family Care** – A certified residence that provides a family-living experience in a structured, stable home environment.
- **Day Habilitation Services** – Help with personal, social, and vocational skills-building to improve community integration.

#### Individuals who get these Medicaid-funded OMRDD services should apply for Medicaid.\*

OMRDD plans to add the services listed below to the new payment rules at a future date\*. It is a good idea to have your family member apply for Medicaid and/or the HCBS waiver now. This will help him or her have the right Medicaid coverage before the payment rule changes take place. If an individual decides not to apply, he or she may have to pay for services in the future.

If an individual or their family thinks that applying for Medicaid or the HCBS waiver might not be right at this time, they should tell the service provider. The provider can help to answer questions and help to decide what is best for the individual. If the individual does not enroll in the right Medicaid and/or HCBS waiver program, the provider can tell you if he or she will have to pay for the service(s).

\* Talk to the provider you want services from if you have any questions.

\* See chart given with this booklet for expected start dates for each service.

## Medicaid-funded services:

- Medicaid Service Coordination (MSC) – Help from a service coordinator to get you the right services and supports to meet your needs.
- Day Treatment Services – Combination of medical treatment and habilitation services at a specific site.

## Medicaid-funded HCBS Waiver services:

- At Home Residential Habilitation – Help with self-care and skills-building for someone who lives with family or independently
- Prevocational Services – Help learning work-related skills before a job starts.
- Supported Employment Services – Help finding and keeping a job and improving work skills.
- Respite Services – Temporary caregiving for individuals.
- Blended and Comprehensive Services – Combination of different waiver services to meet individual needs.

Certain family support services – such as support or training groups, advocacy, information and referral – are not funded through Medicaid, and there is no cost to individuals or families for these services.

## Who is eligible for Medicaid?

Individuals with disabilities age 18 years or older are eligible for Medicaid if their income and resources (bank accounts, life insurance, etc.), are 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 age 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 **spenddown**. In most cases, any money spent out of pocket on medical needs can be used to meet a spenddown. 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.

## What other benefits does Medicaid provide?

In addition to covering many OMRDD services, Medicaid provides health insurance that will pay for medical care and also for specialized medical care that is not covered by other types of insurance. For example, Medicaid can pay for home health aides and transportation to medical services. An individual can have other insurance coverage and still apply for Medicaid.

## How to apply for Medicaid:

Individuals or families should work with the agency they want services from when applying for Medicaid. The agency can help with the application and explain what documents will be needed. The agency can connect individuals or families with a "service coordinator" who can assist with the application process.

In order to apply, an individual will need his or her personal records. For example: his or her birth certificate; proof of where he or she lives, such as a rent receipt or utility bill; proof of income, such as a Social Security check; and proof of his or her resources, such as bank records.

## How to find out what type of Medicaid to apply for:

Individuals or families should talk to the agency they want services from to get help with applying for the right Medicaid coverage. The agency will know what type of Medicaid coverage is needed.

## What if an individual or family decides not to apply for Medicaid?

If an individual or family does not apply for coverage or does not complete the application process then payment must be made for the full cost of the service. The agency the individual wants services from will tell him or her how much will have to be paid for the services.

However, if an individual is not eligible for Medicaid because of a reason other than income or resource level, then that person or their family should ask the agency for assistance.

## What if Medicaid finds that an individual is not eligible?

If Medicaid finds that an individual is not eligible for coverage, Medicaid will send a letter stating that Medicaid coverage has been denied. If an individual or family receives a denial letter, the letter must be saved and shown to the agency the individual wants services from to see if he or she should appeal the decision. The agency can help with the appeals process.

If an individual is not eligible due to income or resources, the individual may have to pay a spenddown to get Medicaid to pay for the desired services. If the individual or family does not take steps to pay the spenddown or to put the resources in a Medicaid qualifying trust, then they will have to pay the full cost of services.

### **What if an individual already gets Medicaid or HCBS Waiver-funded services?**

If an individual is getting services right now and is not enrolled in the correct Medicaid coverage for those services, he or she must apply for the correct Medicaid coverage that will pay for those services.

### **What if an individual wants a new Medicaid or HCBS Waiver-funded service?**

If an individual wants a new service, the person or their family should talk to the agency they want the service from. The agency will tell you if they can provide the service to the individual and will also explain if the individual has the right Medicaid coverage to pay for the service. If the individual does not have the right Medicaid coverage, he or she must enroll in the right coverage before new services will be provided.

If the individual or family does not apply for the Medicaid coverage needed, the agency can deny the request for service. However, in cases where the person's health or safety would be in danger without the service, the agency may choose to provide the service before the individual has enrolled in Medicaid.

### **I still need help! What do I do?**

If you have more questions, our Revenue Support Field Offices can help. There are nine Revenue Support Field Offices (RSFOs) located throughout New York State. RSFO staff share their expertise with voluntary provider agencies, individuals with disabilities, their families, advocates, and other representatives.

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\* Talk to the provider you want services from if you have any questions.



## OMRDD REVENUE SUPPORT FIELD OFFICES (RSFO)

There are nine RSFOs located throughout New York State. Each RSFO is associated with one or more Developmental Disabilities Services Offices (DDSOs). RSFO staff share their expertise with voluntary provider agencies, individuals with disabilities, their families, advocates, and other representatives.

### BROOME RSFO

229-231 State Street- 3rd Floor  
Binghamton, NY 13901  
Phone: (607) 771-7210  
Fax: (607) 771-1098  
Counties Served: Broome, Chenango,  
Delaware, Otsego, Tioga, Tompkins

### CAPITAL DISTRICT RSFO

O.D. Heck DC – Bldg #12  
Balltown & Consaul Road  
Schenectady, NY 12304  
Phone: (518) 370-2010  
Fax: (518) 370-2297  
Counties Served: Albany, Fulton,  
Montgomery, Rensselaer, Saratoga,  
Schenectady, Schoharie, Warren,  
Washington

### CENTRAL/SUNMOUNT RSFO

101 W. Liberty Street, P.O. Box 388  
Rome, NY 13440  
Phone: (315) 339-3440  
Fax: (315) 336-0407  
Counties Served: Cayuga, Clinton,  
Cortland, Essex, Franklin, Hamilton,  
Herkimer, Jefferson, Lewis, Madison,  
Oneida, Onondaga, Oswego, St.  
Lawrence

### FINGER LAKES RSFO

509 Vienna Street  
Newark, NY 14513  
Phone: (315) 331-7141  
Fax: (315) 331-0182  
Counties Served: Chemung, Livingston,  
Monroe, Ontario, Schuyler, Seneca,  
Steuben, Wayne, Wyoming, Yates

### HUDSON VALLEY RSFO

3 Wilbur Road, Room 45, P.O. Box 470  
Thiells, NY 10984-0470  
Phone: (845) 947-6250  
Fax: (845) 947-6161  
Counties Served: Orange, Rockland,  
Sullivan, Westchester

### LONG ISLAND RSFO

415A Oser Avenue  
Hauppauge, NY 11788  
Phone: (631) 434-6109  
Fax: (631) 434-6511  
Counties Served: Nassau, Suffolk

### NEW YORK CITY RSFO

75 Morton Street, 5th Floor  
New York, NY 10014-5798  
Phone: (212) 229-3343  
Fax: (212) 229-3095  
Counties Served: Bronx, Kings,  
Manhattan, Queens, Richmond

### TACONIC RSFO

36 Firemen's Way  
Poughkeepsie, NY 12603  
Phone: (845) 473-8210  
Fax: (845) 473-8204  
Counties Served: Columbia, Dutchess,  
Greene, Putnam, Ulster

### WESTERN NY RSFO

West Seneca DC, Bldg #70, 2nd Floor  
1200 East and West Road  
West Seneca, NY 14224  
Phone: (716) 675-8666  
Fax: (716) 675-8919  
Counties Served: Allegany,  
Cattaraugus, Chautauqua, Erie,  
Genesee, Niagara, Orleans

For more information about becoming an OMRDD multicultural not-for-profit voluntary provider, contact the agency's Technical Assistance and Consultation Unit at (518) 402-4210. Information is also available through OMRDD's toll free Information Line at (866) 946-9733 voice, or (866) 933-4889 TTY; OMRDD's regional DDSOs; or at OMRDD's Web Site: [www.omr.state.ny.us](http://www.omr.state.ny.us). A listing of OMRDD regional DDSOs is included on the back of this brochure.

This document is published by the OMRDD Office of Public Information, located at 44 Holland Ave., Albany, N.Y. 12229.



NYS Office of Mental Retardation & Developmental Disabilities

**Putting People First**

**For More Information**



[www.omr.state.ny.us](http://www.omr.state.ny.us)  
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