The City of New York
Administration for Children's Services

Policy and Procedure
#2016/06

Homemaking Services Authorization Procedure

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Supporting Regulations: 18 NYCRR Part 460	**Supporting Case Law:** N/A	**Bulletins & Directives:** ACS Special Bulletin: Confidentiality and Access to and/or Release of Information from Confidential Databases, June, 2014	
Key Words: homemaking, homemaking services, homemaker, authorization, reauthorization, re-authorization, procedure, home care, family home care	**Related Policies:** ACS Policy # 2010/07 Security of Confidential, Case Specific, and/or Personally Identifiable Information	**Supersedes:** Procedure #99 Family Homemaking Services, September 24, 1997	

Related Forms (Attached):

1. FSS 008A Referral for Homemaker Services
2. FSS 008B Authorization for Homemaking Service
3. FSS 008C Notice of Denial of Home Care Services
4. FSS 008D Homemaker Task Plan
5. FSS 008E Notice of Intent to Reduce or Terminate Homemaker Services
6. FSS 008F Authorization for Termination of Homemaker Service
7. FSS 008G Agreement of Relative/Friend to Participate in Home Care Service Plan
8. FSS 008H Confirmation of Overtime Homemaker Service Hours
9. FSS 008I Homemaking Reauthorization
10. FSS 008J Contract Agency Home Care Request
11. FSS 008K Authorization to Extend Homemaking Service - No Changes in Service Hours
12. FSS 008L Authorization for Homemaker Service on a 24-Hour Basis
13. M-11Q Medical Request for Home Care
14. HCSP-712B Eight Helpful Hints for Accurate Completion of the Medical Request for Home Care

15. OCFS-4940 Designation of Person in Parental Relationship
SUMMARY: This policy outlines the responsibilities of ACS and provider agency case planning staff and homemaker contractors regarding the proper submission and processing of homemaking services forms. The procedures in the policy must be used for all requests regarding homemaking services that ACS authorizes and oversees.

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I. INTRODUCTION

A. Homemaking is a short-term specialized service provided to families in their homes to support their efforts to maintain household operations during periods of stress or crisis. A homemaker can teach child care and household management techniques to parents/caretakers in order to strengthen the family and prevent the need for foster care placement or re-placement.

B. This policy outlines the responsibilities of the Administration for Children's Services (ACS), including Family Home Care, provider agencies, and homemaker contractors regarding the proper submission and processing of homemaking services forms.

C. All emails and faxes sent by ACS, provider agency, or homemaker contractor staff, regarding children and families, must comply with ACS Policy #2010/07 *Security of Confidential, Case Specific, and/or Personally Identifiable Information* and the ACS Special E-Bulletin, entitled *Confidentiality and Access to and/or Release of Information from Confidential Databases*, dated June, 2014.
Security of Confidential, Case Specific, and/or Personally Identifiable Information.

II. CRITERIA AND SCOPE OF SERVICES

A. Criteria for Services

1. Homemaking services shall only be offered in emergencies when an adult member of the family is unable to assume continuing responsibility for maintenance and direction of the family unit, and such services are necessary for the care and protection of dependent persons in the home.[1]

2. Case planning staff determine service needs based on an assessment of current family functioning and skills, the availability of community supports, and an exploration of whether services, such as child care, after-school programming, mentoring, mental health treatment, and services for developmental disabilities would meet the family's needs.

B. Scope of Services

1. Homemaking services may include, but are not limited to, teaching and providing support with the following:

   a. Household tasks, such as shopping, preparing and serving meals, cleaning, light laundry, ironing, and mending;

[1] See 18 NYCRR Part 460.

b. Personal services, such as assistance with bathing and other personal care of small children or elderly or adults who are disabled, payment of bills, errands, accompanying the elderly person to the clinic or the doctor;

c. Supervising children during the hours a responsible adult is absent from the home due to an emergency or required /mandated appointments.

2. The homemaker's duties do not include the provision of medical care.

III. RESPONSIBLE PARTIES

A. Case Planners – Preventive services and foster care provider agency case planners and ACS Division of Child Protection (DCP) child protective specialists (CPSs) (hereinafter, "case planners") are responsible for assessing safety and risk to children and families and making appropriate service referrals, including referrals for homemaking services.

B. Family Home Care (FHC) – The ACS Division of Preventive Services (DPS) Family Home Care (FHC) program provides oversight of homemaker contractors.

C. Vendor Assignment Unit (VAU) – The Vendor Assignment Unit (VAU) is the unit, within FHC, responsible for reviewing requests for homemaking services and determining the appropriate level of services.

D. Homemaker Contractors – Homemaker contractors are contracted providers who deliver homemaking services to ACS clients.

E. Home Care Liaisons – Home care liaisons are ACS staff members, located in the borough offices and FHC. They act as intermediaries between FHC, the borough offices, provider agencies, other community providers (e.g., doctors, hospitals, home care agencies), and the Human Resources Administration (HRA) Home Care Services Program (HCSP) and HIV/AIDS Services Administration (HASA) program. They work with staff to resolve home care case and billing issues. Home care liaisons for ACS staff are located in the borough offices; and home care liaisons for provider agency staff are located within FHC.

IV. INITIAL HOMEMAKING SERVICES AUTHORIZATION

A. Case Planner Responsibilities

1. Division of Child Protection

a. When a CPS has determined that a case meets the criteria for homemaking services, the CPS must submit the following completed forms to the home

care liaison for review by email to HomecareReferrals@acs.nyc.gov or by fax to (212) 676-9402:

i. FSS 008A *Referral for Homemaker Services*;
ii. FSS 008B *Authorization for Homemaking Service*;
iii. M11Q *Medical Request for Home Care* (this form must be submitted for all household members with a known physical or mental health disability);
iv. FSS 008G *Agreement of Relative/Friend to Participate in Home Care Service Plan;* and
v. OCFS-4940 *Designation of Person in Parental Relationship*[2].
Note: No staff member having a professional role in a client's case, whether ACS, provider agency, or homemaker contractor staff, may accept designation as or assume the role of a "Person in Parental Relationship." Such decision-making is beyond the scope of services provided to our clients.

2. Provider Agencies

a. When a provider agency case planner has determined that a case meets the criteria for homemaking services, the case planner must submit the following completed forms to the identified home care liaison by email to HomecareReferrals@acs.nyc.gov or by fax to (212) 676-9402:

i. Form FSS 008J *Contract Agency Home Care Request,*
ii. Form M11Q (if applicable), and
iii. OCFS-4940 *Designation of Person in Parental Relationship* for an initial request.
Note: No staff member having a professional role in a client's case, whether ACS or provider agency case planning staff or homemaker contractor staff, may accept designation as or assume the role of a "Person in Parental Relationship." Such decision-making is beyond the scope of services provided to our clients.

b. FHC staff must make a field assessment in response to the request for services and complete the documents listed above in section IV(A)(1)(a)(i), (ii), and (iv).

[2] Form OCFS-4940, *Designation of Person in Parental Relationship* allows a parent to designate another person to make medical and educational decisions for his or her child(ren) for a specified period of time if the parent is unable to make such decisions. This document should be completed with the initial application and is valid for 30 days.

B. Family Home Care Responsibilities

1. When a family has been deemed eligible for homemaking services, the FHC VAU shall contact the homemaker contractor's designated staff person to provide the following:

    a. Client information: name, Social Security number, date of birth, gender, address, directions to the client's residence, phone number, and language spoken;
    b. ACS case planning information: referral office, unit, worker, names of supervisor I and supervisor II, Welfare Management System (WMS) case number, and CONNECTIONS (CNNX) Case ID;
    c. Docket number, if the services are court-ordered;
    d. Emergency contact information for individuals living in the New York City area who can assist the family in case of emergency;
    e. Names of children in the household;
    f. Children's dates of birth, educational or out-of-home program information, including, but not limited to, early care and education, and after-school programs;
    g. Names of other adults in the household not requiring assistance;
    h. A brief narrative of household conditions and why the services are being requested, including medical information for individual household members, as applicable;
    i. A list of the most critical homemaking tasks needed to help bring the current crisis under control;
    j. Days and hours of service for the family; and
    k. Projected timeframe for service termination if known at the onset.

2. Upon receipt of this information, the FHC VAU shall enter the case information into the HRA Homemaking (HMK)[3] system for a three-month period and shall complete FSS 008B *Authorization for Homemaking Service*. The homemaker contractor must retrieve a copy of the authorization from FHC.[4]

C. Homemaker Contractor Responsibilities

1. Within 72 hours of receiving an initial request for homemaking services, the homemaker contractor must contact the family and initiate homemaking services, as per contractual agreement, unless otherwise specified by FHC. If the homemaker contractor encounters no obstacles to starting within the 72-hour

[3] HMK is the HRA electronic system for homemaking services authorizations, which is used to make payments to providers.
[4] All approved FSS 008B *Authorization for Homemaking Service* forms must be retrieved in person at FHC.

timeframe, the contractor shall provide the following information to FHC by email to HomecareReferrals@acs.nyc.gov or by fax to (212) 676-9402:

a. The exact start date of the services being provided;
b. The number of service hours being provided (the number of service hours must match the original service hours referred to the homemaker contractor); and
c. FSS 008D *Homemaker Task Plan,* which must be completed and signed by the client, the homemaker, and the homemaker's supervisor (case coordinator).

V. IMPLEMENTATION DELAYS AND ALTERNATIVE SERVICE HOURS

A. Occasionally, service implementation is delayed for reasons, including, but not limited to, the following:

1. The primary caretaker has requested an alternative start date in order to meet certain household or court requirements;
2. The family is ordered by the court to accept the services, but is resistant;
3. Heavy-duty cleaning and/or extermination is required in the client's residence;
4. The primary caretaker is hospitalized, and the children are currently residing with another caretaker;
5. The children have not been returned from foster care as initially planned.

B. Case Planner Responsibilities

1. The case planner must speak with the family to verify the appropriateness of the delay. When a parent is hospitalized, and the children are with alternative caretakers, or when the children have not yet been reunified with their parents, the case planner must identify an anticipated date for services to begin.

2. In instances where the home requires heavy-duty cleaning and/or extermination services, the case planner is responsible for verifying that such services have been completed prior to the implementation of homemaking services. Additionally, the case planner shall notify the home care liaison of the anticipated timeframe for service initiation.

C. Family Home Care Responsibilities

1. When homemaking services need to be delayed, FHC staff shall:

a. Communicate the necessary information, by email or fax, to the home care liaison and the homemaker contractor, as necessary;

b. Issue a service initiation suspension, by email, to the homemaker contractor, the home care liaison, and the case planner; and

c. Request (if appropriate) that the case planner and homemaker contractor make a joint home visit to expedite service initiation, as in the case of heavy-duty cleaning.

D. Homemaker Contractor Responsibilities

1. If the homemaker contactor has determined that he or she is unable to initiate homemaking services within 72 hours, he or she must immediately communicate the reasons for the delay to FHC by email to HomecareReferrals@acs.nyc.gov or by fax to (212) 676-9402.

2. During the initial visit, if the homemaker contractor has concerns that the referred service hours are insufficient to provide the support necessary to alleviate the current crisis, he or she can email or fax (see above) a request and justification to FHC to increase the number of service hours. If there are no other reasons for the delay, the homemaker contractor must begin homemaking services based on the referred hours until FHC makes a determination about the requested adjustment.

VI. WITHDRAWAL OF A SERVICE REQUEST

A. A family may withdraw a request for homemaking services **before** services have begun. Such withdrawals must be requested in writing, dated, and signed by the person withdrawing the request. When a parent or guardian decides to withdraw a request for home care services, the case planner must complete the DSS-2921 NYC form and have the parent or guardian sign it.

B. When an outside agency has referred a family for homemaking services, and ACS has approved such services, but the family is refusing services **before** they have begun, the following must occur:

1. The homemaker contractor shall notify FHC.

2. FHC shall notify the home care liaison.

3. The home care liaison shall notify the case planner.

4. FHC shall keep the case open for 30 days pending the case planner's efforts to re-engage the family.

5. If the family continues to refuse services after 30 days, the case planner must complete the FSS 008C *Notice of Denial of Home Care Services*. The case planner must provide a copy of the signed form to the family, the referring agency, and FHC.

C. When a request is made for the withdrawal of homemaking services **after** they have begun, the case planner must complete the FSS 008E *Notice of Intent to Reduce or Terminate Homemaker Services* and obtain the signature of the person requesting the withdrawal.

VII. DENIAL OF A SERVICE REQUEST

A. When a case planner determines that a family does not need the requested homemaking service, the following must occur:

1. The case planner must notify FHC staff immediately.
2. The case planner must complete the FSS 008C *Notice of Denial of Home Care Services* and fax or email it to the home care liaison.
3. The home care liaison must then contact FHC staff and fax or email the FSS 008C *Notice of Denial of Home Care Services*.

B. Reasons for Denial

1. A denial of homemaking services can only occur after the CPS or FHC staff has determined that the services are not needed. Reasons for denial include, but are not limited to, the following situations:

   a. The parent has demonstrated the ability to support the children safely in the community without homemaking services;
   b. The children are being placed or will remain in foster care until the next court hearing; or
   c. The family is moving to a location outside New York City.

C. Notice of a Denial of Homemaking Services

1. The CPS[5] must complete the FSS 008C *Notice of Denial of Home Care Services* form and obtain two (2) levels of approval from the child protective specialist supervisor (CPSS) II and the child protective manager (CPM). The CPS must provide the original form to the family and issue copies to the home care liaison and FHC.

2. The FSS 008C *Notice of Denial of Home Care Services* form advises the family of the right to appeal ACS' decision and request a fair hearing.

[5] The CPS or the Child Welfare Specialist (CWS) (FHC) are the only staff members that can deny homemaking services.

3. FHC staff shall notify the homemaker contractor immediately by phone or email that the service has been withdrawn.

VIII. REAUTHORIZATION AND CHANGES IN SERVICE HOURS

A. Case Planner Responsibilities

1. The case planner must complete the reauthorization package.

2. The case planner shall confirm that the home care liaison has submitted the package to FHC no later than 30 calendar days prior to the service expiration date.

3. Homemaking services must be reauthorized every 90 days;

4. Homemaking reauthorization and change packages must include the following forms:

    a. FSS 008I *Homemaking Reauthorization*;
    b. FSS 008K *Authorization to Extend Homemaking Service - No Changes in Service Hours*;
    c. FSS 008E *Notice of Intent to Reduce or Terminate Homemaker Services*. This would include whenever there is a change in service other than expansion of services;
    d. FSS 008B *Authorization for Homemaking Service*;
    e. M11Q *Medical Request for Home Care* (when necessary) for all identified household members; and
    f. HCSP-712B *Eight Helpful Hints for Accurate Completion of the Medical Request for Home Care*.

5. Upon receipt of the reauthorization or change package, the home care liaison must submit the package to FHC no later than 30 calendar days prior to the service expiration date.

    a. For changes in service hours, the home care liaison must submit the request to change the service hours no later than 14 calendar days prior to the expected date of change.

B. Family Home Care Responsibilities

1. The FHC VAU staff shall enter forms FSS 008B *Authorization for Homemaking Service*,[6] FSS 008K *Authorization to Extend Homemaking Service - No Changes in Service Hours*, and M-20TR[7] into the HRA HMK system.

2. FHC shall contact the case planner and/or the home care liaison to discuss the request for a change in service hours.

3. In cases where it is deemed appropriate, FHC shall work with the case planner and home care liaison to readjust the requested change in hours to better target specific child care and home care training needs for the parent.

4. FHC shall contact the homemaker contractor with any changes in service hours and provide confirmation of the start date for the new hours.

5. FHC shall provide a copy of the documents for the homemaker contractor to pick up in person before the end of the month in which the request was submitted, provided the request was submitted in a timely manner.

C. Homemaker Contractor Responsibilities

1. Homemaker contractors shall service families at the contracted hours unless FHC provides notification of a date for a change in service hours.

2. Homemaker contractors shall not accept verbal requests for changes in hours from a case planner. Only FHC may provide final confirmation of service hour changes.

3. Failure of the homemaker contractor to adhere to ACS' directives may be grounds for nonpayment. This will include non-payment for hours not previously authorized (unapproved hours)

IX. OVERTIME REQUESTS

A. Overtime is defined as the circumstance when homemaking services must be provided beyond the hours authorized. When needed, overtime is allowed on an unplanned basis for unanticipated reasons. ACS may authorize overtime to protect the well-being of the children in the home on a short-term basis. Overtime requests shall not exceed

[6] FSS 008B Authorization for Homemaking Service is submitted when there is an initial request for homemaking services or there is a change in homemaking services.
[7] This is an HRA computer generated form for straight reauthorizations.

a 14-day service authorization period while the case planner explores alternative plans and supports for the children. ACS distinguishes between two (2) types of overtime: crisis overtime and non-crisis overtime. It is important to note that, while case planners can facilitate requests for overtime, they cannot authorize overtime. For ACS cases, the CPSS II and CPM must approve overtime for homemaking services; and for provider agencies, approval from the supervisor and director is required.

1. Crisis Overtime

    a. Crisis overtime is an unplanned need for overtime that is usually anticipated to be required on a short-term basis or until an alternative plan can be made to prevent placement (e.g., a parent is hospitalized on an emergency basis, and the assigned homemaker must remain with the children until other living arrangements can be made).

        i. The homemaker contractor shall notify FHC of the circumstances suggesting the need for crisis overtime.

        ii. FHC shall notify the case planner and case planner's supervisor by email or phone.

        iii. The case planner shall assess the appropriateness of recommending overtime, considering other alternative and the best interests of the child.

        iv. The case planner shall secure the appropriate level of approval for the hours of overtime to be authorized.

        v. If approved, the case planner shall fax or email the approval, indicating the exact dates and hours authorized, to the home care liaison and to FHC.

        vi. In cases where the homemaker contractor informs FHC of the need for overtime due to a crisis in the family, the FSS 008H form, *Confirmation of Overtime Homemaker Service Hours*, shall be completed by the homemaker contractor.

        vii. In cases where the crisis occurs after 5pm on a weekday or any time on a weekend or holiday, the homemaker contractor shall contact FHC's director by phone at (646) 413-2980, or by email to Martha.Boomer@acs.nyc.gov

        viii. The FHC director shall assess the appropriateness of overtime considering other alternatives and the best interests of the children.

ix. If FHC director approves the overtime request, he or she must notify the case planner and supervisor by email on the next business day after receipt of the request.

2. Non-Crisis Overtime

a. Non-crisis overtime is an unplanned need for overtime on a one-day basis because of circumstances beyond the client's or homemaker's control (e.g., a homemaker who has been assigned to accompany a family to a medical appointment must remain with the family beyond the authorized hour.

b. Non-crisis overtime may also be requested if the parent must attend a regularly scheduled program a few days per month over a period of two (2) to three (3) months (e.g., when a parent has to attend anger management classes for three (3) hours each a week over a two-month period, with no set end date).

c. Case Planner's Responsibilities

i. The case planner shall review the appropriateness of the recommended overtime, considering other alternatives and the best interests of the children.

ii. The case planner shall complete and submit the FSS 008H, *Confirmation of Overtime Homemaker Service Hours*, to the home care liaison on the Monday following the week during which the overtime was requested.

iii. The case planner shall have the parent or guardian complete and sign the FSS 008L, *Authorization For Homemaker Service on a 24-Hour Basis*, and submit it to FHC when the parent or guardian has a planned yet critical situation that requires his or her absence from the home, such as a surgery or childbirth, and his or her support system is not readily available.

iv. The case planner shall verify that the OCFS-4940, *Designation of Person in Parental Relationship*, form is still valid. If the form is no longer valid, the case planner shall have the parent complete, sign, and notarize a new form for any planned absences.

v. The home care liaison must confirm receipt of the documents and then submit them to FHC that day.

vi. Note**:** If patterns of non-crisis overtime develop for individual clients, the case planner must reevaluate the appropriateness of days and hours of authorized services. The case planner must monitor for excessive use of

overtime by families and discuss alternative scheduling or services with FHC and the homemaker contractor.

d. Family Home Care Responsibilities

i. FHC shall approve appropriate emergency requests for overtime for a minimum of three (3) days and a maximum of seven (7) days to allow the case planner adequate time to address the necessary child care issues for the family.

ii. FHC shall contact the home care liaison and case planner regarding the emergency authorization to discuss other avenues for ongoing service authorization.

iii. FHC shall enter all approved FSS 008H, *Confirmation of Overtime Homemaker Service Hours*, forms into the HRA HMK system.

iv. FHC must have a copy of the documents ready for the homemaker contractor to pick up in person before the end of the month at the address below:

Administration for Children's Services
Family Home Care Program, 11th Floor
150 William Street
New York, NY 10038

e. Homemaker Contractor Responsibilities

i. The homemaker contractor shall notify FHC, the home care liaison, and the case planner, by email, of the circumstances suggesting the need for overtime.

ii. If a crisis arises after hours, on weekends, or holidays, the contactor must immediately email the FHC director about the issues and request authorization for the hours worked during the emergency. (See section IX(A)(1)(vii), above, for contact information.)

iii. The homemaker contractor shall complete the FSS 008H, *Confirmation of Overtime Homemaker Service Hours*, for the overtime and submit the form to FHC for follow up with the case planner.

X. TERMINATION OF SERVICES

A. Criteria for Terminating Homemaker Services

1. The family's goals have been achieved;
2. FHC or the case planner has determined that services are not needed;
3. The client has refused to accept further services; or
4. There is a court order terminating services.

B. Case Planner Responsibilities

1. The case planner must send the family the FSS 008E, *Notice of Intent to Reduce or Terminate Homemaker Services*, form so that the family receives it no later than 15 calendar days prior to the anticipated termination date;

2. The case planner must complete the FSS 008F, *Authorization for Termination of Homemaker Services*, form identifying the last date of service as well as the homemaker contractor staff person's name, phone number, and date of termination discussion;

3. The case planner must submit the FSS 008F form and a copy of the FSS 008E form to the home care liaison; and

4. The home care liaison must send the documents to FHC so that they are received no later than 10 calendar days prior to the anticipated termination date.

C. Family Home Care Responsibilities

1. FHC must contact the homemaker contractor to confirm the last date of service.

2. Five (5) days prior to the service termination date, FHC must enter the information in the HRA HMK system.

3. Fair Hearings

   a. Clients may request a fair hearing whenever there is a denial, change, or discontinuance of services. Once a fair hearing is requested, ACS will be represented by the Office of the General Counsel (OGC) Fair Hearings and Compliance Unit (FHCU).

   b. The New York State Office of Temporary and Disability Assistance (OTDA) determines whether to grant an appellant "Aid to Continue"; if issued, this "AC" directive is mandatory and overrides any previous reduction or

discontinuance of services. Services must be immediately reinstated or continued at the level in effect at the time the Notice of Intent was issued.

c. Note: "Aid to Continue" may be directed if services have been reduced or discontinued, but it is not generally available when services have been denied.

d. FHC must notify all parties of the case status: "AC" (Aid to Continue) or "NA" (No Aid to Continue) and work with the case planner and the homemaker contactor to confirm compliance with state regulations.

D. Homemaker Contractor Responsibilities

1. The homemaker contractor is responsible for adhering to ACS' directives and must close out the case on the date FHC provides.

2. The failure of the homemaker contractor to adhere to ACS' directives will constitute grounds for nonpayment of hours worked beyond the closing date.

XI. RECONCILIATIONS

A. Monthly Reconciliations

1. All homemaker contractors are responsible for submitting their billing invoices to HRA for monthly processing as required by ACS.

2. All homemaker contractors are responsible for retrieving authorization documents from FHC on a regular basis.

3. Homemaker contractors must retrieve their documents on a monthly basis in order to reconcile their invoices in a timely manner.

4. All homemaker contractors are responsible for setting up a monthly appointment with FHC to review and address any outstanding billing and authorization issues which remain unresolved since the previous month's reconciliation.

B. Year-End Reconciliations

1. FHC shall conduct a year-end reconciliation for the prior fiscal year's unresolved billing issues starting July 1st of each new fiscal year and ending on September 30th (e.g., for Fiscal Year 2025, the year-end reconciliation shall be conducted from July 1, 2025 until September 30, 2025).

2. Each homemaker contractor shall submit all bills not previously resolved for the fiscal year in question and must schedule an appointment with FHC to complete

the year-end reconciliation. Once an appointment has been scheduled and a final reconciliation has concluded, FHC shall not consider any new unresolved billing concerns.

REFERRAL FOR HOMEMAKER SERVICES

I. IDENTIFYING INFORMATION

A. REFERRAL SOURCE:

ACS OFFICE/ZONE/DIVISION _____ UNIT WORKER _____

CASE MANAGER: _____

TELEPHONE: ( ) _____

PLANNING AGENCY
(IF DIFFERENT FROM CASE MANAGEMENT AGENCY) _____

CASE MANAGER: _____

TELEPHONE: ( ) _____

B. CASE INFORMATION

_____ LAST NAME _____ FIRST NAME _____ CASE NUMBER

_____ ADDRESS _____ APT/FLOOR _____ BOROUGH/CITY _____ ZIP CODE ( ) _____ TELEPHONE

NEAREST TRAIN (S) AND STATION AND/OR BUS STOP: _____

C. HOUSEHOLD COMPOSITION

ADULT(S) FOR WHOM SERVICE IS TO BE PROVIDED

	LAST NAME	FIRST NAME	DOB	RELATION	LANGUAGE SPOKEN
1.					
2.					

CHILD(REN) FOR WHOM SERVICE IS TO BE PROVIDED

	LAST NAME	FIRST NAME	DOB	RELATION	SCHOOL/DAY CARE HOURS	LUNCH AT HOME Y/N
3.						☐ YES ☐ NO
4.						☐ YES ☐ NO
5.						☐ YES ☐ NO
6.						☐ YES ☐ NO
7.						☐ YES ☐ NO
8.						☐ YES ☐ NO

OTHERS IN HOUSEHOLD NOT RECEIVING SERVICE

	LAST NAME	FIRST NAME	DOB	RELATION	LANGUAGE SPOKEN
9.					
10.					
11.					
12.					

D. EMPLOYMENT/OTHER PROGRAM PARTICIPATION

LN	NAME OF PROGRAM	ADDRESS	HOUR LEAVES HOME	HOUR ARRIVES HOME	DAYS OF WEEK

NYC Administration for Children's Services

II. LIVING ARRANGEMENTS

A. HOUSING TYPE

☐ APARTMENT ☐ FURNISHED ROOM
☐ PRIVATE APARTMENT ☐ HOTEL/MOTEL ☐ NYCHA
☐ OTHER: _____

☐ 1 FAMILY ☐ 2 – 4 FAMILY
☐ FLOOR: _____ ☐ NO. ROOMS: _____
☐ ELEVATOR ☐ WALK-UP

B. FACILITIES

☐ HEAT ☐ HOT WATER
☐ SINK ☐ BATHROOM ☐ PRIVATE BATHROOM
☐ SHOWER/TUB ☐ LAUNDRY ROOM ☐ REFRIGERATOR
☐ STOVE ☐ WASHER ☐ DRYER
☐ AIR CONDITIONER ☐ ELEVATOR

C. SUPPLIES

ADEQUATE CLEANING SUPPLIES ☐ YES ☐ NO
ADEQUATE FURNISHINGS ☐ YES ☐ NO
HEAVY DUTY CLEANING NEED ☐ YES ☐ NO (**If YES:** Refer to ACS Day Services Program)

D. LIVING CONDITIONS

HOME CONDITIONS NEEDING REPAIR: _____

ARE THERE ANY PETS? (TYPE/NUMBER): _____

DESCRIBE OVERALL HOME CONDITIONS (CLEANLINESS, HEAT, HOT WATER, ETC.): _____

III. HEALTH/MENTAL HEALTH CLEARANCE

IF ANY HOUSEHOLD MEMBER HAS COMMUNICABLE DISEASE OR SERIOUS MENTAL HEALTH CONDITION, OBTAIN A SIGNED STATEMENT (WITH REGISTRY NUMBER) FROM A PHYSICIAN/PSYCHIATRIST REGARDING DANGER OF CONTAGION/HARM OF SELF OR OTHERS:

☐ WRITTEN CLEARANCE ATTACHED

NYC Administration for Children's Services

IV. REASON FOR HOMEMAKER SERVICE

A. SERVICE IS NEEDED AT THIS TIME DUE TO (CHECK ALL THAT APPLY):

☐ CARETAKER UNABLE TO PERFORM ALL PARENTAL FUNCTIONS DUE TO:
- ☐ PHYSICAL ILLNESS (M-11Q ATTACHED)
- ☐ MENTAL ILLNESS (M-11Q ATTACHED)
- ☐ DEVELOPMENTAL DISABILITY (M-11Q ATTACHED)
- ☐ CONVALESCENCE (M-11Q ATTACHED)
- ☐ COMPLICATIONS OF PREGNANCY (M-11Q ATTACHED)
- ☐ INADEQUATE SOCIAL SUPPORT SYSTEM

☐ CARETAKER PREOCCUPIED WITH THE CARE OF ILL MINOR CHILD (BUT HOME ATTENDANT IS INAPPROPRIATE) AND IS IN NEED OF SOME RELIEF FROM REGULAR DUTIES INVOLVING WELL CHILDREN.

☐ CARETAKER DOES NOT KNOW HOW TO CARE FOR CHILDREN OR HOW TO KEEP HOUSE DUE TO:
- ☐ LACK OF PREPARATION OR TRAINING
- ☐ INTELLECTUAL LIMITATIONS
- ☐ EMOTIONAL IMMATURITY
- ☐ CHILDHOOD TRAUMA

☐ AN ALTERNATIVE PLAN (E.G., DAY CARE REPLACEMENT) IS BEING DEVELOPED: { Plan: _____ TIME FRAME: _____

☐ TO PREVENT PLACEMENT (OR REPLACEMENT TO ANOTHER FOSTER CARE FACILITY) DUE TO EMERGENCY THAT WOULD OTHERWISE NECESSITATE PLACEMENT OR REPLACEMENT

☐ CARETAKER ABSENT FROM HOME DUE TO:
☐ HOSPITALIZATION ☐ INCARCERATION ☐ REHABILITATION ☐ OTHER (MEMO ATTACHED):

☐ FSS OO8L (formerly known as CS 445C) 24-HOUR SERVICE.

☐ COURT ORDER/DOCKET NUMBER: _____ ☐ WRITTEN COURT ORDER ATTACHED

B. BRIEFLY DISCUSS CONDITIONS THAT PRECIPITATED THE NEED FOR SERVICES AND HOW FAMILY BECAME KNOWN TO AGENCY:

_____

_____

_____

_____

_____

C. BRIEFLY STATE GOALS OF HOMEMAKER SERVICE (CHECK ALL THAT APPLY):

☐ TO HELP FAMILY MAINTAIN NORMAL HOUSEHOLD OPERATIONS DURING PERIOD OF STRESS/CRISIS.

☐ TO HELP FAMILY WHILE AN ALTERNATIVE PLAN IS BEING DEVELOPED.

☐ TO HELP FAMILY MAINTAIN NORMAL HOUSEHOLD OPERATIONS DURING A PERIOD OF ILLNESS (PHYSICAL, MENTAL, EMOTIONAL) OR RECUPERATION, AS RECOMMENDED BY A PHYSICIAN.

☐ TO TEACH RESPONSIBLE PERSON ESSENTIAL HOME MANAGEMENT SKILLS SO THAT HE/SHE CAN ADEQUATELY PROTECT CHILD(REN) WITHOUT THESE SERVICES.

V. SERVICES NEEDED

A. CHECK ALL APPLICABLE SERVICES NEEDS. ASSISTANCE WITH:

☐ CHORE SERVICES:	☐ CLEANING	☐ LAUNDRY/IRONING	☐ SHOPPING	☐ MEAL PREPARATION
☐ REHEATING MEALS	☐ CHILD CARE	☐ ESCORT TO SCHOOL/CLINIC	☐ MONEY MANAGEMENT	
☐ TRAINING (SPECIFY AREAS): _____				

B. DESCRIBE THE INVOLVEMENT OF FAMILY MEMBERS/OTHERS IN MEETING THESE NEEDS:

_____

_____

_____

NYC Administration for Children's Services

V. SERVICES NEEDED (CONTINUED)

C. **OTHER AGENCIES** (OTHER THAN PLANNING AGENCY) INVOLVED WITH FAMILY
(e.g., SCHOOLS, HOSPITALS, FOSTER CARE/PREVENTIVE AGENCIES, ETC.)

AGENCY	ADDRESS	WORKER'S NAME	TELEPHONE
			( )
			( )
			( )
			( )

VI. RECOMMENDED HOURS OF SERVICE

DAYS (CIRCLE): M T W T F HOURS/FROM: _____ TO: _____

S S HOURS/FROM: _____ TO: _____

ESTIMATED DURATION: _____ (MAX 3 MONTHS, THEN REASSESS FOR SERVICES)

24-HOUR SERVICE (FORM FSS 008L)

1. HAVE ALTERNATIVE PLANS FOR THE CARE OF CHILD (REN) IN THE EVENING BEEN EXPLORED (FAMILY/FRIENDS): _____
2. IS THERE CASH ON HAND? ☐ NO ☐ YES $ _____
3. ARE THERE SEPARATE SLEEPING ACCOMMODATIONS FOR THE PROVIDER? ☐ NO ☐ YES (ROOM WITH DOOR)
   EXPLAIN: _____
4. DOES FAMILY US FOOD STAMPS? ☐ YES ☐ NO
5. PERSON WHO WILL HANDLE FUNDS:
   NAME: _____
   RELATION: _____
   ADDRESS: _____
   TELEPHONE: _____

VII. CLIENT AGREEMENT WITH PLAN

DATE HOMEMAKER PLAN DISCUSSED WITH CLIENTS: ____ /____ /____

DATE OF LAST HOME VISIT: ____ /____ /____

VIII. RECOMMENDATION/APPROVAL

PLANNING AGENCY (IF DIFFERENT FROM CASE MANAGEMENT AGENCY)

PLANNING WORKER	DATE	SUPERVISOR	DATE
	____ /____ /____		____ /____ /____

ACS CASE MANAGEMENT DIVISION

NAME (PRINT)	SIGNATURE	TELEPHONE	DATE
CASE MANAGER			____ /____ /____
SUPERVISOR I			____ /____ /____
SUPERVISOR II			____ /____ /____
MANAGER/DIRECTOR			____ /____ /____

DISPOSITION (FAMILY HOME CARE SERVICES PROGRAM): _____

FSS 008B (FORMERLY KNOWN AS CM 20A)
REV 6/14

Attachment B

Administration for Children's Services

AUTHORIZATION FOR HOMEMAKING SERVICES

(CIRCLE ONE) INITIAL / REOPEN / EXTENSION

CHANGE (CHECK)
☐ HOURS/DAYS ☐ VENDOR ☐ ADDRESS
☐ REFERRAL OFFICE ☐ HOUSEHOLD COMPOSITION
☐ OTHER: _____

SOCIAL SECURITY NUMBER

CASE LAST NAME	CASE FIRST NAME	SEX DOB: ___/___/___
CLIENT LAST NAME	CLIENT FIRST NAME	SEX DOB: ___/___/___

STREET	CITY	ZIP	TELEPHONE
REFERRAL OFFICE / CASE LOAD	CASEWORKER		TELEPHONE

EMERGENCY CONTACT	TELEPHONE	1 – PROBLEM	2 – PROBLEM	SPECIAL CODE

LANGUAGE: LESA CODE: _____

WMS CASE #: CONNECTIONS CASE #: MEDICIAD ID#:

OF ADULTS RECEIVING SERVICES: _____ # OF CHILDREN RECEIVING SERVICES: _____
NOT RECEIVING SERVICES: _____ NOT RECEIVING SERVICES: _____

DUAL SERVICE NAME: SSN: TYPE:

SERVICES REQUIRED:

TRAINING: _____ SOCIAL SUPPORT: _____ CHORE: _____ ESCORT: _____
CHILD CARE: _____ BUDGETING: _____ PERSONAL CARE: _____ ASSIST WITH MEDS: _____

PROBLEM CODES

01 ABUSE
02 NEGLECT
03 HOSP
04 PSYCH
05 HEALTH
06 TRAIL
07 SUPPORT
08 DTH/DES
09 SHOP
10 OTHER

SPECIAL CODES

01 AIDS
02 COURT ORDER
03 FAIR HEARING
04 FOSTER CARE

DUAL TYPE CODE

A = H.A. K = HSK

RECOMMENDED HOURS:
FROM: _____ TO: _____

CASE MANAGER: DATE ___/___/___

SUPV. I: TEL #: APPROVAL DATE: ___/___/___

SUPV. II: TEL #: APPROVAL DATE: ___/___/___

VENDOR	(CIRCLE BELOW) CLAIM	RATE	BILLABLE HRS/DAY MN	TU	WD	TH	FR	SA	SU	AUTH HRS/	BILL HRS	AUTH FROM DATE	AUTH TO DATE
	20 EAF 40 PSA 47 CWRA	10 REG 30 AIDS											

MANAGER/DIRECTOR: DATE:

DE OPERATOR: DATE:

Administration for Children's Services

Attachment C

NOTICE OF DENIAL OF HOME CARE SERVICES

NOTICE DATE: _____ / _____ / _____

EFFECTIVE DATE: _____

ACS CASE NAME: _____

CLIENT NAME: _____

MEDICAID CASE NUMBER: _____

SOCIAL SECURITY NUMBER: _____

ACS CLIENT IDENTIFICATION NUMBER (CIN): _____

THE ADMINISTRATION FOR CHILDREN'S SERVICES IS DENYING YOUR REQUEST FOR HOME CARE SERVICES.

YOU ARE BEING DENIED THESE REQUESTED SERVICES BECAUSE: _____

_____

_____

_____

_____

THIS ACTION IS TAKEN PURSUANT TO **18 NYCRR 505.14** AND/OR **18 NYCRR 360-3, 4** AND **5**.

_____	_____	_____	_____
CASE MANAGER/CASE PLANNER	TITLE	UNIT	TELEPHONE NUMBER
_____	_____	_____	_____
SUPERVISOR	TITLE	UNIT	TELEPHONE NUMBER
_____	_____	_____	_____
MANAGER / DIRECTOR	TITLE	UNIT	TELEPHONE NUMBER

YOU HAVE THE RIGHT TO APPEAL THIS DECISION.
BE SURE TO READ THE NOTICE ON THE REVERSE SIDE ON HOW TO APPEAL THIS DECISION.

Administration for Children's Services

RECIPIENT'S RIGHTS OF APPEAL

NOTICE OF DENIAL OF INTIIAL AUTHORIZATION OF HOMEMAKER SERVICES

CLIENT/FAIR HEARINGS COPY

This action is based upon Social Services Law sections 20, 34, 131, 407, 409, and 409-a and New York Code, Rules and Regulations, 18 NYCRR Part 460. You have the right to appeal this action by requesting an agency conference and/or a state fair hearing.

RIGHT TO AN AGENCY CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made an incorrect decision or if, because of information you provide, we are willing to change our decision, we will take corrective action and give you a new notice.

You may ask for a conference by calling _____ at ( ) _____ or by sending a written request to the address listed at the top right of the first page of this notice. (This number is used only to request a conference or case review).

Requesting a conference is not the way to request a fair hearing. If you want to have your benefits continued unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the manner described below. A request for a conference alone will not result in the continuation of your benefits. If you ask for a conference, you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A STATE FAIR HEARING: If you believe that the above action is incorrect, you may request a state fair hearing. Your request must be made within sixty (60) days of this notice. However, if you want your services to continue unchanged, you must request a state fair hearing within ten (10) days of the date of this notice.

You may request a state fair hearing by:

(1) **Telephone: Call toll free 1-800-342-3334 (Note: Please have this Notice with you when calling and state that you are calling in reference to an "ACS – Preventive Homemaking Services" case), OR**

(2) **Writing:** Send your request for a fair hearing or a **completed** copy of this notice to Office of Temporary and Disability Assistance, Office of Administrative Hearings, P.O. Box 1930, Albany, New York 12201-1930. **(Note: Please keep a copy for yourself.) OR**

(3) **Fax:** Fax your fair hearing request or a completed copy of this notice to (518) 473-6735. **OR**

(4) **Email:** Email your fair hearing request or a completed copy of this notice to: http://www.otda.state.ny.us/oah/forms.asp , **OR**

(5) **In Person (Walk-in Location for New York City):** 14 Boerum Place, First Floor, Brooklyn (near Jay St or Borough Hall Train Stations)

REQUEST FOR A FAIR HEARING

I want a fair hearing. I do not agree with the agency's action. (You may explain why you disagree below, but you do not have to include a written explanation.)

_____

_____

_____

Name: _____ Signature: _____

Address: _____ Case Number: _____

_____ Date: _____

If you request an agency conference or a state fair hearing, you will be sent notification(s) informing you of the time and place of the conference or the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. You also have a right to bring witnesses to speak in your favor. If you need legal assistance for your agency conference or state fair hearing, you may be able to obtain it free if you cannot afford a lawyer, by contacting your local Legal Aid Society or legal services offices.

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: You have the right to bring an attorney or other representative with you to examine your case record to the extent that the case record is not confidential. If you want copies of the pertinent documents from your case file, you should ask for them ahead of time. You will be provided with copies of the pertinent documents which we will give to the hearing officer at the fair hearing. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you specifically ask that they be mailed. To ask for documents or to find out how to look at the pertinent documents in your case file, please call the telephone number listed on this page of this notice.

ADDITIONAL INFORMATION: If you want more information about your case, how to ask for a fair hearing, how to see relevant records, or how to get additional copies of documents, call us at the telephone number listed on this page, or write to us at the address printed on the first page of this notice.

FSS 008D (FORMERLY KNOWN AS CM 20d)
REV 6/14

Attachment D

Administration for Children's Services

HOMEMAKER TASK PLAN

Date Form Completed: _____

AGENCY: _____ TELEPHONE: _____

WMS CASE ID #: _____

CLIENT:	AUTH. HOURS	SERVICE AUTH. PERIOD FROM:	TO:

# AND STREET	APT.	BORO	ZIP	TELEPHONE

HOMEMAKER ASSIGNED:	SOC. SEC. #	# HRS./DAYS:	CASE COORDINATOR:

SERVICE GOAL(S)
SHORT TERM:

LONG TERM:

SERVICE NEEDS:	TASK	HM	FAMILY	SHARED	OTHER
CHILD CARE: BATHE/ DRESS/FEED:					
PLAN PLAY ACTIVITIES:					
ASSIST W/HOMEWORK:					
MEALS: PLANNING:					
MARKETING:					
PREPARATION:					
LAUNDRY: **LIGHT HOUSEKEEPING:**					
DUSTING/VACUUMING:					
KITCHEN:					
BATHROOM:					
OTHER LIVING AREAS:					
ACCOMPANY FAMILY MEMBERS TO SCHOOL:					
OUTINGS TO PARK, ETC:					
TO MEDICAL/HOSPITAL:					
TO HRA/ SS/BANK, ETC:					
PARENT EDUCATION: CHILD DEVELOPMENT:					
HOME MANAGEMENT:					
NUTRITION:					

OTHER:

SIGNATURES

CLIENT:	DATE:	COORDINATOR:	DATE:
HOMEMAKER:	DATE:	HOMEMAKER:	DATE:
HOMEMAKER:	DATE:	HOMEMAKER:	DATE:

WHITE - CLIENT CANARY - HOMEMAKER AGENCY PINK - REFERRING AGENCY GOLD – HOMEMAKER

Attachment E

Administration for Children's Services

ACS CASE NO: _____

DIV/OFF: _____

ADDRESS: _____

NOTICE OF INTENT TO REDUCE OR TERMINATE HOMEMAKER SERVICES

ON THE BASIS OF OUR CASE REVIEW, WE HAVE REACHED A DETERMINATION TO:

☐ REDUCE YOUR HOMEMAKING SERVICES: CURRENT SCHEDULE: _____ AM/PM TO _____ AM/PM
ON M T W TH F SA SU
TO NEW SCHEDULE: _____ AM/PM TO _____ AM/PM
ON M T W TH F SA SU

☐ TERMINATE YOUR HOMEMAKING SERVICES.

THE REASON FOR THIS ACTION (DESCRIBED IN SECTION II OF THIS FORM) IS RELATED TO THE SPECIFIC PURPOSE OF THE HOMEMAKER SERVICES (AS DESCRIBED IN SECTION I OF THIS FORM) THAT WERE PREVIOUSLY AUTHORIZED IN ACCORDANCE WITH YOUR CHILD WELFARE SERVICES PLAN AND WHICH WERE DEEMED NECESSARY TO ACHIEVE YOUR CHILD(REN)'S PERMANENCY PLANNING GOALS:

☐ TO PROTECT THE HEALTH AND SAFETY OF YOUR CHILD(REN).
☐ TO PREVENT FOSTER CARE (RE)PLACEMENT OF YOUR CHILD(REN) WHO WERE ASSESSED TO BE AT IMMINENT RISK OF (RE)PLACEMENT.
☐ TO EXPEDITE THE DISCHARGE OF YOUR CHILD(REN) IN FOSTER CARE.

I. BASIS FOR PROVIDING HOMEMAKER SERVICES

THE REASON THAT WE HAVE PROVIDED YOU WITH HOMEMAKER SERVICES AS A COMPONENT OF YOUR CHILD WELFARE SERVICES PLAN (PROTECTIVE, PREVENTIVE OR PLACEMENT), AND IN THE ABSENCE OF ASSISTANCE FROM ANY OTHER SOURCE WAS:

☐ TO HELP YOU AND YOUR FAMILY MAINTAIN NORMAL HOUSEHOLD OPERATIONS DURING A PERIOD OF STRESS /CRISIS.

☐ TO HELP YOU AND YOUR FAMILY WHILE AN ALTERNATIVE PLAN WAS BEING DEVELOPED.

☐ TO HELP YOU AND YOUR FAMILY MAINTAIN NORMAL HOUSEHOLD OPERATIONS DURING A PERIOD OF ILLNESS (PHYSICAL, MENTAL, EMOTIONAL) OR RECUPERATION, AS RECOMMENDED BY A PHYSICIAN.

☐ TO TEACH YOU/OTHER RESPONSIBLE PERSON ESSENTIAL HOME MANAGEMENT SKILLS SO THAT YOU CAN ADEQUATELY CARE FOR YOUR CHILD(REN) WITHOUT THESE SERVICES.

☐ TO TEACH YOU/OTHER RESPONSIBLE PERSON ESSENTIAL CHILD CARING SKILLS SO THAT YOU CAN ADEQUATELY PROTECT YOUR CHILD(REN) WITHOUT THESE SERVICES.

☐ TO MEET THE TERMS OF A COURT ORDER.

II. REASON(S) FOR REDUCTION/TERMINATION OF SERVICES

WE HAVE NOW DETERMINED THAT THESE SERVICES SHOULD BE REDUCED OR TERMINATED BECAUSE: (CHECK ALL THAT APPLY)

A. CLIENT REQUEST

☐ YOU HAVE REQUESTED TERMINATION OF SERVICES OR YOU HAVE REQUESTED A DECREASE IN SERVICE AND SUCH ACTION HAS BEEN DETERMINED BY YOUR CASEWORKER TO BE APPROPRIATE (NOT VALID IF COURT APPROVAL IS REQUIRED FOR THE ACTION).

B. UNABLE TO CONTACT OR ASSESS CONTINUED NEED

☐ WE ARE UNABLE TO LOCATE YOU.

☐ WE HAVE BEEN NOTIFIED THAT YOU HAVE NOT ADMITTED THE HOMEMAKER TO YOUR HOME.

☐ WE HAVE BEEN NOTIFIED THAT YOU HAVE NOT BEEN AT HOME WHEN THE HOMEMAKER IS SCHEDULED TO PROVIDE SERVICES.

☐ YOU HAVE NOT PERMITTED YOUR AGENCY CASEWORKER/HOMEMAKER SUPERVISOR ACCESS TO YOUR HOME IN ORDER TO MONITOR PROVISION OF THE SERVICES OR TO EVALUATE THE EXTENT TO WHICH YOU ARE BENEFITING FROM THE SERVICES.

C. PROGRAM INELIGIBILITY

☐ YOU ARE NO LONGER PROGRAMMATICALLY ELIGIBLE FOR CHILD PROTECTIVE, PREVENTIVE OR PLACEMENT SERVICES AND ARE THEREFORE INELIGIBLE FOR HOMEMAKER SERVICES THROUGH A CHILD WELFARE SERVICES PROGRAM.

☐ THE CHILDREN WHO CONSTITUTE YOUR ELIGIBILITY FOR SERVICES ARE NO LONGER RESIDING IN YOUR HOUSEHOLD (SPECIFY BY NAME): _____

☐ COURT ORDER NO LONGER IN EFFECT OR COURT ORDER MODIFIED.

D. MEDICAL DOCUMENTATION OR LACK OF MEDICAL DOCUMENTATION

☐ YOU ARE RECEIVING THESE SERVICES BASED ON A PHYSICIAN'S RECOMMENDATION AND YOU HAVE NOT PROVIDED US WITH AN UPDATED MEDICAL REPORT WHICH STATES YOUR HOME MANAGEMENT AND/OR CHILD CARE LIMITATIONS WITHIN _____DAYS OF OUR REQUEST.

☐ YOU ARE RECEIVING THESE SERVICES BASED ON A PHYSICIAN'S RECOMMENDATION AND YOUR UPDATED MEDICAL REPORT INDICATES THAT YOUR FUNCTIONING HAS IMPROVED AND THAT YOU NEED FEWER TASKS TO BE PERFORMED BY THE HOMEMAKER OR THAT YOU NO LONGER REQUIRE A HOMEMAKER.

E. MISUSE OF SERVICES

☐ YOU HAVE MISUSED THE SERVICE BY LEAVING THE HOMEMAKER IN YOUR RESIDENCE WHILE YOU WERE OUT (MISUSE OF HOMEMAKER SERVICES AS "DOMESTIC SERVICES" OR "CHILD CARE SERVICES").

☐ YOUR CHILD(REN) ARE OUT OF THE HOME (e.g., DAY CARE, SCHOOL, ETC.) DURING THE HOURS THAT THE HOMEMAKER IS AUTHORIZED TO ASSIST YOU IN CARING FOR THE CHILD(REN).

☐ YOU HAVE NOT BEEN COOPERATING WITH THE HOMEMAKER/HOMEMAKER AGENCY IN ACCEPTING THE HOMEMAKER SERVICES THAT YOU HAVE BEEN AUTHORIZED TO RECEIVE.

NYC Administration for Children's Services

F. GOALS MET OR LACK OF BENEFIT

☐ WE HAVE DETERMINED THAT THE PERIOD OF STRESS /CRISIS WHICH NECESSITATED HOMEMAKER HAS BEEN ALLEVIATED OR RESOLVED.

☐ WE HAVE DETERMINED THAT YOU HAVE BENEFITED FROM THE HOMEMAKING SERVICES IN TERMS OF IMPROVED PERFORMANCE IN YOUR PARENTAL FUNCTIONS AND YOU NO LONGER NEED ADDITIONAL OR THE SAME LEVEL OF TRAINING OR SERVICES FROM THE HOMEMAKER. (IF ASSESSMENT INDICATES PARENTAL CAPABILITY, BUT REFUSAL TO CARRY OUT RESPONSIBILITIES, REPORT TO SCR).

☐ WE HAVE DETERMINED THAT DESPITE THE PROVISION OF HOMEMAKING SERVICES, YOU HAVE NOT BEEN BENEFITING FROM THEM IN TERMS OF IMPROVED PERFORMANCE IN THE PARENTAL FUNCTIONS BEING TAUGHT.

G. ASSESSMENT THAT ALTERNATE OR SUPPLEMENTAL SERVICES ARE NEEDED.

WE HAVE DETERMINED THAT:

☐ ALTERNATIVE ☐ SUPPLEMENTAL SERVICES ARE NECESSARY:

(CHECK ALL APPLICABLE BOXES)

☐ CHILD CARE/HEADSTART ☐ HOME HEALTH AIDE ☐ HOME ATTENDANT ☐ HOUSEKEEPER

☐ PARENT TRAINING CLASSES ☐ OPWDD SERVICES (Office of Persons with Developmental Disabilities) ☐ PLACEMENT

☐ OTHER PERSON(S) AVAILABLE TO PROVIDE THE ASSISTANCE YOU NEED (NAME(S)/RELATIONSHIP): _____

☐ OTHER: _____

AND (CHECK ONE)

☐ A REFERRAL HAS BEEN MADE FOR THESE SERVICES.

☐ YOU HAVE REFUSED TO ACCEPT A REFERRAL OR TO COOPERATE WITH A REFERRAL.

☐ THE ALTERNATIVE SERVICE(S) HAS BEGUN.

H. OTHER: _____

_____

_____

_____

AUTHORIZING SIGNATURES/EFFECTIVE DATE

_____	_____	( )_____	____/____/____
CASE Manager/Planner NAME (PRINT)	SIGNATURE	TELEPHONE	DATE

I HAVE REVIEWED THIS NOTICE AND THE SUPPORTING DOCUMENTATION AND APPROVE THE INTENDED ACTION

_____	_____	( )_____	____/____/____
SUPERVISOR/MANAGER NAME (PRINT)	SUPERVISOR/MANAGER SIGNATURE	TELEPHONE	DATE

THE EFFECTIVE DATE OF THIS SERVICE ADJUSTMENT IS: _____/_____/_____

RECEIVED ON: _____/_____/_____ CLIENT SIGNATURE: _____

RECIPIENT'S RIGHTS OF APPEAL

NOTICE OF INTENT TO REDUCE OR TERMINATE HOMEMAKER SERVICES

CLIENT/FAIR HEARINGS COPY

This action is based upon Social Services Law sections 20, 34, 131, 407, 409, and 409-a and New York Code, Rules and Regulations, 18 NYCRR Part 460. You have the right to appeal this action by requesting an agency conference and/or a state fair hearing.

RIGHT TO AN AGENCY CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made an incorrect decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice.

You may ask for a conference by calling _____ at ( ) _____ or by sending a written request to the ACS address listed at the top right of the first page of this notice. (This number is used only to request a conference or case review).

Requesting a conference is not the way to request a fair hearing. If you want to have your benefits continued unchanged (aid continuing) until you get a Fair Hearing decision, you must request a Fair Hearing in the manner described below. A request for a conference alone will not result in the continuation of your benefits. If you ask for a conference, you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A STATE FAIR HEARING: If you believe that the above action is incorrect, you may request a state fair hearing. Your request must be made within sixty (60) days of this notice. However, if you want your services to continue unchanged, you must request a state fair hearing within ten (10) days of the date of this notice.

You may request a State Fair Hearing by:

(1) **Telephone: Call 1-800-342-3334 (Toll-free) (Note: Please have this Notice with you when calling and state that you are calling in reference to an "ACS – Preventive Homemaking Services" case). OR**
(2) **Writing:** Send your request for a fair hearing or a **completed** copy of this notice to Office of Temporary and Disability Assistance, Office of Administrative Hearings, P.O. Box 1930, Albany, New York 12201-1930. **(Note: Please keep a copy for yourself.) OR**
(3) **Fax:** Fax your fair hearing request or a completed copy of this notice to (518) 473-6735. **OR**
(4) **Email:** Email your fair hearing request or a completed copy of this notice to: http://www.otda.state.ny.us/oah/forms.asp. **OR**
(5) **In Person (Walk-in Location for New York City):** 14 Boerum Place, First Floor, Brooklyn (near Jay St or Borough Hall Train Stations)

REQUEST FOR A FAIR HEARING

I want a fair hearing. I do not agree with the agency's action. (You may explain why you disagree below, but you do not have to include a written explanation.)

_____

_____

_____

Name: _____ Signature: _____

Address: _____ Case Number: _____

_____ Date: _____

If you request an agency conference or a state fair hearing, you will be sent notification(s) informing you of the time and place of the conference or the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. You also have a right to bring witnesses to speak in your favor. If you need legal assistance for your agency conference or state fair hearing, you may be able to obtain it free if you cannot afford a lawyer, by contacting your local Legal Aid Society or legal services offices.

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: You have the right to bring an attorney or other representative with you to examine your case record to the extent that the case record is not confidential. If you want copies of the pertinent documents from your case file, you should ask for them ahead of time. You will be provided with copies of the pertinent documents which we will give to the hearing officer at the fair hearing. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you specifically ask that they be mailed. To ask for documents or to find out how to look at the pertinent documents in your case file, please call the telephone number listed on this page of this notice.

ADDITIONAL INFORMATION: If you want more information about your case, how to ask for a fair hearing, how to see relevant records, or how to get additional copies of documents, call us at the telephone number listed on this page, or write to us at the address printed on the first page of this notice.

FSS 008F (FORMERLY KNOWN AS CM 20K)
REV 6/14

Attachment F

NYC Administration for Children's Services

AUTHORIZATION FOR TERMINATION OF HOMEMAKER SERVICES

TO: **VENDOR CODE:** | TO: **VENDOR NAME:** _____

ACS CASE NO.: _____

UNIT/WORKER I.D.: _____

FROM: **REFERRING OFFICE:** | REFERRING OFFICE: _____

ADDRESS: _____

CASE INFO

SOCIAL SECURITY NO.	LAST NAME	FIRST NAME

STREET	CITY	ZIP

PLEASE TERMINATE HOMEMAKING SERVICE, THE LAST DATE OF SERVICE IS: _____/_____/_____

NOTE: **SERVICE MUST BE AUTHORIZED UNTIL THE LAST DATE OF SERVICE. PLEASE ATTACH REAUTHORIZATION IF NECESSARY.**

REASON FOR TERMINATION: _____

_____

_____

_____

REFERRAL OFFICE NOTIFIED VENDOR OF TERMINATION ON: _____/_____/_____

VENDOR CONTACT PERSON IS: _____ CONTACT PHONE NO.: _____

PREPARED BY: _____ _____ _____/_____/_____
CASE MANAGER — TELEPHONE — DATE

APPROVED BY: _____ _____ _____/_____/_____
SUPERVISOR — TELEPHONE — DATE

APPROVED BY: _____ _____ _____/_____/_____
SUPERVISOR II — TELEPHONE — DATE

FOR FAMILY HOME CARE USE ONLY

APPROVED BY: _____ _____/_____/_____
FHC WORKER SIGNATURE — DATE

DATA ENTRY DATE: _____/_____/_____ DATA ENTRY OPERATOR: _____

DISTRIBUTION: **WHITE – VENDOR** **CANARY – FIELD OFFICE** **PINK – FHC**

AGREEMENT OF RELATIVE/FRIEND TO PARTICIPATE IN HOME CARE SERVICE PLAN

I. CASE INFORMATION

CASE NAME: _____ CASE NO.: _____ SOC SEC #: _____-__-_____

RECIPIENT OF SERVICE: _____ SOC SEC #: _____-__-_____ RELATION TO CASE NAME: __

ADDRESS OF SERVICE RECIPIENT: _____ BOROUGH: _____ ZIP CODE: _____

TELEPHONE #: ( ) _____

DUAL SERVICE: ☐☐NO ☐☐YES. NAME: _____ SOC SEC #: _____-__-_____

II. RELATIVE/FRIEND INFORMATION

NAME OF RELATIVE/FRIEND: _____ RELATIONSHIP TO RECIPIENT: _____

LIVES WITH CLIENT: ¤ YES ¤ NO ADDRESS: _____

RESIDENCE TELEPHONE #: ( ) _____ AND/OR BUSINESS TELEPHONE #: ( ) _____

III. ACS / PLANNING AGENCY INFORMATION

CASE MANAGER NAME: _____ UNIT/WKR. ID: _____ HMK FIELD ID: _____ TEL #: ( ) _____

SUPERVISOR NAME: TEL #: ( ) _____

PLANNING AGENCY/ADDRESS: _____

CASE PLANNER NAME: _____ TEL #: ( ) _____

IV. RELATIVE/FRIEND CERTIFICATION

I, _____, AGREE TO PARTICIPATE IN THE CHILD CARE PLAN DEVELOPED FOR THE ABOVE-NAMED RECIPIENT BY PERFORMING OR HELPING HIM/HER TO PERFORM THE FOLLOWING TASKS:

A. TASKS I WILL PERFORM OR ASSIST PARENT/GUARDIAN:

SERVICES NEEDED	TASK	SHARED WITH H/H MEMBER	TIME(S)	FREQUENCY (PER DAY/WEEK)	SERVICE RECIPIENT(S)
PERSONAL CARE (E.G., BATHE/DRESS/FEED)					
ESCORT (INDICATE WHERE)					
ADMINISTER MEDICATIONS					
MEDICAL CARE					
MEALS (E.G., PLAN/MARKET/COOK)					
LAUNDRY					
LIGHT HOUSEKEEPING					
ASSIST WITH HOMEWORK					
WEEKEND ACTIVITIES					

B. CHILD CARE

I, _____, AGREE THAT IN THE EVENT OF THE ABOVE-NAME RECIPIENT'S ABSENCE FROM THE HOME (E.G., HOSPITALIZATION, ETC.) I WILL OBSERVE THE FOLLOWING CHILD CARE AGREEMENT:

- ☐☐STAY WITH THE CHILDREN IN THE HOME FOR THE DURATION OF ABSENCE.
- ☐☐HAVE THE CHILDREN STAY IN MY HOME FOR THE DURATION OF THE ABSENCE.
- ☐☐STAY WITH THE CHILDREN UNTIL ALTERNATIVE ARRANGEMENTS CAN BE MADE FOR THEIR CARE.
- ☐☐I AM UNABLE TO ASSIST WHEN PARENT/GUARDIAN IS ABSENT FROM THE HOME.

IF FOR ANY REASON I AM UNABLE TO CONTINUE TO PERFORM OR HELP THE CLIENT TO PERFORM THE TASK(S) I HAVE AGREED TO ABOVE, I WILL INFORM THE CASE PLANNER. RECIPIENT, CASE PLANNER AND I AGREE UPON THE COOPERATIVE PLAN OF CARE.

SIGNATURE OF RECIPIENT: _____ **DATE:** _____/_____/_____

SIGNATURE OF RELATIVE/FRIEND: _____ **DATE:** _____/_____/_____

SIGNATURE OF CASE MANAGER/PLANNER: _____ **DATE:** _____/_____/_____

WHITE: Client YELLOW: Relative/FRIEND BLUE:CASE MANAGER/PLANNER

FSS 008H (FORMERLY KNOWN AS CM 20N)
REV 6/14

Attachment H

Administration for Children's Services

CONFIRMATION OF OVERTIME HOMEMAKER SERVICE HOURS

To:	**ACS FAMILY HOME CARE** **HOMEMAKING VENDOR ASSIGNMENT UNIT** **150 WILLIAM STREET** **NEW YORK, NY 10038**	VENDOR NAME AND CODE	
From:	ACS OFFICE	WORKER/SUPERVISOR NAME	TELEPHONE NO.
Re:	SOCIAL SECURITY NO.	CASE NAME	CASE NUMBER.

This is to confirm **OVERTIME SERVICE HOURS** for the above named client.

Currently the **AUTHORIZED HOMEMAKER SERVICE HOURS** are _____ Hours/Week
(These hours must be accurate for the week in which overtime is being requested.)

DAYS	**DATES OF OVERTIME**		**OVERTIME HOURS**		**IF 24 HOUR SERVICE REQUESTED ( )**	
	MONTH	DAY	FROM (AM/PM)	TO (AM/PM)	SPLIT SHIFT	SLEEP IN
MONDAY						
TUESDAY						
WEDNESDAY						
THURSDAY						
FRIDAY						
SATURDAY						
SUNDAY						

TOTAL OVERTIME SERVICE HOURS _____ FOR WEEK ENDING _____

NOTE: A **NEW** FORM MUST BE SUBMITTED FOR **EACH WEEK** IN WHICH OVERTIME OCCURS

REASON FOR OVERTIME REQUEST: _____

_____

_____

ACS CONTACT PERSON: _____ TITLE: _____ TEL #: _____ DATE OF CONTACT: ____ /____ /____
(CONTACT PERSON MANDATORY IF PREPARER IS A HOMEMAKER AGENCY)

PREPARER:: _____ _____ _____ ____ /____ /____
SIGNATURE TITLE TELEPHONE NUMBER DATE

FOR ACS USEONLY

NAME SIGNATURE TITLE TELEPHONE NUMBER DATE

CASE MANAGER

SUPERVISOR I

SUPERVISOR II

MANAGER OR DEPUTY DIRECTOR

DIRECTOR

FOR ACS/FHC USE ONLY

DATA ENTRY OPERATOR: _____ **DATE:** ____ /____ /____

Attachment I

NYC Administration for Children's Services

HOMEMAKING/REAUTHORIZATION

Complete All Sections – NO BLANK SPACES

Type of Action (check all that apply):

☐ Reauthorization ☐ Change - Increase in Service Days/Hours ☐ Changes - Decrease in Service Days / Hours

Social Security Number:	Case Name:	Sex:	Date of Birth:

Case Address:	Apt #:	Borough:	Zip Code:	Telephone:

ACS Case Number #:	CIN #:
Current Homemaker Service Expiration Date:	Date Homemaker Service Started:
Primary Homemaker Service Goals: 1. 2.	Secondary Homemaker Service Goals: 1. 2.
Date of last ACS home visit:	Date of Last FASP:
Date of Last Homemaker Vendor Report:	Date of last M-11Q: (If Applicable)
Are Services Court Ordered? ☐ Yes ☐ No Docket #:	If yes – Date of Court Order:

1. What progress has the family made toward achieving the established primary and secondary goals for independence during the last homemaker authorization period. (Be Specific):

2. What is the family's present situation? Are there continuing problems? Indicate any new problems identified during the last authorization. Attach any necessary current M-11Qs and clearance forms to clarify medical situations. (Be Specific):

3. Characterize the family's view of the homemaker services during the last authorization period. Have they found the service useful? ¤ Yes ¤ No

4. In what specific area does the family still need the assistance of the homemaker service? (Check all that apply):

☐ Training of Home Management Skills (Parent/Guardian)	☐ Training of Child Care Management Skills (Parent/Guardian)
☐ Training of Money Management Skills (Parent/Guardian)	☐ Training of Home Management Skills (Older Children)
☐ Escort of Young Children	☐ Training of Age-Appropriate Behavior (Children)

Attachment I

5. If there are older children in the home, what tasks are they able to handle under parental supervision? With what household tasks can they assist?

6. Are there any relatives/friends available to assist the family? Which relatives/friends have been explored to assist the family and how have they responded? Attach a copy of the Agreement of Relative/Friend to Participate in Home Care Service Plan (FSS 008G) to this form.

7. What other services or alternate resources are being explored to aid the family in becoming self-sufficient and reduce or terminate homemaker services? (Check all that apply):

☐ Housekeeping Service	☐ Home Attendant/Home Health Aide Service
☐ Parent Training Classes	☐ Employment Services
☐ Child Care/Head Start	☐ After-School Programs/Summer Camps
☐ OPWDD Services (Office of Persons with Developmental; Disabilities):	☐ Other Services (Specify):

7a. i. Expected date of new service implementation: _____/_____/_____
ii. Expected date of homemaking service termination: _____/_____/_____
iii. If the service to be implemented is alternative home care or OPWDD, which individual in the family is to receive this service?

8. After this reauthorization period, will the service be reviewed for reduction or termination? ¤ Yes ¤ No

9. If no, when is it projected that homemaker services can be reduced/terminated? (Based on Initial Start Date of homemaker services): ¤ 3 Months ¤ 6 Months ¤ 9 Months ¤ 12 Months

10. Were any problems identified with the homemaker services during the last authorization period? ¤ Yes ¤ No
If yes, explain:

11. Was a conference held between the homemaking provider, service providers and ACS concerning homemaker service concerns?
¤ Yes ¤ No
If yes, what was the outcome? (Describe the corrective action plan that was agreed upon and the time frames for completion):

Attachment I

Administration for Children's Services

12. What community based referrals (eg.: Support groups, parents association respite) were made on the client's behalf during the last authorization period?

REFERRAL NAME	CONTACT PERSON	TELEPHONE NUMBER
1.		
2.		
3.		
4.		
5.		

13. Indicate Homemaking goals to be achieved during the next authorization period:

☐ To help the family maintain normal household operations during period of stress/crisis.	☐ To help the family maintain normal household operations during period of illness. (M-11Q Required)
☐ To teach responsible person(s) essential home management skills so that they can adequately protect children without services.	☐ To teach responsible person(s) essential home management skills so that they can adequately care for children without services.
☐ To help the family while an alternative plan is being developed.	☐ Other (Specify):

14. Indicate goals to be achieved during the next authorization period:

GOAL	SERVICE PROVIDER/PERSON RESPONSIBLE
1.	
2.	
3.	
4.	
5.	

Authorization Period and Hours of Service Needed:

From: _____/_____/_____ To: _____/_____/_____ Hours of Service: From _____AM/PM To _____AM/PM

Days (Circle): **Mon** **Tues** **Wed** **Thurs** **Fri** **Sat** **Sun**

Prepared by:

Case Manager _____ Agency/ACS Division _____

Telephone No. _____ Date _____/_____/_____

Approved by ACS:

Supervisor I _____ Tel # ( ) _____ Date _____/_____/_____

Supervisor II _____ Tel # ( ) _____ Date _____/_____/_____

CPM _____ Tel # ( ) _____ Date _____/_____/_____

Dep. Dir. _____ Tel # ( ) _____ Date _____/_____/_____

Borough Director_____ Tel # ( ) _____ Date _____/_____/_____

Attachment J

Contract Agency Home Care Request

I. Identifying Information

Case Name: _____ Connections Case ID: _____

Case Address: _____

Agency Name: _____ Case Planner Name: _____

Household Composition

Adults in the home where services are being requested

	LAST NAME	FIRST NAME	DOB	RELATION	LANGUAGE SPOKEN
1.					
2.					
3.					

Children in the home where services are being requested

	LAST NAME	FIRST NAME	DOB	RELATIONSHIP TO ADULT 1	SCHOOL NAME	SCHOOL HOURS
1.						
2.						
3.						
4.						
5.						

Employment/Other Program Participation

LAST NAME	FIRST NAME	EMPLOYMENT/ PROGRAM NAME	EMPLOYMENT/ PROGRAM PHONE	TIME LEAVE HOME	TIME ARRIVE HOME	DAYS OF WEEK

Family/Friends/Community Supports (please use FSS 008G – Relative/Friend Form)

LAST NAME	FIRST NAME	RELATIONSHIP	ADDRESS	TELEPHONE NUMBER	ASSISTANCE PROVIDED

Attachment J

II. Reasons for Home Care Request. (Please check all that apply)

Physical or Mental Health Issues

(A Medical Request for Home Care (M-11Q) is to be supplied for all appropriate household members where applicable)

☐Medical Illness/Physical Disability ☐Mental Illness

☐Developmental Disability ☐Complications of Pregnancy

☐Hospitalization ☐Convalescence

☐Dialysis/Chemo/Radiation/Physical Therapy

Training or Social Limitation for Parent or Guardian

☐Lack of appropriate home/child management training

☐Intellectual Limitations ☐Emotional Immaturity

☐Inadequate Social Support ☐Childhood Trauma

An Alternative Plan is being developed to meet family's community based needs

☐Child Care/Head Start/Afterschool Programs ☐School (Primary/Secondary/Adult Programs)

☐OPWDD Services (Office of Persons with Developmental Disabilities) ☐Employment

☐Other:_____

Time frames determined for alternative plan implementation

☐Three Months ☐Six Months

☐Nine Months ☐Twelve Months

Briefly discuss conditions precipitating the request for services:

_____

_____

SIGNATURES

_____	_____	_____/____/____
CASE PLANNER (PRINT)	SIGNATURE DATE	TELEPHONE
_____	_____	_____/____/____
SUPERVISOR (PRINT)	SIGNATURE DATE	TELEPHONE
_____	_____	_____/____/____
MANAGER/DIRECTOR (PRINT)	SIGNATURE DATE	TELEPHONE

FSS 008K (FORMERLY KNOWN AS CS441C)
REV 6/14

Administration for Children's Services

Attachment K

AUTHORIZATION TO EXTEND HOMEMAKING SERVICE NO CHANGES IN SERVICE HOURS

REFERRAL OFFICE CODE/UNIT: _____ VENDOR ID: _____

SERVICE START DATE: _____ AUTH HRS: _____ BILL HRS: _____

CURRENT AUTH EXPIRES: _____ DAYS: _____ RATE CODE: _____

S.S. #: _____

NAME: _____

ADDR: _____

LOC: _____ ZIP: _____

TEL: _____

CIN: _____ EXP DATE: _____

CASE #: _____

CLAIM CODE: _____

PROBLEM CODES: _____

SPECIAL CODE: _____

– ALL DATA BELOW MUST BE COMPLETED –

SCHEDULE - HOURS PER DAY						
Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.

NUMBER OF MONTHS TO REAUTHORIZE CASE _____

FROM _____ TO _____

RATE CODE _____

CASE # _____

CHANGES CAN BE MADE IN IDENTIFYING INFORMATION EXCEPT (SSN) BY CIRCLING NEW DATA IN RED.
SIGN AND DATE FORM BELOW AND SUBMIT TO: ACS FAMILY HOME CARE – 150 WILLIAM STREET, NY, NY 10038

• PROBLEM CODES (MAX - 2 CODES)	1- ABUSE 5 - HEALTH 9 - SHOP	2 - NEGLECT 6 - TRAINING 10 - OTHER	3 - HOSP 7- SUPPORT	4 - PSYCH 8 - DEATH/DES
• SPECIAL CODES: (1 CODE ONLY)	1- AIDS	2- COURT ORDER	3 - FAIR HEARING	4- FOSTER CARE

CASE MANAGER: _____ DATE: _ /_____/_____ Tel: ( ) _____	SUPERVISOR: _____ DATE: _ /_____/_____ Tel: ( ) _____
SUPERVISOR II: _____ DATE: _ /_____/_____ Tel: ( ) _____	MANAGER/DIRECTOR _____ DATE: _ /_____/_____ Tel: ( ) _____
DATA ENTRY OPERATOR: _____	DATE: _ /_____/_____

DISTRIBUTION: WHITE – VENDOR CANARY – ACS REFFERAL OFFICE PINK – FHC

AUTHORIZATION FOR HOMEMAKER SERVICES ON A 24-HOUR BASIS

Case No. _____ Unit _____ Date _____, 20 _____

This is to certify that I, _____

residing at _____ am the _____ (*Relationship)*

of:

Name: _____ Birthdate: _____

Name: _____ Birthdate: _____

Name: _____ Birthdate: _____

Name: _____ Birthdate: _____

Name: _____ Birthdate: _____

Name: _____ Birthdate: _____

I authorize the Commissioner of the Administration for Children's Services (ACS) to provide homemaker services on a 24-hour basis to said child or children named herein, in accordance with the authority vested in him/her by the Social Services Law of the State of New York; and I hereby authorize him/her to provide such services either through employees of ACS, or through appropriate private agencies providing or furnishing such services; and I hereby release the Commissioner of ACS, his/her employees and representatives and The City of New York from any and all liability arising out of any act or omission of such private agency, or the homemaker provided by such agency.

In witness whereof, I hereunto set my hand this _____ day of _____ ____20 _____

_____

Signature of Parent(s)/Caretaker/Guardian

Signed in the presence of

_____

Signature of Witness Agency

ATTACHMENT M

Human Resources Administration
Home Care Services Program
Form M-11q (Page 1)
Revised 10/09

MEDICAL REQUEST FOR HOME CARE

NYC Human Resources Administration Department of Social Services

GSS District Office _____ Attn: Case Load No. _____

RETURN COMPLETED FORM TO: Address _____ Boro _____

Zip Code _____ Tel. No. _____

Date Returned to/Received byGSS

FOR GSS USE ONLY

1. CLIENT INFORMATION

PATIENT'S NAME	BIRTHDATE	SOCIAL SECURITY NUMBER		MEDICAID NO.
HOME ADDRESS (No. & Street)		BORO	ZIP CODE	TELEPHONE NO.
Hospital/Clinic Chart No.	II. MEDICAL STATUS	Contact Person		Contact Tel. No.

PATIENT'S MEDICAL RELEASE: I hereby authorize all physicians and medical providers to release any information acquired in the course of my examination of treatment to the New York City HRA/ Dept. of Social Services in connection with my request for home care.

DATE: _____ SIGNATURE(X) _____

How long have you treated the patient? _____ Date of this examination: _____ Place of this Examination: _____ Date of next examination: _____

A. CURRENT CONDITION

DATE OF ONSET	Check(✓) prognosis of each	Anticipated Recovery 6 months (✓)	Chronic Condition (✓)	Deterioration of Present Function Level (✓)
_____	1. PRIMARY DIAGNOSIS/ ICD CODE _____			
_____	2. SECONDARY DIAGNOSIS/ ICD CODE _____			
_____	3. _____			
_____	4. _____			
_____	5. _____			

B. HOSPITAL INFORMATION

☐ CURRENTLY IN: (Hospital Name) _____ ADMISSION DATE: _____

Reason for HOSPITALIZATION: _____

EXPECTED DATE OF DISCHARGE:

C. MEDICATION	DOSAGE	ORAL OR PARENTERAL	FREQUENCY
1.			
2.			
3.			
4.			
5.			
6.			
7.			

INDICATE PATIENT'S ABILITY TO TAKE MEDICATION: (*)

1. ☐ can self-administer
2. ☐ needs reminding
3. ☐ needs supervision
4. ☐ needs help with preparation
5. ☐ needs administration

(*) If patient CANNOT self-administer medication

(a) can he/she be trained to self-administer medication? ☐ Yes ☐ No If No, indicate why not: _____

(b) What arrangements have been made for the administration of medications? _____

D. MEDICAL TREATMENT Does the patient receive any of the following medical treatment? ☐ Yes ☐ No
Indicate medical treatment currently received: (✓)

1. Decubitus Care	
2. Dressings: Sterile	
Simple	
3. Bed bound care (turning, exercising, positioning)	
4. Ambulation exercise	
5. ROM/Therapeutic exercise	
6. Enema	

7. Colostomy care	
8. Ostomy care	
9.. Oxygen administration	
10. Catheter care	
11. Tube irrigation	
12. Monitor vital signs	
13. Tube feedings	
14. Inhalation therapy	

15. Suctioning	
16. Speech/hearing/ therapy	
17. Occupational therapy	
18. Rehabilitation therapy	
19. Indicate any special dietary needs	
20. Other	

For each treatment checked, indicate frequency recommended, how the service is currently being provided and what plans have been made to provide the service in the future: (Attach additional documentation as necessary.)

Based on the medical condition, do you recommend the provision of service to assist with personal care and/or light housekeeping tasks?

☐ Yes ☐ No

Please indicate contributing factors (e.g. limited range of motion, muscular motor impairments, etc.) and any other information that may be pertinent to the patient's need for assistance with personal care services tasks.

Can patient direct a home care worker? ☐ Yes ☐ No If No, explain below.

E. EQUIPMENT/SUPPLIES

Please indicate which equipment/supplies the client has, needs or has been ordered.

	Has	Needs	Ordered
Cane			
Crutches			
Walker			
Wheelchair			
Hospital Bed			
Side Rails			

	Has	Needs	Ordered
Bedpan/Urinal			
Commode			
Diapers			
Hoyer Lift			
Dressings			
Respiratory Aids			

	Has	Needs	Ordered
Bath Bar			
Bath Seat			
Grab Bar			
Shower Handle			
Other (Specify)			

If any needed equipment was not ordered, what other plans have been made to meet this need?

SSN:
Form M-11q (Page 3)
Revised 10/09

F. REFERRALS

Has a referral been made to any of these agencies: Certified Home Health Agency, Hospital-Based Home Care Agency, Hospice, a Health Related Facility (HRF), a Skilled Nursing Facility (SNF) or the Lombardi Program? Yes ☐ No ☐

*Identify AGENCY	SERVICE	STATUS OF SERVICE	REFERRAL DATE

G. ADDITIONAL COMMENTS

Describe any other aspects of the patient's medical, social, family or home situation which affects the patient's ability to function, or may affect need for home care. If necessary, please attach an additional sheet(s) explaining the patient's condition in greater detail.

Signature of Person Completing Additional Comments Section	Title	Date
	Agency	

PHYSICIAN'S CERTIFICATION

I, THE UNDERSIGNED PHYSICIAN, CERTIFY THAT THIS PATIENT CAN BE CARED FOR AT HOME, AND THAT I HAVE ACCURATELY DESCRIBED HIS OR HER MEDICAL CONDITION, NEEDS AND REGIMENS, INCLUDING ANY MEDICATION REGIMENS, AT THE TIME I EXAMINED HIM OR HER. I UNDERSTAND THAT I AM NOT TO RECOMMEND THE NUMBER OF HOURS OF PERSONAL CARE SERVICES THIS PATIENT MAY REQUIRE. I ALSO UNDERSTAND THAT THIS PHYSICIAN'S ORDER IS SUBJECT TO THE NEW YORK STATE DEPARTMENT OF HEALTH REGULATIONS AT PART 515, 516, 517, AND 518 OF TITLE 18 NYCRR, WHICH PERMIT THE DEPARTMENT TO IMPOSE MONETARY PENALTIES ON, OR SANCTION AND RECOVER OVERPAYMENTS FROM, PROVIDERS OR PRESCRIBERS OF MEDICAL CARE, SERVICES OR SUPPLIES WHEN MEDICAL CARE, SERVICES OR SUPPLIES THAT ARE UNNECESSARY, IMPROPER OR EXCEED THE PATIENT'S DOCUMENTED MEDICAL CONDITION ARE PROVIDED OR ORDERED.

(PRINT) Physician's Name _____ Specialty _____ Physician's Signature _____ Intern__ Resident___

SIGNATURE DATE MUST BE WITHIN THIRTY DAYS AFTER MEDICAL EXAM OF PATIENT.

Date Form Completed _____ Registry No. _____ Telephone No. _____ Hospital Contact Person _____ Telephone No/ E-mail _____

Indicate where form was completed:

Hospital/Clinic/Inst. Name _____ Address _____ Telephone No. / E-mail _____

If Nurse /social worker/other person assisted in completing this form:

Name _____ Title _____ Address _____ Telephone No. / E-mail _____

Human Resources Administration
Department of Social Services

HCSP -71 2B
1/0 1//20 10

* Please provide this sheet to the physician filing out the Medical Request for Home Care, M11Q

Eight Helpful Hints for Accurate Completion of the Medical Request for Home Care, M11Q

1. The client's name, address and Social Security number must be provided.
2. The medical professional must complete the M11Q by accurately describing the patient's medical condition.
3. The medical professional must not recommend or request the number of hours of personal care services.
4. The M11Q must be signed by a NY State licensed physician.
5. The date of the examination must be provided.
6. The physician must sign and date the M11Q within 30 days after the exam date.
7. The registry number of the physician must be indicated.
8. The completed signed copy of the M11Q must be forwarded within 7 calendar days after the medical examination.

OCFS-4940 (2/2010)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DESIGNATION OF PERSON IN PARENTAL RELATIONSHIP

Pursuant to section 5-1551 of the New York State General Obligations Law.

1. I, _____, hereby state that I am the parent of the child/children/incapacitated person(s) named below and there are no Court Orders now in effect in any jurisdiction that would prohibit me from exercising the power that I now seek to authorize.

2. The address and telephone number(s) where I can be reached while this designation is in effect is:

Address: _____

_____

Telephone: Home ( ) _____; Work ( ) _____

Other ( ) _____

3. I am temporarily entrusting _____, a person over the age of eighteen who resides at _____, _____, New York, telephone number ( ) _____, the care of the following child/children/incapacitated person(s):

_____ {NAME} date of birth _____

_____ {NAME} date of birth _____

_____ {NAME} date of birth _____

_____ {NAME} date of birth _____

4. Any authority granted to the person in parental relationship pursuant to this form shall be valid (check appropriate box and initial):

☐ _____ a. for six months days from the date of signature of this designation, or until the date of revocation, whichever occurs first (must include all parties addresses and telephone numbers and be signed by all parties in the presence of a notary public), or

☐ _____ b. for thirty days from the date of signature of this designation, or until the date of revocation, whichever occurs first, or

☐ _____ c. from _____ (date) until and including _____ (date), or until the date of revocation, whichever occurs first; or

☐ _____ d. commencing upon _____ (state event) and continuing until _____, or until the date of revocation, whichever occurs first.

5. As to the above named child/children/incapacitated person(s), the person in parental relationship named above is authorized to:
(cross out and initial any that do not apply)

a. review school records;

b. enroll in school;

c. excuse absences from school;

d. consent to participation in school program and/or school-sponsored activity;

e. consent to school-related medical care;*

f. enroll in health plans;

g. consent to immunizations;*

h. consent to general health care;*

i. consent to medical procedures;*

j. consent to dental care;

k. consent to developmental screening; and/or

l. consent to mental health examination and/or treatment.

* Except as prohibited by Section 2504 of the Public Health Law

Any of the above authorizations may be further limited by conditions defined by the parent, and, if limited, the limitations are written below (e.g., the parent may grant the authority to consent to a mental health examination, subject to the condition that they cannot be reached by telephone or other electronic means).

_____

_____

_____

6. I further authorize the person in parental relationship to request, receive and review, and be granted full and unlimited access to, and obtain complete unredacted copies of any and all of health, medical, financial information and/or any information and/or records as defined in 45 CFR. §164.501 and regulated by the Standards for Privacy of Individually Identifiable Health Information found in 65 Fed. Reg. 82462 as protected private records or otherwise covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, for each child/incapacitated person listed in paragraph 3 above. I understand that the information contained in such health and medical records may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), AIDS-related complex (ARC) and human immunodeficiency virus (HIV), behavioral or mental health services, treatment for alcohol and/or drug abuse and/or addiction. I further understand that I may have access to and/or receive an accounting of the information to be used or disclosed as provided in 45 CFR §164.524, et seq. I further understand that authorizing the disclosure of this health information is voluntary; that I can refuse to sign this authorization. I further understand that any disclosure of this information carries with it the potential for an unauthorized further disclosure of this information by third parties and that such further disclosure may not be protected under HIPAA. In order to induce the disclosing party to disclose the aforesaid private and/or protected confidential information, I forever release and hold harmless said disclosing party who relies upon this instrument from any liability under confidentiality rules arising under HIPAA as a consequence of said disclosure

7. NOTICE TO PARENTS AND PERSONS IN PARENTAL RELATION: Authorization pursuant to this form is valid until the earlier of revocation by a parent or the date specified in paragraph 4 above. Any parent having signed this designation may revoke such authorization at will, and may notify relevant schools and health care providers of such revocation. A person in parental relation who receives notification from a parent of such revocation, shall forthwith notify any school, health care provider or health plan to which an authorization pursuant to this subdivision has been presented. Failure by the person in parental relation to notify recipients of the authorization or the revocation shall not make notification of revocation by the parent ineffective.

This authorization is temporary, but may be renewed by the parent(s). However, parents and persons in parental relation involved in a long-term care giving arrangement may seek a more permanent legal arrangement by commencing a judicial proceeding to appoint legal guardianship or to determine custody.

Note: All signatures below must be notarized if authorization is for a period exceeding 30 days

Dated:

(Parent signature) _____

Sworn to before me this

_____ day of _____ 20_____.

_____

Notary Public

8. I, _____, am also the parent of the child/children/incapacitated person(s) named herein, there is a Court Order directing that both parents must agree on education and/or health decisions concerning such child/children/incapacitated person(s), and I hereby consent to this designation by my signature below.

The address and telephone number(s) where I can be reached while this designation is in effect is:

Address: _____

_____

Telephone: Home ( ) _____; Work ( ) _____

Other ( ) _____.

Dated:

(Parent signature) _____

Sworn to before me this

_____ day of _____ 20_____.

_____

Notary Public

9. I, _____, the person designated in parental relationship for the child/children/incapacitated person(s) named herein, hereby consent to this designation by my signature below.

Dated:

(Signature) _____

Sworn to before me this

_____ day of _____ 20_____.

_____

Notary Public

Instructions for DESIGNATION OF PERSON IN PARENTAL RELATIONSHIP, pursuant to section 5-1551 of the New York State General Obligations Law.

PURPOSE OF THIS FORM:

This form will allow you to designate another person to make medical and educational decisions for your child(ren) or incapacitated person(s) in your care if you can't do so yourself for a specific period of time. This authorization can only be used for a period of up to six months. If you will need to have your child(ren)/incapacitated person(s) in the care of someone else for more than six months, you may wish to consider other options.

If there is a Court order that requires both parents to agree on education and/or health decisions regarding the child(ren), then both parents must sign the form. If not, only one parent's signature is required.

You keep all of your parental rights with this authorization and can cancel (revoke) this authorization at any time. The person you designate will be able to talk with your child(ren)'s school, teachers and medical providers, and will be able to make routine decisions. The person you designate will not be able to give consent for surgery or other major medical procedures but will be able give consent for routine medical matters. If you do not want the person you designate to be able to make certain decisions, such as decisions concerning immunizations, you can specify that with this form. If the person you designate makes a decision concerning your child(ren)/incapacitated person(s) that you do not agree with, you can override that decision.

The person designated must agree to be "a person in parental authority," and will not be required to assume responsibility for financial support of the child(ren)/incapacitated person(s). Your child(ren) will not have to change their school district if that person resides in another school district. In the event of your death or incapacitation, this designation automatically terminates.

INSTRUCTIONS FOR USING THIS FORM:

Paragraph 1: Fill in your full legal name in the space provided. If there is a Court order in effect that requires both parents to sign, the other parent will fill in their name in the space provided in Paragraph 7.

Paragraph 2: Fill in your address and telephone number(s). If this information is not included, the authorization will not be valid for more than thirty days. Use the address where you will be staying during the period this authorization is in effect, even if it is not your legal residence. For example, if this authorization is to be used while you are hospitalized, you would use the hospital's address.

Paragraph 3: Fill in the name, address, and telephone number of the person whom you wish to designate as able to make educational and/or health decisions for your child(ren)/incapacitated person(s). Fill in the name(s) and date(s) of birth for EACH child/incapacitated person.

Paragraph 4: Specify how long you wish this authorization to be in effect by checking the appropriate box and initialing next to it. Remember, you can always revoke (cancel) this designation sooner if you wish. Information about how to do that is included toward the end of these instructions.

- **Use (a)** if you want this designation to be valid for six months. If you choose this option, you must provide the address and telephone number for the parent(s) and the other person, and all the signatures must be notarized.

- **Use (b)** if you want this designation to be valid for thirty days. You do not have to include addresses and telephone numbers with this choice, but it is suggested that you do so in the event that medical or educational care providers need to contact you.

- **Use (c)** if you want to use specific dates, for a period of less than or more than thirty days. Remember, this designation cannot be used for more than six months, and you must include addresses, telephone numbers, and notarized signatures if you want it to be good for more than thirty days.

- **Use (d)** if you want this designation to begin when something specific, such as in the event you are hospitalized. For this, you write the specific event in the first space provided (example: "When I am admitted to a hospital") and write the date or the event upon which the designation should expire in the second space (example: "thirty days later" or "when I am released from the hospital"). Again, you must include addresses, telephone numbers, and notarized signatures if you want it to be good for more than thirty days.

Paragraph 5: List each of the things you wish the person you designate to be able to do. Cross out and initial EACH item that you do NOT wish to allow the person you designate to perform. If there are other things you want to prevent the person from doing, use the blank lines below the list to write those down. For example, if you want to be contacted before any mental health examination is performed, you can write that in the space provided.

Paragraph 6: This paragraph allows the person you designated to have access to your child(ren)'s/incapacitated person(s)' medical records and medical information.

Paragraph 7: This provides some information regarding this form. The parent whose name appears in Paragraph 1 then signs and dates the form. If this authorization is to be in effect for a period of more than thirty days, the signature must be notarized. In this case, you need to take the form to a notary public before you sign it, and sign the form in front of that notary public, who will then also sign the form to indicate that they witnessed your signature. If don't do this, the authorization will automatically expire after thirty days.

Paragraph 8: If there is a Court order in effect that requires both parents to agree on education and/or health decisions regarding the child(ren), then the other parent will fill in their full legal name, address, and telephone number in the spaces provided. As with the first parent, they do not have to provide their address and telephone number if the authorization is for a period of thirty days or less, but may wish to. They must provide this information, and sign the form in front of a notary public, if the authorization is to be good for more than thirty days. If there is no Court order in effect that requires both parents to agree, you can leave this paragraph blank.

Paragraph 9: Fill in the full legal name of the person to be designated "in parental relationship" to the child(ren)/incapacitated person(s). They then sign and date the form, to show that they agree to be a person in parental relationship. If this authorization is to be good for more than thirty days, they will also need to sign the form in front of a notary public.

OTHER INFORMATION:

- Major medical treatment: The person you designate **CANNOT** give consent for "major medical treatment" which is any medical, surgical, or diagnostic intervention or procedure where a general anesthetic is used or which involves any significant risk or any significant invasion of bodily integrity requiring an incision or producing substantial pain, discomfort, debilitation, or having a significant recovery period. This does not include: any routine diagnosis or treatment such as the administration of medications other than chemotherapy for non-psychiatric conditions or nutrition or the extraction of bodily fluids for analysis; electroconvulsive therapy; dental care performed with a local anesthetic; any procedures which are provided under emergency circumstances, pursuant to section twenty-five hundred four of the public health law; the withdrawal or discontinuance of medical treatment which is sustaining life functions; or sterilization or the termination of a pregnancy.

For example, the person designated can give consent for a child/incapacitated person to have standard dental procedures, such as fillings, but not dental surgery where they would be unconscious during the procedure, such as having their wisdom teeth extracted. A parent's consent will still be required for major medical procedures.

- Revoking this designation: In order to revoke (cancel) the authorization, you simply have to tell the person you designated that you wish to do so, and they are required to notify the appropriate education and medical providers that the authorization has been terminated. While the parent is not required to do this in writing, or to notify the child(ren)/incapacitated person(s) education and medical providers that they have revoked the authorization, they may want to, so that there is no confusion. If two parents signed the form, either parent can cancel the designation by themselves, you do not need both parents.