Instructions for Completing the Foster Care AND 29-I Transmittal Form to Medicaid Managed Care Plans and Child Health Plus Plans

Purpose: This form is for 29-I Health Facilities and Local Departments of Social Services (LDSS) to notify Medicaid Managed Care Plans (MMCPs) and Child Health Plus (CHPlus) Plans of children/youth's initial foster care and/ or 29-I Health Facility placement status. The instructions below provide guidance on the various sections in the Transmittal Form. ***This form must not be modified***; LDSS/29-Is are only required to provide the information listed on this form.

Section I: Enter the name of the 29-I Health Facility or the LDSS (i.e. county) that is completing this form. Guidance regarding scenarios when these parties are responsible for completing and sending the form is located in the description for Section VI.

Section II: Complete all known demographic fields for the child/youth. Please list any alternative Medicaid Client Identification Numbers (CINs) and/or CHPlus Member ID that are known.

Section III: List the primary and/or secondary contact information for the 29-I Health Facility and/or LDSS MMCP Liaison. If the Transmittal Form is being submitted for notification of final discharge from foster care, list the Discharge Resource/Legal Guardian's contact information in the Secondary Contact spot in Section III.

Section IV: This section is completed either upon enrollment to list contact information for the child/youth's Primary Care Physician (PCP), if known, or to report a change in a child/youth's PCP.

Section V: List any important information the MMCP or CHPlus Plan should know about the child/youth's health and behavioral health care needs.

Section VI: This section is completed upon change of a child/youth's placement status and outlines the 29-I Health Facility services the child/youth is eligible to receive, consistent with billing guidelines and the benefit package for populations that may be served by the 29-I (please refer to 'Populations Served by 29-I Health Facilities' in the New York Medicaid Program 29-I Health Facility Billing Guidance for further information). The entity responsible for completing the Transmittal Form differs depending on the type of situation, as indicated below:

- The LDSS is responsible for completing and submitting the form to the MMCP or CHPlus Plan within 5 business days when the child/youth is initially placed in foster care if the child/youth is not placed in a 29-I Health Facility and whenever the LDSS transfers the child/youth to a new MMCP or CHPlus Plan.
- The 29-I Health Facility is responsible for completing and submitting the form to the MMCP or CHPlus Plan within 5 business days of child/youth being placed with the 29-I Health Facility.
- If a child/youth transitions to an alternative 29-I Health Facility, the new agency that the child/youth is transitioning **to** must complete this form and submit to the MMCP or CHPlus Plan within 5 business days of the change.
- If a child/youth placed with a 29-I Health Facility is discharged, the 29-I Health Facility must complete this form and submit to the MMCP or CHPlus Plan within 5 business days of discharge.
- If a child/youth is discharged from foster care and was not placed with a 29-I Health Facility (i.e. direct care, kinship care, or non 29-I Voluntary Foster Care Agency), the LDSS must complete this form and submit to the MMCP or CHPlus Plan within 5 business days of the change.
- When a placement/change of placement occurs for a CHPlus enrollee, the "Other" box in Section VI must be checked. The provided text box must be used to indicate that the child/youth is enrolled in CHPlus and eligible to receive Core Services and CHPlus covered OLHRS.

MMCPs will receive official enrollment notifications via the 834-enrollment form for youth in foster care placement. In instances where MMCPs receive the Transmittal Form prior to the official enrollment notification, MMCPs should perform an internal check prior to definitively stating that the child/youth is not enrolled in Plan, as it may be possible that the Plan has not yet processed the 834.

Note: CHPlus Plans will not receive an 834-enrollment form, and therefore should use the Transmittal Form as the source of truth for CHPlus enrollment information

Foster Care AND 29-I Transmittal Form to Medicaid Managed Care Plans and Child Health Plus Plans
Notification of Child/Youth's Foster Care and/or 29-I Health Facility Placement

Section I: Communication from 29-I Health Facility or Local Department of Social Services (LDSS) to Medicaid Managed Care Plan (MMCP) or Child Health Plus (CHPlus) Plan

1. **Name of entity completing the form**:
   - ☐ **29-I Health Facility** (Choose a 29-I Facility):
   - ☐ **LDSS** (Choose a county) **(note*: LDSS is the district of fiscal responsibility)**:

Section II: Child/Youth Demographics

1. **Child/Youth Name** (First Name, Middle Initial, Last Name)**:**
2. **Date of Birth (DOB):**
3. **Medicaid Client Identification Number (CIN)/CHPlus Member ID:**

Please list any additional Medicaid CINs/CHPlus Member ID (if known):

4. **Child/Youth's Insurance Plan ID (if known and enrolled):**

Section III: Contact Information

MMCP Liaison (LDSS/29-I Health Facility's Primary Contact):

1. First/Last Name:
2. Relationship to Child:
3. Email:
4. Phone #:
5. Address Line 1:
6. Address Line 2:
7. City, State, Zip:

Secondary Contact (If member is being discharged, section must indicate discharge resource):

1. First/Last Name:
2. Relationship to Child:
3. Email:
4. Phone #:
5. Address Line 1:
6. Address Line 2:
7. City, State, Zip:

Section IV: Primary Care Physician (if known)

☐ Current PCP upon enrollment ☐ Notification of change in PCP

1. Physician Name (First, Last):
2. Practice Name (if applicable):
3. Phone #:
4. Address Line 1:
5. Address Line 2:
6. City, State, Zip:

Section V: Additional Important Information

Complete as applicable and known; list any immediate medical needs for the child/youth. Attach documents if available.

List any other actions the MMCP/CHPlus Plan needs to take regarding the child/youth's coverage or care:

Section VI: *Placement/*Change of Placement (select only one box that applies)

☐ Child/youth has been placed in LDSS-certified setting and is eligible for Other Limited Health-Related Services
☐ *foster care* ☐ *8D baby* **Date of placement:**

☐ Child/youth has been placed with or transferred to a 29-I Health Facility and is eligible for both Core and Other Limited Health-Related Services
☐ *foster care* ☐ *8D baby* **Date of placement:**

☐ Child/youth has been placed with a 29-I Health Facility and is eligible for Other Limited Health-Related Services
☐ *CSE* ☐ *pre-dispositional-placed youth* **Date of placement:**

☐ Child/youth has been discharged from the 29-I Health Facility and/or foster care and is eligible for Other Limited Health-Related Services up to one-year post-discharge **Date of discharge:**

☐ OTHER (only complete if child/youth is enrolled in CHPlus OR if all other changes above DO NOT apply)