New York State Department of Health
Division of Home and Community Based Services

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Home and Community-Based Medicaid Waiver For
Individuals with Traumatic Brain Injury (HCBS/TBI)

Addendum to Existing Service Plan

I. Identification

Name: Medicaid #:

Date of Birth: Address:

Date of Onset:

Age at Onset: Cty. Of Fiscal Responsibility

Diagnosis: Medicare #:

SS #: Other Insurance:

Individuals who participated in developing the Interim Service Plan

Name	Relationship	Phone #

Service Coordinator:
Agency:
Address:

Phone #:

Date of Submission of Addendum to the Service Plan:_____.
Dates of Last Approved Service Plan
From_____to_____.
Date of Decision:_____

II. **Summary of Request for Addendum to Existing Service Plan .** Please describe in detail all significant functional and/or psycho-social changes that have occurred since the writing of the current Service Plan which are the basis for this addendum. Include the reasons that the Service Plan needs to be amended, and the specific goals of each HCBS/TBI Waiver service being requested.

MEDICAID STATE PLAN SERVICES

Type	Provider	Effective Date	Frequency & Duration (e.g. 1 time per month)	Annual Amount of Units	Rate	Total Annual Cost**

****NOTE**: Total Cost should represent Projected Annual Total Cost of the Medicaid State Plan Service**

PROJECTED TOTAL ANNUAL COST OF MEDICAID STATE PLAN SERVICES: _____

OLD COST: _____

DIFFERENCE: _____

HCBS/TBI WAIVER SERVICES

Type	Provider	Effective Date	Frequency & Duration (2 hrs., 3X per week)	Annual Amount of Units	Rate	Total Cost **

PROJECTED TOTAL ANNUAL COST OF HCBS/TBI WAIVER SERVICES: _____

OLD COST: _____

DIFFERENCE: _____

PROJECTED TOTAL ANNUAL COST OF ALL MEDICAID SERVICES: _____

OLD COST: _____

DIFFERENCE: _____

Signatures of Individuals Participating in the Development of the Addendum to the Existing Service Plan

Waiver Participant_____ **Date:** _____

Advocate/Representative_____ **Date:** _____
(When applicable)

Service Coordinator_____ **Date:** _____

Service Coordinator _____ **Date:** _____
Supervisor

Regional Resource Development Specialist

( ) the information provided in this Interim Service Plan documents that the Waivers Participant's health and welfare is being maintained and the he/she is not at risk for nursing home placement:

( ) the information provided in this Interim Service Plan raises serious concerns about the Waiver Participant's health and welfare. A Revised Service Plan must be submitted to clarify concerns about he waiver participants' ability to remain in the community.

Signature_____

Print Name_____

Title_____

Date_____