



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	AIDS Service Center NYC dba Allied Service Center NYC
OPTIONAL Joined PPS:	Select PPS

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OASAS 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	License # Pending	PENDING	PENDING
Agency Code:	PENDING		
Billing Entity ID:	PENDING		
	Address	City	State Zip
Address:	2036 Amsterdam Avenue	New York	NY 10032
County:	Manhattan		

**III. Appeal Point of Contact**

Contact Person	Sharen Duke		
Title	ED/CEO		
Contact Phone	212-645-0875	Extension	304
Contact Email	sharen@ascny.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

On behalf of ASCNYC's Board of Directors, staff and clients, we are formally requesting designation as a DSRIP "Vital Access Provider" as ASCNYC is in a pending CMS-approval status category of bulk exceptions as a OASAS1915i provider and is already on the State Pending Safety Net CMH/OASAS 1915i Provider List. ASCNYC has been a licensed Medicaid provider of Health Home Care Management services (formerly Targeted Case Management) for over 20 years, and we have been at the forefront of innovation throughout the Medicaid Redesign process. Furthermore, ASCNYC is a member of iHealth, Inc., and is represented on the governing boards of three Health Homes in New York City: CCMP, QCCP and BHH. At this time ASCNYC has five Health Home contracts to deliver comprehensive care management services: Brooklyn Health Home (formerly Maimonides Health Home), CCMP, Community HealthCare Network Brooklyn Health Home (CHN Brooklyn HH), Mount Sinai Health Home and New York Presbyterian Health Home. The ASCNYC Health Home Care Management Program is receiving direct referrals from all five Health Homes for out-reach and enrollment for clients who are Medicaid-eligible and living with HIV and other chronic conditions. ASCNYC has applied for and was approved by OASAS to open an 822.4 Substance Abuse Outpatient Treatment Program in Washington Heights; license number is pending. Our Health Home Care Management programs and our outpatient substance abuse treatment program are anticipating to serve a large number of HARP-eligible clients who will receive 1915 (i) services, such as crisis intervention, empowerment services and peer support, pre-vocational services, educational support services, and self-directed care planning. In addition, ASCNYC is contracted with an onsite satellite Article 31 Mental Health clinic where clients can receive psychiatric evaluations, medication management, and group and individual therapy. It is essential that CMS approves NYSDOH's request to identify ASCNYC and all converting TCM providers as a "Vital Access Provider". ASCNYC is a vital part of New York State's strategy to achieve the triple aim of improved quality, improved health and reduced costs in New York State.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	90%	10%	AIRS (EMR)	2014

**VIII. Yes I Herby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name Sharen Duke  Yes  No  
 Title ED/CEO  
 Only appeals from the CEO, CFO or comparable will be accepted



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Vital Access Provider Exception: The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

I. Are you a Medicaid Provider

Answer Not Yet

You have chosen the following category: 1

II. Appeal Applicant Information

Organization Name: Anchor House INC
OPTIONAL Joined PPS: Select PPS

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.

Provider Type: OASAS 1915i Provider
Provider Type - Other: DO NOT USE
Operating Certificate/License #
MMIS
NPI
Unique Identifiers:
Agency Code: 610
Billing Entity ID:
City
State
Zip
Address: 1041 Bergen Street
County: KINGS

III. Appeal Point of Contact

Contact Person: Alison King
Title: Administrator/Executive Director
Contact Phone: 718-771-0760
Contact Email: aking@anchorhouseinc.com

IV. Please choose the following 1915i Category:

1 I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
2 I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

V. Percentage of Medicaid & Uninsured members that your facility serves

Table with columns: Medicaid (FFS & MC), Uninsured, Data Source, Year, Percentage

VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.

Name: Simeon Saturn
Title: CFO
Answer: Yes



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**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Argus Community, Inc.
OPTIONAL Joined PPS:	Bronx-Lebanon Hospital Center

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OASAS 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	170411505	2737644	1932241429
Agency Code:			
Billing Entity ID:			
	Address	City	State Zip
Address:	760 E. 160 Street	Bronx	NY 10456
County:	Bronx		

**III. Appeal Point of Contact**

Contact Person	Daniel Lowy		
Title	Vice President		
Contact Phone	718-401-5650	Extension	
Contact Email	dlowy@arguscommunity.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

In the context of the Bronx-Lebanon PPS, for over 44 years we have co-served an overlapping catchment area while providing unique "in-the-community" substance use services to adolescents, teens and adults. We are specialists in providing specialized SUD/SU services to the dually and triply diagnosed; besides outpatient and court mandated outpatient services, we have one of the only/few OASAS approved MICA residences in the Bronx. We are an OASAS licensed and approved Bronx based NYS not-for-profit, our zip codes historically designated as "congressional disaster areas." Along with the decreased SUD/SU services noted above, our services impact the community by assisting: persons transitioning from active substance use to independence; transitioning into the community from the correctional system; teens and adolescents often disconnected from parental oversight or medical care, and; those with mental health issues who self-medicate via illicit substance use/abuse. Bronx-Lebanon values our input and the critical need for our services, the Director, Dr. James G. Schiller, serving on their DSRIP PAC, as well as the Community Needs Assessment committee.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	95%	5%	S/Computer Sci	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Richard Weiss	Answer <input checked="" type="radio"/> Yes <input type="radio"/> No
Title	President & CEO	

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**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Argus Community, Inc.
OPTIONAL Joined PPS:	Mount Sinai Hospitals Group

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OASAS 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	170411505	2737644	1932241429
Agency Code:			
Billing Entity ID:			
	Address	City	State Zip
Address:	760 E. 160 Street	Bronx	NY 10456
County:	Bronx		

**III. Appeal Point of Contact**

Contact Person	Daniel Lowy		
Title	Vice President		
Contact Phone	718-401-5650	Extension	
Contact Email	dlowy@arguscommunity.org		

**IV. Please choose the following 1915i Category:**

1 I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers

2 I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

Argus has a 21 year history of working with St. Luke's/Roosevelt (The Continuum), subsumed into the Mt. Sinai Hospitals Group," together serving those with HIV/AIDS and active substance abuse. Currently, our OASAS director serves on their IT committee and their Minimum Data Set (MDS) subcommittee. Additionally, Argus Community is a co-owner of the CCMP HH with Mt. Sinai. Serving the Bronx and upper Manhattan for over 44 years, Argus has established a comprehensive substance abuse treatment services base in Harlem, originally supported by OASAS to take control of several OASAS outpatient and residential treatment facilities in an area where adolescent and adult SU treatment is heavily needed. The Argus-Mt. Sinai relationship facilitates the provision of our "in-the-community" substance use services to adolescents, teens and adults. We are specialists in providing specialized SUD/SU services to the dually and triply diagnosed; besides outpatient and court mandated outpatient services, we have one of the only/few OASAS approved MICA residences. We are an OASAS licensed and approved NYS not-for-profit, providing on-site services to those in the Bronx and Upper Manhattan/Harlem MAI designated neighborhoods. Along with the decreased SUD/SU services noted above, our services impact the community by assisting: persons transitioning from active substance use to independence; transitioning into the community from the correctional system; teens and adolescents often disconnected from parental oversight or medical care, and; those with mental health issues who self-medicate via illicit substance use/abuse.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	95%	5%	S/Computer Sci	2014

**VIII. Yes I Herby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name Richard Weiss  Yes  No

Title President & CEO

Only appeals from the CEO, CFO or comparable will be accepted



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**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Astor Services for Children & Families
OPTIONAL Joined PPS:	Select PPS

**VI. Restricted to 3500 Characters only!**  
ASTOR SERVICES FOR CHILDREN & FAMILIES was established in 1955 as a residential treatment center for children. Since then, the agency has developed a host of intensive mental health residential and outpatient services as well as special education, early

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:		2994769	1225009806
Agency Code:	18320		
Billing Entity ID:			
	Address	City	State Zip
Address:	6339 Mill St.	Rhinebeck	NY 12572
County:	Dutchess		

**III. Appeal Point of Contact**

Contact Person	James McGuirk PhD		
Title	Executive Director/CEO		
Contact Phone	845-871-1001	Extension	
Contact Email	<a href="mailto:jmcguirk@astorservices.org">jmcguirk@astorservices.org</a>		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	3128%		Electronic Health Re	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	James McGuirk PhD	Answer	
Title	Executive Director/CEO	<input checked="" type="radio"/> Yes	<input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted			



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**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Baltic Street AEH, Inc.
OPTIONAL Joined PPS:	Maimonides Medical Center

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider			
Provider Type - Other:	DO NOT USE			
	Operating Certificate/License #	MMIS	NPI	
Unique Identifiers:				
Agency Code:				
Billing Entity ID:				
	Address	City	State	Zip
Address:	9201 Fourth Avenue - 5th floor	Brooklyn	NY	11209
County:	Kings			

**III. Appeal Point of Contact**

Contact Person	Isaac Brown		
Title	CEO		
Contact Phone	718 833-5929	Extension	
Contact Email	<a href="mailto:ibrown@balticstreet.org">ibrown@balticstreet.org</a>		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	40%	2%	AWARDS	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Isaac Brown	Answer <input checked="" type="radio"/> Yes <input type="radio"/> No
Title	Chief Executive Officer	

Only appeals from the CEO, CFO or comparable will be accepted



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**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Bowery Residents' Committee (BRC)
OPTIONAL Joined PPS:	Lutheran Medical Center

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider			
Provider Type - Other:	DO NOT USE			
	Operating Certificate/License #	MMIS	NPI	
Unique Identifiers:		02995802	1477684967	
Agency Code:				
Billing Entity ID:				
	Address	City	State	Zip
Address:	131 West 25th Street, 12th floor	New York	NY	10001
County:	New York			

BRC is listed as a safety net provider according to the OMH and OASAS calculations, and is applying to be included on the 1915i-like service providers list.

**III. Appeal Point of Contact**

Contact Person	Heather Donahue		
Title	Program Development Coordinator		
Contact Phone	(212) 803-5709	Extension	
Contact Email	hdonahue@brc.org		

**IV. Please choose the following 1915i Category:**

- 1 I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
- 2 I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	88%	5%	BRC records	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name [Signature]  Yes  No  
 Title Chief Program Officer  
 Only appeals from the CEO, CFO or comparable will be accepted



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**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Bowery Residents' Committee (BRC)
OPTIONAL Joined PPS:	Mount Sinai Hospitals Group

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:		02995802	1477684967
Agency Code:			
Billing Entity ID:			
	Address	City	State Zip
Address:	131 West 25th Street, 12th floor	New York	NY 10001
County:	New York		

BRC is listed as a safety net provider according to the OMH and OASAS calculations, and is applying to be included on the 1915i-like service providers list.

**III. Appeal Point of Contact**

Contact Person	Heather Donahue		
Title	Program Development Coordinator		
Contact Phone	(212) 803-5709	Extension	
Contact Email	hdonahue@brc.org		

**IV. Please choose the following 1915i Category:**

- 1 I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
- 2 I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	88%	5%	BRC records	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name \_\_\_\_\_ Title Chief Program Officer Answer  Yes  No

Only appeals from the CEO, CFO or comparable will be accepted





**VAP EXCEPTION FORM IS DUE 10/24/2014 - STATE DESIGNATED HEALTH HOMES AND DOWNSTREAM CARE MANAGEMENT AGENCIES ONLY**

**State of New York Department of Health  
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**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following Health Home category:	1
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**II. Appeal Applicant Information**

Organization Name:	Bowery Residents' Committee (BRC)
OPTIONAL-Joined PPS:	Lutheran Medical Center

**VI. Restricted to 3500 Characters only!**

The narrative section is optional, but you may write additional notes.

**I am hereby requesting approval as a safety net entity as I have been listed by the department of health as a high volume provider of Medicaid care management services or**

Character Count: 0

Provider Type:	Health Home/Care Management Agency			
Provider Type - Other:				
Operating Certificate/License #	MMIS*	NPI*		
Unique Identifiers:	2995802	1477684967		
Agency Code:				
Billing Entity ID:				
Address	City	State	Zip	
Address: 131 W. 25th Street, 12th floor	New York	NY	10001	
County:	New York			

**III. Appeal Point of Contact**

Contact Person	Heather Donahue		
Title	Program Development Coordinator		
Contact Phone	(212) 803-5709	Extension	
Contact Email	hdonahue@brc.org		

**IV. Please choose the following Health Home category. These are all for option 3 of the safety net definition:**

- 1 A State designated Health Home or Health Home provider that is already on the Pending State-Designated State Health Home and Downstream Care Management Agency List.
- 2 If your organization does not appear on the draft Health Home list or on another approved safety net provider list, but your organization believes that it should qualify as a Health Home, please make this selection.

You are choosing VAP Exception iii- The Department has submitted a draft list of State Designated Health Homes and Network Care Management Agencies (CMAs) that have already been approved as safety net providers as well as those that are pending CMS approval. If your Health Home appears on this list as pending approval, you may be granted a VAP Exception pending CMS approval, but should submit this form. If the organization operating your Health Home/CMA already appears on another safety net list, you do not need to submit this form. If your organization does not appear on the draft Health Home list or on another approved safety net provider list, but your organization believes that it should qualify as a Health Home, please complete this form.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	88%	5%	BRC records	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name		Answer
Title	Chief Compliance Officer	<input checked="" type="radio"/> Yes <input type="radio"/> No

Only appeals from the CEO, CFO or comparable will be accepted





**VAP EXCEPTION FORM IS DUE 10/24/2014 - STATE DESIGNATED HEALTH HOMES AND DOWNSTREAM CARE MANAGEMENT AGENCIES ONLY**

**State of New York Department of Health  
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**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following Health Home category:	1
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**II. Appeal Applicant Information**

Organization Name:	Bowery Residents' Committee (BRC)
OPTIONAL-Joined PPS:	Mount Sinai Hospitals Group

**VI. Restricted to 3500 Characters only!**

The narrative section is optional, but you may write additional notes.

I am hereby requesting approval as a safety net entity as I have been listed by the department of health as a high volume provider of Medicaid care management services or

Character Count: 0

Provider Type:	Health Home/Care Management Agency			
Provider Type - Other:				
	Operating Certificate/License #	MMIS*	NPI*	
Unique Identifiers:		2995802	1477684967	
Agency Code:				
Billing Entity ID:				
	Address	City	State	Zip
Address:	131 W. 25th Street, 12th floor	New York	NY	10001
County:	New York			

**III. Appeal Point of Contact**

Contact Person	Heather Donahue		
Title	Program Development Coordinator		
Contact Phone	(212) 803-5709	Extension	
Contact Email	hdonahue@brc.org		

**IV. Please choose the following Health Home category. These are all for option 3 of the safety net definition:**

- 1 A State designated Health Home or Health Home provider that is already on the Pending State-Designated State Health Home and Downstream Care Management Agency List.
- 2 If your organization does not appear on the draft Health Home list or on another approved safety net provider list, but your organization believes that it should qualify as a Health Home, please make this selection.

You are choosing VAP Exception iii- The Department has submitted a draft list of State Designated Health Homes and Network Care Management Agencies (CMAs) that have already been approved as safety net providers as well as those that are pending CMS approval. If your Health Home appears on this list as pending approval, you may be granted a VAP Exception pending CMS approval, but should submit this form. If the organization operating your Health Home/CMA already appears on another safety net list, you do not need to submit this form. If your organization does not appear on the draft Health Home list or on another approved safety net provider list, but your organization believes that it should qualify as a Health Home, please complete this form.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	88%	5%	BRC records	2014

**VIII. Yes** I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.

Name		Answer	<input checked="" type="radio"/> Yes <input type="radio"/> No
Title	Program Development Coordinator		

Only appeals from the CEO, CFO or comparable will be accepted



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Capabilities, Inc
OPTIONAL Joined PPS:	Finger Lakes PPS

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	7560960	2171346	exempt
Agency Code:	40790		
Billing Entity ID:	n/a		
	Address	City	State Zip
Address:	1149 Sullivan Street	Elmira	NY 14901
County:	Chemung		

VAP Exception being completed per updated guidance from Department of Health. We are a vocational rehabilitation agency for employment services for individuals with disabilities.

**III. Appeal Point of Contact**

Contact Person	Aj Kircher		
Title	Director of Vocational Services		
Contact Phone	607-734-2006	Extension	125
Contact Email	ajk@capabilities.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	95%	5%	Self Report	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Aj Kircher	Answer <input checked="" type="radio"/> Yes <input type="radio"/> No
Title	Executive Director	
Only appeals from the CEO, CFO or comparable will be accepted		



VAP EXCEPTION FORM IS DUE 10/24/2014 - STATE DESIGNATED HEALTH HOMES AND DOWNSTREAM CARE MANAGEMENT AGENCIES ONLY

State of New York Department of Health Delivery System Reform Incentive Payment (DSRIP) Program Vital Access Provider Exception Form

Vital Access Provider Exception: The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

I. Are you a Medicaid Provider

Answer Yes

You have chosen the following Health Home category: 1

II. Appeal Applicant Information

Organization Name: Catholic Charities of Cortland County
OPTIONAL-Joined PPS: Select PPS

VI. Restricted to 3500 Characters only!

The narrative section is optional, but you may write additional notes.

I am hereby requesting approval as a safety net entity as I have been listed by the department of health as a high volume provider of Medicaid care management services or

Character Count: 0

Table with Provider Type, Unique Identifiers, Agency Code, Billing Entity ID, and Address information.

III. Appeal Point of Contact

Contact Person: Marie L Walsh, Title: Executive Director, Contact Phone: (607)299-4164, Contact Email: mwalsh@ccccc.org

IV. Please choose the following Health Home category. These are all for option 3 of the safety net definition:

- 1 A State designated Health Home or Health Home provider that is already on the Pending State-Designated State Health Home and Downstream Care Management Agency List.
2 If your organization does not appear on the draft Health Home list or on another approved safety net provider list, but your organization believes that it should qualify as a Health Home, please make this selection.

You are choosing VAP Exception iii- The Department has submitted a draft list of State Designated Health Homes and Network Care Management Agencies (CMAs) that have already been approved as safety net providers as well as those that are pending CMS approval.

V. Percentage of Medicaid & Uninsured members that your facility serves

Table showing Medicaid (FFS & MC) at 95% and Uninsured at 5%. Data Source: Agency Data, Year: 2013.

VIII. Yes I Herby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.

Name: Marie L Walsh, Title: Executive Director, Answer: Yes

Only appeals from the CEO, CFO or comparable will be accepted





**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Catholic Charities of Cortland County
OPTIONAL Joined PPS:	United Health Services Hospitals, Inc

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:		2995435	1366597171
Agency Code:	50760		
Billing Entity ID:	2995435		
	Address	City	State Zip
Address:	33-35 Central Ave	Cortland	NY 13045
County:	Cortland		

**III. Appeal Point of Contact**

Contact Person	Marie L Walsh		
Title	Executive Director		
Contact Phone	(607)299-4164	Extension	1
Contact Email	mwalsh@ccccc.org		

**IV. Please choose the following 1915i Category:**

1 I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers

2 I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	95%	5%	Agency Data	2013

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name Marie L Walsh  Yes  No

Title Executive Director  Yes  No

Only appeals from the CEO, CFO or comparable will be accepted



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	2
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**II. Appeal Applicant Information**

Organization Name:	Catholic Charities of Cortland County
OPTIONAL Joined PPS:	United Health Services Hospitals, Inc

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:		2995435	1366597171
Agency Code:	50760		
Billing Entity ID:	2995435		
	Address	City	State Zip
Address:	33-35 Central Ave	Cortland	NY 13045
County:	Cortland		

**III. Appeal Point of Contact**

Contact Person	Marie L Walsh		
Title	Executive Director		
Contact Phone	(607)299-4164	Extension	1
Contact Email	mwals@ccc.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	95%	5%	Agency Data	2013

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Marie L Walsh	Answer <input checked="" type="radio"/> Yes <input type="radio"/> No
Title	Executive Director	

Only appeals from the CEO, CFO or comparable will be accepted





**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Catholic Charities of Steuben
OPTIONAL Joined PPS:	Finger Lakes PPS

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OASAS 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	160411779		
Agency Code:	44050		
Billing Entity ID:			
	Address	City	State Zip
Address:			
County:			

OASAS reports indicate our Community Residence and Supportive Living Program serves a significantly higher population of individuals with major health problems and mental health diagnosis compared to 40 other upstate, rural residential programs. The % of population with 2 or more diagnosis has been double the median for the last 7-10 years. The majority of referrals come from a State ATC (Dick Van Dyke) and therefore serve residents from 12-14 counties. Kinship Community Residence also contracts with the Veterans Administration (VISN 2-Upstate) to provide services to Homeless Veterans with chronic dependency, health and mental health problems.

**III. Appeal Point of Contact**

Contact Person	Kim Robards-Smith		
Title	Program Director		
Contact Phone	607 324 0909	Extension	
Contact Email	ksmith@dor.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	83%	0%	Budget calculator	2014

**VIII. Yes I Herby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Kim Robards-Smith	Answer
Title	Program Director	<input checked="" type="radio"/> Yes <input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Cayuga Counseling Services
OPTIONAL Joined PPS:	Select PPS

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	7734100A	1014075	1194874610
Agency Code:	2994594		
Billing Entity ID:	DB8		
	Address	City	State Zip
Address:	17 E. Genesee St.	Auburn	NY 13021
County:	Cayuga		

**III. Appeal Point of Contact**

Contact Person	Heather Petrus LMHC		
Title	Executive Director		
Contact Phone	315-253-9795	Extension	127
Contact Email	hpetrus@cayugacounseling.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	60%	5%	Billing System	2013

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Heather Petrus	Answer	
Title	Executive	<input checked="" type="radio"/> Yes	<input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted			





**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Center for Behavioral Health Services
OPTIONAL Joined PPS:	Maimonides Medical Center

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	Select One		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:			
Agency Code:	26310		
Billing Entity ID:			
	Address	City	State Zip
Address:	One Smith Street, 2nd floor	Brooklyn	NY 11201
County:	Kings		

**III. Appeal Point of Contact**

Contact Person	Ilana Adler, LMSW		
Title	Executive Director		
Contact Phone	(718) 210-3800	Extension	3021
Contact Email	iadler@cchsn.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	78%	10%	Patient Records	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Ilana Adler, LSMW	Answer <input checked="" type="radio"/> Yes <input type="radio"/> No
Title	Executive Director	
Only appeals from the CEO, CFO or comparable will be accepted		



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Center for Community Alternatives, Inc.
OPTIONAL Joined PPS:	Finger Lakes PPS

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OASAS 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:		2003170	1003008301
Agency Code:	#02135 (OASAS Provider Code)		
Billing Entity ID:			
	Address	City	State
Address:	115 E. Jefferson St., Suite 300	Syracuse	NY
County:	Onondaga (serving Monroe through a Rochester office)		
		Zip	
		13202	

**III. Appeal Point of Contact**

Contact Person	Marsha Weissman		
Title	Executive Director		
Contact Phone	315-422-5638	Extension	218
Contact Email	<a href="mailto:mweissman@communityalternatives.org">mweissman@communityalternatives.org</a>		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

a. The Rochester/Monroe Recovery Network (RMRN) program of the Center for Community Alternatives, Inc. serves individuals in recovery or seeking support in their recovery, targeting individuals who also have past criminal history or are reentering the community from incarceration. The RMRN serves Rochester, NY. CCA's RMRN is the only Recovery Center in the area.

b. RMRN is a program of the Center for Community Alternatives, not-for-profit corporation with a 33-year history promoting alternatives-to-incarceration that promote public safety. CCA provides a diverse set of services including substance use treatment, recovery support, employment, and health and youth development services. These services help to avert incarceration sentences and help people successfully reenter the community upon release from prison. RMRN services include recovery coaching, a range of workshops on various life skills, assistance with job search, and health and well-being activities. Services also include civic restoration for those facing bars and barrier to civic and community participation due to their criminal history, facilitating a participant's application, if appropriate, for a NYS Certificate of Relief from Civil Disabilities, or Certificate of Good Conduct.

c. For the last four years, RMRN served as the "Upstate NY hub" for NY SOARS (Access to Recovery), a USHHS/SAMHSA program through NYS OASAS. During the past year the RMRN outcomes include a total enrollment of 419 individuals. At enrollment/intake and again after six months of program involvement, a formal assessment is completed. The six-month assessment reported the following findings: 100% were active substance users at intake, with 79% abstinence after 6 months in the program; 150 had past criminal justice involvement, with 50% reporting no new arrests or convictions at 6 months of enrollment; 225 enrollees were in need of employment or education/job training, with 90 (40%) of enrollees obtaining employment or entering training within 6 months of enrollment; and 356 (85%) of enrollees indicated that by being a part of RMRN and NY SOARS their quality of life has greatly improved.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	unknown	unknown		

**VIII. Yes I Herby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Marsha Weissman, Ph.D.	Answer <input checked="" type="radio"/> Yes <input type="radio"/> No
Title	Executive Director	

Only appeals from the CEO, CFO or comparable will be accepted



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Chautauqua County Department of Mental Hygiene
OPTIONAL Joined PPS:	Catholic Medical Partners-Accountable Care IPA INC

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:		2997928	1902897374
Agency Code:			
Billing Entity ID:			
	Address	City	State Zip
Address:	7 N Erie Street	Mayville	NY 14757
County:			

**III. Appeal Point of Contact**

Contact Person	Patricia A Brinkman		
Title	Director		
Contact Phone	716-753-4104	Extension	
Contact Email	<a href="mailto:brinkmap@co.chautauqua.ny.us">brinkmap@co.chautauqua.ny.us</a>		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	100%			2013-14

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Patricia A Brinkman	Answer <input checked="" type="radio"/> Yes <input type="radio"/> No
Title	Director of Community Services	

Only appeals from the CEO, CFO or comparable will be accepted



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Chautauqua County Department of Mental Hygiene
OPTIONAL Joined PPS:	Erie County Medical Center Corporation

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider			
Provider Type - Other:	DO NOT USE			
	Operating Certificate/License #	MMIS	NPI	
Unique Identifiers:		2997928	1902897374	
Agency Code:				
Billing Entity ID:				
	Address	City	State	Zip
Address:	7 N Erie Street	Mayville	NY	14757
County:				

**III. Appeal Point of Contact**

Contact Person	Patricia A Brinkman		
Title	Director		
Contact Phone	716-753-4104	Extension	
Contact Email	<a href="mailto:brinkmap@co.chautauqua.ny.us">brinkmap@co.chautauqua.ny.us</a>		

**IV. Please choose the following 1915i Category:**

1 I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers

2 I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	100%			2013-14

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name Patricia A Brinkman  Yes  No

Title Director of Community Services  Yes  No

Only appeals from the CEO, CFO or comparable will be accepted



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Chautauqua County Health Homes
OPTIONAL Joined PPS:	Erie County Medical Center Corporation

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:		3520990	1477807097
Agency Code:			
Billing Entity ID:			
	Address	City	State Zip
Address:	7 N Erie Street	Mayville	NY 14757
County:			

**III. Appeal Point of Contact**

Contact Person	Patricia A Brinkman		
Title	Director		
Contact Phone	716-753-4104	Extension	
Contact Email	<a href="mailto:brinkmap@co.chautauqua.ny.us">brinkmap@co.chautauqua.ny.us</a>		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	100%			2013-14

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Patricia A Brinkman	Answer <input checked="" type="radio"/> Yes <input type="radio"/> No
Title	Director of Community Services	

Only appeals from the CEO, CFO or comparable will be accepted



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

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**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Chautauqua County Health Homes
OPTIONAL Joined PPS:	Catholic Medical Partners-Accountable Care IPA INC

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider			
Provider Type - Other:	DO NOT USE			
	Operating Certificate/License #	MMIS	NPI	
Unique Identifiers:		3520990	1477807097	
Agency Code:				
Billing Entity ID:				
	Address	City	State	Zip
Address:	7 N Erie Street	Mayville	NY	14757
County:				

**III. Appeal Point of Contact**

Contact Person	Patricia A Brinkman		
Title	Director		
Contact Phone	716-753-4104	Extension	
Contact Email	<a href="mailto:brinkmap@co.chautauqua.ny.us">brinkmap@co.chautauqua.ny.us</a>		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	100%			2013-14

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Patricia A Brinkman	Answer <input checked="" type="radio"/> Yes <input type="radio"/> No
Title	Director of Community Services	
Only appeals from the CEO, CFO or comparable will be accepted		



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

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**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	2
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**II. Appeal Applicant Information**

Organization Name:	Circulo de la Hispanidad
OPTIONAL Joined PPS:	Select PPS

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.

Provider Type:	Select One			
Provider Type - Other:	DO NOT USE			
	Operating Certificate/License #	MMIS	NPI	
Unique Identifiers:				
Agency Code:	13030			
Billing Entity ID:				
	Address	City	State	Zip
Address:	26 West Park Avenue	Long Beach	NY	11561
County:	Nassau			

**III. Appeal Point of Contact**

Contact Person	Sarah Brewster		
Title	Chief Director of Services and Operations		
Contact Phone	516-431-1135	Extension	148
Contact Email	sbrewster@cdlh.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	83% Medicaid 16% other	0%	client files	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Sarah Brewster	Answer
Title	Chief Director of Services and Operations	<input checked="" type="radio"/> Yes <input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

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**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Community Awareness Network for a Drug-free Life and Environment
OPTIONAL Joined PPS:	Montefiore Medical Center

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OASAS 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:			
Agency Code:	1337		
Billing Entity ID:			
	Address	City	State
Address:			
County:			Zip

**III. Appeal Point of Contact**

Contact Person	Joanne Goodman		
Title	Executive Director		
Contact Phone	845-634-6677	Extension	11
Contact Email			

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

Community Awareness Network for a Drug-Free Life and Environment is an OASAS provider of prevention services to both general populations and selected (high-risk) populations of children, youth and young adults. Among the populations we serve are lesbian, gay, bisexual and transgender individuals who often face challenges and barriers to accessing needed health services and, as a result, can experience worse health outcomes. We are the only organization to work with this population in Rockland County and in neighboring communities. Despite growing societal acceptance and understanding, some young people still suffer discrimination at the hands of their family and friends and in their schools and communities, experiences which can lead to serious challenges, such as housing problems, that affect health. There is growing awareness about bullying and violence affecting LGBT youth. These include efforts to promote greater attention to fostering inclusive school climates, teaching youth about online safety, establishment of reporting processes in schools and communities when violence or bullying occur, and referring young people for professional mental and behavioral health services when needed. Key statistics include the following:

- Like their adult counterparts, youth who identify as a sexual and/or gender minority experience higher rates of mental illness, substance abuse, violence, and discrimination compared to the general population. Additionally, LGBT youth are more likely to be homeless and live in poverty than non-LGBT youth. Research has found that parental rejection can increase the likelihood that an LGBT youth will suffer from depression, attempt suicide, use illegal drugs, and/or engage in risky sexual behaviors.<sup>65</sup>
- Approximately 40% of homeless youth are LGBT, and the leading reasons for homelessness among this group are due to family rejection.<sup>66</sup>
- Almost two thirds (64%) of LGB students and 4 out of 10 (44%) transgender students report feeling unsafe at school because of their sexual orientation or gender identity.<sup>67</sup>
- LGBT youth are four times more likely to attempt suicide than heterosexual youth.<sup>68</sup>
- Three times as many LGB youth report ever being raped compared to their heterosexual peers (16% vs. 5%).<sup>68</sup>

Our extensive experience with this high risk population and strategies for working with substance abuse and bullying prevention offer a unique opportunity to collaborate with and join the PPS networks in Rockland County, including Westchester County Medical Center and Refuah. We have extensive experience working with the DPOH on smoking cessation and contributing to smoke free campuses throughout Rockland.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	N/A at this time			

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Joanne Goodman	Answer <input checked="" type="radio"/> Yes <input type="radio"/> No
Title	Executive Director	

Only appeals from the CEO, CFO or comparable will be accepted





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HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

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**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Community Maternity Services
OPTIONAL Joined PPS:	Albany Medical Center Hospital

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

*Sister Mary Ann LoGiudice*

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:		3001498	1689820920
Agency Code:			
Billing Entity ID:			
	Address	City	State Zip
Address:	27 North Main Avenue	Albany	NY 12203
County:	Albany		

Community Maternity Services also has the following MMIS and NPI numbers:MMIS: 03001503 and 00353475; NPI: 1780830026 and 1316193659. Community Maternity Services, an agency of Catholic Charities of the Diocese of Albany, has been serving pregnant and parenting adolescents, vulnerable children and families at risk since 1971. CMS has an excellent reputation in the community especially for the work we do to promote healthy women, infants and children. The services we provide to this population effectively encourage healthy lifestyles and are instrumental in preventing hospitalizations. Our case management services are designed to help each mother have a healthy pregnancy resulting in a healthy birth, and ensure that infants receive continuous health care throughout their first year. We have a very strong success record in reducing premature births. Last year, 92% of infants born to our clients living in the community and 99% of infants born to our clients in our residential programs were born full-term at healthy birth weights and had no medical issues. Our services also help clients address the many obstacles they face in raising children and becoming healthy, self-sufficient adults. Our unique services are vital to the initiatives developed pursuant to New York State's Health Improvement Plan, and Community Maternity Services will be an important player in the DSRIP projects it has joined.

**III. Appeal Point of Contact**

Contact Person	Anne Marie Couser		
Title	Associate Executive Director Administration		
Contact Phone	518-482-8836	Extension	
Contact Email	annemarie@ccms.org		

**IV. Please choose the following 1915i Category:**

1 I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers

2 I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	90%	10%		

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name Sister Mary Ann LoGiudice, RSM  Yes  No

Title Executive Director

Only appeals from the CEO, CFO or comparable will be accepted



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HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
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**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Compeer Inc
OPTIONAL Joined PPS:	Finger Lakes PPS

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:			
Agency Code:	40900		
Billing Entity ID:			
	Address	City	State Zip
Address:	1600 South Avenue, Suite 230	Rochester	NY 14620
County:	Monroe		

**III. Appeal Point of Contact**

Contact Person	Johanna Ambrose		
Title	CEO and Managing Director		
Contact Phone	800-836-0475	Extension	
Contact Email	jambrose@compeer.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

Compeer is a respected, established nonprofit organization with 40 years experience delivering positive client outcomes at lower costs for individuals with a spectrum of mental disorders—at \$2,000 per client annually. The Compeer Model, the basis for services, is a SAMHSA evidence-based program and is twice-recognized this decade as a “best practices model for mental health recovery” by the APA. Compeer’s 20 NYS community-based locations serve on average 3,000 individuals yearly, plus their families. Screened, trained, monitored volunteers are matched by Compeer professional staff with referred clients in 1:1 supportive relationships based on gender, age, interests; additionally a match can support better physical health outcomes. Compeer, an adjunct to therapy, is an effective intervention for people who want to live in the community to achieve a high quality of life. Matches meet weekly for one year in safe environments using natural supports, sharing decision-making around activities, place, and time. Compeer relationships occur in the community, so we work directly to mitigate stigma reduction, social connectivity and inclusion, reintegration into family, home, faith, community. This reduces isolation for one of society’s most vulnerable populations, which in turn decreases use of higher, more expensive levels of care. Compeer Inc/NYS administers an annual survey to collect data, service statistics, and gauge customer satisfaction. Adult respondent constituencies include clients, volunteers, mh professionals. Compeer serves SMI adults, 40% of whom are also MICA and Dual Diagnosis. Programs are driven to positive outcomes for the client. Our largest improvements since 2011 have been in decreasing the need for crisis services (49.8% decrease in 2011 to 63.1% decrease in 2013) and increasing stable housing status (from 25.4% in 2011 to 68.6% in 2013), 2 key areas which will contribute to a successful DSRIP. Additional client outcomes since/while participating in the Compeer Program: 65-80% of adult consumers’ report at least some improvement in their comfort in social situations; 65-80% of adult consumers’ independence in their living situation will remain stable or improve; 65-80% of adult consumers will remain stable and/or experience a reduction in the number of hospitalizations or usage of crisis services. Customer satisfaction across 6 focus areas ranges from 77-99%. Compeer is a quality value-add to the mh services delivery system. We connect people and originated the Client-Centered Planning concept-the first to operationalize it in the U.S. Ingrained within this concept is the focus on Peer Support/Outreach. Compeer uses evidence-based practices/policies to meet the diverse needs of communities through cost-effective volunteer services. Compeer NYS sustains quality assurance through best practice management, technical assistance, training, marketing/communications, partnership facilitation, recruitment strategies. Acting as a liaison to the changing healthcare landscape, Compeer can function as a key partner to assist PPS initiatives. Compeer NYS by Sponsor Agency-County: Compeer Buffalo-Erie; Rochester-Monroe, RSS-Albany; Cty MH Services-Livingston; Cty Community MH-Steuben; Family Services-Chemung; STEL-Chautauqua; NAMI-Sullivan; CFLR-Herkimer/Oneida; Jewish Community Svcs-Westchester; MHAs in Allegany, Broome, Cattaraugus, Dutchess, Fulton, Montgomery, Nassau, Niagara, Orange, Rockland, Ulster.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage				

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Johanna Ambrose	Answer
Title	CEO and Managing Director	<input checked="" type="radio"/> Yes <input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		



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**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Compeer of Greater Buffalo
OPTIONAL Joined PPS:	Erie County Medical Center Corporation

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:			
Agency Code:	25260		
Billing Entity ID:			
	Address	City	State
Address:	135 Delaware Ave., Suite 210	Buffalo	NY
County:	Erie		
		Zip	
		14202	

The Compeer Model is a SAMHSA evidence-based program and has been twice recognized this past decade alone as a "best practices model for recovery". Compeer matches screened, trained, monitored-monthly community volunteers in one-to-one supportive relationships with referred adults, including veterans and older adults, and youth in mentoring relationships. These Compeer matches meet for a minimum of 4 hours a month (one hour a week) for one year in safe environments using natural supports to achieve greater social inclusion and community connectivity. Our stories of personal success are full of hope, healing, inspiration. With client-choice as a basis for matching, a Compeer match can support better physical health outcomes – i.e., a client with diabetes can choose to be matched with a volunteer with diabetes to support each other in healthier living choices.

Compeer originated the client-centered planning concept and was the first to operationalize it nationally. Ingrained in this concept is the focus on peer support and outreach. We work directly to mitigate stigma reduction, social connectivity and inclusion, and reintegration, reducing isolation for a vulnerable population and decreasing use of higher, more expensive levels of care. Because of our volunteer base, cost-effectiveness is built into our service model.

**III. Appeal Point of Contact**

Contact Person	Daniel Colpoys		
Title	Assistant Executive Director		
Contact Phone	716-883-3331	Extension	308
Contact Email	daniel@compeerbuffalo.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage				

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name Michele Brown  Yes  No  
 Title Executive Director  
 Only appeals from the CEO, CFO or comparable will be accepted



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**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Compeer Rochester, Inc
OPTIONAL Joined PPS:	Finger Lakes PPS

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:			
Agency Code:	46040		
Billing Entity ID:			
	Address	City	State Zip
Address:	259 Monroe Avenue	Rochester	NY 14607
County:	Monroe		

Compeer Rochester services provide Psychosocial Rehabilitation Support, Family Support and Training, and Empowerment services. i. a Compeer Rochester is located in Monroe County, NY, and has been providing one to one supportive services in our community for over 40 years. Currently, Our program participants are referred to our agency by therapists and case managers at licensed mental health facilities. The participant has identified our services as a desired strategy to promote their recovery goals. No one else in our community provides a volunteer based one to one support service like ours. The idea of a volunteer who willingly spends their time and is not paid, and is not trying to fix or evaluate is very powerful. Our services provide a safe environment for our "matches" to practice social skills and develop interests in integrated community venues. Compeer addresses the isolation brought on by mental illness and the barriers to community interaction. We stress consistency and dependability to our volunteers-the best way to develop trust. The result is that our programs can be both preventative and restorative. Our community based services combat the stigma and build awareness of mental health recovery.

**III. Appeal Point of Contact**

Contact Person	Dana P. Frame		
Title	President/Executive Director		
Contact Phone	585 546-8280	Extension	203
Contact Email	dframe@compeer.org		

**Our programs include:**

- **One to One Adult Supportive Friends:** Our core program for adults with SMI who want to engage with a Compeer Friend. This is community and peer volunteer based.
- **One to One Supportive Partners for Recovery:** Developed for people transitioning levels of care whose need is immediate and challenging. Trained per diem staff and peers provide this service.
- **CompeerCORPS:** Veterans helping Veterans- serves returning military, Veterans and their families. The program uses the evidenced based Compeer Model to provide peer mentoring for Veterans. The goals are: to foster a positive return to civilian life after military service, broaden interests, create a spirit of service to the community; bridge generational gaps among Veteran eras and encourage overall wellness.
- **One to One Youth Mentoring Program:** Screened, trained and monitored adult caring Mentors matched with youth in mental healthcare, with emotional and behavioural challenges.
- **Peer Family Mentor:** certified Peer staff with lived family experience. She provides outreach and information, engagement, transition support advocacy and empowerment supports.
- **Engagement Programs:** These are programs and group events designed to keep our referred participants connected to Compeer before and after their one to one services.

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

Compeer staff screens, trains, and monitors community volunteers and peers to provide face to face intentional and friendship based relationships with adults, children, and families in mental health care. We communicate at least once a month with our referral sources. These relationships happen in community settings and provide opportunities to practice social and interpersonal skills. Once a trusted relationship is established, they work on individualized recovery goals and build up the positive social networks and natural supports like family, faith communities, and recovery networks. We stress the identification and exposure to personal interests such as physical activity, artistic and creative opportunities, culinary and nutritional, and community service. Our staff and volunteers are trained in Cultural Competence and are representative or experienced with the populations we serve.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	66%	13%	eferrals/databas	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Dana P. Frame	Answer
Title	President/Executive Director	<input checked="" type="radio"/> Yes <input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Housing Options Made Easy, Inc.
OPTIONAL Joined PPS:	Erie County Medical Center Corporation

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:			
Agency Code:			
Billing Entity ID:	16-1370949		
	Address	City	State Zip
Address:	75 Jamestown Street	Gowanda	NY 14070
County:	Cattaraugus County (Main Office - serves 6 counties)		

Housing Options will provide the following 1915i Waiver services

- Empowerment Services - Peer Supports
- Habilitation Services
- Residential Supports/Supported Housing
- Individual Employment Support Services
- Self-Directed Services
- Peer Respite
- Peer Bridger
- Peer Wellness and Navigation

**III. Appeal Point of Contact**

Contact Person	Joseph M. Woodward		
Title	CEO		
Contact Phone	(716) 532-5508	Extension	14
Contact Email	<a href="mailto:joe@housingoptions.org">joe@housingoptions.org</a>		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	100%		Client database	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Joseph M. Woodward	Answer	
Title	CEO	<input checked="" type="radio"/> Yes	<input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted			



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Not Yet
--------	---------

You have chosen the following category:	1
---	---

**II. Appeal Applicant Information**

Organization Name:	Housing Options Made Easy, Inc.
OPTIONAL Joined PPS:	Finger Lakes PPS

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:			
Agency Code:			
Billing Entity ID:	16-1370949		
	Address	City	State
Address:	75 Jamestown Street	Gowanda	NY
County:	Cattaraugus County (Main Office - serves 6 counties)		

Housing Options will provide the following 1915i Waiver services

- Empowerment Services - Peer Supports
- Habilitation Services
- Residential Supports/Supported Housing
- Individual Employment Support Services
- Self-Directed Services
- Peer Respite
- Peer Bridger
- Peer Wellness and Navigation

**III. Appeal Point of Contact**

Contact Person	Joseph M. Woodward		
Title	CEO		
Contact Phone	(716) 532-5508	Extension	14
Contact Email	joe@housingoptions.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	100%		Client database	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Joseph M. Woodward	Answer	
Title	CEO	<input checked="" type="radio"/> Yes	<input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted			



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Housing Options Made Easy, Inc.
OPTIONAL Joined PPS:	Niagara Falls Memorial Medical Center

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:			
Agency Code:			
Billing Entity ID:	16-1370949		
	Address	City	State Zip
Address:	75 Jamestown Street	Gowanda	NY 14070
County:	Cattaraugus County (Main Office - serves 6 counties)		

Housing Options will provide the following 1915i Waiver services

- Empowerment Services - Peer Supports
- Habilitation Services
- Residential Supports/Supported Housing
- Individual Employment Support Services
- Self-Directed Services
- Peer Respite
- Peer Bridger
- Peer Wellness and Navigation

**III. Appeal Point of Contact**

Contact Person	Joseph M. Woodward		
Title	CEO		
Contact Phone	(716) 532-5508	Extension	14
Contact Email	<a href="mailto:joe@housingoptions.org">joe@housingoptions.org</a>		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	100%		Client database	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Joseph M. Woodward	Answer <input checked="" type="radio"/> Yes <input type="radio"/> No
Title	CEO	

Only appeals from the CEO, CFO or comparable will be accepted



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Council on Addiction Recovery Services Inc
OPTIONAL Joined PPS:	Finger Lakes PPS

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OASAS 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	170910702	933817	1144395054
Agency Code:	38160		
Billing Entity ID:	161160187		
	Address	City	State Zip
Address:	201 South Union Street	Olean	NY 14760
County:	Cattaraugus		

Additional residential case management services would qualify.

**III. Appeal Point of Contact**

Contact Person	Laura Elliott-Engel		
Title	Executive Director		
Contact Phone	716 373 4303	Extension	502
Contact Email	admin@councilonaddiction.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	45%	7%	IPMES	2013

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Laura Elliott-Engel	Answer
Title	Executive Director	<input checked="" type="radio"/> Yes <input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		





**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	EAC Inc
OPTIONAL Joined PPS:	Select PPS

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**We have an outpatient clinic in Nassau County that bills Medicaid, but none of our other programs (including those providing downstream Health Home Care Coordination) do.  
=E40=IF(Data!J23=1,Sheet1!G3,IF(Data!J23=2,Sheet1!G9,IF(Data!J23=3,Sheet1!G16,"This field is populated when you select a VAP Exception in Section IV"))**

Provider Type:	OASAS 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	160511510	2249145	1346302346
Agency Code:			
Billing Entity ID:			
	Address	City	State Zip
Address:	50 Clinton St, Ste 107	Hempstead	NY 11550
County:	Nassau		

**III. Appeal Point of Contact**

Contact Person	Angie Malone		
Title	Health Promotion Program Coordinator		
Contact Phone	516-539-0150	Extension	109
Contact Email	angela.malone@eacinc.org		

**IV. Please choose the following 1915i Category:**

1 I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers

2 I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	80%	5%	stats	2014

**VIII. Yes I Herby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name Rebecca Bell  Yes  No

Title Vice President & COO

Only appeals from the CEO, CFO or comparable will be accepted



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	2
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**II. Appeal Applicant Information**

Organization Name:	Erie County Council for the Prevention of Alcohol and Substance Abuse
OPTIONAL Joined PPS:	Erie County Medical Center Corporation

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OASAS 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:			
Agency Code:			
Billing Entity ID:			
	Address	City	State Zip
Address:	1625 Hertel Avenue	Buffalo	NY 14216
County:	Erie		

**III. Appeal Point of Contact**

Contact Person	Andrea J. Wanat		
Title	Executive Director		
Contact Phone	716.831.2298	Extension	101
Contact Email	ajwanat@eccpasa.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage				

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Andrea J. Wanat	Answer
Title	Executive Director	<input checked="" type="radio"/> Yes <input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		



**VAP EXCEPTION FORM IS DUE 10/14/2014 - NO EXTENSIONS WILL BE GRANTED**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval. Three allowed reasons for granting an exception are shown in Section IV.

**I. Are you a Medicaid Provider**

Answer  No  Yes

You have chosen the following VAP Exception:  i  ii  iii

**II. Appeal Applicant Information**

Organization Name: Every Person Influences Children Inc.  
 Joined PPS: Erie County Medical Center Corporation

^^ The VAP Exception is evaluated in the context of the PPS you are joining. If you are joining more than one PPS, you have the option of applying for the VAP Exception in that PPS as well (if applicable). Please see the "VII\_Additional PPSs" tab to select multiple PPS's. See Section II and VII of the instructions for further clarification!

Provider Type: Other  
 Provider Type - Other: 1915 OMH/OASAS  
 Operating Certificate/License #  
 MMIS\*  
 NPI\*  
 Unique Identifiers:  
 Agency Code: 38180  
 Billing Entity ID:  
 Address: 1000 Main St, City: Buffalo, State: NY, Zip: 14202  
 \*REQUIRED

**III. Appeal Point of Contact**

Contact Person: Jennifer Majeski  
 Title: Interim President  
 Contact Phone: 716-332-4122, Extension:  
 Contact Email: majeskij@epicforchildren.org

**IV. Please choose the following VAP Exception:**

- i A community will not be served without granting the exception because no other eligible provider is willing or capable of serving the community.
- ii Any hospital is uniquely qualified to serve based on services provided, financial viability, relationships within the community, and/or clear track record of success in reducing avoidable hospital use.
- iii Any state-designated health home or group of health homes. \*\*

When choosing VAP Exception i & ii – Please indicate what Performing Provider System (PPS) you plan on joining. If you do not indicate what PPS you intend to join, then you will be denied. Please indicate the name of the PPS in the "Appeal Applicant Information – Section II". If you are part of multiple PPSs, see section VII tab.

\*\* When choosing VAP Exception iii– The Department has submitted a draft list of State Designated Health Homes and Network Care Management Agencies (CMAs) that have already been approved as safety net providers as well as those that are pending CMS approval. If your Health Home appears on this list as pending approval, you will be granted a VAP Exception pending CMS approval and do not need to submit this form. If the organization operating your Health Home/CMA already appears on another safety net list, you do not need to submit this form. If your organization does not appear on the draft Health Home list or on another approved safety net provider list, but your organization believes that it should qualify as a Health Home, please complete this form. List is available on the DSRIP website.

~ For Section IV, if you are joining more than one PPS, use second tab (Section VII) to add additional PPSs.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	unknown	unknown	NA	NA

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name: Jennifer Majeski  
 Title: Interim President  
 Answer:  Yes  No  
 Only appeals from the CEO, CFO or comparable will be accepted

**VI. Restricted to 3500 Characters only! - Please read instructions for clarification!**

~ The VAP Exception relies heavily on the statement you provide, so please be concise and thorough~

Character Count: 3271

a. Based on the Prevention Gaps and Barriers Analysis for Erie County completed by the Center for Human and Social Research, at Buffalo State College, there is a high need for prevention related services including parenting in specified ZIP codes within Erie County. Three of EPIC's program, Ready Set Parent, Families in Transition (FiT) and Just for Teens (JFT) participants (85%) are residents of those ZIP codes, specifically: (Highest participation frequency to lowest) 14215, 14213, 14211, 14210, 14206, 14207, 14214, 14218 (Lackawanna), 14209, 14043 (Depew), 14224 (West Seneca), and 14150 (Tonawanda). These programs have also served high need parents in outlying high need, low service ZIP codes including: Akron, Alden, Amherst, Williamsville, Cheektowaga, Maryvale, Grand Island, Lancaster/Depew, and Orchard Park. Participants in EPIC's FIT parenting workshops are parents ages 18 and older who are "at risk" for a variety of personal and familial problems including substance abuse or continued use of substances, domestic violence, and child abuse and neglect, resulting in loss of custody of their children. EPIC is a preferred source of parenting education for judges from many Erie County and Buffalo City Courts. It is also important to note that our ongoing work in this community has indicated to us that prevention-oriented parenting programming is also a need across the entire city and county. Currently most parenting education is funded and offered via treatment programming in a clinical setting as opposed to our work which is free, group based and educational versus clinical. Another indication of the need for EPIC's FIT program is the fact that, despite gaining efficiencies in our operation for increased service numbers (which currently average 350 per year), we have a two –three month waiting time to access this program.

b. EPIC - Every Person Influences Children, Inc. is a not-for-profit organization dedicated to helping families, schools, and communities raise children to become responsible and capable adults. Founded in Buffalo in 1980, EPIC supports parents (male and female) ages 18 and older in both Erie and Niagara counties. We are the only agency of our kind in Erie or Niagara County solely dedicated to parenting education and family engagement. We own our curricula and also have developed a delivery system to implement our curricula which includes training and certifying facilitators to do our work. Additionally, we can provide the workshops directly to our participants or train other agency personnel to do this work. Our key parenting education services include Ready Set Parent which provides educational services to parents in the Buffalo birthing hospitals within 48 hours of delivery (Ready Set Parent) and community based parenting workshops for parents of children ages 0-18, as well as a curriculum for pregnant and parenting teens ages 14-19 (Just for Teens). Our services enhance this network by 1) being a high quality agency that can provide one stop shopping for parenting education for all parents 2) Serving high risk parents in the zip codes of highest need, 3) offering a continuum of services from the birth of their child through age 18. 4) alignment with NYS OASAS Prevention guidelines



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Families Child Advocacy Network
OPTIONAL Joined PPS:	Select PPS

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:			
Agency Code:	48540		
Billing Entity ID:			
	Address	City	State
Address:	135 Delaware Ave Ste 210	Buffalo	NY
			Zip
County:	Erie		14202

**III. Appeal Point of Contact**

Contact Person	Vicki McCarthy		
Title	Executive Director		
Contact Phone	716-884-2599	Extension	302
Contact Email	v.mccarthy@fcanwny.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage				

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Vicki McCarthy	Answer
Title	Executive Meeting	<input checked="" type="radio"/> Yes <input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

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**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Families First in Essex County Inc.
OPTIONAL Joined PPS:	Adirondack Health Institute

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:		2997428	1811190663
Agency Code:	18590		
Billing Entity ID:			
	Address	City	State
Address:	196 Water St. / PO Box 565	Elizabethtown	NY
			Zip
County:	Essex		

We are the only 1915i Medicaid provider in Essex County.

**III. Appeal Point of Contact**

Contact Person	JoAnne Caswell		
Title	Executive Director		
Contact Phone	518 873 9544	Extension	23
Contact Email	<a href="mailto:jcaswell@familiesfirstessex.org">jcaswell@familiesfirstessex.org</a>		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	85%	5%	medicaid billing	2013

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	JoAnne Caswell	Answer <input checked="" type="radio"/> Yes <input type="radio"/> No
Title	Executive Director	
Only appeals from the CEO, CFO or comparable will be accepted		



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	2
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**II. Appeal Applicant Information**

Organization Name:	Families On The Move of New York City, Inc.
OPTIONAL Joined PPS:	Select PPS

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	Harm Reduction 1915i Provider			
Provider Type - Other:	DO NOT USE			
	Operating Certificate/License #	MMIS	NPI	
Unique Identifiers:				
Agency Code:				
Billing Entity ID:				
	Address	City	State	Zip
Address:				
County:				

**III. Appeal Point of Contact**

Contact Person	Euphemia S. Adams		
Title	CEO		
Contact Phone	347-682-4870	Extension	
Contact Email	eadams@fotmny.org		

**IV. Please choose the following 1915i Category:**

<input type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input checked="" type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage				

**VIII. No** I Herby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.

Name	Euphemia S. Adams	Answer
Title	CEO	<input type="radio"/> Yes <input checked="" type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		

Families On The Move of New York City, Inc. (FOTM) is a family and youth peer support provider that is currently contracted with the New York State Office of Mental Health. Services currently contracted include: Family Peer Support, Youth Peer Support, Young Adult Supported and Education, trainings, Parenting classes, Anger Management classes and substance use prevention, screening brief intervention referral to treatment (SBIRT), Motivational Interviewing, technical assistance, advocacy and educational workshops for youth, and families of youth that have behavioral, mental health, emotional, and/or substance abuse challenges with behavioral systems and juvenile justice involvement or at risk of involvement. FOTM promotes and has demonstrated the facilitation of systems change/transformation and culture change in the childrens behavioral health systems. FOTM is also in the process of becoming Peer Respite Care Providers.



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Family Help Center
OPTIONAL Joined PPS:	Erie County Medical Center Corporation

**VI. Restricted to 3500 Characters only!**  
The mission of the Family Help Center is to provide free support to families and safety to children when parenting gets tough, 24/7. FHC is a 501c3 organization serving all of Erie County with the vast majority of our families are living in poverty in the City.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider			
Provider Type - Other:	DO NOT USE			
	Operating Certificate/License #	MMIS	NPI	
Unique Identifiers:				
Agency Code:				
Billing Entity ID:				
	Address	City	State	Zip
Address:	60 Dingens St.	Buffalo	NY	14206
County:	Erie			

**III. Appeal Point of Contact**

Contact Person	Deborah A. Merrifield		
Title	Executive Director		
Contact Phone	716-822-0919	Extension	237
Contact Email	<a href="mailto:dmerrifield@familyhelpcenter.net">dmerrifield@familyhelpcenter.net</a>		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	77%	11%	intake data	2013

**VIII. Yes I Herby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Deborah A. Merrifield	Answer	
Title	Executive Director	<input checked="" type="radio"/> Yes	<input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted			



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Family Service League, Inc.
OPTIONAL Joined PPS:	Stony Brook University Hospital

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:		02996069	1528093242
Agency Code:	50440		
Billing Entity ID:			
	Address	City	State Zip
Address:	790 Park Avenue	Huntington	N.Y. 11743
County:			

I do not believe we have to fill this out, since our Agency is already a designated safety net provider (OMH and OASAS-not pending list), but given the confusion surrounding this issue we are sending as an extra precautionary step. Thank you. Any questions, please let me know.

**III. Appeal Point of Contact**

Contact Person	Dr. Jeffrey Steigman		
Title	VP for Integrated Healthcare		
Contact Phone	631-470-6790	Extension	
Contact Email	jsteigman@fsl-li.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	44%	15%	PM System	2013

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Karen Boorshetein, LCSW	Answer
Title	President and CEO	<input checked="" type="radio"/> Yes <input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		





**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Family Ties of Westchester, Inc.
OPTIONAL Joined PPS:	Select PPS

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:			
Agency Code:	43530		
Billing Entity ID:			
	Address	City	State Zip
Address:	112 East Post Road, 3rd floor	White Plains	NY 10601
County:	Westchester		

**III. Appeal Point of Contact**

Contact Person	Carol Hardesty		
Title	Executive Director		
Contact Phone	914-995-5238	Extension	
Contact Email	<a href="mailto:chh2@westchestergov.com">chh2@westchestergov.com</a>		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	70%	30%		

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Carol Hardesty	Answer
Title	Executive Director	<input checked="" type="radio"/> Yes <input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	FEGS Health & Human Services
OPTIONAL Joined PPS:	Bronx-Lebanon Hospital Center

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider			
Provider Type - Other:	DO NOT USE			
	Operating Certificate/License #	MMIS	NPI	
Unique Identifiers:				
Agency Code:				
Billing Entity ID:				
	Address	City	State	Zip
Address:	315 Hudson Street	New York	NY	10013
County:				

**III. Appeal Point of Contact**

Contact Person	Amy Dorin		
Title	Senior Vice President		
Contact Phone	212-366-8010	Extension	
Contact Email	adorin@fegs.org		

**IV. Please choose the following 1915i Category:**

- 1 I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
- 2 I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	85%	7%	IMA	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name Kristin M. Woodlock/ *Kristin Woodlock* Answer  Yes  No  
 Title Chief Operating Officer  
 Only appeals from the CEO, CFO or comparable will be accepted



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	FEGS Health & Human Services
OPTIONAL Joined PPS:	Bronx-Lebanon Hospital Center

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:			
Agency Code:			
Billing Entity ID:			
	Address	City	State Zip
Address:	315 Hudson Street	New York	NY 10013
County:			

**III. Appeal Point of Contact**

Contact Person	Amy Dorin		
Title	Senior Vice President		
Contact Phone	212-366-8010	Extension	
Contact Email	adorin@fegs.org		

**IV. Please choose the following 1915i Category:**

- 1 I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
- 2 I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	85%	7%	IMA	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name Kristin M. Woodlock/ *Kristin Woodlock* Answer  Yes  No  
 Title Chief Operating Officer  
 Only appeals from the CEO, CFO or comparable will be accepted



**VAP EXCEPTION FORM IS DUE 10/24/2014 - STATE DESIGNATED HEALTH HOMES AND DOWNSTREAM CARE MANAGEMENT AGENCIES ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following Health Home category:	1
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**II. Appeal Applicant Information**

Organization Name:	FEGS Health & Human Services
OPTIONAL-Joined PPS:	Stony Brook University Hospital

**VI. Restricted to 3500 Characters only!**

The narrative section is optional, but you may write additional notes.

**I am hereby requesting approval as a safety net entity as I have been listed by the department of health as a high volume provider of Medicaid care management services**  
or

Character Count: 0

Provider Type:	Health Home/Care Management Agency			
Provider Type - Other:				
	Operating Certificate/License #	MMIS*	NPI*	
Unique Identifiers:		1371571	1912164120	
Agency Code:				
Billing Entity ID:	E0162796			
	Address	City	State	Zip
Address:	315 Hudson Street	New York	NY	10013
County:				

**III. Appeal Point of Contact**

Contact Person	Steve Rutter		
Title	Associate Vice President		
Contact Phone	516-505-2003	Extension	211
Contact Email	srutter@fegs.org		

**IV. Please choose the following Health Home category. These are all for option 3 of the safety net definition:**

- 1 A State designated Health Home or Health Home provider that is already on the Pending State-Designated State Health Home and Downstream Care Management Agency List.
- 2 If your organization does not appear on the draft Health Home list or on another approved safety net provider list, but your organization believes that it should qualify as a Health Home, please make this selection.

**You are choosing VAP Exception iii-** The Department has submitted a draft list of State Designated Health Homes and Network Care Management Agencies (CMAs) that have already been approved as safety net providers as well as those that are pending CMS approval. If your Health Home appears on this list as pending approval, you may be granted a VAP Exception pending CMS approval, but should submit this form. If the organization operating your Health Home/CMA already appears on another safety net list, you do not need to submit this form. If your organization does not appear on the draft Health Home list or on another approved safety net provider list, but your organization believes that it should qualify as a Health Home, please complete this form.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	85%	7%	IMA	2014

**VIII. Yes** I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.

Name Kristin M. Woodlock/ *Kristin Woodlock*  Yes  No



Title Chief Operating Officer

Only appeals from the CEO, CFO or comparable will be accepted





**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Fountain House, INC.
OPTIONAL Joined PPS:	Select PPS

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	6110503 (CSS-PSYCHOSOCIAL CLUBHOUSE)	1303502	1578642054
Agency Code:	18140		
Billing Entity ID:			
	Address	City	State Zip
Address:	425 West 47th Street	New York	NY 10036
County:	New York		

Fountain House meets the safety net definition because it is a non-hospital based provider, not participating as part of a state-designated health home, that has 86.5 percent of all patient volume in its primary lines of business associated with Medicaid, uninsured and Dual Eligible individuals. Fountain House has been serving individuals with serious mental illness in New York City for 66 years. The data used was reported to the DOH for Fiscal Year 2012, which ran from July 1, 2011, until June 30, 2012.

**III. Appeal Point of Contact**

Contact Person	ANDREW SCHONEBAUM		
Title	CHIEF FINANCIAL OFFICER		
Contact Phone	212-582-0340	Extension	230
Contact Email	aschonebaum@fountainhouse.org		

**IV. Please choose the following 1915i Category:**

1 I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers

2 I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	83.11%	3.38%	AWARDS	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name ANDREW SCHONEBAUM  Yes  No

Title CHIEF FINANCIAL OFFICER

Only appeals from the CEO, CFO or comparable will be accepted



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

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**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Goddard Riverside Community Center
OPTIONAL Joined PPS:	Mount Sinai Hospitals Group

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	7296471A (for ACT services)	02995733	1457444234
Agency Code:	18380		
Billing Entity ID:			
	Address	City	State
Address:	593 Columbus Avenue	New York	NY
	County:	New York	
		Zip	10024

Goddard Riverside Community Center serves individuals with mental illness and histories of homelessness through two 1915i-like programs: The Other Place (TOP) and TOP Opportunities (TOPOP). TOP, which began in 1988, is a psychosocial rehab, using a clubhouse model. TOPOP, which began in 1999 as an outgrowth of TOP, is an Assisted Competitive Employment program. There are very few providers of these vital services in the community. Without this designation, many people recovering from significant mental health issues would be without these important and long standing supportive services in the community. The organization is partnering with the following Health Homes as a downstream provider: Pathways to Wellness (CBC), NYC Health and Hospitals Corporation, Community Care Management Partners, and Mt. Sinai Health Home.

**III. Appeal Point of Contact**

Contact Person	Karen Smith-Moore		
Title	Associate Director of Programs		
Contact Phone	212-873-6600	Extension	304
Contact Email	<a href="mailto:ksmith-moore@goddard.org">ksmith-moore@goddard.org</a>		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	87%	3%	case records	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Stephan Russo	Answer
Title	Executive Director	<input checked="" type="radio"/> Yes <input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		





**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

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**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	2
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**II. Appeal Applicant Information**

Organization Name:	Village of Haverstraw DAPC
OPTIONAL Joined PPS:	Select PPS

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OASAS 1915i Provider		
Provider Type - Other:	DO NOT USE		
Unique Identifiers:	Operating Certificate/License #	MMIS	NPI
Agency Code:	90015	n/a	n/a
Billing Entity ID:			
Address:	Haverstraw Center, 50 West Broad Street	Haverstraw	NY 10927
County:	Rockland		

**III. Appeal Point of Contact**

Contact Person	Marion E Breland, LCSW, CASAC, CPP		
Title	Executive Director		
Contact Phone	845-429-5731	Extension	11
Contact Email	<a href="mailto:Marion.E.Breland@vohny.com">Marion.E.Breland@vohny.com</a>		

**IV. Please choose the following 1915i Category:**

1 I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers

2 I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	35%	40%	Participant Case Rec	2014

The Village of Haverstraw DAPC/Haverstraw Center is the only licensed prevention counseling program in Rockland County, and one of the few left in New York State. We provide assessments, individual, group, family and crisis counseling services to youth ages 8-21 and their family members, especially those who are affected by someone with a substance use problem, and/or who may be at risk of becoming addicted themselves. Services are currently provided on a sliding scale- no insurance is accepted at present, but this is something now under consideration. The program is currently funded by the local municipalities, grants and NYSOASAS. In addition to the services described, the Center offers positive alternative activities, recreation (a full-sized gymnasium), and other prevention education programs for the participants and the community at large.

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name Marion E. Breland, LCSW, CASAC, CPP  Yes  No

Title Executive Director

Only appeals from the CEO, CFO or comparable will be accepted



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Heights-Hill Mental Health Service SBPC Community Advisory Board, Inc.
OPTIONAL Joined PPS:	Select PPS

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	N/A		
Agency Code:	42860		
Billing Entity ID:			
	Address	City	State Zip
Address:	25 Flatbush Ave Third Floor	Brooklyn	NY 11217
County:	Kings		

**III. Appeal Point of Contact**

Contact Person	Christian Huygen, Ph.D.		
Title	Executive Director		
Contact Phone	718 852 5212	Extension	
Contact Email	<a href="mailto:christianhuygen@rainbowheights.org">christianhuygen@rainbowheights.org</a>		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	90%	1%	survey	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Christian Huygen, Ph.D.	Answer
Title	Executive Director	<input checked="" type="radio"/> Yes <input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Hillside Children's Center
OPTIONAL Joined PPS:	Finger Lakes PPS

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	Select One		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	We have many- avail on request	969333	1639267933
Agency Code:	EIN: 16-1453581		
Billing Entity ID:	1639267933		
	Address	City	State Zip
Address:	1183 Monroe avenue	Rochester	NY 14620
County:	Monroe		

**III. Appeal Point of Contact**

Contact Person	Pamela Ayers		
Title	Director of Service Development		
Contact Phone	(585) 766-1265	Extension	
Contact Email	payers@hillside.com		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	56%	1%	Hillside Business In	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Clyde Comstock	Answer
Title	COO	<input checked="" type="radio"/> Yes <input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Hillside Children's Center
OPTIONAL Joined PPS:	Erie County Medical Center Corporation

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	Select One		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	We have many- avail on request	969333	1639267933
Agency Code:	EIN: 16-1453581		
Billing Entity ID:	1639267933		
	Address	City	State Zip
Address:	1183 Monroe avenue	Rochester	NY 14620
County:	Monroe		

**III. Appeal Point of Contact**

Contact Person	Pamela Ayers		
Title	Director of Service Development		
Contact Phone	(585) 766-1265	Extension	
Contact Email	payers@hillside.com		

**IV. Please choose the following 1915i Category:**

1 I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers

2 I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	56%	1%	Hillside Business In	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name Clyde Comstock  Yes  No

Title COO

Only appeals from the CEO, CFO or comparable will be accepted



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Hillside Children's Center
OPTIONAL Joined PPS:	St. Joseph's Hospital Health Center

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	Select One		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	We have many- avail on request	969333	1639267933
Agency Code:	EIN: 16-1453581		
Billing Entity ID:	1639267933		
	Address	City	State Zip
Address:	1183 Monroe avenue	Rochester	NY 14620
County:	Monroe		

**III. Appeal Point of Contact**

Contact Person	Pamela Ayers		
Title	Director of Service Development		
Contact Phone	(585) 766-1265	Extension	
Contact Email	payers@hillside.com		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	56%	1%	Hillside Business In	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Clyde Comstock	Answer
Title	COO	<input checked="" type="radio"/> Yes <input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Hillside Children's Center
OPTIONAL Joined PPS:	Upstate University Hospital

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	Select One		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	We have many- avail on request	969333	1639267933
Agency Code:	EIN: 16-1453581		
Billing Entity ID:	1639267933		
	Address	City	State Zip
Address:	1183 Monroe avenue	Rochester	NY 14620
County:	Monroe		

**III. Appeal Point of Contact**

Contact Person	Pamela Ayers		
Title	Director of Service Development		
Contact Phone	(585) 766-1265	Extension	
Contact Email	payers@hillside.com		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	56%	1%	Hillside Business In	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Clyde Comstock	Answer
Title	COO	<input checked="" type="radio"/> Yes <input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	2
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**II. Appeal Applicant Information**

Organization Name:	Housing Works Inc
OPTIONAL Joined PPS:	Mount Sinai Hospitals Group

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	Harm Reduction 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	04-71--84		
Agency Code:	45980		
Billing Entity ID:			
	Address	City	State Zip
Address:	130 Crosby Street	New York	NY 10012
County:	New York		

We are a Harm Reduction Provider who will likely be a provider of 1915i services. We serve almost entirely a Medicaid population. Our charity ID is 04-71-84.

**III. Appeal Point of Contact**

Contact Person	Michael Clarke		
Title	Senior VP, Health Home, ADHC, Community Partnerships		
Contact Phone	347-473-7475	Extension	
Contact Email	clarke@housingworks.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	95%	5%	AIRS	2013

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Charles King	Answer
Title	CEO	<input checked="" type="radio"/> Yes <input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		





**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Kids Oneida
OPTIONAL Joined PPS:	Faxton St. Luke's Healthcare

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	9063010A	2276286	1770787079
Agency Code:	28220		
Billing Entity ID:			
	Address	City	State Zip
Address:	310 Main Street	Utica	NY 13501
County:	Oneida/ Herkimer		

**III. Appeal Point of Contact**

Contact Person	Steven Bulger		
Title	CEO/Executive Director- Interim		
Contact Phone	315-731-2603	Extension	
Contact Email	sbulger@kidsoneida.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	92%	3%	Report/ Client Mgmt	2013

**VIII. No** I Herby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.

Name	Steven Bulger	Answer <input type="radio"/> Yes <input checked="" type="radio"/> No
Title	CEO/Executive Director- Interim	

Only appeals from the CEO, CFO or comparable will be accepted



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exemption Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Lake Shore Behavioral Health, Inc.
OPTIONAL Joined PPS:	Catholic Medical Partners-Accountable Care IPA INC

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OASAS 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	6783100A, 6783110B, 6783110A,	03005290, 03005314, 03,	1497967129, 1184897258,
Agency Code:	50250		
Billing Entity ID:	E0232519		
	Address	City	State Zip
Address:	255 Delaware Avenue, Suite 300	Buffalo	NY 14202
County:	Erie		

**III. Appeal Point of Contact**

Contact Person	Howard K. Hitzel, Psy.D.		
Title	President		
Contact Phone	716-218-2321	Extension	
Contact Email	<a href="mailto:hhitzel@lake-shore.org">hhitzel@lake-shore.org</a>		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	73%	1%	CFR	2013

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Howard K. Hitzel, Psy. D.	Answer	
Title	President	<input checked="" type="radio"/> Yes	<input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted			



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Lake Shore Behavioral Health, Inc.
OPTIONAL Joined PPS:	Catholic Medical Partners-Accountable Care IPA INC

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	6783100A, 6783110B, 6783110A,	03005290, 03005314, 03,	1497967129, 1184897258,
Agency Code:	50250		
Billing Entity ID:	E0232519		
	Address	City	State Zip
Address:	255 Delaware Avenue, Suite 300	Buffalo	NY 14202
County:	Erie		

**III. Appeal Point of Contact**

Contact Person	Howard K. Hitzel, Psy.D.		
Title	President		
Contact Phone	716-218-2321	Extension	
Contact Email	<a href="mailto:hhitzel@lake-shore.org">hhitzel@lake-shore.org</a>		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	73%	1%	CFR	2013

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Howard K. Hitzel, Psy. D.	Answer	
Title	President	<input checked="" type="radio"/> Yes	<input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted			



**VAP EXCEPTION FORM IS DUE 10/24/2014 - STATE DESIGNATED HEALTH HOMES AND DOWNSTREAM CARE MANAGEMENT AGENCIES ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer  Yes  No

You have chosen the following Health Home category:  1

**II. Appeal Applicant Information**

Organization Name: Lake Shore Behavioral Health, Inc.  
OPTIONAL-Joined PPS: Catholic Medical Partners-Accountable Care IPA INC

VI. Restricted to 3500 Characters only!

The narrative section is optional, but you may write additional notes.

I am hereby requesting approval as a safety net entity as I have been listed by the department of health as a high volume provider of Medicaid care management services  
or

Character Count: 0

Provider Type:	Health Home/Care Management Agency			
Provider Type - Other:				
	Operating Certificate/License #	MMIS*	NPI*	
Unique Identifiers:	783011A, 6783010A, 6783012A, 6783484A,	00671765, 02370363, 03005290, 03005314	967129, 1184897258, 192221	
Agency Code:	50250			
Billing Entity ID:	E0232519			
	Address	City	State	Zip
Address :	255 Delaware Avenue, Suite 300	Buffalo	NY	14202
County:	Erie			

**III. Appeal Point of Contact**

Contact Person: Howard K. Hitzel, Psy. D.  
Title: President  
Contact Phone: (716)218-2321 Extension:   
Contact Email: hhitzel@lake-shore.org.

**IV. Please choose the following Health Home category. These are all for option 3 of the safety net definition:**

- 1 A State designated Health Home or Health Home provider that is already on the Pending State-Designated State Health Home and Downstream Care Management Agency List.
- 2 If your organization does not appear on the draft Health Home list or on another approved safety net provider list, but your organization believes that it should qualify as a Health Home, please make this selection.

**You are choosing VAP Exception iii-** The Department has submitted a draft list of State Designated Health Homes and Network Care Management Agencies (CMAs) that have already been approved as safety net providers as well as those that are pending CMS approval. If your Health Home appears on this list as pending approval, you may be granted a VAP Exception pending CMS approval, but should submit this form. If the organization operating your Health Home/CMA already appears on another safety net list, you do not need to submit this form. If your organization does not appear on the draft Health Home list or on another approved safety net provider list, but your organization believes that it should qualify as a Health Home, please complete this form.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	73%	1%	CFR	2013

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name Howard K. Hitzel, Psy.D.  Yes  No  
Title President  
Only appeals from the CEO, CFO or comparable will be accepted



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Lake Shore Behavioral Health, Inc.
OPTIONAL Joined PPS:	Erie County Medical Center Corporation

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OASAS 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	6783100A, 6783110B, 6783110A,	03005290, 03005314, 03,	1497967129, 1184897258,
Agency Code:	50250		
Billing Entity ID:	E0232519		
	Address	City	State Zip
Address:	255 Delaware Avenue, Suite 300	Buffalo	NY 14202
County:	Erie		

**III. Appeal Point of Contact**

Contact Person	Howard K. Hitzel, Psy.D.		
Title	President		
Contact Phone	716-218-2321	Extension	
Contact Email	hhitzel@lake-shore.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	73%	1%	CFR	2013

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Howard K. Hitzel, Psy. D.	Answer <input checked="" type="radio"/> Yes <input type="radio"/> No
Title	President	
Only appeals from the CEO, CFO or comparable will be accepted		



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
--------	-----

You have chosen the following category:	1
---	---

**II. Appeal Applicant Information**

Organization Name:	Lake Shore Behavioral Health, Inc.
OPTIONAL Joined PPS:	Erie County Medical Center Corporation

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	6783100A, 6783110B, 6783110A,	03005290, 03005314, 03,	1497967129, 1184897258,
Agency Code:	50250		
Billing Entity ID:	E0232519		
	Address	City	State Zip
Address:	255 Delaware Avenue, Suite 300	Buffalo	NY 14202
County:	Erie		

**III. Appeal Point of Contact**

Contact Person	Howard K. Hitzel, Psy.D.		
Title	President		
Contact Phone	716-218-2321	Extension	
Contact Email	hhitzel@lake-shore.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	73%	1%	CFR	2013

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Howard K. Hitzel, Psy. D.	Answer <input checked="" type="radio"/> Yes <input type="radio"/> No
Title	President	

Only appeals from the CEO, CFO or comparable will be accepted



**VAP EXCEPTION FORM IS DUE 10/24/2014 - STATE DESIGNATED HEALTH HOMES AND DOWNSTREAM CARE MANAGEMENT AGENCIES ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer Yes  No

You have chosen the following Health Home category: 1

**II. Appeal Applicant Information**

Organization Name: Lake Shore Behavioral Health, Inc.  
OPTIONAL-Joined PPS: Erie County Medical Center Corporation

**VI. Restricted to 3500 Characters only!**

The narrative section is optional, but you may write additional notes.

I am hereby requesting approval as a safety net entity as I have been listed by the department of health as a high volume provider of Medicaid care management services or

Character Count: 0

Provider Type:	Health Home/Care Management Agency			
Provider Type - Other:				
	Operating Certificate/License #	MMIS*	NPI*	
Unique Identifiers:	783011A, 6783010A, 6783012A, 6783484A,	00671765, 02370363, 03005290, 03005314	967129, 1184897258, 192221	
Agency Code:	50250			
Billing Entity ID:	E0232519			
	Address	City	State	Zip
Address :	255 Delaware Avenue, Suite 300	Buffalo	NY	14202
County:				

**III. Appeal Point of Contact**

Contact Person: Howard K. Hitzel, Psy. D.  
Title: President  
Contact Phone: (716)218-2321 Extension:   
Contact Email: hhitzel@lake-shore.org

**IV. Please choose the following Health Home category. These are all for option 3 of the safety net definition:**

- 1 A State designated Health Home or Health Home provider that is already on the Pending State-Designated State Health Home and Downstream Care Management Agency List.
- 2 If your organization does not appear on the draft Health Home list or on another approved safety net provider list, but your organization believes that it should qualify as a Health Home, please make this selection.

**You are choosing VAP Exception iii-** The Department has submitted a draft list of State Designated Health Homes and Network Care Management Agencies (CMAs) that have already been approved as safety net providers as well as those that are pending CMS approval. If your Health Home appears on this list as pending approval, you may be granted a VAP Exception pending CMS approval, but should submit this form. If the organization operating your Health Home/CMA already appears on another safety net list, you do not need to submit this form. If your organization does not appear on the draft Health Home list or on another approved safety net provider list, but your organization believes that it should qualify as a Health Home, please complete this form.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	73%	1%	CFR	2013

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name: Howard K. Hitzel, Psy.D.  Yes  No  
Title: President  
Only appeals from the CEO, CFO or comparable will be accepted





**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Liberty House Foundation, Inc.
OPTIONAL Joined PPS:	Adirondack Health Institute

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

Liberty House Foundation, Inc. provides psychiatric/vocational rehabilitation services to individuals with psychiatric impairments in Warren and Washington counties. Currently, Liberty House Foundation, Inc. is the only provider in these two counties that offers Pre-Vocational Training, Work Readiness Training, Supported Employment and Follow-Along Services to individuals with mental health disorders. These services are vital in the recovery process, contribute to overall wellness and decrease hospitalizations for individuals with severe and persistent mental illness. Liberty House Foundation, Inc. was founded in 1972. We are a private, not-for profit psychiatric and vocational rehabilitation

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:		03131871/02171828	
Agency Code:	40100		
Billing Entity ID:			
	Address	City	State
Address:	54 Bay Street	Glens Falls	NY
	County:	Warren	Zip
			12801

**III. Appeal Point of Contact**

Contact Person	Julia Beebe		
Title	Executive Director		
Contact Phone	518-798-1066	Extension	
Contact Email	jbeebe.libertyhouse@choiceoemail.com		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	95%	5%	Case Record	2013

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Julia Beebe	Answer	
Title	Executive Director	<input checked="" type="radio"/> Yes	<input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted			



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Liberty Resources, Inc.
OPTIONAL Joined PPS:	Finger Lakes PPS

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OASAS 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	50660	2994810	1225254881
Agency Code:			
Billing Entity ID:	E0001939		
	Address	City	State Zip
Address:	1045 James Street	Syracuse	NY 13203
County:	Onondaga		

**III. Appeal Point of Contact**

Contact Person	Marta Durkin		
Title	Vice President of Behavioral Healthcare		
Contact Phone	(315) 425-1004	Extension	1556
Contact Email	mdurkin@liberty-resources.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	95%	5%	CFR	2013

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Carl Coyle	Answer
Title	CEO	<input checked="" type="radio"/> Yes <input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Liberty Resources, Inc.
OPTIONAL Joined PPS:	Upstate University Hospital

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OASAS 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	50660	2994810	1225254881
Agency Code:			
Billing Entity ID:	E0001939		
	Address	City	State Zip
Address:	1045 James Street	Syracuse	NY 13203
County:	Onondaga		

**III. Appeal Point of Contact**

Contact Person	Marta Durkin		
Title	Vice President of Behavioral Healthcare		
Contact Phone	(315) 425-1004	Extension	1556
Contact Email	mdurkin@liberty-resources.org		

**IV. Please choose the following 1915i Category:**

1 I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers

2 I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	95%	5%	CFR	2013

**VIII. No** I Herby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.

Name Carl Coyle  Yes  No

Title CEO

Only appeals from the CEO, CFO or comparable will be accepted



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Liberty Resources, Inc.
OPTIONAL Joined PPS:	Finger Lakes PPS

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	7241441	2994810	1225254881
Agency Code:			
Billing Entity ID:	E0001939		
	Address	City	State Zip
Address:	1045 James Street	Syracuse	NY 13203
County:	Onondaga		

**III. Appeal Point of Contact**

Contact Person	Marta Durkin		
Title	Vice President of Behavioral Healthcare		
Contact Phone	(315) 425-1004	Extension	1556
Contact Email	mdurkin@liberty-resources.org		

**IV. Please choose the following 1915i Category:**

1 I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers

2 I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	100%	0%	Program Stats	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name Carl Coyle  Yes  No

Title CEO

Only appeals from the CEO, CFO or comparable will be accepted



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

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**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Liberty Resources, Inc.
OPTIONAL Joined PPS:	Upstate University Hospital

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	7241441	2994810	1225254881
Agency Code:			
Billing Entity ID:	E0001939		
	Address	City	State Zip
Address:	1045 James Street	Syracuse	NY 13203
County:	Onondaga		

**III. Appeal Point of Contact**

Contact Person	Marta Durkin		
Title	Vice President of Behavioral Healthcare		
Contact Phone	(315) 425-1004	Extension	1556
Contact Email	mdurkin@liberty-resources.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	100%	0%	Program Stats	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Carl Coyle	Answer	
Title	CEO	<input checked="" type="radio"/> Yes	<input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted			



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

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**I. Are you a Medicaid Provider**

Answer	Not Yet
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**II. Appeal Applicant Information**

Organization Name:	Long Island Families Together, Inc.
OPTIONAL Joined PPS:	Select PPS

You have chosen the following category:	1
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**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	n/a		
Agency Code:	41470		
Billing Entity ID:	n/a		
	Address	City	State
Address:	193 A Broadway	Amityville	NY
County:	Nassau/Suffolk		
	Zip		
	11762		

**III. Appeal Point of Contact**

Contact Person	Susan Burger		
Title	Executive Director		
Contact Phone	631-234-5438	Extension	105
Contact Email	sburger@lift4kids.org		

**IV. Please choose the following 1915i Category:**

1 I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers

2 I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	n/a	n/a		

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name Susan Burger Answer  Yes  No

Title Executive Director

Only appeals from the CEO, CFO or comparable will be accepted

Long Island Families Together is a Peer Family run not-for-profit agency that provides peer family support to families in Nassau and Suffolk County. We are the only agency that provides this type of family support service to both Counties, so families moving between counties would be able to stay with the same provider, affording them continuity of care. We provide peer family support, information, education and system navigation to families raising children with behavioral health concerns. This service is valuable to the PPS as it provides caregivers with assistance finding and staying connected to the services they need to keep their children out of the ED and inpatient units. The specialized services that we provide that are not provided by other agencies include, but are not limited to: 1. Family Peer Support addressing the special needs of families who are raising children with mental health issues who were adopted internationally, domestically and through foster care. These youth are at high risk of out of home placements. Lift offers targeted peer support, parent training, system navigation and advocacy to these families; 2. Youth Peer Advocate lead youth support groups for young people with behavioral health challenges who came to their families through adoption; 3. Youth Peer Advocate lead empowerment/support groups specifically for girls, ages 13-21 who have behavioral health challenges; 4. A Youth Peer Advocate Program providing individual youth peersupport and advocacy to young people with behavioral health challenges. Additionally, a recent analysis of data from the Family Assessment of Care (FAC) and the Youth Assessment of Care (YAC) indicates that a greater proportion of youth or caregivers with access to peer advocates compared to those without access responded positively on the satisfaction domains of access to services, appropriateness of services, participation in services and overall/global satisfaction. Access to peer advocates was also positively associated with agreement on the psychotropic medication comprehension domain for youth and on perceptions of child functioning and social connectedness for caregivers compared to those without access. This study adds to the growing understanding of the important role peer advocates play in engaging youth with mental health needs and their caregivers in mental health services.



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

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**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	2
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**II. Appeal Applicant Information**

Organization Name:	Long Island Minority AIDS Coalition
OPTIONAL Joined PPS:	Select PPS

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OASAS 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:			
Agency Code:			
Billing Entity ID:			
Address:	Address	City	State Zip
County:			

**III. Appeal Point of Contact**

Contact Person	Rabia A. Aziz		
Title	Chief Executive Officer		
Contact Phone	631-225-5500	Extension	
Contact Email	RAZIZ@limac.us		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	10.6 %	89%	AIRS	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Rabia A. Aziz	Answer
Title	Chief Executive Officer	<input checked="" type="radio"/> Yes <input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		





**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
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**State of New York Department of Health  
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Vital Access Provider Exception Form**

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**I. Are you a Medicaid Provider**

Answer	Not Yet
--------	---------

You have chosen the following category:	2
---	---

**II. Appeal Applicant Information**

Organization Name:	Long Island Minority AIDS Coalition
OPTIONAL Joined PPS:	Select PPS

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OASAS 1915i Provider			
Provider Type - Other:	DO NOT USE			
	Operating Certificate/License #	MMIS	NPI	
Unique Identifiers:				
Agency Code:				
Billing Entity ID:				
	Address	City	State	Zip
Address:				
County:				

**III. Appeal Point of Contact**

Contact Person	Rabia A. Aziz		
Title	Chief Executive Officer		
Contact Phone	631-225-5500	Extension	
Contact Email	RAZIZ@limac.us		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	10.6 %	89%	AIRS	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Rabia A. Aziz	Answer
Title	Chief Executive Officer	<input checked="" type="radio"/> Yes <input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	2
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**II. Appeal Applicant Information**

Organization Name:	Loretto Independent Living Services Inc.
OPTIONAL Joined PPS:	Select PPS

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	Harm Reduction 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	3301209R	01519162	1740624709
Agency Code:			
Billing Entity ID:			
	Address	City	State Zip
Address:	100 Malta Lane	North Syracuse	NY 13212
County:	Onondaga		

**III. Appeal Point of Contact**

Contact Person	Penny Abulencia		
Title	Executive Director		
Contact Phone	(315) 413-4527	Extension	N/A
Contact Email	pabulenc@lorettosystem.org		

**IV. Please choose the following 1915i Category:**

1 I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers

2 I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	99%	0%	Cost Reports	2013

Loretto Independent Living Services, Inc. (DBA PACE CNY) is a Program of All-inclusive Care for the Elderly (PACE) that has been granted a certificate of authority to operate pursuant to Article 44 of the New York State Public Health Law. It is both a healthcare provider and a health plan. For the purposes of DSRIP, the organization requests that PACE be considered a safety net provider based on the following distinctions: 1. Unlike other managed care organizations, PACE, by State regulation, provides primary care via an Article 28 Diagnostic and Treatment Center (D&TC) and has an Operating Certificate Number. 2. NYS DOH performs D&TC inspections and surveys. 3. PACE physicians are salaried employees and qualify as eligible providers for purposes of receiving EHR meaningful use payments from Medicaid and Medicare. 4. The PACE model is predicated on an Adult Day Health Care model.

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name Penny Abulencia  Yes  No

Title Executive Director

Only appeals from the CEO, CFO or comparable will be accepted



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Maryhaven Center of Hope
OPTIONAL Joined PPS:	Catholic Health Services of Long Island

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	6825012A / 6825006A	02882424	1215120399
Agency Code:	86050		
Billing Entity ID:	11-2861698		
	Address	City	State Zip
Address:	51 Terryville Road	Port Jefferson Station	NY 11776
County:	Suffolk		

**III. Appeal Point of Contact**

Contact Person	Diane Brown		
Title	Office Manager		
Contact Phone	631.474.4120	Extension	227
Contact Email	Diane.Brown@CHSLI.org		

**IV. Please choose the following 1915i Category:**

1 I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers

2 I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	65%	1%	enrollment	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name Karen Estrada  Yes  No

Title V.P. of Finance

Only appeals from the CEO, CFO or comparable will be accepted



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Maryhaven Center of Hope
OPTIONAL Joined PPS:	Catholic Health Services of Long Island

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	6825014A	03012315	1417149386
Agency Code:	86050		
Billing Entity ID:	11-2861698		
	Address	City	State Zip
Address:	51 Terryville Road	Port Jefferson Station	NY 11776
County:	Suffolk		

**III. Appeal Point of Contact**

Contact Person	Diane Brown		
Title	Office Manager		
Contact Phone	631.474.4120	Extension	227
Contact Email	Diane.Brown@CHSLI.org		

**IV. Please choose the following 1915i Category:**

1 I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers

2 I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	65%	1%	enrollment	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name Karen Estrada  Yes  No

Title V.P. of Finance

Only appeals from the CEO, CFO or comparable will be accepted



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Maryhaven Center of Hope
OPTIONAL Joined PPS:	Catholic Health Services of Long Island

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OASAS 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	150511768	02870437	1730218546
Agency Code:	86050		
Billing Entity ID:	11-2861698		
	Address	City	State Zip
Address:	51 Terryville Rd	Port Jefferson Station	NY 11776
County:	Suffolk		

**III. Appeal Point of Contact**

Contact Person	Diane Brown		
Title	Office Manager		
Contact Phone	631-474-4120	Extension	227
Contact Email	<a href="mailto:diane.brown@chsl.org">diane.brown@chsl.org</a>		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	25%	1%	enrollment	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Karen Estrada	Answer
Title	V.P. of Finance	<input checked="" type="radio"/> Yes <input type="radio"/> NO
Only appeals from the CEO, CFO or comparable will be accepted		



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	2
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**II. Appeal Applicant Information**

Organization Name:	Mental Health Association of Erie County, Inc.
OPTIONAL Joined PPS:	Erie County Medical Center Corporation

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	Harm Reduction 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:			
Agency Code:	10550		
Billing Entity ID:			
	Address	City	State Zip
Address:	999 Delaware Avenue	Buffalo	NY 14209
County:	Erie		

**III. Appeal Point of Contact**

Contact Person	Jenny Laney		
Title	Director Child and Family Support Program		
Contact Phone	716 886-1242	Extension	313
Contact Email	laney@eriemha.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage				

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Kenneth Houseknecht	Answer
Title	Executive Director Mental Health Association of Erie County, Inc.	<input checked="" type="radio"/> Yes <input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		

The Child and Family Support Program is a program of the Mental Health Association of Erie County, Inc. MHA is in the process of getting a Medicaid number with the purpose of becoming Medicaid billable for family support and peer support services. Family advocates are presently working in the psychiatric emergency room at the Erie County Medical Center providing family support and linking families to community resources. Our agency would like to be a provider of family support in the Children's system of care to include being a provider working with health homes. Family Support Programs have been working closely with Angela Keller, LMSW, Medicaid Managed Care Transition Consultant for the New York State Office of Mental Health. The Child and Family Support Program presently has peer family advocates and a peer youth mentor working with the behavioral health units at the Erie County Medical Center. The Child and Family Support Program is a family support program providing education, support and advocacy to caregivers who have a child diagnosed with a mental illness. The program also provides short-term respite services, social skills groups and the Expression through Art program for children and teens.



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	2
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**II. Appeal Applicant Information**

Organization Name:	Mental Health Association in Niagara County Inc
OPTIONAL Joined PPS:	Niagara Falls Memorial Medical Center

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:			
Agency Code:	10050		
Billing Entity ID:			
	Address	City	State Zip
Address:	36 pine street	lockport	ny 14094
County:	niagara		

The Mental Health Association in Niagara County Inc. will be working with Niagara Falls Memorial Medical Center providing Peer led Programs, trainings and advocacy. The MHA covers all of Niagara County. We are a partner with NFMCC's Health Home.

**III. Appeal Point of Contact**

Contact Person	Cheryl Blacklock		
Title	Executive Director		
	(716) 433-3780	Extension	
Contact Email	<a href="mailto:cablacklock@mhanc.com">cablacklock@mhanc.com</a>		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage				

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Cheryl Blacklock	Answer	
Title	Executive Director	<input checked="" type="radio"/> Yes	<input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted			





**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Mental Health Association in Suffolk County
OPTIONAL Joined PPS:	Stony Brook University Hospital

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:			
Agency Code:	16160		
Billing Entity ID:			
	Address	City	State Zip
Address:	939 Johnson Avenue	Ronkonkoma	NY 11779
County:	Suffolk		

**III. Appeal Point of Contact**

Contact Person	Michael Stoltz		
Title	CEO		
Contact Phone	631-471-7242	Extension	1304
Contact Email	mstoltz@mhaw.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	60%	40%	Records	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Michael Stoltz	Answer
Title	CEO	<input checked="" type="radio"/> Yes <input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Mental Health Association of Columbia-Greene Counties, Inc.
OPTIONAL Joined PPS:	Albany Medical Center Hospital

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider			
Provider Type - Other:	DO NOT USE			
	Operating Certificate/License #	MMIS	NPI	
Unique Identifiers:	We have many. Here is one op cert#7418022		1700938560	
Agency Code:	program specific			
Billing Entity ID:	2996990			
	Address	City	State	Zip
Address:	713 Union Street	Hudson	NY	12534
County:	Columbia			

I am completing this, although I don't know if it is required of us. I simply want to assure that we are on some list that allows the agency to provide 1915i services. Please inform me if there is something else we need to do.

**III. Appeal Point of Contact**

Contact Person	Jeffrey Rovitz		
Title	Executive Director		
Contact Phone	518 828 4619	Extension	333
Contact Email	jrovitz@mhacg.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	90%	5%		

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Jeffrey Rovitz	Answer	
Title	Executive Director	<input checked="" type="radio"/> Yes	<input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted			



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Not Yet
--------	---------

You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Mental Health Association in Jefferson County, Inc.
OPTIONAL Joined PPS:	Samaritan Medical Center

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:			
Agency Code:	10590		
Billing Entity ID:			
	Address	City	State Zip
Address:	425 Washington St	Watertown	NY 13601
County:	Jefferson		

**III. Appeal Point of Contact**

Contact Person	Korin Scheible		
Title	Executive Director		
Contact Phone	315-788-0970	Extension	235
Contact Email	KScheible@mhajc.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	73%	9%	Self Reported	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Korin Kingman	Answer
Title	Executive Director	<input checked="" type="radio"/> Yes <input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		



**VAP EXCEPTION FORM IS DUE 10/14/2014 - NO EXTENSIONS WILL BE GRANTED**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval. Three allowed reasons for granting an exception are shown in Section IV.

**I. Are you a Medicaid Provider**

Answer Yes

You have chosen the following VAP Exception:  i

**II. Appeal Applicant Information**

Organization Name: MHA-NYC  
 Joined PPS: Mount Sinai Hospitals Group

^^ The VAP Exception is evaluated in the context of the PPS you are joining. If you are joining more than one PPS, you have the option of applying for the VAP Exception in that PPS as well (if applicable). Please see the "VII\_Additional PPSs" tab to select multiple PPS's. See Section II and VII of the instructions for further clarification!

Provider Type: Other  
 Provider Type - Other: 1915i services  
 Operating Certificate/License #: 7957018A  
 MMIS\*: 3421029  
 NPI\*: 10132374  
 Agency Code:  
 Billing Entity ID:  
 Address: 50 Broadway, 19th Floor  
 City: New York  
 State: NY  
 Zip: 10004

**VI. Restricted to 3500 Characters only! - Please read instructions for clarification!**

~ The VAP Exception relies heavily on the statement you provide, so please be concise and thorough~

You chose the qualification i, in the space below please include:

a. A specific definition of the community (ies) that would otherwise not be served by the selected PPS. Be sure to include descriptions of the geographic area, the population, and how the services in this community are insufficient without your organization's involvement given the PPS current configuration of network providers.  
 b. A description of the applicant's organization, the services provided, and how the services will enhance the network of services for the PPS in this community (ies).  
 c. Any supporting documentation to substantiate your narrative (attach as PDF in the email when submitting)

Character Count: 1588

**III. Appeal Point of Contact**

Contact Person: Kathryn Salisbury  
 Title: Executive Vice President  
 Contact Phone: 212-254-0333  
 Extension: 796  
 Contact Email: Ksalisbury@mhaofnyc.org

**IV. Please choose the following VAP Exception:**

- i A community will not be served without granting the exception because no other eligible provider is willing or capable of serving the community.
- ii Any hospital is uniquely qualified to serve based on services provided, financial viability, relationships within the community, and/or clear track record of success in reducing avoidable hospital use.
- iii Any state-designated health home or group of health homes. \*\*

When choosing VAP Exception i & ii – Please indicate what Performing Provider System (PPS) you plan on joining. If you do not indicate what PPS you intend to join, then you will be denied. Please indicate the name of the PPS in the "Appeal Applicant Information – Section II". If you are part of multiple PPSs, see section VII tab.

\*\* When choosing VAP Exception iii– The Department has submitted a draft list of State Designated Health Homes and Network Care Management Agencies (CMAs) that have already been approved as safety net providers as well as those that are pending CMS approval. If your Health Home appears on this list as pending approval, you will be granted a VAP Exception pending CMS approval and do not need to submit this form. If the organization operating your Health Home/CMA already appears on another safety net list, you do not need to submit this form. If your organization does not appear on the draft Health Home list or on another approved safety net provider list, but your organization believes that it should qualify as a Health Home, please complete this form. List is available on the DSRIP website.

~ For Section IV, if you are joining more than one PPS, use second tab (Section VII) to add additional PPSs.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	70%	15%	ram enrollment	2013

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name: Susan Shanklin ESQ.  
 Title: COO  
 Answer:  Yes  No  
 Only appeals from the CEO, CFO or comparable will be accepted

The Mental Health Association of New York City has been placed on the list of agencies that are known to operate "1915 i -like" services that will be available to HARP enrollees. We are the primary provider of family support and peer support services within the Mt. Sinai PPS with services provided by the Northern Manhattan Family Resource Center and the Southern Manhattan Family Resource Center, We also provide care management services, peer supports, psychosocial rehabilitation services, education support services and individual employment support services through our Manhattan Adolescent Skills Center and Harlem BAY PROS programs. The Manhattan Adolescent Skills Center is one of two Adolescent Skills Centers funded in Mahattan. Additionally, MHA-NYC operates Recovery Works, transitional living facility for individuals with co-occurring mental health and substance abuse disorders and a scatter-site housing program for this population In addition our H2H Contact Center provides crisis intervention and care transition services. MHA-NYC operates programs in all 5 boroughs of NYC that serve individuals who have behavioral health needs and their families. The services provided by MHA-NYC will enhance the network of services for the Mt. Sinai PPS by filling critical needs for family support, peer services, and employment supports within the network. MHA-NYC's LifeNet crisis intervention services also play a critical role in coordinating access to a variety of crisis intervention services and function as the single point of access to mobile crisis services in NYC.



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Multi-County Community Development Corporation
OPTIONAL Joined PPS:	Westchester Medical Center

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	8276445	2248671	1154517928
Agency Code:	14640		
Billing Entity ID:	E0169477		
	Address	City	State Zip
Address:	11 Twin Maples Plaza, Suite 5	Saugerties	NY 12477
County:	Ulster		

Multi-County Community Development Corporation (MCCDC) serves the complex care needs for individuals with serious mental illness (OMH Supported Housing), serious substance use (OASAS Shelter Plus Care), People for HIV/AIDS (HOPWA) as well as individuals in OPWDD licensed IRA's and apartment programs. MCCDC is participating in 4 PPS's: Westchester Medical Center, Montefiore, Health Alliance of Hudson Valley and Albany Medical Center. MCCDC has another MMIS number (02248704) in addition to the number in Section II. MCCDC also has the following additional OPWDD Operating Certificate numbers - 8276442, 8276441, 8276444, 8276443, 8276440, 8276446.

**III. Appeal Point of Contact**

Contact Person	Jerry Lesczynski		
Title	Managing Director		
Contact Phone	845-247-9110	Extension	222
Contact Email	jleszczynski@rehab.org		

**IV. Please choose the following 1915i Category:**

1 I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers

2 I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	99%	1%	Client Record	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name William DeVita  Yes  No

Title President, Board of Directors

Only appeals from the CEO, CFO or comparable will be accepted



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
---	---

**II. Appeal Applicant Information**

Organization Name:	NADAP
OPTIONAL Joined PPS:	Select PPS

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OASAS 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:		03439925	1295006526
Agency Code:			
Billing Entity ID:			
	Address	City	State Zip
Address:	355 Lexington Avenue	New York	NY 10017
County:	New York		

**III. Appeal Point of Contact**

Contact Person	John A. Darin		
Title	President and CEO		
Contact Phone	212-986-1170	Extension	132
Contact Email	jdarin@nadap.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

NADAP's Comprehensive Employment Services (CES) program prepares individuals with barriers to employment to successfully enter the workforce. CES provides customized services for people with chemical dependency, ex-offenders and individuals with co-occurring disorders. All participants receive a comprehensive vocational assessment, pre-vocational services including job preparation and job placement, and employment retention services. CES works closely with NYC businesses and industries to develop job opportunities for participants.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	90%	10%	Program Enrollment	2013

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	John A. Darin	Answer <input checked="" type="radio"/> Yes <input type="radio"/> No
Title	President and CEO	

Only appeals from the CEO, CFO or comparable will be accepted



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Select One
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	
OPTIONAL Joined PPS:	Montefiore Medical Center

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**We have also applied to the Westchester Medical Center and Refuah as a PPS Provider**

Provider Type:	Select One			
Provider Type - Other:	DO NOT USE			
Operating Certificate/License #	MMIS	NPI		
Unique Identifiers:				
Agency Code:	43070			
Billing Entity ID:				
Address:	PO Box 635	Orangeburg	NY	10962
County:				

**III. Appeal Point of Contact**

Contact Person	Rena Finkelstein
Title	President of the Board of Directors, CEO
Contact Phone	(845) 359-8785
Contact Email	<a href="mailto:rena@namirockland.org">rena@namirockland.org</a>

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	N/A			

NAMI-FAMILYA of Rockland County Inc. ( NAMI-FAMILYA ) organized 33 years ago provides a broad and comprehensive array of family support, education and training services meeting the definition of Family Support and Training under NYS HARP and HCBS. We assist families/caregivers to provide a safe and supportive environment in the home and community, coping and communication skills, understanding mental disorders and dual diagnosis (substance abuse disorder/ development disabilities), treatment options and behavioral interventions through NAMI evidence based courses, for family members with adult relatives with mental illness and families/caregivers of children and adolescents with behavioral disorders, mental and emotional issues. Courses taught by NAMI trained family members to develop and enhance families' problem solving skills strategies & tools for symptom and behavior management and prevention of relapse. Monthly educational meetings provide vital information and understanding of treatments and rehabilitation current research, etc. We also have a **Helpline and support groups in English and Spanish. A new program will provide a certified family peer advocate and more intensive one on one counseling, skill building, small group workshops, and advocacy under supervision of a social worker. This will also offer guidance in understanding the waiver process and assistance in obtaining placement in appropriate programs and services.** in various settings in the home, school and community, as needed. We will also provide tools for relapse regulation, violence prevention and suicide, and includes development of a crisis/safety plan. Our website [www.namirockland.org](http://www.namirockland.org) provides a more detailed description of our many programs.

**VIII. Yes I Herby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Rena Finkelstein	Answer <input checked="" type="radio"/> Yes <input type="radio"/> No
Title	President of the Board, CEO	

Only appeals from the CEO, CFO or comparable will be accepted



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
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**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	NAMI-NYC Metro
OPTIONAL Joined PPS:	Maimonides Medical Center

**VI. Restricted to 3500 Characters only!**

*NAMI-NYC Metro provides support, education, and advocacy for families and individuals of all ethnic backgrounds who live with serious mental illness in all five boroughs in New York City.*

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	N/A		
Agency Code:	17320		
Billing Entity ID:	N/A		
	Address	City	State Zip
Address:	505 8th Avenue Suite 1103	New York	NY 10018
County:	New York		

**III. Appeal Point of Contact**

Contact Person	Wendy Brennan		
Title	Executive Director		
Contact Phone	212-684-3365	Extension	208
Contact Email	wbrennan@naminyc.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	65%	5%	self-report	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Wendy Brennan	Answer <input checked="" type="radio"/> Yes <input type="radio"/> No
Title	Executive Director	
Only appeals from the CEO, CFO or comparable will be accepted		





**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
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**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

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**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	NAMI-NYC Metro
OPTIONAL Joined PPS:	Maimonides Medical Center

**VI. Restricted to 3500 Characters only!**

*NAMI-NYC Metro provides support, education, and advocacy for families and individuals of all ethnic backgrounds who live with serious mental illness in all five boroughs in New York City.*

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider			
Provider Type - Other:	DO NOT USE			
	Operating Certificate/License #	MMIS	NPI	
Unique Identifiers:	N/A			
Agency Code:	17320			
Billing Entity ID:	N/A			
	Address	City	State	Zip
Address:	505 8th Avenue Suite 1103	New York	NY	10018
County:	New York			

**III. Appeal Point of Contact**

Contact Person	Wendy Brennan		
Title	Executive Director		
Contact Phone	212-684-3365	Extension	208
Contact Email	wbrennan@naminyc.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	65%	5%	self-report	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Wendy Brennan	Answer
Title	Executive Director	<input checked="" type="radio"/> Yes <input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	2
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**II. Appeal Applicant Information**

Organization Name:	New York Harm Reduction Educators
OPTIONAL Joined PPS:	Select PPS

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	Harm Reduction 1915i Provider			
Provider Type - Other:	DO NOT USE			
	Operating Certificate/License #	MMIS	NPI	
Unique Identifiers:				
Agency Code:				
Billing Entity ID:				
	Address	City	State	Zip
Address:	155 East 149th St, 2nd Fl	Bronx	NY	10451
County:	Bronx			

**III. Appeal Point of Contact**

Contact Person	Carolina Lopez		
Title	Executive Director		
Contact Phone	718.842.6050	Extension	205
Contact Email	clopez@nyhre.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	9%	89%	AIRS	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Carolina Lopez	Answer
Title	Executive Director	<input checked="" type="radio"/> Yes <input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		



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**State of New York Department of Health  
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Vital Access Provider Exception Form**

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**I. Are you a Medicaid Provider**

Answer	Not Yet
--------	---------

You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	North Country Freedom Homes, Inc.
OPTIONAL Joined PPS:	Samaritan Medical Center

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OASAS 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	151110151		
Agency Code:	36160		
Billing Entity ID:			
	Address	City	State Zip
Address:	25 Dies Street	Canton	NY 13617
County:	St. Lawrence		

**III. Appeal Point of Contact**

Contact Person	Sharon Peabody		
Title	Administrative Assistant		
Contact Phone	315-379-0139	Extension	103
Contact Email	Sharon.Peabody		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	99%		ation Forms/In	2013-14

**VIII. No** I Herby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.

Name Sharon Peabody  Yes  No

Title Administrative Assistant/CFO

Only appeals from the CEO, CFO or comparable will be accepted



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**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

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**I. Are you a Medicaid Provider**

Answer	Not Yet
--------	---------

You have chosen the following category:	1
---	---

**II. Appeal Applicant Information**

Organization Name:	North Country Freedom Homes, Inc.
OPTIONAL Joined PPS:	Samaritan Medical Center

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OASAS 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	151110151		
Agency Code:	36160		
Billing Entity ID:			
	Address	City	State Zip
Address:	25 Dies Street	Canton	NY 13617
County:	St. Lawrence		

**III. Appeal Point of Contact**

Contact Person	Sharon Peabody		
Title	Administrative Assistant		
Contact Phone	315-379-0139	Extension	103
Contact Email	Sharon.Peabody		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	99%		ation Forms/In	2013-14

**VIII. No** I Herby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.

Name Sharon Peabody  Yes  No

Title Administrative Assistant/CFO

Only appeals from the CEO, CFO or comparable will be accepted



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
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**I. Are you a Medicaid Provider**

Answer	Yes
--------	-----

You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Northeast Parent & Child Society, Inc.
OPTIONAL Joined PPS:	Select PPS

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	7308001A	02664359	1003901695
Agency Code:	13050		
Billing Entity ID:			
	Address	City	State Zip
Address:	530 Franklin Street	Schenectady	NY 12305
County:	Schenectady		

**III. Appeal Point of Contact**

Contact Person	Audrey LaFrenier		
Title	Chief Operating Officer		
Contact Phone	(518) 431-1652	Extension	
Contact Email	audrey.lafrenier@northernrivers.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	83%	6%	EMR	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Audrey LaFrenier	Answer
Title	Chief Operating Officer	<input checked="" type="radio"/> Yes <input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
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**State of New York Department of Health  
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**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Northern Manhattan Perinatal Partnership, Inc.
OPTIONAL Joined PPS:	The New York and Presbyterian Hospital

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
Operating Certificate/License #	3121542	1245467810	
Unique Identifiers:			
Agency Code:			
Billing Entity ID:			
Address:	127 West 127th Street, 3rd floor	New York	NY 10027
County:	New York		

Northern Manhattan Perinatal Partnership, Inc. is a twenty-two old organization that is a national MCH leader delivering critical health and social services in the greater Harlem community. Northern Manhattan core competencies include: preconception/interconceptional health, case management services through home visiting, doula care, and health and wellness services. These services are provided to men and women of child bearing age.

**III. Appeal Point of Contact**

Contact Person	Mario Drummonds		
Title	CEO		
Contact Phone	347-489-4769	Extension	
Contact Email	mdrummonds@msn.com		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	85%	15%	intake data bas	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Mario Drummonds	Answer	
Title	CEO	<input checked="" type="radio"/> Yes	<input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted			



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	NYSARC INC NEW YORK CITY CHAPTER
OPTIONAL Joined PPS:	Health & Hospital Corporation

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	6198	02703602	
Agency Code:	28310		
Billing Entity ID:	135596746		
	Address	City	State Zip
Address:	83 Maiden Lane	New York City	NY 10038
County:			

**III. Appeal Point of Contact**

Contact Person	Stephen Towler		
Title	Assistant Executive Director		
Contact Phone	(212) 634-8644	Extension	
Contact Email	Steve.Towler@ahrcnyc.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	98%	2%	REVENUE REPOR	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Stephen Towler	Answer <input checked="" type="radio"/> Yes <input type="radio"/> No
Title	Assistant Executive Director	
Only appeals from the CEO, CFO or comparable will be accepted		



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Vital Access Provider Exception Form**

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**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Odyssey House, Inc.
OPTIONAL Joined PPS:	Mount Sinai Hospitals Group

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OASAS 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	7002141R	1399760	1013976976
Agency Code:			
Billing Entity ID:	9D3		
	Address	City	State
Address:	120 Wall Street	New York	NY
	County	Zip	
	New York	10005	

Odyssey House (OH) is a provider of Office of Mental Health, Office of Alcoholism and Substance Abuse Services and Department of Health licensed/certified services operating primarily in East Harlem and the South Bronx. We currently provide scatter-site and congregate supported housing; residential and outpatient substance use disorder (SUD) treatment; and medical, dental and psychiatric care. Our programs serve people with Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD). It is clear that HCBS/1915i-like services will help these individuals to remain in the community and reduce unnecessary hospitalizations.

**III. Appeal Point of Contact**

Contact Person	John Tavalacci		
Title	Executive Vice President & Chief Operating Officer		
Contact Phone	212-361-1600	Extension	
Contact Email	jtavalacci@odysseyhouseinc.org		

The South Bronx is one of the poorest communities in the city, 45% of residents live below the poverty level, more than double the New York City average of 21%. The Hunts Point community consists of 73% Hispanic residents, 24% African-American, and 3% other. Most residents (55%) do not have a High School diploma or equivalent, and 55.3% receive some form of public assistance. The US Health Resources and Services Administration classifies the South Bronx community as an underserved area for both physical and mental health services, and is the poorest of the nation's 435 Congressional Districts. East Harlem shows similar burdens of poverty and poor health: 44% of East Harlem residents live below the poverty level, 46% do not have a High School diploma or equivalent, and 56.2% receive some form of public assistance. These data for East Harlem and the South Bronx are derived from New York City and the Department of Health and Human Services. Overwhelmingly, the individuals OH treats are Medicaid beneficiaries; many fall under the category of high-cost, high-frequency users, the primary patient population targeted by DSRIP. Due to the prevalence of chronic conditions and complex primary and behavioral healthcare needs, we believe that those who overlap with the DSRIP attributed patient population will be accessing HCBS services at OH once they become reimbursable under Medicaid. HCBS services will be provided through OH's Part 822 outpatient clinic in the South Bronx and the Article 28 clinic in East Harlem.

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

As one of the most comprehensive behavioral healthcare organizations in these neighborhoods, OH will play a vital role in bringing HCBS services to the community. We currently have the capacity to provide the following HCBS services to the benefit of individuals living in community settings operated by OH and in the community-at-large. Psychosocial Rehabilitation aligns with our mission, as we treat not only behavioral health conditions such as SUD and/or SMI, but also functional deficits that impact the individual. We also anticipate providing Community Psychiatric Support and Treatment to those individuals who may live independently within the community. Complementing OH's robust portfolio of supportive housing services, we will also offer Habilitation/Residential Support Services to individuals. Additionally, many individuals who come to OH face strained or estranged relationships with their families. Family support is integral to the ongoing recovery of individuals with SUD and/or SMI. As such, OH will provide Family Support and Training services. Furthermore, as a pioneer in providing peer-based recovery services to transition age youth, adults, and older adults in New York City, OH is uniquely poised to provide Empowerment Services - Peer Supports to a range of DSRIP-attributed individuals in New York.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	85%	15%	OH Records	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	John Tavalacci	Answer <input checked="" type="radio"/> Yes <input type="radio"/> No
Title	Executive Vice President & Chief Operating Officer	

Only appeals from the CEO, CFO or comparable will be accepted





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HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

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**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Onondaga Case Management Services Inc.
OPTIONAL Joined PPS:	Upstate University Hospital

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	8044025A	02994838	1235184235
Agency Code:	12600		
Billing Entity ID:	E0028423		
	Address	City	State Zip
Address:	620 Erie Boulevard West, Suite 302	Syracuse	NY 13204
County:	Onondaga		

Our behavioral health clinic was started in 2011 to serve a specific set of behavioral health recipients who had not been able to maintain connection to outpatient clinical services in other clinics. As a care management entity, we saw the need for a clinic that could work with people in our care management services who were not successful at other clinics. In addition, we knew that capacity was an issue in the existing behavioral health clinics. This approach was a significant challenge financially but we continue to try and focus on a hard to engage population. We anticipate that primary care integration into our clinic setting will be a significant part of a potential DSRIP project due to our collocation with Health Home Care Management. In addition we believe that vocational, peer support, and wellness self management projects under 1915i will play a role in how we deliver services.

**III. Appeal Point of Contact**

Contact Person	Scott Ebner		
Title	Executive Director		
Contact Phone	315-472-7363	Extension	145
Contact Email	sebner@ocmsinc.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one of the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	85%		ECR	2013

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Scott Ebner	Answer <input checked="" type="radio"/> Yes <input type="radio"/> No
Title	Executive Director	

Only appeals from the CEO, CFO or comparable will be accepted



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HCBS/1915i SERVICE PROVIDERS ONLY**

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**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Ontario ARC
OPTIONAL Joined PPS:	Finger Lakes PPS

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	61330	2702005	N/A
Agency Code:	40530		
Billing Entity ID:			
	Address	City	State Zip
Address:	3071 County Complex Drive	Canandaigua	NY 14424
County:	Ontario		

**III. Appeal Point of Contact**

Contact Person	Ann Scheetz		
Title	Executive Director		
Contact Phone	585-394-7500	Extension	
Contact Email	ascheetz@ontarioarc.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	77%	0%	Audited Finl Statms	2013

**VIII. No** I Herby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.

Name Ann Scheetz  Yes  No

Title Executive Director

Only appeals from the CEO, CFO or comparable will be accepted



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**State of New York Department of Health  
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**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Ontario ARC
OPTIONAL Joined PPS:	Finger Lakes PPS

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	61330	2702005	N/A
Agency Code:	40530		
Billing Entity ID:			
	Address	City	State Zip
Address:	3071 County Complex Drive	Canandaigua	NY 14424
County:	Ontario		

**III. Appeal Point of Contact**

Contact Person	Ann Scheetz		
Title	Executive Director		
Contact Phone	585-394-7500	Extension	
Contact Email	ascheetz@ontarioarc.org		

**IV. Please choose the following 1915i Category:**

1 I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers

2 I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	77%	0%	Audited Finl Statms	2013

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name Ann Scheetz  Yes  No

Title Executive Director

Only appeals from the CEO, CFO or comparable will be accepted



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

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**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	2
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**II. Appeal Applicant Information**

Organization Name:	Open Arms Incorporated
OPTIONAL Joined PPS:	Select PPS

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OASAS 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	160810119, 150811472, 151011771	n/a	n/a
Agency Code:	34360, 51524, 52613		
Billing Entity ID:			
	Address	City	State Zip
Address:	57-59 Sharp Street	Haverstraw	NY 10927
County:	Rockland		

Open Arms Inc. is the only housing provider in Rockland County for individuals with a primary diagnosis of a substance use disorder. Services provided in-house include individual, group and family counseling, case management, referrals for employment and vocational education, and other supportive services. Open Arms operates three facilities- an 18 bed community residence for men, a 12 bed community residence for women, and a 20 bed supportive living program, all located in a community with many natural supports.

**III. Appeal Point of Contact**

Contact Person	Betsy Rauschart		
Title	Executive Director		
Contact Phone	845-271-3787	Extension	
Contact Email	oabetsy@optimum.net		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	98%	0%	Resident files	2014

**VIII. Yes I Herby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Betsy Rauschart	Answer
Title	Executive Director	<input checked="" type="radio"/> Yes <input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		



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**I. Are you a Medicaid Provider**

Answer	Yes
--------	-----

You have chosen the following category:	1
---	---

**II. Appeal Applicant Information**

Organization Name:	Parsons Child and Family Center
OPTIONAL Joined PPS:	Select PPS

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	6223100A	02998034	1922171305
Agency Code:	40400		
Billing Entity ID:			
	Address	City	State Zip
Address:	60 Academy Road	Albany	NY 12208
County:	Albany		

**III. Appeal Point of Contact**

Contact Person	Audrey LaFrenier		
Title	Chief Operating Officer		
Contact Phone	(518) 431-1652	Extension	
Contact Email	audrey.lafrenier@northernrivers.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	63%	3%	PARMENU	2013

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Audrey LaFrenier	Answer
Title	Chief Operating Officer	<input checked="" type="radio"/> Yes <input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		



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**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	2
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**II. Appeal Applicant Information**

Organization Name:	Positive Health Project
OPTIONAL Joined PPS:	Mount Sinai Hospitals Group

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	Harm Reduction 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	05-77-18		
Agency Code:	05-77-18		
Billing Entity ID:			
	Address	City	State
Address:	301 West 37th Street	New York	NY
	County:	New York	

We do not yet have an MMIS or Billing Entity ID. As indicated on the Harm Reduction 1915i pending list, our charity ID is 05-77-18.

**III. Appeal Point of Contact**

Contact Person	Michael Clarke		
Title	Senior VP		
Contact Phone	347-473-7475	Extension	
Contact Email	clarke@housingworks.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	95%	5%	AIRS	2013

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Linney Smith	Answer
Title	Executive Director	<input checked="" type="radio"/> Yes <input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

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**I. Are you a Medicaid Provider**

no	Select One
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You have chosen the following category:	2
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**II. Appeal Applicant Information**

Organization Name:	Projects to Empower and Organize the Psychiatrically Labeled, Inc. (PEOPLE, Inc.)
OPTIONAL Joined PPS:	Select PPS

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.

Provider Type:	Select One		
Provider Type - Other:	DO NOT USE		
Operating Certificate/License #	MMIS	NPI	
Unique Identifiers:		1215273503	
Agency Code:	N/A		
Billing Entity ID:			
Address:	City	State	Zip
126 Innis Avenue	Poughkeepsie	NY	12601
County:	Dutchess		

**III. Appeal Point of Contact**

Contact Person	Steve Miccio		
Title	CEO		
Contact Phone	845-452-2728	Extension	214
Contact Email	<a href="mailto:stevemiccio@projectstoempower.org">stevemiccio@projectstoempower.org</a>		

**IV. Please choose the following 1915i Category:**

<input type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input checked="" type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage				

**VIII. No** I Herby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.

Name	Steve Miccio	Answer	
Title	CEO	<input type="radio"/> Yes	<input checked="" type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted			



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Rehabilitation Support Services, Inc.
OPTIONAL Joined PPS:	Ellis Hospital

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OASAS 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	50111313	2998070	1922293745
Agency Code:	14370		
Billing Entity ID:	E01655585		
	Address	City	State Zip
Address:	5172 Western Turnpike	Altamont	NY 12009
County:	Albany		

Rehabilitation Support Services, Inc. is on the OMH Safety Net List, OASAS Safety Net List and the 1915i OASAS Provider list. RSS operates in 12 counties and is participating in 8 PPS's - Albany Medical Center Hospital, Ellis Hospital, Health Alliance of the Hudson Valley, Montefiore Medical Center, Refuah Health Center, Westchester Medical Center, Mary Imogene Hospital, United Health Services Hospitals, Inc. In addition to the OASAS Operating Certificate, RSS holds 41 OMH Operating Certificates. RSS has an additional NPI number (1245481209), MMIS number (03308192), and Billing Entity ID (E0316644).

**III. Appeal Point of Contact**

Contact Person	Elizabeth Kadatz		
Title	Director of Operations		
Contact Phone	518-579-4215	Extension	
Contact Email	ekadatz@rehab.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	99%	1%	OMH Safety Net List	2014

**VIII. Yes I Herby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	William DeVita	Answer <input checked="" type="radio"/> Yes <input type="radio"/> No
Title	Executive Director	

Only appeals from the CEO, CFO or comparable will be accepted





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HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

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**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Rockland County Department of Mental Health
OPTIONAL Joined PPS:	Montefiore Medical Center

**VI. Restricted to 3500 Characters only!**

Please note that the Rockland County Department of Mental Health, UMH Agency Code 70460, is a separate facility from UMH Agency Code 87100, Summit Park Hospital, Rockland County Department of Mental Health, County of Rockland NPI#

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:			
Agency Code:	70460		
Billing Entity ID:			
	Address	City	State Zip
Address:	50 Sanatorium Road, Building F	Pomona	NY 10970
County:	Rockland		

**III. Appeal Point of Contact**

Contact Person	Bonnie Halley		
Title	Unified Services Coordinator		
Contact Phone	(845) 364-2382	Extension	
Contact Email	Halleyb@co.rockland.ny.us		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

The Rockland County Department of Mental Health functions as the Local Governmental Unit (LGU) as per the Mental Hygiene Law. The Department is responsible for the planning, coordination, administration and budgetary oversight of the Local Services system of behavioral health care including all agencies licensed or funded by OMH, OASAS and OPWDD. Services provided by the Department include: Adult SPOA, Child & Adolescent SPOA, Emergency Operations Center Liaison, Forensic Mental Health Services, Behavioral Health Services in the Rockland County Jail, Sex Offender Behavioral Management Program, Consumer Advocate, Employee Assistance Program, approval of 9.39, 9.45 and all other involuntary commitments under the Mental Hygiene Law, review and submission of 9.46 Safe Act reports, and approval of HCBS Waiver Level of Care and Initial Service Plan. LGU activities include oversight, local services planning, coordination and oversight of Assisted Outpatient Treatment (AOT) services, and contract management.

The Department was awarded \$449,668 by OMH on an annualized basis effective 7/1/14 for a Mobile Crisis Intervention program. The Department has just recently issued an RFP to contact out this program. The establishment of a Mobile Crisis Intervention program is designed to provide mobile crisis mental health services to individuals in the Rockland community in need of mental health intervention. This team will work closely with the emergency departments at Nyack Hospital, Good Samaritan Hospital, local police and emergency services, as well as all other providers of behavioral health care.

The mobile crisis intervention team can receive calls from community agencies, community residences/adult homes, human service providers including police, Department of Social Services and Department of Health, mental health providers, and individuals and families in the Rockland community. The mobile crisis intervention team will provide critical back up services to those individuals currently being treated by other programs within Rockland County.

The establishment of this program is critical as the County currently does not have a Mobile Crisis Intervention Program. This program will enhance the network of services in each of the PPS networks in Rockland County, two of which are proposing Behavioral Health Community Crisis Stabilization Services as one of their projects (Montefiore Hospital and Westchester Medical Center).

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	N/A - Program not yet operational	N/A	N/A	N/A

**VIII. Yes I Herby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name Michael Leitzes, MBA Answer  
 Title Acting Commissioner  Yes  No  
 Only appeals from the CEO, CFO or comparable will be accepted



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HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Rockland Independent Living Center
OPTIONAL Joined PPS:	Refuah Health Center

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:		01666031	1770829624
Agency Code:	73390		
Billing Entity ID:			
	Address	City	State
Address:	873 Route 45, Suite 108	New City	NY
County:	Rockland		
			Zip
			10956

**III. Appeal Point of Contact**

Contact Person	George Hoehmann		
Title	CEO/Executive Director		
Contact Phone	845-624-1366	Extension	111
Contact Email	Ghoehmann@rilc.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

We strongly believe RILC has the qualifications and experience to be a safety net entity. For twenty-seven years we have worked with our consumers, people with disabilities, in this arena.

Our staff consists of several mental health peer advocates, a certified parent advocate and a NAMI certified teacher enabling us to offer six week presentations to parents of children with mental health diagnoses. Our Director of Independent Living Services is the chair for the Special Ed PTAs in the Central Hudson Area. We offer a peer-led anxiety support group for young adults and therapeutic horse-back riding for young children and teens. We are one of the largest providers of CDPAS services in the region, located in Rockland; self-directed services are also provided through our approvals with OPWDD.

We are subcontractors for Rockland Psychiatric Center and St. Dominic's Home, providing Job Coaching and Development Services and peer-led group services in an outpatient clinic, as well as Skill Building, Respite and Family Support Services respectively. We offer a weekly co-occurring (substance abuse and mental health) support group. We are a member of the Re-Entry Task Force and are the coordinators for over 121 offenders, many of whom have co-occurring disorders. Our Executive Director sits on the SAMHSA Recovery Month Planning Partners Committee. In 2012, with a grant from SAMHSA's Million Hearts campaign, we produced "Heart & Soul: A Film Promoting Whole Body Wellness in Behavioral Health," which won the first-ever "Wellness Initiative Award" from the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA).

We are a point of contact for Nyack Hospital's Behavioral Health Center and Peer Advocates for people transitioning from the hospital to the community. Local mental health agencies, like the Mental Health Association, use our staff to support children they serve for academic support and remediation.

Our ties to community organizations consist of memberships in the following organizations: Bi-Polar Alliance, Mental Health Workgroup, Transition Consortium, SPOA and the Mental Health Coalition. Through our affiliation with NAMI-FAMILYA and the Mental Health Coalition, we formed The School Mental Health Education Project. This project provides free student mental health presentations, free in-services for school staff and free in-services for PTA's and SEPTA's. Our staff makes yearly disability awareness trainings in local high school health classes and we train EMT workers in NY and NJ to prepare them for dealing with people with autism and mental health diagnoses. We also train fire and emergency workers as well as probation officers about working with different populations.

We plan to join all three PPS networks in our area: Refuah, Westchester Medical and Montefiore. We feel our experience demonstrates the expertise and skills to be effective safety net providers of the following services: Accessibility Modifications Local Government Unit (LGU)/Single Point of Access (SPOA), Community Advocacy and Support Non-Medical Transportation, Community Center Peer Supports, Corrections Pre-Vocational Employment, Education Support services self-directed Services, Family Peer Support Services Short-Term Crisis Respite, Peer Supports, Pre-Vocational Employment, Self-Directed Services, Skill Building, Supported Employment and Youth Peer Advocacy and Training.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	75%	25%	consumer data	2013

**VIII. Yes I Herby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	George Hoehmann	Answer <input checked="" type="radio"/> Yes <input type="radio"/> No
Title	CEO/Executive Director	

Only appeals from the CEO, CFO or comparable will be accepted



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**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Samuel Field Y
OPTIONAL Joined PPS:	Mount Sinai Hospitals Group

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	8600150A	1382663	1205862950
Agency Code:	40390		
Billing Entity ID:	1382663		
	Address	City	State Zip
Address:	Samuel Field Y 58-20 Little Neck Parkway	Little Neck	NY 11362
County:	Queens		

We are not applying as a Safety Net Entity but rather as a service provider within a PPS (both Mt. Sinai and CBC) in the delivery of 1915i Medicaid services to the DSRIP. Our Medicaid reimbursement from all sources, including those who are dual eligible is at 23%. However we will be applying for HCBS waiver to provide Community Psychiatric Support and Treatment. The Samuel Field Y's CAPE Geriatric Mental Health Clinic is the only specialized mental health clinic in Queens to provide integrated behavioral health services for both clinic and homebound elderly and disabled individuals by our social work, psychiatric and RN staff. We also provide health monitoring services by an RN and peer support services through telephone reassurance on a regular basis. We provide transportation for eligible individuals. The clinic, based in Little Neck Queens, believes in the importance of treating elderly mentally ill people within the places where they are most able to access services including senior centers and specialized day programs. We have three licensed satellites, the Clearview Senior Center, Bayside, NY, the Central Queens Y, Forest Hills, NY and the Friendship Club of JSPOA in Jamaica, NY. In addition, when older adults are unable to leave their homes for treatment as the result of frailty or illness, CAPE provides ongoing psychiatric and social work services as well as medication monitoring within the home. Important clinic practices include our integrated work with primary health providers as well as significant work and contact with the patients' families and caregivers. We have joined DSRIP provider groups to be a provider of services and not as a Safety Net Entity.

**III. Appeal Point of Contact**

Contact Person	Michael Upston, LCSW		
Title	Director		
Contact Phone	718 224-0566	Extension	
Contact Email	mupston@sfy.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	10%	2%	Accumed	7/13-6/14

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	<i>for Michael Upston</i>	Answer
Title	Executive Vice-President & CEO	<input checked="" type="radio"/> Yes <input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
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**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	The Fortune Society
OPTIONAL Joined PPS:	Select PPS

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OASAS 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	171011539	02740141	1235357237
Agency Code:	01523		
Billing Entity ID:	132645436		
	Address	City	State Zip
Address:	29-76 Northern Boulevard, 2nd Floor	Long Island City	NY 11101-2822
County:	Queens		

Fortune's overriding mission is to support the successful re-entry of individuals coming home from prison, and to promote alternatives to incarceration, thus strengthening the fabric of our communities. We achieve our mission by believing in the individuals' power to change; building lives through service programs shaped by the needs and experience of our clients; changing minds through education; and advocating for the creation of a fair, humane, and truly rehabilitative correctional system. Fortune's services are available to anyone who has been involved with the adult criminal justice system, regardless of the crime. We accept clients that other agencies turn away due to the nature of their crime(s) or because certain individuals are harder to work with and more likely to recidivate. Our only restricting criterion is that individuals not be a danger to themselves or others.

Fortune is dually licensed by OMH and OASAS, and provides approximately 500 individuals with housing, annually. Consequently, we are able to provide a holistic array of services through a "one-stop shop" model that currently includes the following:

- Housing Services, including emergency, transitional, and permanent supportive housing through the Fortune Academy ("the Castle") and Castle Gardens, and scatter-site housing – we provide housing to approximately 500 individuals per year, approximately 80% who were formerly Homeless, including approximately 100, annually, at the Fortune Academy;
- Licensed Outpatient Behavioral Health through our NYS OMH Article 31 license;
- Licensed Outpatient Substance Abuse Treatment through our NYS OASAS Part 822 license;
- Case Management (crisis intervention, needs assessment, referral & counseling), housing (emergency, congregate, & scatter-site);
- Education (literacy, math, and High School Equivalency (HSE) exam preparation);
- Employment Services (job readiness, hard skills training, job placement and retention);
- Family Services (parenting classes, support groups, family reunification, legal services, and healthy cooking and nutrition workshops);
- HIV/AIDS services;
- Discharge Planning services for individuals preparing for release from NYC jails (Rikers Island) and NYS prison facilities – we served approximately 560 individuals in our Individualized Corrections Achievement Network (I-CAN) program on Rikers Island in 2013; and 500 annually from Queensboro Correctional Facility
- Alternatives to Incarceration (ATI), including specialized services for individuals with substance abuse histories and mental health disorders;
- Court-based Intervention Resource Team (CIRT) for mentally ill defendants in the borough of Queens, which includes ATI and Alternatives to Detention (ATD)

Given our unique and extensive expertise in serving the criminal justice population, along with our wide array of holistic services, Fortune has an unmatched ability to engage, provide, and retain currently and formerly incarcerated individuals. In 2013, we served over 5,000 clients across the agency, including new enrollees and clients remaining with us from previous years. Of these clients, 87% were male, 13% were female, and the average age was 37. While the vast majority of these clients reside in East and Central Harlem, Manhattan; Central and East New York, Brooklyn; South and Central Bronx; and Jamaica, Queens, we serve clients from all NYC neighborhoods.

**III. Appeal Point of Contact**

Contact Person	Peggy Arroyo		
Title	Vice President of Programs		
Contact Phone	212-691-7554	Extension	235
Contact Email	parroyo@fortunesociety.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one of the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	85%	15%	Fortune Society	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Joanne Page	Answer <input checked="" type="radio"/> Yes <input type="radio"/> No
Title	President and CEO	
Only appeals from the CEO, CFO or comparable will be accepted		



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HCBS/1915i SERVICE PROVIDERS ONLY**

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**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	The Fortune Society
OPTIONAL Joined PPS:	Select PPS

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	8095001A	02740141	1235357237
Agency Code:	01523		
Billing Entity ID:	132645436		
	Address	City	State Zip
Address:	29-76 Northern Boulevard, 2nd Floor	Long Island City	NY 11101-2822
County:	Queens		

**III. Appeal Point of Contact**

Contact Person	Peggy Arroyo		
Title	Vice President of Programs		
Contact Phone	212-691-7554	Extension	235
Contact Email	parroyo@fortunesociety.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
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- Licensed Outpatient Substance Abuse Treatment through our NYS OASAS Part 822 license;
- Case Management (crisis intervention, needs assessment, referral & counseling), housing (emergency, congregate, & scatter-site);
- Education (literacy, math, and High School Equivalency (HSE) exam preparation);
- Employment Services (job readiness, hard skills training, job placement and retention);
- Family Services (parenting classes, support groups, family reunification, legal services, and healthy cooking and nutrition workshops);
- HIV/AIDS services;
- Discharge Planning services for individuals preparing for release from NYC jails (Rikers Island) and NYS prison facilities – we served approximately 560 individuals in our Individualized Corrections Achievement Network (I-CAN) program on Rikers Island in 2013; and 500 annually from Queensboro Correctional Facility
- Alternatives to Incarceration (ATI), including specialized services for individuals with substance abuse histories and mental health disorders;
- Court-based Intervention Resource Team (CIRT) for mentally ill defendants in the borough of Queens, which includes ATI and Alternatives to Detention (ATD)

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**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	85%	15%	Fortune Society	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Joanne Page	Answer <input checked="" type="radio"/> Yes <input type="radio"/> No
Title	President and CEO	

Only appeals from the CEO, CFO or comparable will be accepted



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HCBS/1915i SERVICE PROVIDERS ONLY**

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**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	St. Anne Institute
OPTIONAL Joined PPS:	Select PPS

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:		00353535	1629243407
Agency Code:	14350		
Billing Entity ID:			
	Address	City	State Zip
Address:	160 North Main Avenue	Albany	NY 12206
County:	Albany		

**III. Appeal Point of Contact**

Contact Person	Diane T. Malecki		
Title	Chief Financial Officer		
Contact Phone	518-437-6510	Extension	
Contact Email	dmalecki@s-a-i.org		

**IV. Please choose the following 1915i Category:**

1 I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers

2 I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage				

**VIII. Yes** I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.

Name Diane T. Malecki  Yes  No

Title Chief Financial Officer

Only appeals from the CEO, CFO or comparable will be accepted



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Peninsula Counseling Center
OPTIONAL Joined PPS:	Nassau University Medical Center

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OASAS 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	160910937	244817	1437262839
Agency Code:	50630		
Billing Entity ID:	9KY		
	Address	City	State
Address:	50 West Hawthorne Ave	Valley Stream	NY
			Zip
County:	Nassau		11580

**III. Appeal Point of Contact**

Contact Person	Lois Goldsmith, DSW		
Title	Executive Director		
Contact Phone	516 569 6600	Extension	
Contact Email	<a href="mailto:lgoldsmith@pccli.org">lgoldsmith@pccli.org</a>		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

Medicaid (FFS & MC)	Uninsured	Data Source	Year
35%	4%	Avatar	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Lois Goldsmith, DSW	Answer
Title	Executive Director	<input checked="" type="radio"/> Yes <input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		





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HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

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**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Skills Unlimited, Inc.
OPTIONAL Joined PPS:	Stony Brook University Hospital

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	6868110A	468759	1487789392
Agency Code:	40290		
Billing Entity ID:			
	Address	City	State Zip
Address:	405 Locust Ave	Oakdale	NY 11769-1651
County:	Suffolk		

**III. Appeal Point of Contact**

Contact Person	Anu Arnold		
Title	Vice President		
Contact Phone	516-870-1623	Extension	
Contact Email	aarnold@familyres.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

Skills Unlimited is already designated as a safety Net provider and will also be applying to provide 1915i services. Skills Unlimited has the expertise in providing supports and services to individuals with complex needs. We offer services to individuals diagnosed with mental illness and intellectual disabilities that most other organizations within PPS do not have. Skills offers services to all residents of Suffolk County in our PROS program and Article 31 Mental Health Clinic. Skills PROSwith Clinic is a person centered recovery focused day program opportunity operated under the auspices of the Family Residences and Essential Enterprises, Inc. (FREE) and is licensed by the Office of Mental Health (OMH), currently serving the needs of 65 enrolled individuals. At Skills Unlimited, Inc. individuals receive a myriad of services aimed at promoting empowerment, self-determination and the realization of their life goals. The diverse team of Vocational Counselors; Licensed Social Workers; Psychiatric Nurse Practitioner; Psychiatrist; Psychologist; Art Therapist work alongside the individuals to help develop the skills and abilities that will help enhance their quality of life. Men and women also receive clinical services at the program to help manage their symptoms and participate in group and individual therapy ranging from Anger Management and Developing Interests to Preparing for Work and Maintaining Recovery. Employment is of particular emphasis at PROS and Vocational Counselors work with individuals towards securing and maintaining employment. PROS also offers ongoing job-site support for individuals employed in the community.

Individuals engaged in PROS participate in the following services:

CRS: Community Rehabilitation and Support – The basic services provided at PROS that help individuals address mental health barriers that prevent them from moving forward with their recovery.

IR: Intensive Rehabilitation – Services that are time limited and geared towards quicker pace of goal attainment for individuals participating (i.e. symptom stability after a hospitalization, employment, movement to a more independent setting)

ORS: Ongoing Rehabilitation and Support – Services designed to support an individual currently employed in the competitive workforce. Services are provided offsite in the community.

CT: Clinical Treatment - A full Mental Health Clinic component comprised of Psychiatrist, Nurse Practitioner and Registered Nurse. The clinic component offers a holistic approach to mental health which incorporates all aspects of person's life into their treatment. A particular emphasis on a person's medical needs and its effect on their overall mental health are addressed. Skills has operated an Article 31 Outpatient Mental Health Clinic in Suffolk County since 1977 servicing individuals diagnosed with mental illness and intellectual disabilities. Staffing consists of a Psychiatrist, Psychiatric Nurse Practitioner, Licensed Social Workers, and a Psychiatric Registered Nurse. The Clinic provides individual and group therapies, medication therapy, and psychiatric evaluations to all residents of Suffolk County. It is centrally located and easily accessible for those individuals using public transportation. These services are not readily offered within this geographic area by other organizations who are members of PPS.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage				

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Anu Arnold	Answer	
Title	Vice President	<input checked="" type="radio"/> Yes	<input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted			





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HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

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**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	South Hsore Assocaition for Independent Living, Inc.
OPTIONAL Joined PPS:	Nassau University Medical Center

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevent. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	DA, 7552001, 7552434, 7552435, 7552431, 7	02994503	1043267339
Agency Code:	16330		
Billing Entity ID:	3K6		
	Address	City	State Zip
Address:	1976 Gran Ave.	Baldwin	NY 11510
County:	Nassau County		

**III. Appeal Point of Contact**

Contact Person	Brian Cohen		
Title	Assocaite Director		
Contact Phone	(516) 855-1800	Extension	1027
Contact Email	bcohen@sail-inc.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	83%	10%	HER	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Brian Cohen	Answer
Title	Assocaite Director	<input checked="" type="radio"/> Yes <input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		

Nassu University Medical center



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
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**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

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**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Spectrum Human Services
OPTIONAL Joined PPS:	Finger Lakes PPS

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider			
Provider Type - Other:	DO NOT USE			
	Operating Certificate/License #	MMIS	NPI	
Unique Identifiers:			1487601837	
Agency Code:				
Billing Entity ID:				
	Address	City	State	Zip
Address:	227 Thorn Avenue	Orchard Park	NY	14127
County:				

Spectrum Human Services is already identified by DOH as a safety net provider but I was advised, when I submitted a question to DOH on our new Orleans non-Medicaid Crisis Intervention program and how to become qualified as a 1915i provider for this program, to submit this form also. We have just commenced (October 20th) a new 24/7 crisis intervention program including outreach teams with the Orleans County Department of Mental Health serving the entire adult as well as youth population of the county. The program is 100 per cent funded by non-Medicaid OMH reinvestment dollars. This service I believe would qualify as a 1915i service but has not been listed as it is just starting. I am filing this appeal to be included as a 1915i eligible provider. Thank you.

**III. Appeal Point of Contact**

Contact Person	Bruce Nisbet		
Title	President/CEO		
Contact Phone	716 597 8336	Extension	
Contact Email	Nisbetb@shswny.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage				

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Bruce Nisbet	Answer	
Title	President/CEO	<input checked="" type="radio"/> Yes	<input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted			



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

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**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Standing Together Effectively for People By Standing Together Effectively for People,INC
OPTIONAL Joined PPS:	St. Joseph's Hospital Health Center

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:			
Agency Code:	c000148-3650631		
Billing Entity ID:			
	Address	City	State Zip
Address:	103 ford st	ogdensburg	ny 13669
		st. lawrence	

**III. Appeal Point of Contact**

Contact Person	David Bayne		
Title	Executive Director		
Contact Phone	315-394-0597	Extension	13
Contact Email	mindwork@ne.twcbc.ne.com		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	90%	5%	survey	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	David Bayne	Answer <input checked="" type="radio"/> YES <input type="radio"/> NO
Title	Executive Director	
Only appeals from the CEO, CFO or comparable will be accepted		



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

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**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Standing Together Effectively for People By Standing Together Effectively for People,INC
OPTIONAL Joined PPS:	Adirondack Health Institute

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider			
Provider Type - Other:	DO NOT USE			
	Operating Certificate/License #	MMIS	NPI	
Unique Identifiers:				
Agency Code:	c000148-3650631			
Billing Entity ID:				
	Address	City	State	Zip
Address:	103 ford st	ogdensburg	ny	13669
		st. lawrence		

**III. Appeal Point of Contact**

Contact Person	David Bayne		
Title	Executive Director		
Contact Phone	315-394-0597	Extension	13
Contact Email	mindwork@ne.twcbc.ne.com		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	90%	5%	survey	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	David Bayne	Answer	
Title	Executive Director	<input checked="" type="radio"/> YES	<input type="radio"/> NO
Only appeals from the CEO, CFO or comparable will be accepted			



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

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**I. Are you a Medicaid Provider**

Answer	Not Yet
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Standing Together Effectively for People By Standing Together Effectively for People,INC
OPTIONAL Joined PPS:	Samaritan Medical Center

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider			
Provider Type - Other:	DO NOT USE			
	Operating Certificate/License #	MMIS	NPI	
Unique Identifiers:				
Agency Code:	c000148-3650631			
Billing Entity ID:				
	Address	City	State	Zip
Address:	103 ford st	ogdensburg	ny	13669
		st. lawrence		

**III. Appeal Point of Contact**

Contact Person	David Bayne		
Title	Executive Director		
Contact Phone	315-394-0597	Extension	13
Contact Email	mindwork@ne.twcbc.ne.com		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	90%	5%	survey	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	David Bayne	Answer	
Title	Executive Director	<input checked="" type="radio"/> YES	<input type="radio"/> NO
Only appeals from the CEO, CFO or comparable will be accepted			



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**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	The Family Counseling Center of Fulton County
OPTIONAL Joined PPS:	Ellis Hospital

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	8549100A	1384734	1164473831
Agency Code:	15980		
Billing Entity ID:	E0159395		
	Address	City	State Zip
Address:	11-21 Broadway	Gloversville	NY 12078
County:	Fulton		

The Family Counseling Center is the sole OMH Children's Mental Health Clinic provider in Fulton County. We have partnered with the Adirondack Health Institute and Ellis Hospital DSRIP application. Beyond our Clinic are many OMH licensed children and family oriented services who's mission is to maintain children in the community and at home. Most notably is our Family Support Program which is staffed with licensed peer advocates.

**III. Appeal Point of Contact**

Contact Person	Michael L. Countryman		
Title	Executive Director		
Contact Phone	518-725-4310	Extension	118
Contact Email	<a href="mailto:mcountryman@thefamilycounselingcenter.org">mcountryman@thefamilycounselingcenter.org</a>		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	60%	7%	Claims	2014 YTD

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Michael L. Countryman	Answer	
Title	Executive Director	<input checked="" type="radio"/> Yes	<input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted			



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**I. Are you a Medicaid Provider**

Answer	Yes
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You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	The Pederson Krag Center
OPTIONAL Joined PPS:	Stony Brook University Hospital

VI. Restricted to 3500 Characters only!

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OASAS 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	6816100/A	2993575	1013964170
Agency Code:	50430		
Billing Entity ID:			
	Address	City	State Zip
Address:	55 Horizon Drive	Huntington	NY 11743
County:	Suffolk		

The Pederson Krag Center provides services under both OMH and OASAS licenses that are person centered and reflect a continuum of care. Our intent is to support strengths that promote self reliance and positive outcomes as defined by the consumer/family. Treatment and supportive counseling to include, but not limited to, skill building and care coordination are provided in clinical settings, homes, community venues and schools. The Pederson Krag Center has provided service in communities throughout Suffolk County with a strong commitment and innovative approaches regardless of ability to pay.

**III. Appeal Point of Contact**

Contact Person	Dean Weinstock		
Title	CEO		
Contact Phone	631-920-8009	Extension	
Contact Email	dweinsto@pedersonkrag.org		

**IV. Please choose the following 1915i Category:**

1 I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers

2 I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	39%	20%	EMR	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name Dean Weinstock  Yes  No

Title CEO

Only appeals from the CEO, CFO or comparable will be accepted



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HCBS/1915i SERVICE PROVIDERS ONLY**

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**I. Are you a Medicaid Provider**

Answer	Yes
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**II. Appeal Applicant Information**

Organization Name:	The Osborne Association
OPTIONAL Joined PPS:	Bronx-Lebanon Hospital Center

Provider Type:	OASAS 1915i Provider			
Provider Type - Other:	DO NOT USE			
	Operating Certificate/License #	MMIS	NPI	
Unique Identifiers:				
Agency Code:				
Billing Entity ID:				
	Address	City	State	Zip
Address:	809 Westchester Ave	Bronx	NY	10455
County:	Bronx			

**III. Appeal Point of Contact**

Contact Person	Elizabeth Gaynes		
Title	Executive Director		
Contact Phone	718-707-2649	Extension	
Contact Email	egaynes@osborneny.org		

**IV. Please choose the following 1915i Category:**

1 I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers

2 I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	92%	8%	Internal	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name Elizabeth Gaynes  YES  NO

Title Executive Director

Only appeals from the CEO, CFO or comparable will be accepted

You have chosen the following category:	1
---	---

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

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Osborne has 175 full time, 45 part time staff, and more than 25 volunteers. Osborne's staff is representative of population served (including formerly incarcerated people and people with family members in prison/jail). Osborne's FY 2015 operating budget is more than \$20 million. Osborne successfully manages more than 40 city, state and federal contracts and garners nearly \$2 million in private donations annually.

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**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

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**I. Are you a Medicaid Provider**

Answer	Yes
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**II. Appeal Applicant Information**

Organization Name:	The Osborne Association
OPTIONAL Joined PPS:	Health & Hospital Corporation

Provider Type:	OASAS 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:			
Agency Code:			
Billing Entity ID:			
Address:	809 Westchester Ave	Bronx	NY 10455
County:	Bronx		

**III. Appeal Point of Contact**

Contact Person	Elizabeth Gaynes		
Title	Executive Director		
Contact Phone	718-707-2649	Extension	
Contact Email	egaynes@osborneny.org		

**IV. Please choose the following 1915i Category:**

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**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	92%	8%	Internal	2014

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Name Elizabeth Gaynes  YES  NO

Title Executive Director

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You have chosen the following category:	1
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**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

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Vital Access Provider Exception Form**

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**I. Are you a Medicaid Provider**

Answer	Yes
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**II. Appeal Applicant Information**

Organization Name:	The Osborne Association
OPTIONAL Joined PPS:	Maimonides Medical Center

Provider Type:	OASAS 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:			
Agency Code:			
Billing Entity ID:			
Address:	809 Westchester Ave	Bronx	NY 10455
County:	Bronx		

**III. Appeal Point of Contact**

Contact Person	Elizabeth Gaynes		
Title	Executive Director		
Contact Phone	718-707-2649	Extension	
Contact Email	egaynes@osborneny.org		

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**V. Percentage of Medicaid & Uninsured members that your facility serves**

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Name Elizabeth Gaynes Answer  YES  NO

Title Executive Director

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You have chosen the following category:	1
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HCBS/1915i SERVICE PROVIDERS ONLY**

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**I. Are you a Medicaid Provider**

Answer	Yes
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**II. Appeal Applicant Information**

Organization Name:	The Osborne Association
OPTIONAL Joined PPS:	Montefiore Medical Center

Provider Type:	OASAS 1915i Provider			
Provider Type - Other:	DO NOT USE			
	Operating Certificate/License #	MMIS	NPI	
Unique Identifiers:				
Agency Code:				
Billing Entity ID:				
	Address	City	State	Zip
Address:	809 Westchester Ave	Bronx	NY	10455
County:	Bronx			

**III. Appeal Point of Contact**

Contact Person	Elizabeth Gaynes		
Title	Executive Director		
Contact Phone	718-707-2649	Extension	
Contact Email	egaynes@osborneny.org		

**IV. Please choose the following 1915i Category:**

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**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
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Name Elizabeth Gaynes Answer  YES  NO

Title Executive Director

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You have chosen the following category:	1
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HCBS/1915i SERVICE PROVIDERS ONLY**

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**I. Are you a Medicaid Provider**

Answer	Yes
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**II. Appeal Applicant Information**

Organization Name:	The Osborne Association
OPTIONAL Joined PPS:	St. Barnabas Hospital (dba SBH Health System)

Provider Type:	OASAS 1915i Provider			
Provider Type - Other:	DO NOT USE			
	Operating Certificate/License #	MMIS	NPI	
Unique Identifiers:				
Agency Code:				
Billing Entity ID:				
	Address	City	State	Zip
Address:	809 Westchester Ave	Bronx	NY	10455
County:	Bronx			

**III. Appeal Point of Contact**

Contact Person	Elizabeth Gaynes		
Title	Executive Director		
Contact Phone	718-707-2649	Extension	
Contact Email	egaynes@osborneny.org		

**IV. Please choose the following 1915i Category:**

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**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	92%	8%	Internal	2014

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Name Elizabeth Gaynes      Answer  YES  NO

Title Executive Director

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You have chosen the following category:	1
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**I. Are you a Medicaid Provider**

Answer	Yes
--------	-----

You have chosen the following category:	1
---	---

**II. Appeal Applicant Information**

Organization Name:	Villa of Hope
OPTIONAL Joined PPS:	Finger Lakes PPS

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**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OASAS 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	160911629 & 160511362	2996312	15789640298
Agency Code:	37220		
Billing Entity ID:	n/a		
	Address	City	State Zip
Address:	3300 Dewey Ave	Rochester	NY 14616
County:	Monroe		

The Villa of Hope is a downstream care management provider for both the HHUNY (Health Homes of Upstate New York) and GRHHN (Greater Rochester Health Home Network) as well as a provider of OASAS, OMH, and OCFS Foster Care services. We are on the Safety Net Provider list as CMH, OASAS, Foster Care agencies, and downstream Care Management providers. We are applying to be on the 1915i services safety net provider services. We currently provide HCBS for children and adolescents and we will be applying for eligibility for adults for both OMH and OASAS.

**III. Appeal Point of Contact**

Contact Person	Jodi Barbera		
Title	Director of Program Development and Quality		
Contact Phone	585-865-1550	Extension	370
Contact Email	jodi.barbera@villaofhope.org		

**IV. Please choose the following 1915i Category:**

<input checked="" type="radio"/>	1	I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
<input type="radio"/>	2	I am a Harm Reduction 1915i provider that is on one the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	OASAS-89.8%/OMH&FosterCare100%	none	DOH-DSRIP site	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Christina Gullo	Answer
Title	President/CEO	<input checked="" type="radio"/> Yes <input type="radio"/> No
Only appeals from the CEO, CFO or comparable will be accepted		



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**I. Are you a Medicaid Provider**

Answer	Yes
--------	-----

You have chosen the following category:	1
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**II. Appeal Applicant Information**

Organization Name:	Villa of Hope
OPTIONAL Joined PPS:	Finger Lakes PPS

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Provider Type:	OMH 1915i Provider		
Provider Type - Other:	DO NOT USE		
	Operating Certificate/License #	MMIS	NPI
Unique Identifiers:	7598040 & 7598431	2996312	15789640298
Agency Code:	37220		
Billing Entity ID:	n/a		
	Address	City	State Zip
Address:	3300 Dewey Ave	Rochester	NY 14616
County:	Monroe		

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Contact Person	Jodi Barbera		
Title	Director of Program Development and Quality		
Contact Phone	585-865-1550	Extension	370
Contact Email	jodi.barbera@villaofhope.org		

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Percentage	OASAS-89.8%/OMH&FosterCare100%	none	DOH-DSRIP site	2014

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name	Christina Gullo	Answer	
Title	President/CEO	<input checked="" type="radio"/> Yes	<input type="radio"/> No

Only appeals from the CEO, CFO or comparable will be accepted



**VAP EXCEPTION FORM IS DUE 10/24/2014 -  
HCBS/1915i SERVICE PROVIDERS ONLY**

**State of New York Department of Health  
Delivery System Reform Incentive Payment (DSRIP) Program  
Vital Access Provider Exception Form**

**Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

**I. Are you a Medicaid Provider**

Answer:  Not Yet

You have chosen the following category:

**II. Appeal Applicant Information**

Organization Name:   
 OPTIONAL Joined PPS:

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:   
 Provider Type - Other:   
 Operating Certificate/License #  MMIS  NPI   
 Unique Identifiers:   
 Agency Code:   
 Billing Entity ID:   
 Address:  City:  State:  Zip:   
 County:

**III. Appeal Point of Contact**

Contact Person:   
 Title:   
 Contact Phone:  Extension:   
 Contact Email:

**IV. Please choose the following 1915i Category:**

I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers  
 I am a Harm Reduction 1915i provider that is on one of the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	79%	4%	Client Data	2014

VOCAL-NY provides health services to a population of low-income people who inject drugs, which has substantial co-occurrence of mental illness, homelessness, and chronic illness. VOCAL is the only NYS waived syringe exchange program in western Brooklyn, with a catchment area serving Boerum Hill and Downtown Brooklyn, and parts of Sunset Park, Red Hook, Prospect-Lefferts Gardens, and nearby neighborhoods through drop-in center and outreach-based programs. VOCAL-NY intends to join the PPS's organized by the Health and Hospitals Corporation and Mount Sinai.

Our participants largely represent a high-need, high-cost population with limited engagement with non-emergency healthcare. VOCAL-NY's ability to identify and link to care marginalized people experiencing multiple serious health issues offers a platform for achieving DSRIP goals in a population in distinct need of prevention, primary care, and care coordination services in order to avoid hospital utilization and other high-cost medical services.

Based on a 2014 survey of our participants:

- 30% are street homeless or sleep in a shelter, and 21% are unstably housed in three-quarter residences or other temporary accommodations;
  - 49% reported current serious depression, and 37% anxiety;
- In the past year 53% reported emergency department visit, 26% had been hospitalized, and a majority had been in residential or outpatient drug treatment;
  - About 18% reported living with HIV, and 26% with hepatitis C;
- 35% reported having been diagnosed with hypertension, 23% with asthma, 14% with diabetes, and 11% with liver disease;
  - 46.5% had been arrested or incarcerated in the past year;
  - 79% are Medicaid enrollees, and less than 5% are uninsured.

Established in 1998 as the NYC AIDS Housing Network, VOCAL-NY's primary mandate is to promote policy change in relation to the HIV and viral hepatitis epidemics, drug policy, criminal justice, and related issues. VOCAL-NY began offering harm reduction services in 2008, and today provides an array of NYS- and NYC-funded services including:

- Drop-in- and outreach-based syringe exchange, safer injection education, and wound care;
  - Harm reduction and women's support groups;
- Overdose prevention and reversal training and naloxone distribution;
  - Hepatitis C testing and linkage to care;
- Referrals for HIV testing, drug treatment, housing, legal aid, nutritional programs, and other services;
  - HAV, HBV, meningitis, and influenza immunization;
    - Acupuncture;
  - Crisis intervention and bereavement support.

VOCAL-NY extensively collaborates with 13 other NYC syringe exchange providers through the Injection Drug Users Health Alliance (IDUHA) coalition, which has recently included efforts to clinically integrate services, build linkages with broader health and social services networks, develop original research to inform program design, and shape emerging policies around insurance coverage for harm reduction services.

We are attaching a map of current NYS DOH-waived syringe exchange services in Brooklyn. Notably, the closest office-based harm reduction service provider is approximately five miles from VOCAL-NY, and more than one mile separates the closest part-time outreach-based program from our services.

**VIII. No I hereby certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name:   
 Title:   
 Only appeals from the CEO, CFO or comparable will be accepted

Answer:  Yes  No





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**I. Are you a Medicaid Provider**

Answer	Not Yet
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**II. Appeal Applicant Information**

Organization Name:	Washington Heights CORNER Project
OPTIONAL Joined PPS:	The New York and Presbyterian Hospital

You have chosen the following category:	2
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**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	Harm Reduction 1915i Provider			
Provider Type - Other:	DO NOT USE			
	Operating Certificate/License #	MMIS	NPI	
Unique Identifiers:				
Agency Code:				
Billing Entity ID:				
	Address	City	State	Zip
Address:	566 West 181st Street, 2nd Floor	New York	NY	10033
County:	New York			

**III. Appeal Point of Contact**

Contact Person	Taeko Frost, MPH		
Title	Executive Director		
Contact Phone	212-923-7600	Extension	123
Contact Email	admin@cornerproject.org		

**IV. Please choose the following 1915i Category:**

1 I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers

2 I am a Harm Reduction 1915i provider that is on one of the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage				

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name Taeko Frost, MPH Answer  YES  NO

Title Executive Director

Only appeals from the CEO, CFO or comparable will be accepted

Washington Heights CORNER Project (WHCP) is a harm-reduction program that has been serving sex workers and injection drug users (IDUs) since its inception in 2005. WHCP is the only pro-active HIV prevention program in Northern Manhattan covering over 70 city block north of Harlem and has been leading the expansion of essential life-saving services for the underserved and often invisible active drug using population. WHCP provides syringes to over 1,600 unique individuals, non-injection drug user resources to an additional 500 individuals, and provides HIV prevention education and resources to over 5,000 unique individuals per year (2013). Over 90% of participants at WHCP are Medicaid eligible, Medicaid recipients, or uninsured. Over 60% of participants report they are unstably housed or street-homeless. Over 50% of participants reported using the emergency room for services in the last year. Northern Manhattan is, as both service provider knowledge and epidemiological data suggests, underserved. According to the New York City HIV/AIDS Annual Surveillance Statistics, in 2012 there are 4,173 people living with HIV/AIDS in Washington Heights/Inwood, 15% of which have a history of injection drug use; 45% of HIV-related deaths in 2011 were among injection drug users (IDUs). In Central Harlem/Morningside Heights, there are 4,573 people living with HIV/AIDS, 18.2% of which have an injection drug use history; 32% of HIV-related deaths in 2011 were among IDUs. In 2009, the neighborhood rate for newly report hepatitis C cases in Washington Heights/Inwood (113.6 per 100,000) and Central Harlem/Morningside (219.0 per 100,000) are comparable or higher than the New York City overall (129.7 per 100,000). In 2011, the rates of drug overdose death for Washington Heights/Inwood (12.4 per 100,000) and Central Harlem/Morningside Heights (18.7 per 100,000) were higher than New York City overall (9.5 per 100,000). According to the NYCDOHMH Community Health Profiles, after cancer and heart disease, the most common causes of death in this geographical area are HIV-related (8% Inwood/Washington Heights, 14% Central Harlem) and drug-related (7% Inwood/Washington Heights, 6% Central Harlem). A recent needs assessment survey among WHCP participants (n=123) indicated that 85% reported they had witnessed an overdose, 38% reported they had experienced an overdose themselves, 52% had reversed and overdose, and 25% had used naloxone. The majority (62%) of participants report they have tested positive for hepatitis C, yet only 17% are in treatment. WHCP provides case management services, referrals to medical care and drug treatment, onsite low-threshold primary care, peer education training, escort and navigation, naloxone provision, and support groups. WHCP provides a drop-in center during weekday business hours for participants of the program. This space serves as an opportunity for individuals to speak with case managers to be reconnected to services when they are unsure of where to access services, such as housing placement or medical care. WHCP works with a large team of peer educators to provide low-threshold referrals to the most at risk, disengaged population that accesses WHCP services outside (e.g. abandoned buildings, parks, shooting galleries) in Northern Manhattan and portions of Morningside Heights and the Bronx.





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**I. Are you a Medicaid Provider**

Answer	Not Yet
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**II. Appeal Applicant Information**

Organization Name:	Washington Heights CORNER Project
OPTIONAL Joined PPS:	The New York and Presbyterian Hospital

You have chosen the following category:	2
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**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	Harm Reduction 1915i Provider			
Provider Type - Other:	DO NOT USE			
	Operating Certificate/License #	MMIS	NPI	
Unique Identifiers:				
Agency Code:				
Billing Entity ID:				
	Address	City	State	Zip
Address:	566 West 181st Street, 2nd Floor	New York	NY	10033
County:	New York			

**III. Appeal Point of Contact**

Contact Person	Taeko Frost, MPH		
Title	Executive Director		
Contact Phone	212-923-7600	Extension	123
Contact Email	admin@cornerproject.org		

**IV. Please choose the following 1915i Category:**

1 I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers

2 I am a Harm Reduction 1915i provider that is on one of the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage				

**VIII. Yes I Hereby Certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.**

Name Taeko Frost, MPH Answer  YES  NO

Title Executive Director

Only appeals from the CEO, CFO or comparable will be accepted

Washington Heights CORNER Project (WHCP) is a harm-reduction program that has been serving sex workers and injection drug users (IDUs) since its inception in 2005. WHCP is the only pro-active HIV prevention program in Northern Manhattan covering over 70 city block north of Harlem and has been leading the expansion of essential life-saving services for the underserved and often invisible active drug using population. WHCP provides syringes to over 1,600 unique individuals, non-injection drug user resources to an additional 500 individuals, and provides HIV prevention education and resources to over 5,000 unique individuals per year (2013). Over 90% of participants at WHCP are Medicaid eligible, Medicaid recipients, or uninsured. Over 60% of participants report they are unstably housed or street-homeless. Over 50% of participants reported using the emergency room for services in the last year. Northern Manhattan is, as both service provider knowledge and epidemiological data suggests, underserved. According to the New York City HIV/AIDS Annual Surveillance Statistics, in 2012 there are 4,173 people living with HIV/AIDS in Washington Heights/Inwood, 15% of which have a history of injection drug use; 45% of HIV-related deaths in 2011 were among injection drug users (IDUs). In Central Harlem/Morningside Heights, there are 4,573 people living with HIV/AIDS, 18.2% of which have an injection drug use history; 32% of HIV-related deaths in 2011 were among IDUs. In 2009, the neighborhood rate for newly report hepatitis C cases in Washington Heights/Inwood (113.6 per 100,000) and Central Harlem/Morningside (219.0 per 100,000) are comparable or higher than the New York City overall (129.7 per 100,000). In 2011, the rates of drug overdose death for Washington Heights/Inwood (12.4 per 100,000) and Central Harlem/Morningside Heights (18.7 per 100,000) were higher than New York City overall (9.5 per 100,000). According to the NYCDOHMH Community Health Profiles, after cancer and heart disease, the most common causes of death in this geographical area are HIV-related (8% Inwood/Washington Heights, 14% Central Harlem) and drug-related (7% Inwood/Washington Heights, 6% Central Harlem). A recent needs assessment survey among WHCP participants (n=123) indicated that 85% reported they had witnessed an overdose, 38% reported they had experienced an overdose themselves, 52% had reversed and overdose, and 25% had used naloxone. The majority (62%) of participants report they have tested positive for hepatitis C, yet only 17% are in treatment. WHCP provides case management services, referrals to medical care and drug treatment, onsite low-threshold primary care, peer education training, escort and navigation, naloxone provision, and support groups. WHCP provides a drop-in center during weekday business hours for participants of the program. This space serves as an opportunity for individuals to speak with case managers to be reconnected to services when they are unsure of where to access services, such as housing placement or medical care. WHCP works with a large team of peer educators to provide low-threshold referrals to the most at risk, disengaged population that accesses WHCP services outside (e.g. abandoned buildings, parks, shooting galleries) in Northern Manhattan and portions of Morningside Heights and the Bronx.



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**I. Are you a Medicaid Provider**

Answer Yes  No

You have chosen the following category: **1**

**II. Appeal Applicant Information**

Organization Name: Western New York Independent Living, Inc.  
OPTIONAL Joined PPS: Erie: Erie County Medical Center Corporation

**VI. Restricted to 3500 Characters only!**

Please put any additional notes below that you feel are relevant. This section is optional for 1915i providers.

**I am hereby requesting approval as a safety net entity as I have been approved by OMH/OASAS/DOH as a likely agency to participate in delivering 1915i Medicaid services to the DSRIP attributed patient population.**

Provider Type:	OMH OMH 1915i Provider			
Provider Type - Other:	DO NOT USE			
	Operating Certificate/License #	MMIS	NPI	
Unique Identifiers:		01586098	1427267806	
Agency Code:	15620			
Billing Entity ID:				
	Address	City	State	Zip
Address:	3108 Main St.	Buffalo	NY	14214
County:	Erie			

**III. Appeal Point of Contact**

Contact Person: Douglas J Usiak  
Title: Executive Director  
Contact Phone: 716-836-0822 Extension: 117  
Contact Email: [dusiak@wnyil.org](mailto:dusiak@wnyil.org)

**IV. Please choose the following 1915i Category:**

- 1 I am an OMH 1915i or OASAS 1915i provider that is already on one of the following pending DSRIP lists: Pending Safety Net OMH/OASAS 1915i Providers
- 2 I am a Harm Reduction 1915i provider that is on one of the following pending DSRIP lists: Pending Safety Net Harm Reduction 1915i Providers.

**V. Percentage of Medicaid & Uninsured members that your facility serves**

	Medicaid (FFS & MC)	Uninsured	Data Source	Year
Percentage	82%	N/A	Internal	2013-2014

**VIII. No** I hereby certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.

Name: Douglas J Usiak  
Title: Executive Director  
Only appeals from the CEO, CFO or comparable will be accepted

Answer Yes  No

1. WNYIL, Inc. has joined Erie County Medical Center Corporation and is also working with Finger Lakes PPS and Niagara Falls Memorial Medical Center.

2. WNYIL, Inc. has two MMIS numbers, one is for Medicaid Case Management and is indicated in the box labeled "MMIS" in Section II, and the other is for CDPAS and is 02407789.

3. Though WNYIL, Inc. serves individuals who are uninsured, we do not have an accurate percentage to offer at this time.

4. Due to an error in this form we are unable to check "Yes" in Section VIII. "No" is automatically chosen and when "Yes" is selected, number "1" in Section IV is unselected. Please be assured that I, Douglas J. Usiak, Executive Director, certify that the information and data provided on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of this appeal.