NEW TO NORTH EAST PROGRAMS?

North East proudly serves children, teens and adults with developmental disabilities who reside in our consortium region: Bedford, Briarcliff, Lewisboro, Mt. Kisco, Mt. Pleasant, New Castle, North Castle, North Salem, Pleasantville, Pound Ridge, Sleepy Hollow, and Somers. Each municipality help to financially support North East. Anyone living outside of our region must be approved by NY Office for People With Developmental Disabilities (OPWDD) for respite services.

Anyone new to North East must schedule an intake meeting with one of our Recreation Therapists. Please call our office as soon as you can to make sure the desired programs still have availability. During the intake meeting, you, your child, and our staff will work together to determine which programs will be best suited and of interest to your child.

North East can no longer accept new registrants who are 21 years of age or older residing outside our consortium region who are not approved by OPWDD for respite services.

For new Individuals who are enrolled with HCBS Medicaid Waiver and are 21 years & older: North East will only accept those residing outside of our consortium region who are approved for respite services. Individual may not start programs until all required documentation is properly submitted by Care Manager or Parent. Documents include Service Authorization, Notice of Decision, Level of Care, and Individual Service Plan. North East must be included in the person's ISP. Individuals may not begin programs until North East is notified the billing for reimbursement process is completed.

The required forms for new applicants and registration can be found on our website. If you need, just call our office and we can email or mail forms to you. Please bring the completed forms to the scheduled intake meeting.

We are continually assessing our programs and the needs of our participants. We reserve the right to change or recommend alternative programs to best meet the needs of the participants. We will discuss all recommendations; the final decision will be with North East.

NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

Welcome!

Thank you for contacting the **Office for People With Developmental Disabilities (OPWDD) Front Door**. We look forward to helping you get the services you need. Enclosed is a Welcome Packet with important information to help guide you through the Front Door process.

Below is a checklist of key steps you need to complete to get OPWDD services. You can find more details about each step on the following page. If you are ever not sure where you are in the process or have any questions, please contact:

Front Door Liaison Frandy Osias by Phone: (914) 332-8961 or Email: Frandy.X.Osias@opwdd.ny.gov

Since you are receiving this letter, you have probably already completed the first step: **Make Initial Contact with the Front Door**. If so, the next important step to take, if you have not already, is to **Contact and Choose a Care Coordination Organization** to help you with this process. Information on these agencies is included in your Welcome Packet.

☑	**Front Door Key Steps** Please see reverse for more details on these steps	Notes	Contact Person
	Make **Initial Contact** with OPWDD through the Front Door		
	Choose a **Care Coordination Organization (CCO)**		
	Establish OPWDD **Eligibility**		
	Attend a **Front Door Information Session**		
	Work with OPWDD to complete an **Assessment of Service Needs**		
	Develop your **Life Plan** working with your Care Manager		

Your welcome packet includes, at a minimum, the following items.

- Front Door Brochure (How Can I Get Services?)
- Front Door Information Sessions Schedule
- Care Management Brochures: Coverage Areas AND Frequently Asked Questions OR information on Non-Medicaid Service Coordination (N-MSC) Agencies, where available.

Initial Contact
When you contact your local OPWDD Front Door, you will be asked for some basic information such as your address, current phone numbers, email address and the best times to contact you. Please let the Front Door staff know if you need documents translated and conversations interpreted into another language. The person you speak to will briefly describe the Front Door and eligibility processes, may connect you with a Care Coordination Organization (CCO) if needed, and will send you information you will need.

Care Coordination
Making contact with a Care Coordination Organization (CCO) is an important next step in this process. A CCO can help you apply for OPWDD eligibility and Medicaid and can help you plan for and access OPWDD services. If you are found OPWDD eligible, and if you need the support of care management, you will be assigned a Care Manager from the CCO you select. Your Care Manager will help you to develop your Life Plan and connect you to the OPWDD services you need. Please Note: in some communities, where available, you may be referred to a Non-Medicaid Service Coordination (N-MSC) Agency instead of a CCO.

Eligibility
If you are not already OPWDD eligible, you will need to provide certain documents and evaluations so that an eligibility determination can be made. In some cases, you may need to have new assessments and/or evaluations done. Your CCO or N-MSC agency will assist you with the eligibility process.

Information Session
At the **Front Door Information Session**, you will learn about OPWDD services and steps needed to start services. A family member or advocate may attend for you. Included in your welcome packet is a schedule of upcoming sessions in your area. Sessions are also listed on OPWDD's website https://opwdd.ny.gov/. You can go to the information session at any time during the Front Door process but it's best if you attend early in the process. You do not need to be found eligible for OPWDD services in order to attend. Most services and supports cannot start until you have attended a session. If you want to Self-Direct your services, you need to attend a Self-Direction Informational Session before your initial budget can be approved.

Assessment of Service Needs
Front Door staff and your care manager (if you have one and they are available) will talk with you and complete or update a **Developmental Disabilities Profile (DDP2)** to identify your strengths and support needs. If you are 18 years old or older and newly found OPWDD eligible, you will also work with OPWDD to complete a **Coordinated Assessment System (CAS) assessment**. This is OPWDD's person-centered needs assessment. A family member/advocate can take part with you. If a family member/advocate has attended the Front Door Information Session on your behalf, that person should be at your assessment.

Plan for Services
During the Front Door process, you will work with your care manager to identify and plan for the services and supports that best meet your needs. Be sure to share your interests, services and supports that you already receive, as well as supports from your family and community, what you are currently doing, and your plans for the future. Be honest and accurate – the more your care manager understands you and your needs, the better your **Life Plan** will be. Your care manager will request OPWDD approval for the services you need and will help you identify, contact, and choose agencies to deliver the services and supports listed in your Life Plan.

FAQ's for Individuals and Family Members New to Services

What is Health Home Care Management?

Health Home Care Management is a way to coordinate care that combines developmental disability services and supports with health and wellness services, to provide more options, greater flexibility and better outcomes.

Health Home Care Management is provided by Care Coordination Organizations (CCOs).

What is a CCO?

CCOs are organizations formed by developmental disability service providers. These organizations are staffed by Care Managers with training and experience in the field of developmental disabilities.

What is a Care Manager?

A Care Manager is a person who works with you to create your Life Plan. Your Care Manager helps coordinate services across systems, including the Office for People With Developmental Disabilities (OPWDD), the Department of Health and the Office of Mental Health, providing you one place to plan all your service needs.

What is a Life Plan?

The Life Plan reflects your life goals and changing needs. Your Care Manager will work with you to create a plan based on your wants and needs. Your Life Plan will include coordination of your developmental disability related supports and your other services, like medical, dental and mental health. It is reviewed routinely and updated as needed.

Am I required to participate in Health Home Care Management?

If you do not want to receive the more comprehensive care management that will be provided with Health Home Care Management, you can consider the option of Basic Home and Community Based Services (HCBS) Plan Support. Basic HCBS Plan Support will also be provided by the CCO, but it is a very minimal coordination option, and will not include coordination of health care or mental health services. With Basic HCBS Plan Support, your contact with the person coordinating your services will be limited.

Will I be able to choose my own services and providers?

Yes, you will choose your services and providers. Within the CCO, a team of professionals, including your Care Manager, will work together with you to coordinate your developmental disability and/or long-term care services, as well as other types of services, based on your wants and needs. You will be able to choose a CCO provider in your region and your service providers.

How do I enroll with a CCO to receive Care Management?

Your OPWDD Front Door contact will provide you with information about CCOs available in your area. The CCO you choose will assist you with enrollment. You will also need to choose between Health Home Care Management and Basic HCBS Plan Support.

Who will have access to my plan and how will my personal information be protected?

CCOs are required to have an electronic health record system that links the service providers involved in your care and allows your health information and Life Plan to be accessible to you and your care team. All CCOs must follow strict security protocols to protect your Personal Health Information.

Can I change my mind once I choose a CCO?

If you are not happy with the Care Management being provided by the CCO you choose, you can choose another Care Manager in that CCO and/or change the level of service you receive. You may also choose a different CCO within your region.

What will happen if the CCO decides to change my services or give me fewer services?

The CCO does not authorize services and therefore will not be able to take away or lessen your services, including self-directed services. You, in partnership with your care team, will identify the supports and services you receive based on your wants and needs. OPWDD Regional Offices will continue to authorize supports and services.

Is Health Home Care Management a form of Managed Care?

No, Health Home Care Management should not be confused with Managed Care. Managed Care will take several years to develop in the OPWDD system and will be offered at a future date.

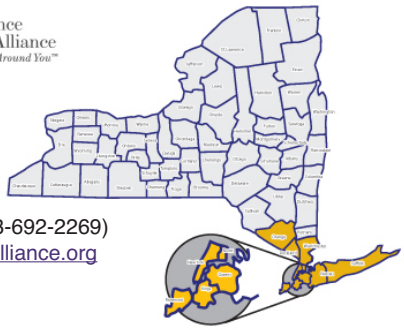
Health Home Care Management vs. Basic HCBS Plan Support	Health Home Care Management	Basic HCBS Plan Support
Develops Care Plan and Reviews Bi-Annually	■	■
Monitors Health and Safety	■	■
Coordinates Access to Behavioral Health Services	■	
Coordinates Access to Medical and Dental Services	■	
Identifies Community-Based Resources	■	
Uses Technology to Link Your Services	■	
Connects Your Care Providers	■	
Takes Burden of Navigating Systems From Families and Individuals	■	
Anticipates Future Needs	■	

NEW YORK STATE OF OPPORTUNITY. Office for People With Developmental Disabilities

Care Management

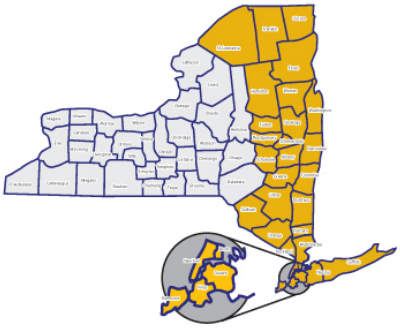
CCO Coverage Areas

ACA Advance Care Alliance *Centered Around You™*



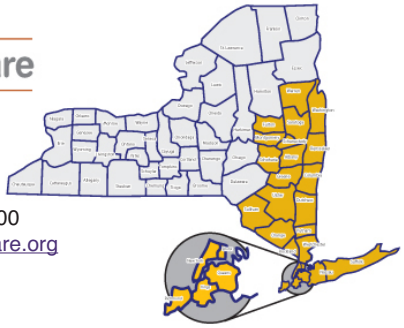
833-MYACANY (833-692-2269)
www.advancecarealliance.org

CAREdesign NEW YORK
making supports work



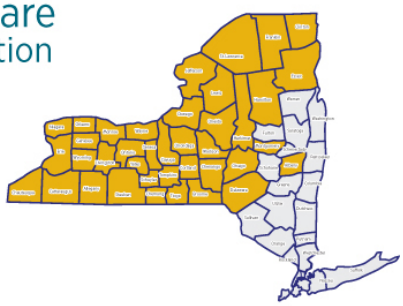
518-235-1888
www.caredesignny.org

Tri · County Care



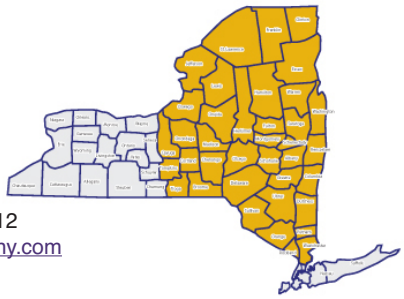
844-504-8400
www.tricountycare.org

Prime Care Coordination



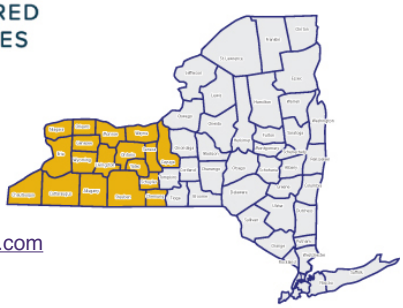
844-347-3168
www.primecareny.org

LIFEPlan CCO NY
Centered on Resources for Life



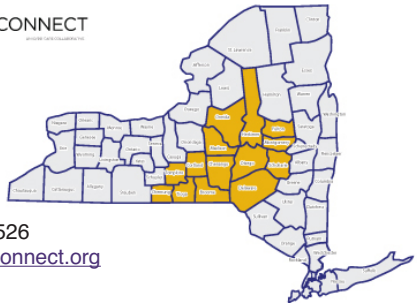
315-565-2612
http://lifeplanccony.com

PERSON CENTERED SERVICES
Reach Your Potential



888-977-7030
www.personcenteredservices.com

SOUTHERNTIERCONNECT



607-376-7526
www.southerntierconnect.org

The Care Coordination Organizations identified here were formed by existing providers of developmental disability services begin providing Health Home Care Management and Basic HCBS Plan Support on July 1, 2018.

See reverse for County coverage

NEW YORK STATE OF OPPORTUNITY. Department of Health | Office for People With Developmental Disabilities

County	Advance Care Alliance	Care Design NY	LIFEPlan CCO	Prime Care Coordination	Person Centered Services	Southern Tier Connect	Tri-County Care
Albany		■	■	■			■
Allegany				■	■		
Bronx	■	■					■
Broome			■	■		■	
Cattaraugus				■	■		
Cayuga			■	■	■		
Chautauqua				■	■		
Chemung				■	■	■	
Chenango			■	■		■	
Clinton		■	■	■			
Columbia		■	■				■
Cortland			■	■		■	
Delaware			■	■		■	
Dutchess		■	■				■
Erie				■	■		
Essex		■	■	■			
Franklin		■	■	■			
Fulton		■	■			■	■
Genesee				■	■		
Greene		■	■				■
Hamilton		■	■	■			
Herkimer			■	■		■	
Jefferson			■	■			
Kings (Brooklyn)	■	■					■
Lewis			■	■			
Livingston				■	■		
Madison			■	■		■	
Monroe				■	■		
Montgomery		■	■	■		■	■
Nassau	■	■					■
New York (Manhattan)	■	■					■
Niagara				■	■		
Oneida			■	■		■	
Onondaga			■	■			
Ontario				■	■		
Orange	■	■	■				■
Orleans				■	■		
Oswego			■	■			
Otsego			■	■		■	
Putnam		■	■				■
Queens	■	■					■
Rensselaer		■	■				■
Richmond (Staten Island)	■	■					■
Rockland	■	■	■				■
Saint Lawrence		■	■	■			
Saratoga		■	■				■
Schenectady		■	■				■
Schoharie		■	■			■	■
Schuyler				■	■		
Seneca				■	■		
Steuben				■	■		
Suffolk	■	■					■
Sullivan		■	■				■
Tioga			■	■		■	
Tompkins			■	■		■	
Ulster		■	■				■
Warren		■	■				■
Washington		■	■				■
Wayne				■	■		
Westchester	■	■	■				■
Wyoming				■	■		
Yates				■	■		