



ABBOTT HOUSE

Home and Community Based Services (HCBS) Request for HCBS Services Form

Request Date:	Child's Name (First/MI/Last)	DOB	Medicaid CIN#
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Person Making Referral/Title:	Contact Number:
Referring Agency Name:	Contact Number:
Care Coordinator Name:	Contact Number:
Case Planner Name:	Contact Number:

Managed Care Company Name:	Contact Number:
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Member ID#

Demographic Information for Child:

Gender	Address	City	State	Zip
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School Name:	School Address
School Contact Name/Title:	School Contact Number:

Caregiver Information:

Name:	Primary Contact Number:	Second Contact Number
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Address:	City	State	Zip
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Presenting Behaviors (Please Explain)

HCBS Service Request

*Please Note:

- Child must be Medicaid-eligible
- Access is through Children's Health Home (HH) or State-Designated Independent Entity C-YES
- HH Care Manager or C-YES will complete HCBS Level of Care Eligibility Determination

- Community Habilitation
- Caregiver/Family Supports and Services
- Respite
- Prevocational Services
- Supported Employment
- Community Self-Advocacy Training and Supports

All Service Request forms must be submitted to:

Lower Hudson Valley: FAX: (914) 650-1242 or EMAIL: ServicesReferral-LHV@abbotthouse.net

New York City: FAX (917) 793-3645 or EMAIL: ServicesReferral-NYC@abbotthouse.net