NEW YORK STATE DEPARTMENT OF HEALTH
Office of Long Term Care

CARE AT HOME I/II PALLIATIVE CARE

Pain and Symptom Management Selection Form

_____Care at Home I _____Care at Home II

NOTE: Signed copies of this form must be supplied to the child's parent/guardian, case manager, Family Pain & Symptom Management Agency and the LDSS.

I understand that in order for my child to receive Care at Home I/II Pain and Symptom Management Waiver service, I must select a palliative care agency from the attached list of approved providers. I have been encouraged to interview these providers prior to making my selection.

I understand that the Pain and Symptom Management palliative care agency will assist me in developing, implementing and monitoring my child's plan of care regarding Pain and Symptom Management.

I may choose to discontinue this service or select a different palliative care agency for Pain and Symptom management at any time. My child will still be eligible for the CAH I/II waiver if I choose to discontinue services or change providers.

From the approved provider list, I have selected the following agency:

_____
Palliative Care Agency Telephone

_____
Agency Address

_____
Applicant (Child's) Name Date

_____
Parent/Guardian Signature Date

_____
Case Manager Signature Date

To be completed by the Palliative Care Agency:

_____
Palliative Care Agency

_____ **will** provide Pain and Symptom management to the above named applicant

_____ **will not** provide Pain and Symptom Management to the above applicant.

_____
Explanation

_____
Palliative Care Agency Representative Signature (Include Title) Date

_____
LDSS CAH Coordinator Signature Date

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