NEW YORK STATE DEPARTMENT OF HEALTH
Office of Long Term Care

LONG TERM HOME HEALTH CARE PROGRAM
MEDICAID HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER

FREEDOM OF CHOICE

NYS DOH Sponsored HCBS Medicaid Waivers you may be eligible for:

- ☐ Long Term Home Health Care Program (LTHHCP) / AIDS Home Care Program (AHCP)
- ☐ Nursing Home Transition and Diversion (NHTD)
- ☐ Care at Home (CAH) I/II
- ☐ Care at Home (CAH) III; IV; & VI
- ☐ Traumatic Brain Injury (TBI)

Other NYS HCBS Medicaid Waivers:

- ☐ Bridges to Health (B2H)
- ☐ Office of Mental Retardation and Developmental Disabilities (OMRDD)
- ☐ Office of Mental Health (OMH) Children w/ Serious Emotional Disturbance (SED)

The following has been provided to me and/or my legal guardian:

1. Information about available HCBS waivers, other Medicaid home care services, services provided through a nursing home and my right to choose whether or not to apply for the LTHHCP/AHCP at this time.
2. The description and goals of the LTHHCP/AHCP.
3. The eligibility criteria for the LTHHCP/AHCP and available services.
4. The list of available LTHHCP agencies in my area and an explanation of my ability to select the LTHHCP agency of my choice and to change that choice at any time.

I have received information regarding the above and (check one below):

_____ I have chosen to apply for the LTHHCP/AHCP waiver.

_____ I have chosen to apply for other ________________________ (specify Medicaid home care services and/or another waiver).

_____ I have chosen **NOT** to apply for Medicaid home care services and/or another waiver at this time.

____

Applicant Name (Print) Signature Date

____

Legal Guardian Name (as applicable) (Print) Signature Date

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LDSS Staff (Print) or LTHHCP Agency Staff *(For alternate entry cases)* Signature Date