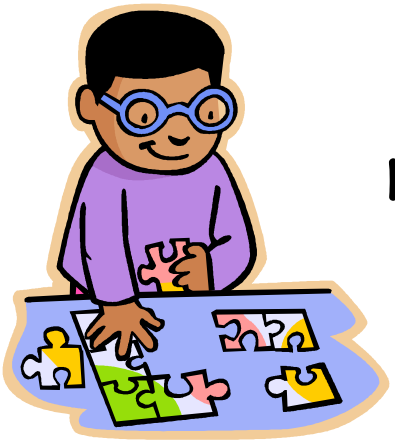
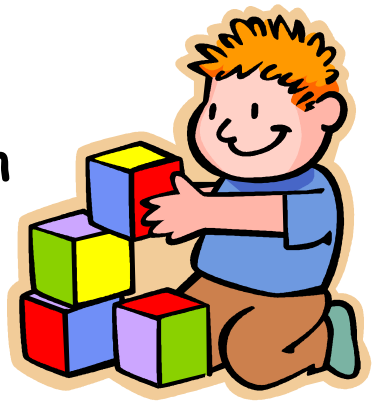


New York City Administration for Children's Services



IS OFFERING

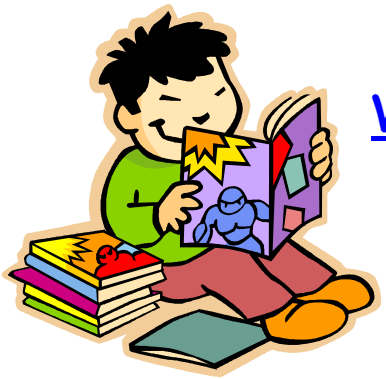
FREE ID/DD EVALUATIONS

The New York City Administration for Children's Services is proud to offer free comprehensive psychological & psychosocial evaluations to youth in foster care five (5) years of age and older, identified or suspected of having an Intellectual Disability (ID)/Developmental Disability (DD).

These Psychological and Psychosocial Evaluations are an essential part of the OPWDD eligibility process.

To make a referral for an evaluation please contact:

NYC Administration for Children's Services
Developmental Disabilities Unit
212.341.3116
Whitney.Jarvis2@acs.nyc.gov
DDUnit@acs.nyc.gov



Jess Dannhauser
Commissioner

Angel V. Mendoza, Jr., MD
Chief Medical Officer
Office of Child and Family Health

Angela Medina-Braddox
Director
Developmental Disabilities Unit

150 William Street, 11th FL
New York, NY 10038
212-341-0934

ACS/AHRC Evaluation Project Referral Checklist

The following is a list of required materials for an ACS/AHRC Psychological referral: Please submit a complete packet of required documentation as specified below. Please check off **all completed items** on the blanks provided before each item on the checklist below.

Incomplete packets can NOT be processed.

_____ **ACS-AHRC Referral Form:** two pages.

_____ **AHRC Authorization for Release of Information:** (*Note: The original copy of the signed consent form is required by AHRC and must accompany the child at the time of evaluation.)

_____ **AHRC Assignment of Insurance Benefits**

_____ **Clinical Documentation:** That describes why there is a reasonable suspicion of mental retardation and/or developmental disability

_____ **IEP Report From School:** (classification of ID/DD, multiply handicap, MR/ED, Autism etc., are seen as appropriate)

_____ **Previous Psychological Evaluations:** Any previous psychological evaluation that shows intelligence testing and levels of adaptive functioning

_____ **Psycho-Social History:** include relevant details about the child's history and functioning (current within the last six months).

_____ **Psychiatric Evaluation:** if the child is dually diagnosed, exhibits severe behavioral challenges and/or is prescribed psychotropic medications.

_____ **5 Years old and older:** The child must be at least 5 years old to participate

_____ **Supervisor Sign-off:** Initial here that the packet is complete and has been reviewed by a supervisor/director within your organization: **DO NOT INITIAL UNLESS ALL THE ITEMS ABOVE ARE PRESENT IN THE PACKET.**

Please send the completed package to: **Whitney.Jarvis2@acs.nyc.gov**

ACS IDDD

EVALUATION PROJECT

AHRC FAMILY & CLINICAL SERVICE REQUEST

Date: / /

Client Name _____ ID# 0 0 _____

Last name *First name*

ACS Case # _____ **Case Name** _____

Date of Birth ___/___/___ SSN___-___-_____ Gender ( ) Male ( ) Female

Address _____ Apt _____ City _____ State _____ Zip Code _____

Home Phone (___)_____ Work Phone (___)_____ Ext_____

Do you receive services from other agencies? ( )YES ( )NO If yes, list services _____

List Article 16 services received from other agencies _____

Is the consumer in Foster Care? (X) YES ( ) NO Who is the Legal Guardian? _____

Language: ( ) English ( ) Cantonese ( ) Russian ( ) Spanish ( ) Mandarin ( ) Other

Ethnicity: ( ) African American ( ) Asian ( ) Caucasian ( ) Hispanic / Latino ( ) Pacific Islander ( )Other ( )Unknown

Referral Source

Referral made by _____ Title _____

Agency _____ Dept _____

Address _____ City _____ State _____ Zip Code _____

Phone **(___)** _____ Ext. _____

Send copy of report to: Whitney Jarvis Agency **ACS Developmental Disabilities Unit**

Address **150 William Street, 11th Floor, Section O** City **New York** State **NY** Zip Code **10038** Tel **(212) 341-3116**

Service requested: ( ) **Psychological Evaluation** ( ) ***Psychosocial History**

Please include a copy of any previous psychological report and the original Authorization for Release of Information and Insurance Benefits form.

Reason requested: Eligibility Determination for OPWDD Residential Services and/or the HCBS Waiver: developmental disabilities category due to reasonable suspicion of Intellectual Disability and/or Developmental Disability

Please specify purpose of evaluation (check one): ( ) HCBS Waiver

( ) ACS Developmental Disabilities Unit Attn: Jill Ryan

( ) Other: Please specify_____

Preferred location of service (circle one): MANHATTAN **OR** BRONX **Language Preferred:**

Insurance Information

Other Insurance **ACS Contract** ID# **CT** Effective Date ___/___/___

Consumer Name: _____

CONTACT INFORMATION

Appointment Confirmation (This is the foster care agency representative who is facilitating)

Last Name _____ First Name _____ Relationship _____

Address _____ Apt ____ City _____ State _____ Zip Code _____

Home Phone (____) _____ Emergency Phone (____) _____

Business Phone ( ) Ext Co. Name Dept

Caregiver / Family (Please specify if this person has *lived with and cared for* the client and will be available to serve as "respondent" for the evaluation of level of functioning)

Last Name _____ *First Name* _____ *Relationship* _____

Address _____ Apt ____ City _____ State _____ Zip Code _____

Home Phone (____) _____ Emergency Phone (____) _____

Business Phone ( ) Ext Co. Name Dept

Legal Guardian

Last Name _____ *First Name* _____

Address _____ City _____ State _____ Zip Code _____

Home Phone (____) _____ Emergency Phone (____) _____

Business Phone ( ) Ext Co. Name Dept

ACS Case Manager

Last Name _____ First Name _____

Address _____ City _____ State _____ Zip Code _____

Business Phone ( ) Emergency Phone ( )

Primary Care Physician

Facility Name _____ Dept _____

Physician's Last Name _____ *First Name* _____

Address _____ City _____ State _____ Zip Code _____

Business Phone ( ) Ext Emergency Phone ( )

Non AHRC Medicaid Service Coordinator (Medicaid Service Coordinator, if applicable)

Name _____ Agency Name _____

Address _____ City _____ State _____ Zip Code _____

Service Coordinator's Last Name _____ First Name _____

Business Phone ( ) Ext Emergency Phone ( )

Department of Family and Clinical Services

Authorization for Release of Information
For Children in Foster Care

AHRC Client #

I hereby authorize the Department of Family and Clinical Services of AHRC to:

☐ Disclose information to: ☐ Obtain information from: ☐ Exchange information on an Ongoing basis with:

NAME/AGENCY _____

ADDRESS _____

REGARDING _____
Client Name **DOB**

The name to be disclosed is:

☐ Summary of treatment

☐ Other (specify): _____

Please indicate which of the following apply:

☐ Parental rights have been terminated. Undersigned is authorized to allow release of information.

☐ Parental rights have not been terminated. Parents have given permission to release information.

☐ Parental rights have not been terminated. No response from parent regarding this release.

_____

I understand that I may revoke this authorization at any time. I also understand that any authorization which was made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of this child's confidentiality. Unless I revoke this authorization prior to such time, this authorization shall expire when the desired information is released by AHRC or when treatment is terminated.

This consent shall remain effective for the duration of treatment or for the purposes or periods indicated. If no specific date, event, or condition is indicated, this consent will last no longer than reasonably necessary to serve the purpose for which it is given.

Date, event or condition at which authorization expires:
_____

_____ _____
Foster Care Caseworker (Signature) Today's Date

_____
Foster Care Caseworker (please print)

_____
Agency

AHRC Client # _____

A16 Department of Family and Clinical Services

ASSOCIATION FOR THE HELP OF RETARDED CHILDREN

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize my insurance company **ACS CT**
(**name of company**)
to pay the AHRC Department of Family and Clinical Services, 83 Maiden Lane, New York, NY 10038 directly for services provided to members of my family. If payments are made directly to me, such payments shall not exceed the Department of Family and Clinical Service charges for those services.

Client's Name: _____

Authorized Signature: _____

Date: _____

Jess Dannhauser
Commissioner

Angel V. Mendoza, Jr., MD
Chief Medical Officer
Office of Child and Family Health

Angela Medina-Braddox
Director
Developmental Disabilities Unit

150 William Street, 11th FL
New York, NY 10038
212-341-0934

ACS IDDD EVALUATION PROJECT
Information Guide

PURPOSE: To provide psychological evaluations for ***ID/DD eligibility determination*** to children and teens in foster care (ages 5 and up).

A specialized IDDD psychological evaluation is the first important step in determining whether a foster child or teen is eligible for **the HCBS Waiver** and/or OPWDD services.

These evaluations are available for any foster children for whom:

- there is a ***reasonable suspicion of Intellectual Disability (ID) and/or Developmental Disability (DD)*** but formal required testing has not been completed, or
- for whom ***prior ID/DD evaluations*** produced vague or ambiguous results and there is strong justification for further assessment

Bridges to Health eligibility determination is based on the same 3 essential factors as **OPWDD eligibility determination**:

- Low IQ (<70) or higher with another qualifying developmental disability
- Low level of adaptive functioning (<70 in 2 areas on a standardized test for adaptive functioning)
- Documented history of disability during an earlier stage of development.

REQUIRED for REFERRAL: Foster Care case planners must submit

- **ACS-AHRC Referral Form:** two pages
- **AHRC authorization for release of information** (*)
- **AHRC authorization for insurance payment**
- **Clinical documentation**: that describes why there is a strong suspicion of an Intellectual Disability and/or Developmental Disability that was first observed during early childhood.
  WE WILL NOT BE ABLE TO ACCEPT REFERRALS WITHOUT SUPPORTING CLINICAL DOCUMENTS.
- **Name of the respondent:** S*omeone who has lived with and cared for the child/*teen for at least the last **Six (6)** months and is available to provide information to the evaluator.

All referral materials must be sent to: **Whitney.Jarvis2@acs.nyc.gov**

(*) Note: The original copy of the signed consent form is required by AHRC and must accompany the child at the time of the evaluation.

Completing the AHRC Referral Form:

- All referrals must specify the ***Reason for Referral*** – indicating why there is reasonable suspicion of Intellectual Disability and/or Developmental Disability.

- The vendor has locations in **Manhattan** and the **Bronx**.

- The AHRC Referral Form must specify ***Appointment Confirmation Contact Information*** – The name of the primary contact person at the foster care agency who will facilitate the scheduling of the appointment and who will receive the report when completed.

- The AHRC Referral Form must also specify the name of the ***Caregiver/Family Member*** who will accompany the foster child to the evaluation and serve as the ***"RESPONDENT"*** for the evaluation. An evaluation will usually take about 2 hours.

Important Note: OPWDD eligibility criteria requires the **"Respondent"** to be ***someone who has lived with and cared for the child***. Therefore the foster care caseworker **cannot** serve this function, nor can a teacher or other social service worker-- *Except* in cases in which a teen is in congregate care and there is a consistent house parent who knows the teen's functional capacities well.

- ***Background clinical documentation is required for all referrals.*** This can include psychosocial, prior psychiatric reports, prior psychological reports and school reports (such as IEPs).

Important note: Evaluations to support OPWDD eligibility cannot be completed without background developmental history – especially for teens undergoing evaluations. The clinical reports must give special attention to the age at which the signs of an Intellectual Disability or Developmental Delay were first noted. OPWDD will not certify any child or teen for whom there is no evidence of delay that appeared during early childhood. ***The foster care case planner is responsible to provide a psychosocial summary***, which should indicate evidence of disability from the point it was first noted in the child's developmental history.

ID/DD evaluations are provided **free of charge** at AHRC as part of this special ACS-funded project. The child's insurance will not be charged.

How does a foster child benefit from being certified as OPWDD eligible? Foster children and teens with developmental disabilities that live in the community are now eligible for a broad array of specialized treatment and support services through the HCBS Waiver. Clients who need a higher level of care can be placed in OPWDD residential care when they age-out of foster care. This process is facilitated by the ACS Developmental Disabilities Unit.

If you have any questions or require additional assistance, please contact:

Whitney Jarvis
212-341-0934
Whitney.Jarvis2@acs.nyc.gov