Section XI

APPENDIX
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RRDC:_____

EMPLOYEE VERIFICATION OF QUALIFICATIONS

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Employee to provide the Waiver Service	Service Provider Name
Waiver Service you are applying for	Address
Waiver Service Position, if applicable	Telephone

I have submitted my resume and supporting documents which accurately reflects my education and work experience.

Employee Signature Date

This individual has met the eligibility criteria for this position in the following manner:

Education: A copy of this individual's _____diploma or official sealed transcript
_____ license is attached to this form.

Experience: ___This individual's experience, relevant to this position, is highlighted on his/her attached resume. ***(**Please circle this person's relevant experience on the attached resume for quick reference for the interviewers)***.

I have interviewed this individual and reviewed his/her resume. I verified his/her education, required licensures and work experience. Per waiver eligibility criteria, this individual is qualified to provide waiver services in the above named position and has been hired as an employee of our agency.

Service Provider Representative Title Signature Date

Provider Agency Name:_____
RRDC:_____

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER

NURSING HOME TRANSITION AND DIVERSION (NHTD)

AGREEMENT BETWEEN THE NEW YORK STATE DEPARTMENT OF HEALTH AND A PROVIDER OF HOME AND COMMUNITY-BASED WAIVER SERVICES

This Agreement is between the New York State Department of Health (DOH) and _____ (Provider), who is approved to provide New York State Home and Community-Based Services (HCBS). The Provider will receive a letter from DOH indicating the approved waiver services.

For the purpose of establishing eligibility for payment under Title XIX of the Federal Social Security Act, the Provider agrees to comply with all provisions of the New York State Social Services Law and regulations adopted under the authority of such law; the terms of the addenda attached to this contract and 42 CFR 431.107; the standards of operation set forth in the DOH Program Manual for Home and Community Based Services (HCBS) waivers; and all revisions and updates to the Manual and this agreement.

The Provider also agrees to:

I. Keep any records necessary to disclose the type and extent of services furnished to recipients and on request, furnish to DOH, its designees, the Secretary of the U.S. Department of Health and Human Services or the State Medicaid Fraud Control Unit, information regarding these services and payments claimed under Title XIX;

II. Collect personal information concerning a waiver applicant or participant directly from the waiver applicant or participant, whenever applicable. The Provider must keep confidential all information contained in the applicant or participant's records, regardless of the form or storage methods, except when release is required to fulfill the contractual responsibilities set forth in this agreement. The use of information obtained by the Provider in the performance of its duties under this Agreement shall be limited to purposes directly connected with such duties;

III. Treat all information collected and utilized by its officers, agents, employees and subcontractors, with particular emphasis on information relating to waiver applicants and participants, obtained by it through its performance under this Agreement, as confidential information to the extent required by the laws and regulations of the State of New York, including the Personal Privacy Protection Law as may be applicable when personal information is being collected on behalf of the New York State Department of Health;

IV. Abide by all applicable federal and State laws, and regulations of DOH and the Department of Health and Human Services including all requirements of the Health Insurance Portability and Accountability Act (HIPAA);

V. Report all revenues and expenses associated with the provision of waiver services using the forms and procedures established in the Program Manual;

VI. Submit claims for waiver services in accordance with instructions issued, specifically ensuring that services billed as waiver services are <u>not</u> also billed to Medicaid under the existing State Plan services;

VII. Submit claims for all waiver service(s), except Service Coordination and Environmental Modifications, only when the recipient is Medicaid eligible, an approved waiver participant, and residing in the community;

VIII. Submit claims for Service Coordination only when the recipient is Medicaid eligible, and an approved waiver participant and residing in the community or, when a waiver participant is hospitalized, in accordance with the Program Manual;

IX. Submit claims for prior approved Environmental Modifications only when the recipient is Medicaid eligible, an approved waiver participant, and residing in the community. In situations where the individual is not

discharged into the community as anticipated, billing must be prior approved by the RRDS in accordance with the Program Manual;

X. Attend fair hearings and provide testimony regarding the recipient of waiver services when requested by DOH or its designee and comply with such fair hearing decisions in accordance with 18 NYCRR 358-6.4;

XI. When a provider is contacted by an individual inquiring about the HCBS waivers, the provider must refer the individual to the appropriate Regional Resource Development Center (RRDC) for information and referral. This will ensure that the individual is informed of their right to select waiver services from a list of approved service providers.

This Agreement shall be effective upon approval by DOH and shall remain in effect no later than **August 31, 2010**. This Agreement may be terminated sooner by either party for any reason upon sixty (60) days written notice to the other party. In the event the Agreement expires or is terminated, the Provider will cooperate with and assist DOH or its designee in obtaining services determined to be necessary and appropriate for waiver participants.

_____

Provider Agency | Address

_____

Authorized by | Signature | Date

_____

Contact Person | Telephone

SERVICE CERTIFICATION

Issuance of a Provider Agreement constitutes certification of the covered services. It does not constitute a blanket commitment to sponsor unlimited services.

Provider Agency Name:_____
RRDC:_____

AGREEMENT BETWEEN THE NEW YORK STATE DEPARTMENT OF HEALTH AND A PROVIDER OF HOME AND COMMUNITY-BASED WAIVER SERVICES (cont'd)

Addendum I

Rights of Waiver Participants

(A) Providers of HCBS waiver services must protect and promote the exercise of basic rights for participants including their right to:

1. Select or change individual service provider(s) and/or choose to receive waiver services from different agencies or different providers within the same agency without affecting overall waiver eligibility;
2. Participate in the planning of his or her services and supports. In addition to the Service Plan, plans for each waiver service must be developed, implemented and updated in accordance with the waiver participant's requests and with the requirements established in the Program Manual for the HCBS waiver;
3. Be given a statement of the services available to the participant under the waiver;
4. Be informed of when and how approved services described in the Service Plan will be provided, and the name and functions of any person and affiliated entity providing care and services;
5. Refuse care, treatment and services after being fully informed and understanding of the consequences of such actions;
6. Submit complaints about care and services provided or not provided and complaints concerning lack of respect for the individual's rights and property. Receive support and direction from the Service Coordinator, the Regional Resource Development Specialist (RRDS), Quality Management Specialist (QMS) for resolving waiver participant's concerns and complaints about services and service providers. Such complaints may be directed to the agency employing the service provider, any outside representative of the individual's choice or the Department of Health, and must be investigated as outlined in the Program Manual. The resolution of such investigation must be provided to the participant. The participant may not be subjected to restraint, interference, coercion, discrimination or reprisal as a result of filing such complaint;
7. Be treated with consideration, respect and full recognition of his or her dignity, property rights and individuality;
8. Be afforded privacy, including confidential treatment of waiver participant records, and refusal of their release to any individual not authorized to have such records, except in the case of the participant's transfer to a health care facility, or as required by law or Medicaid requirements;
9. Be informed of the rights contained herein and the right to exercise such rights, in writing, prior to the initiation of care as evidenced by written documentation in the record maintained by each service provider who has ongoing contact with the participant; and
10. Be advised in writing of the address and telephone number of the Service Coordinator, all service providers and their supervisors, the Regional Resource Development Specialist (RRDS), Quality Management Specialist (QMS) and the NHTD Complaint line;

(B) Each provider agency must inform its personnel providing services to waiver participants of the rights of participants and the responsibility of all personnel to protect and promote the exercise of such rights.

(C) If a participant lacks capacity to exercise these rights, the participant's legal guardian will exercise those rights.

(D) If a participant has been adjudicated incompetent in accordance with State law, all rights and responsibilities specified in this addendum may be exercised by the appointed [committee or legal] guardian authorized to act on behalf of the participant.

Provider Agency Name:_____
RRDC:_____

Addendum II

Provision of HCBS Waiver Services

Each provider of waiver services MUST adhere to the following standards:

1. Services must be provided in accordance with the participant's assessed needs, accepted standards of quality and effectiveness and the provider's recognized scope of practice and competence.

2. Services must be provided in a manner that promotes, and does not jeopardize the participant's health and welfare.

3. A Service Plan for the participant must be developed, implemented and updated in accordance with the requirements established in the Program Manual for the HCBS waiver.

4. Services will be provided to participants without regard to race, religion, color, creed, gender, national origin, sexual orientation, marital status or disability.

5. Provider personnel shall be governed by the applicable federal and State labor laws and regulations.

6. Providers must refer the participant to the Service Coordinator for other health and social community resources which may benefit the participant.

7. The Provider must oversee the provision of services to ensure that quality services are delivered in a timely manner and in accordance with the Service Plan.

8. Providers must support the participant's right to choose services from approved providers.

9. Participant records must include documentation of changes in the participant's condition, adverse reactions, and problems. Any changes impacting the participant's environment, health and welfare must be noted and immediately reported to a supervisor and the participant's Service Coordinator. All records must be maintained in accordance with applicable law. DOH or its representatives reserve the right to review records at any time.

10. There must be effective communication between the Service Coordinator and all service providers to ensure that the participant's health and welfare are maintained in accordance with the Service Plan. The Provider will inform the waiver participant of information that will be shared among service providers.

11. The Provider will document all Serious Reportable and Recordable Incidents and manage in accordance with the Incident Policy in the Program Manual.

The Regional Resource Development Specialist (RRDS), Nurse Evaluator (NE), and Quality Management Specialist (QMS), as designees of the DOH, shall have full access to all provider records regarding a participant and the provision of HCBS waiver services.

I acknowledge the information presented in Addendum I and II of this Agreement.

Provider Agency	Contact Person	Title
Authorized by	Signature	Date
Contact Person		Telephone

REFERRAL FORM

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Transferred from: _____ (RRDS Region)

Referral # _____ (Date YYYYMMDD + Region number + R + referral counter, Ex. 20061015-02-R012)

Applicant Name: ☐ Mr. ☐ Mrs. ☐ Ms _____ (First/MI/Last/Generational Suffixes)

Date of Initial Referral: _____ **Region**: _____

Applicant Information

Current Telephone: (___) _____ Medicaid Active: ☐ Yes ☐ No ☐ Unknown

Current Location:
☐ Private Residence ☐ Hospital ☐ Physical Rehabilitation Facility ☐ Psychiatric Facility
☐ Nursing Home ☐ Adult Home/Assisted Living ☐ Substance Abuse Rehab. Facility
☐ Jail/Prison ☐ Other: _____

Location Address: _____ Street

_____ City State Zip

Comments: _____

Is Applicant: ☐ Diverting from: ☐ In-state ☐ Out of State ☐ Transitioning from: ☐ In-state ☐ Out of State

Is applicant proficient in English? ☐ Yes ☐ No

Does the applicant need a translator? ☐ Yes ☐ No If yes, what language? _____
Does applicant need a sign language interpreter? ☐ Yes ☐ No
If yes, translation/interpretation provided by: _____
Telephone: (___) _____ Telephone: (___) _____

Does applicant require written materials in alternative formats? ☐ Yes ☐ No
Specify: _____

Contact Information

Legal Guardian ☐ Yes ☐ No

Name (if applicable): _____ Telephone: (___) _____

Contact Person Name: _____ Relationship to Applicant: _____

Address: ☐ same as above _____ Street

_____ City State Zip

Telephone: (___) _____

Referral Form (continued)

Applicant Name: **Referral #**

Demographics

Applicant Age:_____ Applicant Sex: ☐ Female ☐ Male

Applicant Birth Date (if known):___/___/_____ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Referral Information

Reported Primary Diagnosis: _____

Areas of Concern:_____

Currently Living With: ☐ Alone ☐ Spouse ☐ Adult Children ☐ Minor Children ☐ Parents ☐ Siblings ☐ Other Family Members ☐ Friends/Significant Others ☐ Other _____

Onset of Needs Occurred Within: ☐ the last 3 months ☐ last 3-6 months ☐ last 6-12 months ☐ last 1-2 years ☐ last 2-5 years ☐ more than 5 years

Does Applicant have help in the home now? ☐ Yes ☐ No
If yes, specify type of service(s): _____

Proposed Living Arrangements

Proposed Region: _____ Proposed County:_____

Proposed Address: ☐ same as Current Location above ☐ Unknown

_____
Street City State Zip

Proposed Living Situation: _____

Referral Source

☐ **Self Referral** Comments: _____

☐ **Informal Referral** ☐ Same as Contact Person above

Name: _____ Relationship to Applicant:_____

Telephone:(___)_____ Informal referral comments: _____

Referral Form (continued)

Applicant Name:	**Referral #**

☐ **Formal Referral**

Provider Name: _____ Telephone:(___)_____

Referral Source type:

- ☐ Nursing Home
- ☐ Adult Home/Assisted Living
- ☐ Criminal Justice
- ☐ Hospital
- ☐ Medical Personnel
- ☐ Community Based Services
- ☐ MDS data
- ☐ Physical Rehab. Facility
- ☐ Other: _____
- ☐ Independent Living Center
- ☐ Psychiatric Facility
- ☐ Local Department of Social Services
- ☐ Substance Abuse Rehab. Facility

Provider Contact/Title:_____ Email:_____

Formal Referral Comments: _____

How did the referral source learn about the waiver?

- ☐ RRDC
- ☐ Local Department of Social Services
- ☐ Psychiatric Facility
- ☐ Nursing Home
- ☐ Home Care Agency
- ☐ Substance Abuse Rehab. Facility
- ☐ Hospital
- ☐ Medical Personnel
- ☐ Media (TV, Radio, Newspaper)
- ☐ Point of Entry
- ☐ Staff from other waiver
- ☐ Pamphlets
- ☐ Independent Living Center
- ☐ Physical Rehab. Facility
- ☐ Other:_____

Outcomes – this section to be completed by RRDC

Referral Status: ☐ Proceed to Intake Date:___/___/_____ ☐ Closed Date:___/___/_____

☐ Transferred to:_____Date:___/___/_____ Comments:_____

If closed, why? ☐ Age ☐ Medicaid status ☐ Medically unstable ☐ Choose to stay in Nursing Home
☐ Unable to contact ☐ Other:_____

Referral made to other resource(s): ☐ Point of Entry ☐ TBI Waiver ☐ NHTD Waiver ☐ LTHHCP
☐ OMH ☐ OMRDD ☐ Consumer Directed/PCS ☐ CHHA
☐ Office for the Aging ☐ None ☐ Other:_____

RRDS Name/Signature:_____ Date:_____

Comments

INTAKE FORM

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Date of Referral: ___/___/___ Referral #: _____
Region: _____ (Date YYYYMMDD + Region number +R + referral counter, Ex. 20061015-02-R012)

Applicant Name: ☐ Mr. ☐ Mrs. ☐ Ms _____
(First/MI/Last/Generational Suffixes)

Date Contacted : ___/___/___ Date Intake Scheduled for: ___/___/___ Final Intake Date:___/____/___

Applicant Information

Current Telephone: (___) _____

Current Location:
☐ Private Residence ☐ Hospital ☐ Physical Rehabilitation Facility ☐ Psychiatric Facility
☐ Nursing Home ☐ Adult Home/Assisted Living ☐ Substance Abuse Rehab. Facility
☐ Jail/Prison ☐ Other: _____

Location Address: _____
Street City State Zip

Comments: _____

Legal Residence: ☐ same as Current Location Address _____
Street

_____
City County/Region State Zip

Comments: _____

Mailing Address (Please check which one applies): ☐ Current ☐ Legal

Is applicant proficient in English? ☐ Yes ☐ No
Does the applicant need a translator? ☐ Yes ☐ No
If yes, what language? _____

Translation provided by: _____ Telephone: (___) _____

Does applicant need a sign language interpreter? ☐ Yes ☐ No
If yes, interpretation provided by: _____ Telephone: (___) _____

Does applicant require written materials in alternative formats? ☐ Yes ☐ No
Specify: _____

Contact Information

Legal Guardianship ☐Yes ☐ No If yes, obtain documentation.
Legal Guardian Name (if applicable): _____ Telephone: (___) _____
Contact Person Name: _____ Relationship to Applicant: _____

Address: ☐ same as above _____
Street

_____
City State Zip

Telephone: (___) _____

Intake Form (continued)

Applicant Name: **Referral #**

Demographics

Applicant Birth Date: ___/___/_____

Applicant Sex: ☐ Female ☐ Male

Applicant Age:_____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race/Ethnicity:
☐ Caucasian ☐ Black or African American ☐ Asian ☐ Native American/ Alaskan Native
☐ Hispanic/Latino ☐ Other:_____

Insurance

Medicaid Status: ☐ Active ☐ Pending ☐ Spend down ☐ Needs to Apply CIN:_____
☐ Denied ☐ Unknown ☐ Managed County of fiscal responsibility:_____

Medicare Status: ☐ Active ☐ A ☐ B ☐ D ☐ Managed ☐ Pending
☐ Denied ☐ Needs to Apply ☐ N/A Medicare #:_____

Veteran: ☐ Yes ☐ No

Other insurance plan:_____

Diagnosis/Needs

Reported Primary Diagnosis:_____

Reported Other Diagnosis:_____

Population category (check all that apply)
☐ Senior (65+) ☐ Physical Disability (18-64) ☐ MR/DD ☐ Mental Illness

Impact on the Individual:
☐ Describe Physical Disabilities:_____

☐ Describe Cognitive Disabilities:_____

☐ Describe Behavioral Concerns:_____

Intake Form (continued)

Applicant Name: **Referral #**

Currently Living With: ☐ Alone ☐ Spouse ☐ Adult Children ☐ Minor Children ☐ Parents ☐ Siblings ☐ Other Family Members ☐ Friends/Significant Others ☐ Other _____

Onset of Needs Occurred Within: ☐ the last 3 months ☐ last 3-6 months ☐ last 6-12 months ☐ last 1-2 years ☐ last 2-5 years ☐ more than 5 years

Expected Needs: ☐ personal care ☐ housekeeping ☐ meals ☐ getting out of bed ☐ supervision for safety reasons ☐ bill paying ☐ home modification ☐ assistive medical equipment ☐ structured social activities ☐ other:_____

Is there help in the home now? ☐ Yes ☐ No

Informal: ☐ Spouse ☐ Adult Children ☐ Minor Children ☐ Parents ☐ Siblings ☐ Other Family Members ☐ Friends/Significant Others ☐ Other:_____

Type of help:_____

Formal: ☐ TBI Waiver ☐ NHTD Waiver ☐ LTHHCP ☐ OMRDD ☐ OMH ☐ State Plan, Please list: _____ ☐ Other:_____

Type of help:_____

Previous experience with NYS HCBS Waivers. ☐ Yes ☐ No If yes, which waiver:

☐ NHTD ☐ TBI ☐ LTHHCP ☐ Care at Home ☐ OMRDD
☐ OMH Children with Serious Emotional Disturbance ☐ Other:_____

Is Applicant: ☐ Diverting from: ☐ In-state ☐ Out of State ☐ Transitioning from: ☐ In-state ☐ Out of State

*Was the applicant going to go to an Out of State facility? ☐ Yes ☐ No

If Transitioning, approximate length of stay in the nursing facility: ☐ under 3 months ☐ 3-6 months ☐ 7-11 months ☐ 1-2 years ☐ over 2 years

Proposed Living Arrangements

Proposed County:_____ Proposed Region:_____

Proposed Address: ☐ same as Current Location above ☐ Unknown

_____
Street City State Zip Code

Intake Form (continued)

Applicant Name:	Referral #

Proposed Living Situation: ☐ Alone ☐ Spouse ☐ Adult Children ☐ Minor Children
☐ Parent ☐ Siblings ☐ Other Family Members
☐ Friends/Significant Others ☐ Unknown ☐ Other: _____

Proposed type of community residence:
☐ Home (owned or leased by individual or family)
☐ Apartment (individual lease, lockable access, etc.)
☐ Group home or other residence in which 4 or fewer unrelated individuals live
☐ Other:_____
☐ Unknown at this time

Intake Status: ☐ Pending Date:_____/_____/_____ ☐ Completed Date:_____/_____/_____

Intake Status

Decision reached Date:____/____/____

☐ Pending

☐ Transfer: Region _____ Date_____
Comments:_____
_____

☐ Proceed to Application

☐ Do not proceed to Application due to:

☐ Level of Care
☐ Age
☐ Not MA eligible
☐ Guardian refused participation
☐ Chose not to apply
☐ Unable to meet for Intake within 60 days of the scheduled date
☐ Other:_____
_____

☐ Notice of Decision – Denial of Waiver Program – Issued NOD Date: _____/_____/_____
Date DOH WMS notified: _/_____/_____

Intake Form (continued)

Applicant Name:	Referral #

Referral made to other resource(s):
☐ Point of Entry ☐ TBI Waiver ☐ NHTD Waiver ☐ LTHHCP
☐ OMH ☐ OMRDD ☐ Consumer Directed/PCS
☐ CHHA ☐ Office for the Aging
☐ None ☐ Other _____

Forms Checklist

☐ Initial Applicant Interview Acknowledgement Date: _____/_____/_____

☐ Freedom of Choice Date: _____/_____/_____

☐ Application for Participation Date: _____/_____/_____

☐ Service Coordinator Selection Sent Date: _____/_____/_____ Accepted date:____/____/____

Service Coordination Agency Name:_____

Existing PRI/SCREEN: ☐ Yes ☐ No Completed: ____/___/___ Expires: ____/____/____
(90 days from PRI Date)

Location of PRI/SCREEN, comments:_____

Indicates nursing home level of care? ☐ Yes ☐ No

Areas of Concern: ☐ Diagnosis ☐ Housing ☐ Level of care determination
☐ Medicaid status ☐ Intensity of support/service needs

Comments:_____

_____

_____

Date sent to Service Coordinator Agency ____/____/_____

Potential MFP Demonstration candidate ☐ Yes ☐ No

Intake completed by:_____
(Signature) (Title)

Contact Sheet/Comments

Signature:_____ Date: _____

INITIAL APPLICANT INTERVIEW AND ACKNOWLEDGEMENT

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

_____
Referral #

Applicant Name | Date of Interview

CIN | Regional Resource Development Specialist (RRDS)

The following has been provided to me and/or my legal guardian:

1. The philosophy and mission of the Home and Community Based Medicaid Services(HCBS) provided by the Nursing Home Transition and Diversion Waiver and the Traumatic Brain Injury Waiver.

2. Information about HCBS waivers and other Medicaid services to support people in the community and my right to choose whether or not to apply at this time.

3. The steps necessary to complete the application process including the roles and responsibilities of the participant, the Regional Resource Development Specialist, the Quality Management Specialist or Clinical Consultant, Service Coordinator and Service Providers.

4. The process of interviewing and choosing an approved Service Coordination agency and Provider agencies of my choice.

5. The process of changing waiver service providers at any time once I am approved as a participant in this waiver.

6. The process for the development and implementation of the Service Plan, the Revised Service Plan and subsequent addendums, change of providers and revisions, that will provide services to support me in the community if I am approved as a participant.

7. The process of receiving Notices of Decision forms including requesting an Informal Conference and /or a Fair Hearing.

Applicant and/or Legal Guardian or Authorized Representative (as applicable) Signature | Date

Regional Resource Development Specialist (RRDS) Signature | Date

FREEDOM OF CHOICE

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

I, _____ have been informed that I may be eligible for services provided through either a nursing facility or a Home and Community Based Services Medicaid Waiver.

Check One:

_____ I have chosen to apply for the Nursing Home Transition and Diversion Medicaid Waiver.

_____ I have chosen to apply for Medicaid State Plan Services and/or another Home and Community Based Services Medicaid Waiver

_____ I have chosen **NOT** to apply for services through a Home and Community Based Services Medicaid waiver at this time.

Applicant Signature		Date
Legal Guardian Name (as applicable)	Signature	Date
Authorized Representative (as applicable)	Signature	Date
Regional Resource Development Specialist	Signature	Date

SERVICE COORDINATOR SELECTION

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

NOTE: This form must be returned to the Regional Resource Development Specialist (RRDS) to continue the waiver application process.

I understand that as an applicant for the Nursing Home Transition and Diversion Medicaid Waiver or the Traumatic Brain Injury Medicaid Waiver, I must select a Service Coordinator from the attached list of approved Service Coordination Agencies. I have been encouraged to interview these providers prior to making my selection.

I understand that this Service Coordinator will assist me in developing, implementing and monitoring my Service Plan.

I also understand that at any time I may change my Service Coordinator or the Service Coordination Agency and still be eligible for the waiver.

From the approved Service Coordinator Agency list, I have selected the following provider of Service Coordination:

Service Coordination Provider Agency | Telephone | Service Coordinator selected (if known)

Agency Address

Applicant Name | Applicant Signature | Date

Legal Guardian Signature (if applicable) | Date

Authorized Representative Signature (if applicable) | Date

To be completed by the Service Coordination Agency:

Service Coordination Agency

_____ will provide Service Coordination to the above named applicant

_____ will not provide Service Coordination to the above named applicant because:

Service Coordinator Signature | Date

Service Coordination Supervisor Signature | Date

Regional Resource Development Specialist Signature | Date

APPLICATION FOR PARTICIPATION

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Applicant Name CIN

Current Residence

Telephone Date of Birth

( ) Not enrolled in Medicaid
( ) Medicaid application is pending

I am requesting participation in a Home and Community Based Services Medicaid Waiver.
I understand that approval to participate in the waiver is based on documentation of the following:

- **o** Nursing home level of care
- **o** Eligibility and authorization for Medicaid coverage of Community Based Long Term Care Services
- **o** Being able to live in the community with the needed assistance of available informal supports; or non Medicaid supports; or Medicaid State Plan Services; and at least one waiver service(s)
- **o** Age of at least eighteen (18) years at the time of approval for the waiver

Applicant Signature Date

Legal Guardian Name (as applicable) Signature Date

Authorized Representative Name (as applicable) Signature Date

Regional Resource Development Specialist Name Signature Date

Home and Community Based Services Waiver
Nursing Home Transition and Diversion (NHTD) Waiver

Letter of Introduction to Social Services District

Date: _____
LDSS Name: _____
Address: _____
_____
_____

Dear Social Services District:

This is to notify you that _____ is an applicant for the Home and Community Based Services Waiver for Nursing Home Transition and Diversion (HCBS/NHTD Waiver).

Participation in the NHTD Waiver is contingent, in part, upon the applicant being eligible for Medical Assistance (MA) and certified as disabled. In order to participate in the HCBS/NHTD Waiver, Medicaid eligibility must be determined for coverage of community-based long-term care services (which includes coverage for waiver services).

A Waiver participant is only required to provide documentation of his/her current resources. These individuals are not subject to a transfer of assets "look-back" period nor to a transfer penalty period. This applicant has not yet been determined to be MA eligible and/or certified as disabled. Please (check all that apply):

- ☐ Determine MA eligibility for this applicant and send us a copy of your decision.

- ☐ Determine MA eligibility for this applicant and the applicant's family and send us a copy of your decision. Spousal budgeting rules may be used.

- ☐ Determine disability for this applicant and send us a copy of your decision.

A prompt response to this request would be appreciated. If you have any questions about the applicant, you may call _____ _____at _____.

Thank you for your cooperation.

Sincerely,

_____
(Signature)

_____
(Title)

_____
(Telephone)

Provider Agency Name:_____
RRDC:_____

Waiver Service Provider Interview

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Regional Resource Development Specialist

RRDS:_____Region(s):_____ Date:_____

Service Provider Agency:_____ Contact Person: _____Title:_____

Service Provider Address:_____Telephone:_____

Regional Satellite Office(s)? ☐ Yes ☐ No If Yes, please complete attached page at the end of this interview form.

Interested region(s): _____

Interested county(ies):_____

Approved for other TBI/NHTD Waiver Services ☐ Yes ☐ No If Yes, what service(s)/waiver: _____

Approved in what region(s): _____

What counties served: _____

Name and title of designee for signing contracts:_____Telephone:_____

Executive Director:_____Telephone:_____

Representatives of Agency in Attendance:

Representative:_____Title:_____

Representative:_____Title:_____

Representative:_____ Title:_____

Provider has requested to provide the following services:

___Service Coordination
___Assistive Technology
___Community Integration Counseling
___Community Transitional Services
___Congregate and Home Delivered Meals
___Environmental Modifications Services
___Home and Community Support Services
___Home Visits by Medical Personnel
___Independent Living Skills Training Services
___Moving Assistance
___Nutritional Counseling/Educational Services
___Peer Mentoring
___Positive Behavioral Interventions and Supports
___Respiratory Therapy
___Respite Services
___Structured Day Program Services
___Wellness Counseling Service

Provider Agency Name:_____
RRDC:_____

Waiver Service Provider Interview
Part I: Overall Questions

RRDS provides a comprehensive description of the program.

1. Does the provider representative indicate that he/she understands how the waiver program works? Yes ( ) No ( )
   RRDS Comments:

2. In what capacity has the provider served as a provider of services to seniors and/or people with disabilities?
   Explain in detail:

3. The following written Policies and Procedures have been reviewed and are consistent with the corresponding section of the Program Manual:

Providers applying for AT, CTS, Congregate and Home Delivered Meals, E-mods, Home Visits by Medical Personnel, Moving Assistance, and Respiratory Therapy must satisfy the following:

__HIPAA compliance
__Safety & Emergency Procedures
__Human Resources Policies/Procedures
__Knowledge of Incident Reporting Policy
__Service provision tracking & billing system
__Participant satisfaction survey
__Handling of complaints and grievances from participants, advocates and family members
__Recording/addressing concerns from Service Coordinator, RRDS/NE and QMS
__Recordkeeping/documentation for each participant
__Cooperate with NYS DOH, OMIG & other government agencies with jurisdiction to conduct surveys & audits

Providers applying for all other services must satisfy the following:

__HIPAA compliance
__Safety & Emergency Procedures
__Human Resources Policies/Procedures
__Incident Reporting/SRI Committee
__Service provision tracking system
__Plan for self-appraisal of services provision including suggestions and methods for improvements
__Participant satisfaction survey
__Recording/addressing concerns from SC, RRDS, QMS, and/or DOH waiver management staff
__Recordkeeping/documentation for each participant
__Waiver service training
__Handling of complaints and grievances from participants, advocates and family members
__Additional training programs for staff
__Cooperate with NYS DOH, OMIG & other government agencies with jurisdiction to conduct surveys & audits

RRDS Comments:

Provider Agency Name:_____
RRDC:_____

Waiver Service Provider Interview
Part I continued

4. Is the provider currently enrolled as a provider in eMedNY? Yes ( ) No ( )
   In what capacity?
   RRDS Comments:

5. Did the provider representative read the Program Manual before applying to become a provider? Yes ( ) No ( )
   RRDS Comments:

6. Does he/she understand the importance and timeliness issues associated with the Service Plan and Individual Service Reports as well as the policy related to late submission?
   Yes ( ) No ( )
   RRDS Comments:

Provider Agency Name:_____
RRDC:_____

Waiver Service Provider Interview
Part II Specific Services

A. _____(if applying for more than one service, attach additional copies of this section)
Name of Service

The RRDS explains the service, and the qualifications and responsibilities of the provider. (Refer to Program Manual).

Does the provider representative indicate that he/she understands:

1. The definition of the service? Yes ( ) No ( )
2. The qualification requirements for: (a) provider, and Yes ( ) No ( )
   (b) staff? Yes ( ) No ( )
3. How this service relates to other services? Yes ( ) No ( )
4. The agency's record keeping responsibilities? Yes ( ) No ( )
5. The participant's Right of Choice? Yes ( ) No ( )
6. The role of the Service Coordinator? Yes ( ) No ( )
7. That this is a prior approval program? Yes ( ) No ( )
8. The survey/audit procedure? Yes ( ) No ( )
9. Does the provider understand the qualifications (including any requirements of licensure) and requirements of the entity providing the service and/or the qualifications for the individuals providing this service? Yes ( ) No ( ) *If licensure is required, the RRDS must review the entity's license.*
10. Did the provider submit a resume and an Employee Verification Qualification form for each individual who is projected to provide this service? Yes ( ) No ( )
11. The RRDS should list the names of the individuals who appear to be qualified to provide this service.

    _____
    _____
    _____

    General comments:

Provider Agency Name:_____
RRDC:_____

Waiver Service Provider Interview
Part II continued

B. Structured Day Program

The RRDS explains the service and the qualifications and responsibilities of the Structured Day Program provider.

Does the provider representative indicate that he/she understands?

1. The definition of the service? Yes ( ) No ( )
2. The qualification requirements for: (a) provider, and Yes ( ) No ( )
   (b) staff? Yes ( ) No ( )
3. How this service relates to other services? Yes ( ) No ( )
4. The agency's record keeping responsibilities? Yes ( ) No ( )
5. The participant's Right of Choice? Yes ( ) No ( )
6. The role of the Service Coordinator? Yes ( ) No ( )
7. That this is a prior approval program? Yes ( ) No ( )
8. The survey/audit procedure? Yes ( ) No ( )
9. The qualifications (including any requirements of licensure) and requirements of the entity providing the service and/or the qualifications for the individuals providing this service? Yes ( ) No ( ) *If licensure is require, the RRDS must review the entity's license.*
10. Did the provider submit a resume and an Employee Verification Qualification form for each individual who is projected to provide this service? Yes ( ) No ( )
11. The RRDS should list the names of the individuals who appear to be qualified to provide this service.

    _____
    _____
    _____

11. Did the provider submit a copy of the Certificate of Occupancy? Yes ( ) No ( )
12. From the site visit, the RRDS should list any outstanding issues that need to be addressed in order to be considered as a provider of this service:

Provider Agency Name:_____
RRDC:_____

Waiver Service Provider Interview
Part III

1. Does the provider representative have any other questions? Yes ( ) No ( )
   If yes, what are they?

2. Were you able to answer his/her questions? Yes ( ) No ( )

3. Did the provider understand your responses? Yes ( ) No ( )

4. Did you need to refer him/her to someone else to answer questions? Yes ( ) No ( )
   If yes, who?

5. RRDS Evaluation of Agency (Strengths, weaknesses and/or concerns):

Provider Agency Name:_____
RRDC:_____

Waiver Service Provider Interview

Part III continued

6. RRDS recommends this agency to provide the following services: (please specify regions(s)):

Applied To Provide		Service	Recommended	Not Recommended	Counties
Yes	No				
☐	☐	Service Coordination	☐	☐	
☐	☐	Assistive Technology	☐	☐	
☐	☐	Community Transitional Services	☐	☐	
☐	☐	Community Integration Counseling	☐	☐	
☐	☐	Congregate and Home Delivered Meals	☐	☐	
☐	☐	Environmental Modifications Services	☐	☐	
☐	☐	Home and Community Support Services	☐	☐	
☐	☐	Home Visits by Medical Personnel	☐	☐	
☐	☐	Independent Living Skills Training	☐	☐	
☐	☐	Moving Assistance	☐	☐	
☐	☐	Nutritional Counseling/Educational Services	☐	☐	
☐	☐	Peer Mentoring	☐	☐	
☐	☐	Positive Behavioral Interventions and Supports	☐	☐	
☐	☐	Respiratory Therapy	☐	☐	
☐	☐	Respite Care Services	☐	☐	
☐	☐	Structured Day Program	☐	☐	
☐	☐	Wellness Counseling Service	☐	☐	

7. RRDS Reasons for the Decision:

_____
RRDS Signature/Date

Provider Agency Name:_____
RRDC:_____

Waiver Service Provider Interview
Part IV

DOH Waiver Management Decision:

___Approves
___Disapproves

DOH Waiver Management Comments:

_____
DOH Waiver Management Signature/Date

Waiver Service Provider Interview
Part V

Regional Satellite Office:______________________

County(ies) served:______________________

Contact Person/Title:______________________

Telephone:______________________

Address:______________________

City/Zip:______________________
Note: Have you verified the LHCSA license for this satellite office? Yes ( ) No ( )

Regional Satellite Office:______________________

County(ies) served:______________________

Contact Person/Title:______________________

Telephone:______________________

Address:______________________

City/Zip:______________________
Note: Have you verified the LHCSA license for this satellite office? Yes ( ) No ( )

Regional Satellite Office:______________________

County(ies) served:______________________

Contact Person/Title:______________________

Telephone:______________________

Address:______________________

City/Zip:______________________
Note: Have you verified the LHCSA license for this satellite office? Yes ( ) No ( )

Regional Satellite Office:______________________

County(ies) served:______________________

Contact Person/Title:______________________

Telephone:______________________

Address:______________________

City/Zip:______________________
Note: Have you verified the LHCSA license for this satellite office? Yes ( ) No ( )

****If you need additional space, please make copies of this page.**

RRDS APPLICATION PACKET REVIEW FORM

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Date: _____ Referral number: _____

Applicant Name: ☐ Mr. ☐ Mrs. ☐ Ms _____
(First/MI/Last/Generational Suffixes)

DOB: _____ CIN: _____ Region: _____

SC Coordinator Name: _____ SC agency: _____

Has the applicant submitted the Application Packet? ☐ Yes ☐ No (If no, go to Page 7)

Status: received, approved, denied, withdrawn, corrections needed RRDS review, QMS reviewed

*Application Packet Received By RRDS	Date:
*Applicant/Legal Guardian signed/dated ISP	Date:
*SC signed ISP	Date:
*SC Supervisor signed ISP	Date:
*ISP Returned to SC for corrections	Date:
*Attachments Returned to SC for Corrections	Date:
*Review Completed by SC	Date:
*Received by RRDS from SC with corrections	Date:
Submission to QMS (if applicable) over $300/day Submission to QMS for consultation	Date: Date:
Returned to RRDS from QMS	Date:
*Final Decision by RRDS	Date:

Attachments	**Signed and Completed**	**Comments**
Freedom of Choice form	**Date** __/__/__ **__Y __N**	_____
Service Coordinator Selection form	**Date** __/__/__ **__Y __N**	_____
Documentation of disability is present	**__Y __N __ N/A**	_____
Age requirement met	**__Y __N**	_____
Medicaid eligibility verification Co._____	**Date** __/__/__ **__Y __N**	_____
PRI/SCREEN	**Date** __/__/__ **__Y __N**	_____
LOC appropriate for eligibility?	**__Y __N**	_____
Application for Participation form	**Date** __/__/__ **__Y __N**	_____
Participant Rights/Responsibilities	**Date** __/__/__ **__Y __N**	_____
Provider Selection form(s)	**Date** __/__/__ **__Y __N**	_____
Plan for Protective Oversight	**Date** __/__/__ **__Y __N**	_____
Insurance, Resource and Funding Information form	**Date** __/__/__ **__Y __N**	_____

Additional Comments: _____

INSTRUCTIONS: **For each of the following sections, please indicate whether the ISP has been *completed correctly by checking YES or NO. If NO is selected, use the COMMENTS area to document corrections that are needed. For questions that are not applicable to the participant, document "N/A" under Comments column.***

SERVICE PLAN:

I. Personal Identification Information	**YES**	**NO**
All identification items are completed including Transition/Diversion		
Comments:		

II. Individuals Selected by the Applicant to Participate in ISP Development	**YES**	**NO**
All individuals selected by applicant are listed		
Comments:		

III. Profile of Applicant	**YES**	**NO**	**COMMENTS**
A. Personal History includes the following description of:			
•Developmental History			
•Family History			
•Educational History			
•Work History			
•Unique Characteristics and Strengths			
•Hobbies and Interests			
•Criminal Justice History			

III. Profile of Applicant (cont)	Yes	No	Comments
B. Medical/Functional Information			
1. Diagnosis and Medical Status			
•Mental Health History			
•Substance Abuse History			
2. Impact of disability or illness/injury on applicant			
3. Applicants response to disability/illness, or injury			
4. Medications			
A• All prescriptions and/or over-the-counter medications			
B• Medical Supplies/Durable Medical Equipment (DME)			
•Total Projected Medicaid Monthly Cost (x12) provided			
5. Physicians/Dentist			
6. Management of Medical Needs			
7. Dietary Needs			
8. Visual Ability			
9. Hearing Ability			
10.Communication Skills			
11.Other Needs			
Comments:			
C. Present			
•Goals			
•Hobbies/Interests			
•Culture and/or Religion			
Comments:			

IV. Applicant's Plans For Community Living	YES	NO	COMMENTS
A. Living Situation			
***Type of Dwelling			
B. Anticipated Activities			
Comments:			

V. Current Supports and Services	YES	NO
A. Informal Supports		
•Family		
•Friends		
•Community		
B. Formal Supports		
•All State and Federal non-Medicaid services received or anticipated are listed		
•Information transferred to the Insurance, Resources and Funding Info. form		
•All Medicaid State Plan services received or anticipated described		
•Information transferred to Medicaid State Plan Services chart		
Comments:		

VI. Oversight/Supervision and/or Assistance with ADLs and/or IADLs	YES	NO
A. Applicant needs Oversight/Supervision due to cognitive difficulties		
B. Applicants needing assistance with ADLs/IADLs tasks but no Oversight/Supervision		
C. Alternatives Considered		
Comments:		

VII. Explanation of Need for Waiver Services	YES	NO
Clear description of need for waiver service(s) to prevent Nursing Home placement or transition from Nursing Home		
Comments:		

<u>Instructions</u>: For section VIII, check "yes" or "no" to indicate whether each service requested has been justified, the applicant's desired needs have been identified, the frequency/amount of service clearly indicated, and specific activities targeted.U*se* N/A (not applicable) to indicate whenever a particular service was not requested.**

VIII. Requested Waiver Services	YES	NO	N/A	COMMENTS
•Service Coordination				
•Assistive Technology				

VIII. Requested Waiver Services (cont.)	YES	NO	N/A	COMMENTS
•Community Integration Counseling (CIC)				
•Community Transitional Service (CTS)				
•Congregate and Home Delivered Meals				
•Environmental Modifications (E-Mods)				
•Home and Community Support Services (HCSS)				
•Home Visits by Medical Personnel				
•Independent Living Skills Training (ILST)				
•Moving Assistance				
•Nutritional Counseling/Educational Services				
•Peer Mentoring				
•Positive Behavioral Intervention and Supports (PBIS)				
•Respiratory Therapy				
•Respite Services				
•Structured Day Program Services				
•Wellness Counseling Services				

IX. Medicaid State Plan Services	YES	NO	N/A
•All Medicaid State Plan Services items listed in the chart			
Comments:			
•The Consumer Directed Personal Assistance Program (CDPAP) is included in the ISP			

X. Waiver Services and Projected Total Projected Annual Costs for ISP		YES	NO
•Waiver Service(s)			
•Provider(s)			
•Effective Date			
•Frequency and Duration			
•Annual Amount of Units			
•Rate of each service	$		
•Total Projected Medicaid Annual Cost	$		
Comments:			

XI. Projected Total Annual Costs for ISP		YES	NO
•Total Medicaid Costs of Medicaid State Plan Services	$		
•Total Medicaid Costs of Waiver Services	$		
•Total Medicaid Annual Cost of Medicaid Spend-down incurred	$		
•Total Medicaid Annual Cost of all Medicaid Services	$		
•Total Medicaid Daily Rate of all Medicaid Services	$		
Comments:			

XII. Projected Weekly Schedule of All Services	YES	NO
•All Services are documented appropriately		
Comments:		

RRDS Recommendation:

____ Corrections needed
____ Submit to QMS

Final Decision by RRDS

____ Approved
____ Denied
DOH WMS Notified: ____/____/____
Date NOD – Denial of Waiver Program Sent: ____/____/____
____ Withdrawn by Applicant

If Application has been denied or withdrawn, please specify reason:

- ☐ Too physically ill
- ☐ Too cognitively impaired
- ☐ Mental Illness
- ☐ Guardian refused participation
- ☐ Could not locate appropriate housing arrangement
- ☐ Could not secure affordable housing
- ☐ Individual changed his/her mind
- ☐ Individual would not cooperate in Initial Service Plan development
- ☐ Service needs greater than what could be provided in the community
- ☐ Other, specify: _____

Comments: _____

_____

_____

_____

_____

RRDS Reviewer Signature Date

I have received and accept all corrections and/or additional information provided and approve this Initial Service Plan (ISP) and Application Packet.

NOD Issue Date: _____

NOD Effective Date (if applicable): _____

NOD type: _____

Initial Service Plan (ISP) Effective Date: from ____/____/____ to ____/____/____

_____

RRDS Reviewer Signature Date

RRDS REVISED SERVICE PLAN (RSP) REVIEW FORM
HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER

Nursing Home Transition and Diversion (NHTD)

Date: _____

Participant's Name: _____ CIN: _____ Region: _____

SC Coordinator Name: _____ SC agency: _____

Status: received, approved, denied, corrections need RRDS review, QMS reviewed

*RSP Packet Downloaded By RRDS	Date:
*Participant/Legal Guardian signed/dated RSP	Date:
*SC signed RSP	Date:
*SC Supervisor signed RSP	Date:
*RSP Returned to SC for corrections	Date:
*Attachments Returned to SC for Corrections	Date:
*Review Completed by SC	Date:
*Received by RRDS from SC with corrections	Date:
Submission to QMS (if applicable) over $300/day Submission to QMS for consultation	Date: Date:
Returned to RRDS from QMS	Date:
*Final Decision by RRDS	Date:

Attachments	**Signed and Completed**	**Comments**
Medicaid eligibility verification Co._____	**Date** __/__/__ **__Y __N**	_____
PRI/SCREEN	**Date** __/__/__ **__Y __N __ N/A**	_____
LOC appropriate for eligibility?	**__Y __N**	_____
Participant Rights/Responsibilities	**Date** __/__/__ **__Y __N __ N/A**	_____
Provider Selection form(s)	**Date** __/__/__ **__Y __N __ N/A**	_____
Plan for Protective Oversight	**Date** __/__/__ **__Y __N**	_____
Insurance, Resource and Funding form	**Date** __/__/__ **__Y __N**	_____

Additional Comments: _____

_____

INSTRUCTIONS: For each of the following sections, please indicate whether the RSP has been completed correctly by checking YES or NO. If NO is selected, use the COMMENTS area to document corrections that are needed. For questions that are not applicable to the participant, document "N/A" under Comments column. YES NO N/A Comments

SERVICE PLAN:

I. Identification	**YES**	**NO**
All identification items are completed		
Comments:		

II. Individuals Selected by the Participant to Participate in RSP Development	**YES**	**NO**
All individuals selected by participant are listed		
Comments:		

III. Profile of Participant	**YES**	**NO**	**N/A**	**COMMENTS**
A. Medical/Functional Information				
•Medical				
•Physical				
•Cognitive				
•Behavioral				
•Psychiatric				
•Substance Abuse				
•Criminal Justice				

III. Profile of Participant

B. Medical/Functional Information (cont)	YES	NO	N/A	COMMENTS
How does the participant view his/her life in the community during the last Service Plan period				
Discuss any changes in significant relationships that have occurred during last Service Plan period				
Describe whether the participant's involvement in community activities have met the expectation of the last Service Plan and any changes anticipated for the next Service Plan period				
Describe any other Successes/Setbacks/Concerns participant has experienced including the participant's view regarding overall status, successes, goals, etc. during the last Service Plan period				
Describe the Service Coordinator's overall impression regarding the effectiveness of the last Service Plan in meeting the participant's health and welfare, and goals				
1. Medications				
• All prescriptions and/or over-the-counter medications				
2. Medical Supplies/Durable Medical Equipment (DME)				
•Total Projected Medicaid Monthly Cost (x12) provided				
3. Does medication regime differ from last Service Plan?				
4. What is current plan to assist participant with medication administration?				
5. Physicians/Dentist				
6. Management of Medical Needs				
7. Dietary Needs				
8. Visual Ability				
9. Hearing Ability				
10.Communication Skills				
11.Other Needs				

IV. Current Community Living Situation

***List any changes to participant's living situation since last service plan**		
***Type of Dwelling Participant Currently Resides In**		
Comments:		

IV. Current Supports and Services	**YES**	**NO**
a. Social/Informal Supports		
•Family		
•Friends		
•Community		
b. Formal Supports		
c. Medicaid State Plan Services		
• CDPAP		
Comments:		

V. Oversight/Supervision and/or Assistance with ADLs and/or IADLs	**YES**	**NO**
A. Applicants needing Oversight/Supervision for cognitive needs		
B. Applicants needing assistance with ADLs/IADLs tasks but no Oversight/Supervision		
C. Alternatives Considered		
Comments:		

VI. Explanation of Need for Waiver Services	**YES**	**NO**
Clear description of need for waiver service(s) to prevent Nursing Home placement or transition from Nursing Home		
Comments:		

VII. Service Coordination Overview of Waiver Services	**YES**	**NO**	**N/A**	**COMMENTS**
1a. Describe which of the following services were used in the last Service Plan and include the accomplished goals for each				
1b. Describe which of the following services will continue to be utilized in this Service Plan including desired goals, justification of need, and the frequency/amount of each service				
2. List all waiver services that will continue from the last Service Plan				

•An ISR is attached to this Service Plan for each service listed				
3. Describe any new service(s) requested in this Service Plan				
•Each service has been listed in the corresponding chart				
For each new service requested in this Service Plan, list each service in the following boxes and indicate if all information provided is appropriate:				
Service:				
Service:				
Service:				
Service:				

VII. Service Coordination Overview of Waiver Services	**YES**	**NO**	**N/A**	**COMMENTS**

VIII. Medicaid State Plan Services and Cost Projection	**YES**	**NO**	**N/A**
•All Medicaid State Plan Services items listed			
Comments:			

IX. Waiver Services and Cost Projection		**YES**	**NO**
•Waiver Service(s)			
•Provider(s)			
•Effective Date			
•Frequency and Duration			
•Annual Amount of Units			
•Rate of each service	$		
•Total Projected Medicaid Annual Cost	$		
Comments:			

X. Projected Total Annual Costs for RSP		YES	NO
•Total Medicaid Costs of Medicaid State Plan Services	$		
•Total Medicaid Costs of Waiver Services	$		
•Total Medicaid Annual Cost of Medicaid Spend-down incurred	$		
•Total Medicaid Annual Cost of all Medicaid Services	$		
•Total Medicaid daily Rate of all Medicaid Services	$		
Comments:			

XI. Projected Weekly Schedule of All Services	YES	NO
•All Services are documented appropriately		
Comments:		

XII. Waiver Services Comparison Chart	YES	NO
•Chart is completed according to instructions		
Comments:		

Money Follows the Person (MFP) Housing Supplement	YES	NO
Low income housing tax credits		
HOME dollars		
CDBG funds		
Housing choice vouchers (such as tenant based, project based, mainstream or homeownership vouchers)		
Housing trust funds		
Section 811		
202 funds		
USDA rural housing funds		
Veterans Affairs housing funds		
Funds for home modifications		
Funds for assistive technology as it relates to housing		
Other, specify:		

RRDS Recommendation:

____ Approved
____ Denied
____ Corrections needed
____ Submit to QMS

Comments: _____

_____

_____

_____

_____

_____

_____

_____
RRDS Reviewer Signature Date

I have received and accept all corrections and/or additional information provided and approve this Revised Service Plan (RSP).

NOD Issue Date (if applicable): _____

NOD Effective Date (if applicable): _____

NOD type (if applicable): _____

Revised Service Plan (RSP) Effective Date: from _____/____/_____ to _____/____/_____

_____
RRDS Reviewer Signature Date

RRDS ADDENDUM REVIEW FORM
HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER

Nursing Home Transition and Diversion (NHTD)

Date: _____

Participant's Name: _____ CIN: _____ Region: _____

SC Coordinator Name:_____ SC agency:_____

Current Service Plan period _____to _____

Status: received, approved, denied, withdrawn, corrections needed RRDS review, QMS reviewed

*Addendum received by the RRDS	Date:
*Participant/Legal Guardian signed/dated Addendum	Date:
*SC/SC Supervisor signed Addendum	Date:
*Returned to SC for corrections	Date:
*Received by RRDS from the SC with corrections	Date:
Submission to QMS (if applicable) over $300/day Submission to QMS for consultation	Date: Date:
Returned to RRDS from QMS	Date:
*Final Decision by RRDS	Date:

Attachments	**Signed and Completed**	**Comments**
Functional Assessment, if needed	**Date** __/__/__ **__Y __N __ N/A**	_____
Revised Waiver Contact List	**__Y __N __ N/A**	_____
Insurance, Resource, Funding form	**Date** __/__/__ **__Y __N __ N/A**	_____
Provider Selection form(s)	**Date** __/__/__ **__Y __N __ N/A**	_____
Plan for Protective Oversight	**Date** __/__/__ **__Y __N**	_____

Additional Comments: _____

_____

INSTRUCTIONS: ***For each of the following sections, please indicate whether the ISP has been completed correctly by checking YES or NO. If NO is selected, use the COMMENTS area to document corrections that are needed. For questions that are not applicable to the participant, document "N/A" under Comments column.***

SERVICE PLAN:

I. Individuals who participated in developing the Addendum	**YES**	**NO**
All individuals selected by participant are listed		
Comments:		

II. Summary of Request for changes in Waiver Services	YES	NO	COMMENTS
A. Describe the changes that the participant has experienced which resulted in the need for this Addendum			
B. Describe which services will be added and/or changed Note: ISR attached			
C. Describe what, if any, impact the requested changes in the NHTD waiver service(s) have on the Plan of Protective Oversight			

III. Medicaid State Plan Services	YES	NO	COMMENTS
•All Medicaid State Plan Services items listed			
Comments:			

IV. Waiver Services and Cost Projection		YES	NO
•Waiver Service(s)			
• Provider(s) name, address, telephone number			
•Effective Date			
•Frequency and Duration			
•Annual Amount of Units			
•Daily Rate of each service	$		
•Total Projected Medicaid Annual Cost	$		

V.. Projected Total Annual Costs for ISP		YES	NO
•Total Medicaid Costs of Medicaid State Plan Services	$		
•Total Medicaid Costs of Waiver Services	$		
•Total Medicaid Annual Cost of Medicaid Spend-down incurred	$		
•Total Medicaid Annual Cost of all Medicaid Services	$		
•Total Medicaid daily Rate of all Medicaid Services	$		
Comments:			

VI. Projected Weekly Schedule of All Services	YES	NO
•All Services are documented appropriately		
Comments:		

RRDS Recommendation:

____ Corrections needed
____ Submit to QMS

Comments: _____

_____

_____

_____

Final Decision by RRDS

____ Approved
____ Denied

I have received and accept all corrections and/or additional information provided and approve this Addendum.

NOD Notice Date: _____

NOD Effective Date: _____

NOD type: _____

Addendum Effective Date: ____/____/____

Current Service Plan period: from _____/____/____ to _____/____/____

_____

RRDS Reviewer Signature Date

(RRDS LETTERHEAD)

Late Individual Service Report (ISR) Notification

Date:

Name of Agency Supervisor:
Name of Agency:
Address of Agency:

Dear ,

The Individual Service Report (ISR) for Nursing Home Transition and Diversion (NHTD) waiver Participant, _____ is now late.

We recognize that many factors can contribute to not submitting the ISR in a timely manner. However, as you know, timely submission of the ISR to the Service Coordinator is imperative to assure the Service Plan is developed comprehensively and to avoid any delay in the provision of services to the participant.

Approval of service provision can not be issued until the required Service Plan is received and approved by the RRDS. In addition, the waiver participant may not be able to access needed services which may result in his/her inability to be maintained safely in the community.

Please submit the required ISR to the Service Coordinator within seven (7) calendar days of the date of this letter. To avoid notification to DOH Waiver Management staff and issuance of a Vendor Hold on your agency, the ISR must be received within this timeframe.

If you have any questions, please contact me at (_____) _____ - _____ .

Sincerely,

Regional Resource Development Specialist

(RRDS LETTERHEAD)

Late Revised Service Plan Notification

Date:

Name of Agency Supervisor:
Name of Agency:
Address of Agency:

Dear ,

The Revised Service Plan for _____, who is a Participant of the NHTD waiver is now late.

We recognize that many factors can contribute to not completing the RSP in a timely manner. However, as you know, the approval of service provision can not be issued until the required RSP is received and approved by the RRDS. The lack of a current RSP may prohibit the waiver participant from accessing needed services, which may result in his/her inability to be maintained safely in the community.

Please submit the required RSP to me within seven (7) calendar days of the date of this letter, to avoid notification to DOH Waiver Management staff and the issuance of a Vendor Hold on your agency.

If you have any questions, please contact me at (_____) _____ - _____ .

Sincerely,

Regional Resource Development Specialist

cc: Service Coordinator

CHANGE OF SERVICE COORDINATOR REQUEST
HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER

Nursing Home Transition and Diversion (NHTD)

I, (Participant Name)_____ (CIN) _____ request to make the following change in Service Coordinator or Service Coordination agency currently providing this service to me.

I have been informed of my right to remain with this current Service Coordinator and/or Service Coordination agency or select a new Service Coordinator or Service Coordination agency from a list of all available waiver service providers for this service.

Current Service Coordinator Name and Telephone	Current Service Coordination Agency and Telephone	Requested Service Coordinator / Agency Name and Telephone

NOTE: THE REGIONAL RESOURCE DEVELOPMENT SPECIALIST (RRDS) MUST CONTACT CURRENT SERVICE COORDINATOR/AGENCY AND THE NEWLY REQUESTED SERVICE COORDINATOR/AGENCY.

Participant Signature _____ Date _____

Legal Guardian Signature (as applicable) _____ Date _____

Authorized Representative Signature (as applicable) _____ Date _____

Current Service Coordinator Signature _____ Date _____

Current SC Supervisor Signature _____ Date _____

Transition Meeting to be held on: ____/____/20____ at _____am / pm

To be completed by the Requested Service Coordinator and/or Requested Service Coordination Agency:

_____ _____ will provide service(s) to the above named participant
Service Coordinator/Agency _____ will not provide service(s) to the above named participant
Reason: _____

_____

_____
Service Coordinator Signature Date

_____
Service Coordination Supervisor Signature Date

To be completed by the Regional Resource Development Specialist:

This request for change in Service Coordinator and/or Service Coordination Agency has been reviewed and:
☐ approved Services to begin effective: ____/____/ 20_____
☐ denied (explanation) _____

_____

Regional Resource Development Specialist Signature _____ Date _____

cc: Participant
Guardian (if applicable)
Authorized Representative (If applicable)
Current Service Coordinator and/or Service Coordination Agency
New Service Coordinator and/or Service Coordination Agency
All current Provider Agencies

HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER
FOR
NURSING HOME TRANSITION AND DIVERSION (NHTD)

NOTICE OF DECISION
AUTHORIZATION

Name & Address of Waiver Participant:	Client Identification Number (CIN): _____ Notice Date: _____

This is to inform you that your participation in the Home and Community-Based Services Medicaid Waiver for Nursing Home Transition and Diversion (NHTD) has been:

AUTHORIZED effective on _____. The services you are authorized to receive are identified in your Service Plan and will be reassessed at least every six (6) months.

The laws that allow us to do this are:

Section 1915(c) of the Social Security Act and, Section 366 (6-a) of the NYS Social Services Law

_____ _____
Regional Resource Development Specialist (Signature) Regional Resource Development Specialist (Print)

_____
Name of Regional Resource Development Center (RRDC)

_____
Address

_____
Address

_____
Telephone

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING, OR BOTH. PLEASE READ THE BACK OF THIS NOTICE TO FIND OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.

cc: Legal Guardian
Authorized Representative
Service Coordinator
NYS DOH NHTD Waiver Program
Social Services District with fiscal responsibility
Social Services District of residence (If different from county of fiscal responsibility)

RIGHT TO CONFERENCE: You may have a conference with the Regional Resource Development Specialist (RRDS) to review these actions. If you want a conference you should ask for one as soon as possible. At the conference, if the RRDS discovers that the wrong decision has been made, or if, because of information you provide, the RRDS decides to change the decision, corrective action will be taken. You will receive a new Notice of Decision. You may ask for a conference by calling the RRDS at the telephone number listed on the first page of this notice or by sending a written request to the address listed on the first page of this notice. ***This is not the way to request a fair hearing.*** If you ask for a conference, you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A Fair Hearing: If you believe that the above action is wrong, you may request a State Fair Hearing by:

1. **Telephone:** You may call the statewide toll free number at 1-800-342-3334. (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL) **OR**

2. **Fax:** Complete and fax a copy of this notice to (518) 473-6735 **OR**

3. **On-Line:** Complete and send the online request form at: https://www.otda.state.ny.us/oah/forms.asp **OR**

   If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, or on-line, please write to ask for a fair hearing before 60 days from the date of this notice.

4. **Mail:** Complete and send a copy of this notice to the Fair Hearing Section, New York State Office of Temporary Disability Assistance, P. O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

5. **New York City ONLY:** You may also walk-in to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 14 Boerum Place, Brooklyn, New York **or** 330 West 34th Street, 3rd. Floor, NY, NY. Bring a copy of this notice with you.

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING
If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend, or other person or 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. Also, you have the right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

☐ I want a fair hearing. The decision is wrong because: _____

_____

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your Legal Aid Society of other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking the yellow pages of your telephone book under “lawyer.”

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your file. If you call or write to the RRDS, they will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. Also, if you call or write to the RRDS, they will provide you with free copies of other documents from your file, which you think you may need for your fair hearing. To ask for documents or to find out how to look at your file, call or write to the RRDS at the telephone number and address listed on the front page of this Notice. If you want copies of documents from your file, you should ask for them within a reasonable time before the date of the fair hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your file, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, please call or write the RRDS at the telephone number and address listed on the front page of this Notice.

Print Name _____ Client Identification Number (CIN) _____

Address _____ Telephone _____

Signature _____ Date _____

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

HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER
FOR
NURSING HOME TRANSITION AND DIVERSION (NHTD)

NOTICE OF DECISION
DENIAL OF WAIVER PROGRAM

Name & Address of Waiver Applicant:

Client Identification Number (CIN): _____

Notice Date: _____

This is to inform you that your application for participation in the Home and Community-Based Services Medicaid Waiver for Nursing Home Transition and Diversion (NHTD) has been **DENIED.**

Your participation in the NHTD waiver has been **DENIED** for the following reason(s):

_____

_____

The laws that allows us to do this are:
Section 1915(c) of the Social Security Act and, Section 366 (6-a) of the Social Services Law.

_____ _____
Regional Resource Development Specialist (Signature) Regional Resource Development Specialist (Print)

_____
Name of Regional Resource Development Center (RRDC)

_____
Address

_____
Address

_____
Telephone

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING, OR BOTH. PLEASE READ THE BACK OF THIS NOTICE TO FIND OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.

cc: Legal Guardian
Authorized Representative
NYS DOH NHTD Waiver Program
Service Coordinator
Social Services District with fiscal responsibility
Social Services District in county of residence (If different from county of fiscal responsibility)

RIGHT TO CONFERENCE: You may have a conference with the Regional Resource Development Specialist (RRDS) to review these actions. If you want a conference you should ask for one as soon as possible. At the conference, if the RRDS discovers that the wrong decision has been made, or if, because of information you provide, the RRDS decides to change the decision, corrective action will be taken. You will receive a new Notice of Decision. You may ask for a conference by calling the RRDS at the telephone number listed on the first page of this notice or by sending a written request to the address listed on the first page of this notice. ***This is not the way to request a fair hearing.*** If you ask for a conference, you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A Fair Hearing: If you believe that the above action is wrong, you may request a State Fair Hearing by:

1. **Telephone:** You may call the statewide toll free number at 1-800-342-3334. (PLEASE HAVE THIS NOTICE WITH WITH YOU WHEN YOU CALL) **OR**

2. **Fax:** Complete and fax a copy of this notice to (518) 473-6735 **OR**

3. **On-Line:** Complete and send the online request form at: https://www.otda.state.ny.us/oah/forms.asp **OR**

   If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, or on-line, please write to ask for a fair hearing before 60 days from the date of this notice.

4. **Mail:** Complete and send a copy of this notice to the Fair Hearing Section, New York State Office of Temporary Disability Assistance, P. O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

5. **New York City ONLY:** You may also walk-in to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 14 Boerum Place, Brooklyn, New York **or** 330 West 34th Street, 3rd. Floor, NY, NY. Bring a copy of this notice with you.

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING
If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend, or other person or 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. Also, you have the right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

☐ I want a fair hearing. The decision is wrong because: _____

_____

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your Legal Aid Society of other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking the yellow pages of your telephone book under “lawyer.”

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your file. If you call or write to the RRDS, they will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. Also, if you call or write to the RRDS, they will provide you with free copies of other documents from your file, which you think you may need for your fair hearing. To ask for documents or to find out how to look at your file, call or write to the RRDS at the telephone number and address listed on the front page of this Notice. If you want copies of documents from your file, you should ask for them within a reasonable time before the date of the fair hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your file, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, please call or write the RRDS at the telephone number and address listed on the front page of this Notice.

Print Name _____ Client Identification Number (CIN) _____

Address _____ Telephone _____

Signature _____ Date _____

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

HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER
FOR
NURSING HOME TRANSITION AND DIVERSION (NHTD)

NOTICE OF INTENT TO DISCONTINUE FROM THE WAIVER PROGRAM

Name & Address of Waiver Participant:	Client Identification Number (CIN): _____ Notice Date: _____ Effective Date: _____

This is to inform you that your participation in the Home and Community-Based Services Medicaid Waiver for Nursing Home Transition and Diversion (NHTD) is being **DISCONTINUED** as of the Effective Date above.

Your participation in the waiver is being **DISCONTINUED** because you have chosen to no longer receive waiver services(s).

Explanation:

_____

_____

The laws that allows us to do this are:

Section 1915(c) of the Social Security Act and, Section 366 (6-a) of the Social Services Law.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING, OR BOTH. PLEASE READ THE BACK OF THIS NOTICE TO FIND OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.

_____ _____
Regional Resource Development Specialist (Signature) Regional Resource Development Specialist (Print)

_____
Name of Regional Resource Development Center (RRDC)

_____
Address

_____
Address

_____
Telephone

cc: Legal Guardian
Authorized Representative
Service Coordinator
NYS DOH NHTD Waiver Program
Social NEW Services District with fiscal responsibility
Social Services District in county of residence (If different from county of fiscal responsibility)

RIGHT TO CONFERENCE: You may have a conference with the Regional Resource Development Specialist (RRDS) to review these actions. If you want a conference you should ask for one as soon as possible. At the conference, if the RRDS discovers that the wrong decision has been made, or if, because of information you provide, the RRDS decides to change the decision, corrective action will be taken. You will receive a new Notice of Decision. You may ask for a conference by calling the RRDS at the telephone number listed on the first page of this notice or by sending a written request to the address listed on the first page of this notice. ***This is not the way to request a fair hearing.*** If you ask for a conference, you are still entitled to a fair hearing. Read below for fair hearing information.

If you only ask for a Conference, we will not keep your benefits the same while you appeal. Your benefits will stay the same only if you ask for a fair hearing. (See Continuing Your Benefits)

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

1. **Telephone:** You may call the statewide toll free number at 1-800-342-3334. (PLEASE HAVE THIS NOTICE WITH WITH YOU WHEN YOU CALL) **OR**
2. **Fax:** Complete and fax a copy of this notice to (518) 473-6735 **OR**
3. **On-Line:** Complete and send the online request form at: https://www.otda.state.ny.us/oah/forms.asp **OR**

   If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, or on-line, please write to ask for a fair hearing before 60 days from the date of this notice.
4. **Mail:** Complete and send a copy of this notice to the Fair Hearing Section, New York State Office of Temporary Disability Assistance, P. O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.
5. **New York City ONLY:** You may also walk-in to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 14 Boerum Place, Brooklyn, New York **or** 330 West 34th Street, 3rd. Floor, NY, NY. Bring a copy of this notice with you.

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING.

If you request a fair hearing, the State will send you a notice informing you of the time and place of 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. Also, you have the right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

☐ I want a fair hearing. The decision is wrong because: _____

_____

CONTINUING YOUR BENEFITS: If you request a Fair Hearing before the Effective Date stated on the front page of this Notice, you will continue to receive your benefits unchanged until the fair hearing decision is issued. However, if you lose the Fair Hearing, New York State may recover the cost of any Medical Assistance benefits that you should not have received.

☐ I want to continue my Medical Assistance benefits until the Fair Hearing decision is issued.

If you do NOT want your Medical Assistance benefits to continue while waiting for the decision of the fair hearing, check the box below and send this page to the Fair Hearing Section, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York, 12201.

☐ I do NOT want to continue my Medical Assistance benefits while waiting for the decision of the Fair Hearing. I understand if I lose the Fair Hearing I may be responsible for the cost of any Medical Assistance benefits that the Fair Hearing determines I should not have received.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking the yellow pages of your telephone book under "lawyers."

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your file. If you call or write to the RRDS, they will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. Also, if you call or write to the RRDS, they will provide you with free copies of other documents from your file, which you think you may need for your fair hearing. To ask for documents or to find out how to look at your file, call or write to the RRDS at the telephone number and address listed on the front page of this Notice. If you want copies of documents from your file, you should ask for them within a reasonable time before the date of the fair hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your file, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, please call or write the RRDS at the telephone number and address listed on the front page of this Notice.

Print Name _____ Client Identification Number (CIN) _____

Address _____ Telephone _____

Signature _____ Date _____

HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER
FOR
NURSING HOME TRANSITION AND DIVERSION (NHTD)

NOTICE OF INTENT TO DISCONTINUE FROM THE WAIVER PROGRAM

Name & Address of Waiver Participant:	Client Identification Number (CIN): _____ Notice Date: _____ Effective Date: _____

This is to inform you that your participation in the Home and Community-Based Services Medicaid Waiver for Nursing Home Transition and Diversion (NHTD) is being **DISCONTINUED** as of the Effective Date above.

Your participation in the waiver is being **DISCONTINUED** because:

☐ You are determined to no longer be eligible for nursing home level of care, per H/C Patient Review Instrument and SCREEN.

☐ Waiver services cannot safely maintain you in the community.

☐ You do not have a current Service Plan.

☐ Other: _____

Explanation:

_____

_____

The laws that allows us to do this are:
Section 1915(c) of the Social Security Act and, Section 366 (6-a) of the Social Services Law.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING, OR BOTH. PLEASE READ THE BACK OF THIS NOTICE TO FIND OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.

_____ _____
Regional Resource Development Specialist (Signature) Regional Resource Development Specialist (Print)

_____
Name of Regional Resource Development Center (RRDC)

_____
Address

_____
Address

_____
Telephone

cc: Legal Guardian
Authorized Representative
Service Coordinator
NYS DOH NHTD Waiver Program
Social Services District with fiscal responsibility
Social Services District in county of residence (If different from county of fiscal responsibility)

RIGHT TO CONFERENCE: You may have a conference with the Regional Resource Development Specialist (RRDS) to review these actions. If you want a conference you should ask for one as soon as possible. At the conference, if the RRDS discovers that the wrong decision has been made, or if, because of information you provide, the RRDS decides to change the decision, corrective action will be taken. You will receive a new Notice of Decision. You may ask for a conference by calling the RRDS at the telephone number listed on the first page of this notice or by sending a written request to the address listed on the first page of this notice. ***This is not the way to request a fair hearing.*** If you ask for a conference, you are still entitled to a fair hearing. Read below for fair hearing information.

If you only ask for a Conference, we will not keep your benefits the same while you appeal. Your benefits will stay the same only if you ask for a fair hearing. (See Continuing Your Benefits)

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

1. **Telephone:** You may call the statewide toll free number at 1-800-342-3334. (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL) **OR**

2. **Fax:** Complete and fax a copy of this notice to (518) 473-6735 **OR**

3. **On-Line:** Complete and send the online request form at: https://www.otda.state.ny.us/oah/forms.asp **OR**

   If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, or on-line, please write to ask for a fair hearing before 60 days from the date of this notice.

4. **Mail:** Complete and send a copy of this notice to the Fair Hearing Section, New York State Office of Temporary Disability Assistance, P. O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

5. **New York City ONLY:** You may also walk-in to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 14 Boerum Place, Brooklyn, New York **or** 330 West 34th Street, 3rd. Floor, NY, NY. Bring a copy of this notice with you.

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING.

If you request a fair hearing, the State will send you a notice informing you of the time and place of 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. Also, you have the right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

☐ I want a fair hearing. The decision is wrong because: _____

_____

CONTINUING YOUR BENEFITS: If you request a Fair Hearing before the Effective Date stated in this notice, you will continue to receive your Medical Assistance benefits unchanged until the Fair Hearing decision is issued. However, if you lose the Fair Hearing, you may have to pay back any Medical Assistance benefits you should not have received while waiting for the decision.

☐ I want to continue my Medical Assistance benefits until the Fair Hearing decision is issued.

If you do not want your Medical Assistance benefits to continue until the Fair Hearing decision is issued, you must tell the State when you call for a Fair Hearing, **or** if you send back this notice, check the box below:

☐ I do not want to continue my Medical Assistance benefits until the Fair Hearing decision is issued.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking the yellow pages of your telephone book under "lawyers."

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your file. If you call or write to the RRDS, they will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. Also, if you call or write to the RRDS, they will provide you with free copies of other documents from your file, which you think you may need for your fair hearing. To ask for documents or to find out how to look at your file, call or write to the RRDS at the telephone number and address listed on the front page of this Notice. If you want copies of documents from your file, you should ask for them within a reasonable time before the date of the fair hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your file, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, please call or write the RRDS at the telephone number and address listed on the front page of this Notice.

Print Name _____ Client Identification Number (CIN) _____

Address _____ Telephone _____

Signature _____ Date _____

HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER
FOR
NURSING HOME TRANSITION AND DIVERSION PROGRAM (NHTD)

NOTICE OF DECISION
REDUCTION AND/OR DISCONTINUATION OF WAIVER SERVICE(S)

Name & Address of Waiver Participant:

Client Identification Number (CIN): _____

Notice Date: _____

Effective Date: _____

This notice is for waiver services approved for _____ to _____ as established in your most recent service plan.

1a. ☐ No reduction in waiver services is indicated at this time.
1b. The following waiver service(s) will be **reduced** as of the Effective Date of this notice.

_____	from _____	to _____	
waiver service	hours/frequency	hours/frequency	
_____	from _____	to _____	
waiver service	hours/frequency	hours/frequency	
_____	from _____	to _____	
waiver service	hours/frequency	hours/frequency	

2a. ☐ No discontinuation of waiver services is indicated at this time.
2b. The following waiver service(s) will be **discontinued** as of the Effective Date on this notice.

_____	_____
waiver service	waiver service
_____	_____
waiver service	waiver service
_____	_____
waiver service	waiver service

3a. We intend to take the action(s) identified above because:

_____

_____

The laws that allows us to do this are:
Section 1915(c) of the Social Security Act and, Section 366 (6-a) of the Social Services Law.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING OR BOTH. PLEASE READ THE BACK OF THIS NOTICE TO FIND OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.

_____ _____
Regional Resource Development Specialist (Signature) Regional Resource Development Specialist (Print)

_____
Name of Regional Resource Development Center (RRDC)

_____ _____
Address Telephone

_____
Address

cc: Legal Guardian
Authorized Representative
Service Coordinator
NYS DOH NHTD Waiver Program

RIGHT TO CONFERENCE: You may have a conference with the Regional Resource Development Specialist (RRDS) to review these actions. If you want a conference you should ask for one as soon as possible. At the conference, if the RRDS discovers that the wrong decision has been made, or if, because of information you provide, the RRDS decides to change the decision, corrective action will be taken. You will receive a new Notice of Decision. You may ask for a conference by calling the RRDS at the telephone number listed on the first page of this notice or by sending a written request to the address listed on the first page of this notice. ***This is not the way to request a fair hearing.*** If you ask for a conference, you are still entitled to a fair hearing. Read below for fair hearing information.

If you only ask for a Conference, we will not keep your benefits the same while you appeal. Your benefits will stay the same only if you ask for a fair hearing. (See Continuing Your Benefits).

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

1. **Telephone:** You may call the statewide toll free number at 1-800-342-3334. (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL) **OR**

2. **Fax:** Complete and fax a copy of this notice to (518) 473-6735 **OR**

3. **On-Line:** Complete and send the online request form at: https://www.otda.state.ny.us/oah/forms.asp **OR**

   If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, or on-line, please write to ask for a fair hearing before 60 days from the date of this notice.

4. **Mail:** Complete and send a copy of this notice to the Fair Hearing Section, New York State Office of Temporary Disability Assistance, P. O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

5. **New York City ONLY:** You may also walk-in to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 14 Boerum Place, Brooklyn, New York **or** 330 West 34th Street, 3rd. Floor, NY, NY. Bring a copy of this notice with you.

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING.

If you request a fair hearing, the State will send you a notice informing you of the time and place of 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. Also, you have the right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

☐ I want a fair hearing. The decision is wrong because:_____

_____

CONTINUING YOUR BENEFITS: If you request a Fair Hearing before the Effective Date stated in this notice, you will continue to receive your Medical Assistance benefits unchanged until the Fair Hearing decision is issued. However, if you lose the Fair Hearing, you may have to pay back any Medical Assistance benefits you should not have received while waiting for the decision.

☐ I want to continue my Medical Assistance benefits until the Fair Hearing decision is issued for (specify action(s) from changes on page 1 above):

_____

_____

_____

If you do not want your Medical Assistance to continue until the Fair Hearing decision is issued, you must tell the State when you call for a Fair Hearing, **or** if you send back this notice, check the box below:

☐ I do not want to continue my Medical Assistance benefits until the Fair Hearing decision is issued.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking the yellow pages of your telephone book under "lawyers."

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your file. If you call or write to the RRDS, they will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. Also, if you call or write to the RRDS, they will provide you with free copies of other documents from your file, which you think you may need for your fair hearing. To ask for documents or to find out how to look at your file, call or write to the RRDS at the telephone number and address listed on the front page of this Notice. If you want copies of documents from your file, you should ask for them within a reasonable time before the date of the fair hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your file, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, please call or write the RRDS at the telephone number and address listed on the front page of this Notice.

Print Name _____ Client Identification Number (CIN) _____

Address _____ Telephone _____

Signature _____ Date _____

HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER
FOR
NURSING HOME TRANSITION AND DIVERSION (NHTD)

NOTICE OF DECISION
INCREASE AND/OR ADDITION OF WAIVER SERVICE(S)

Name & Address of Waiver Participant:

Client Identification Number (CIN): _____

Notice Date: _____

Effective Date: _____

This notice is for waiver services approved for _____ to _____ as set forth in your most recent service plan:

1a. ☐ No increase in waiver service(s) indicated at this time.
1b. The following waiver service(s) will be **increased** as of the Effective Date of this notice:

_____ from: _____ to: _____
waiver service hours/frequency hours/frequency

_____ from: _____ to: _____
waiver service hours/frequency hours/frequency

_____ from: _____ to: _____
waiver service hours/frequency hours/frequency

2a. ☐ No addition of waiver service(s) indicated at this time.
2b. The following waiver service(s) will be **added** as of the Effective Date of this notice:

_____ at: _____
waiver service hours/frequency

_____ at: _____
waiver service hours/frequency

_____ at: _____
waiver service hours/frequency

3. We intend to take the action(s) identified above because:

_____

_____

The laws that allows us to do this are:
Section 1915(c) of the Social Security Act and, Section 366 (6-a) of the Social Services Law.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING, OR BOTH. PLEASE READ THE REST OF THIS NOTICE TO FIND OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.

_____ _____
Regional Resource Development Specialist (Signature) Regional Resource Development Specialist (Print)

_____ _____
Name of Regional Resource Development Center (RRDC) Telephone

_____
Address

cc: Legal Guardian
Authorized Representative
Service Coordinator

RIGHT TO 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 the Regional Resource Development Specialist (RRDS) discovers that the wrong decision has been made, or if, because of information you provide, the RRDS decides to change the decision, corrective action will be taken. You will receive a new Notice of Decision. You may ask for a conference by calling the RRDS at the telephone number listed on the first page of this notice or by sending a written request to the address listed on the first page of this notice. ***This is not the way to request a fair hearing.*** If you ask for a conference, you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

1. **Telephone:** You may call the statewide toll free number at 1-800-342-3334. (PLEASE HAVE THIS NOTICE WITH WITH YOU WHEN YOU CALL) **OR**

2. **Fax:** Complete and fax a copy of this notice to (518) 473-6735 **OR**

3. **On-Line:** Complete and send the online request form at: https://www.otda.state.ny.us/oah/forms.asp **OR**

   If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, or on-line, please write to ask for a Fair Hearing before 60 days from the date of this notice.

4. **Mail:** Complete and send a copy of this notice to the Fair Hearing Section, New York State Office of Temporary Disability Assistance, P. O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

5. **New York City ONLY:** You may also walk-in to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 14 Boerum Place, Brooklyn, New York **or** 330 West 34th Street, 3rd. Floor, NY, NY. Bring a copy of this notice with you.

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING.
If you request a fair hearing, the State will send you a notice informing you of the time and place of 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. Also, you have the right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

☐ I want a fair hearing. The decision is wrong because: _____

_____

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking the yellow pages of your telephone book under “lawyers.”

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your file. If you call or write to the RRDS, they will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. Also, if you call or write to the RRDS, they will provide you with free copies of other documents from your file, which you think you may need for your fair hearing. To ask for documents or to find out how to look at your file, call or write to the RRDS at the telephone number and address listed on the front page of this Notice. If you want copies of documents from your file, you should ask for them within a reasonable time before the date of the fair hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your file, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, please call or write the RRDS at the telephone number and address listed on the front page of this Notice.

Print Name _____ Client Identification Number (CIN) _____

Address _____ Telephone _____

Signature _____ Date _____

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

HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER
FOR
NURSING HOME TRANSITION AND DIVERSION (NHTD)

NOTICE OF DECISION
SUSPENSION

Client Identification Number (CIN): _____

Name and Address of Waiver Participant

Notice Date: _____

Effective Date: _____

This is to inform you that your participation in the Home and Community-Based Services Medicaid Waiver for Nursing Home Transition and Diversion (NHTD) is being **SUSPENDED** as of the Effective Date above.

Your participation in the waiver is being **SUSPENDED** because:

☐ You have been hospitalized;

☐ You have been admitted into a Nursing Home;

☐ You are incarcerated;

☐ You have been admitted into an inpatient psychiatric or substance abuse facility;

☐ You have been admitted into an Intermediate Care Facility for persons with developmental disabilities

☐ Other: _____

Explanation:

_____

_____

The laws that allows us to do this are:
Section 1915(c) of the Social Security Act and, Section 366 (6-a) of the Social Services Law.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING, OR BOTH. PLEASE READ THE BACK OF THIS NOTICE TO FIND OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.

_____ _____
Regional Resource Development Specialist (Signature) Regional Resource Development Specialist (Print)

_____
Name of Regional Resource Development Center (RRDC)

_____
Address

_____
Address

_____
Telephone

cc: Legal Guardian
Authorized Representative
Service Coordinator
NYS DOH NHTD Waiver Program

RIGHT TO CONFERENCE: You may have a conference with the Regional Resource Development Specialist (RRDS) to review these actions. If you want a conference you should ask for one as soon as possible. At the conference, if the RRDS discovers that the wrong decision has been made, or if, because of information you provide, the RRDS decides to change the decision, corrective action will be taken. You will receive a new Notice of Decision. You may ask for a conference by calling the RRDS at the telephone number listed on the first page of this notice or by sending a written request to the address listed on the first page of this notice. ***This is not the way to request a fair hearing.*** If you ask for a conference, you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

1. **Telephone:** You may call the statewide toll free number at 1-800-342-3334. (PLEASE HAVE THIS NOTICE WITH WITH YOU WHEN YOU CALL) **OR**

2. **Fax:** Complete and fax a copy of this notice to (518) 473-6735 **OR**

3. **On-Line:** Complete and send the online request form at: https://www.otda.state.ny.us/oah/forms.asp **OR**

   If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, or on-line, please write to ask for a fair hearing before 60 days from the date of this notice.

4. **Mail:** Complete and send a copy of this notice to the Fair Hearing Section, New York State Office of Temporary Disability Assistance, P. O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

5. **New York City participants ONLY:** You may also walk-in to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 14 Boerum Place, Brooklyn, New York **or** 330 West 34th Street, 3rd. Floor, NY, NY. Bring a copy of this notice with you.

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING.
If you request a fair hearing, the State will send you a notice informing you of the time and place of 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. Also, you have the right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

☐ I want a fair hearing. The decision is wrong because: _____

_____

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking the yellow pages of your telephone book under “lawyers.”

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your file. If you call or write to the RRDS, they will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. Also, if you call or write to the RRDS, they will provide you with free copies of other documents from your file, which you think you may need for your fair hearing. To ask for documents or to find out how to look at your file, call or write to the RRDS at the telephone number and address listed on the front page of this Notice. If you want copies of documents from your file, you should ask for them within a reasonable time before the date of the fair hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your file, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, please call or write the RRDS at the telephone number and address listed on the front page of this Notice.

Print Name _____ Client Identification Number (CIN) _____

Address _____ Telephone _____

Signature _____ Date _____

HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER
FOR
NURSING HOME TRANSITION AND DIVERSION (NHTD)

NOTICE OF DECISION
DENIAL OF A WAIVER SERVICE and/or
DENIAL OF A WAIVER PROVIDER

Name & Address of Waiver Participant:

Client Identification Number (CIN): _____

Notice Date: _____

Effective Date: _____

1. Your request for the following NHTD waiver service(s) has been denied:

Service(s) requested: _____

We intend to take this action because:

2. Your request for the following NHTD waiver provider has been denied:

Provider requested: _____

We intend to take this action because: _____

The laws that allows us to do this are:
Section 1915(c) of the Social Security Act and Section 366 (6-a) of the Social Services Law.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING, OR BOTH. PLEASE READ THE REST OF THIS NOTICE TO FIND OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.

_____ _____
Regional Resource Development Specialist (Signature) Regional Resource Development Specialist (Print)

_____
Name of Regional Resource Development Center (RRDC)

_____
Address

_____
Address

_____
Telephone

cc: Legal Guardian
Authorized Representative
Service Coordinator
NYS DOH NHTD Waiver Program

RIGHT TO CONFERENCE: You may have a conference with the Regional Resource Development Specialist (RRDS) to review these actions. If you want a conference you should ask for one as soon as possible. At the conference, if the RRDS discovers that the wrong decision has been made, or if, because of information you provide, the RRDS decides to change the decision, corrective action will be taken. You will receive a new Notice of Decision. You may ask for a conference by calling the RRDS at the telephone number listed on the first page of this notice or by sending a written request to the address listed on the first page of this notice. ***This is not the way to request a fair hearing.*** If you ask for a conference, you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

1. **Telephone:** You may call the statewide toll free number at 1-800-342-3334. (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL) **OR**
2. **Fax:** Complete and fax a copy of this notice to (518) 473-6735 **OR**
3. **On-Line:** Complete and send the online request form at: https://www.otda.state.ny.us/oah/forms.asp **OR**

   If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, or on-line, please write to ask for a fair hearing before 60 days from the date of this notice.
4. **Mail:** Complete and send a copy of this notice to the Fair Hearing Section, New York State Office of Temporary Disability Assistance, P. O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.
5. **New York City ONLY:** You may also walk-in to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 14 Boerum Place, Brooklyn, New York **or** 330 West 34th Street, 3rd. Floor, NY, NY. Bring a copy of this notice with you.

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☐ I want a fair hearing. The decision is wrong because: _____

_____

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking the yellow pages of your telephone book under “lawyers.”

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your file. If you call or write to the RRDS, they will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. Also, if you call or write to the RRDS, they will provide you with free copies of other documents from your file, which you think you may need for your fair hearing. To ask for documents or to find out how to look at your file, call or write to the RRDS at the telephone number and address listed on the front page of this Notice. If you want copies of documents from your file, you should ask for them within a reasonable time before the date of the fair hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your file, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, please call or write the RRDS at the telephone number and address listed on the front page of this Notice.

Print Name _____ Client Identification Number (CIN) _____

Address _____ Telephone _____

Signature _____ Date _____

HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER
FOR
NURSING HOME TRANSITION AND DIVERSION (NHTD)

NOTIFICATION OF DEATH OF A WAIVER PARTICIPANT TO LOCAL DEPARTMENT OF SOCIAL SERVICES

Name & Address of Waiver Participant:	Client Identification Number (CIN): _____ Notice Date: _____

This is to inform you that the individual name above is discontinued from the Nursing Home Transition and Diversion waiver due to the death of the waiver participant on _____.
(date)

_____ _____
Regional Resource Development Specialist (Signature) Regional Resource Development Specialist (Print)

_____
Name of Regional Resource Development Center (RRDC)

_____
Address

_____
Address

_____
Telephone

cc: Service Coordinator
NYS DOH NHTD Waiver Program
Social Services District with fiscal responsibility
Social Services District in county of residence (If different from county of fiscal responsibility)

INITIAL SERVICE PLAN

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Date: ____/____/____ Ref. #: _____

1. Identification

Applicant Name: ☐ Mr. ☐ Mrs. ☐ Ms _____
(First/MI/Last/Generational Suffixes)

Date of Birth: _____

CIN: _____ County of Fiscal Responsibility: _____ Verified ☐ Yes ☐ No
***Attach documented proof of Medicaid eligibility**

Address: _____
Street

_____
City County State Zip

Mailing Address (if different from above): _____

Phone: Home (____) _____ Work (____) _____ Cell (____) _____

Check boxes that apply:

☐ Transition ☐ Diversion ☐ In-State ☐ Out-of-state

2. Individuals selected by the applicant to participate in developing this Service Plan

Name	Relationship to Applicant	Telephone

INITIAL SERVICE PLAN

3. **Profile of Applicant** (use "N/A" for any sections that do not apply. Do not leave blank)

A. <u>Personal History</u> (Use additional pages for explanations, if needed)

- **Developmental History** (Include any significant events)

- **Family History** (Include family of origin, parents, siblings etc.)

- **Educational History** (Include the highest level of education achieved, degrees, special education, etc.)

- **Work History** (Describe the most significant employment experience(s); Volunteer positions)

- **Unique Characteristics and Strengths** (Describe how the applicant sees him/herself in this capacity)

- **Hobbies and Interests** (List activities applicant was involved in prior to application to waiver)

- **Criminal Justice History** (Describe any history that impacts the applicant's life including current involvement in the criminal justice system, if applicable)

INITIAL SERVICE PLAN

3. **Profile of Applicant** (continued)

B. Medical/Functional Information

1. Diagnoses and Medical Status

Primary Diagnosis: _____
Other Diagnosis: _____

_____

Any known allergies: _____

Summarize the applicant's significant diagnosis/injury/illness/disability. Include all applicable dates and circumstances (e.g. date of onset, rehab, treatments, surgeries, etc.)

Summarize the applicant's health and medical status as it relates to functional ability prior to application to the waiver.

Mental Health History (If applicable.) (Include hospitalizations, treatment(s))

Substance Abuse History (If applicable) (Include alcohol, drugs and etc.)

INITIAL SERVICE PLAN

3. **Profile of Applicant** (continued)

2. Describe if and how the applicant's disability or illness/injury has impacted his/her cognitive, physical and behavioral status. Also, include the applicant's strengths in each area):

Cognitive Status (e.g. memory, organizational skills, judgment, orientation, problem solving, and attention and learning abilities)

Physical Ability (e.g. functional performance)

Behavioral Status (e.g. changes in expected response to situations and environment)

3. Applicant's response to the disability, illness or injury:

Describe how the applicant views himself/herself using his/her own words:

Since disability or illness/ injury began, describe strategies and tools applicant has used to manage these issues (e.g. assistive technology, environmental modifications, reminders, cues):

Describe the applicant's interest in and willingness to use available strategies/tools:

Describe the applicant's emotional response (coping) to current physical status:

INITIAL SERVICE PLAN

3. **Profile of Applicant** (continued)

B. Medical/Functional Information (continued)

Describe how the applicant feels he/she is managing his/her disability, illness or injury:

Describe family and informal supports response to the applicant living in the community, his/her disability and its impact on his/her life:

4. Medications (**NOTE**: Use the charts that follow to list all medications and complete additional columns as indicated.)

Describe applicant's ability to self-administer medications (including the ability to prepare medications and to follow prescribed schedule and dosage):

If unable, who will assist applicant, and how will this be carried out?

Describe any assistance needed getting prescription(s) filled in a timely manner:

Identify whom will be contacted if there are concerns about the applicant's use of medications(s):

INITIAL SERVICE PLAN

3. **Profile of Applicant** (continued)

B. Medical/Functional Information (continued)

A. Medications (use additional pages, if needed)

Medications (prescription and over-the-counter)	Dosage	Route (injection, oral, etc.)	Purpose	Prescribed By and Phone Number	Pharmacy/Supply Co. and Phone Number	Payer Source	Total Projected Medicaid Monthly Cost

B. Medical Supplies and Durable Medical Equipment (use additional pages, if needed)

Supply or Equipment Item	Pharmacy/DME Co. and Phone Number	Prescribed By and Phone Number	Payer Source	Total Projected Medicaid Monthly Cost

Total "A" **$_____**

Total "B" **+** **$_____**

Total Projected Medicaid Annual Costs for All Medications, Medical Supplies and Durable Medical Equipment

= **$_____**

(Total Projected Medicaid Monthly Cost x 12) **(**transfer total to page 22)**

INITIAL SERVICE PLAN

3. **Profile of Applicant** (continued)

B. Medical/Functional Information (continued)

4. Physician/Dentist(s) applicant is currently being treated by (include all primary and specialty physicians and nurse practitioner, if applicable):

Primary Physician name: _____ Telephone:_____

Physician name/Specialty: _____ Telephone:_____

Physician name/Specialty: _____ Telephone: _____

Physician name/Specialty: _____ Telephone:_____

Dentist name: _____ Specialty:_____

Are referrals to any other doctor's indicated at this time? ☐Yes ☐ No
If yes, specify type and reason: _____

_____

_____

Can the applicant schedule his/her appointments? ☐Yes ☐ No
If no, who will assist the applicant with scheduling appointments? _____

Does the applicant need the Service Coordinator's assistance finding physician's? ☐ Yes ☐ No

Does applicant need someone to accompany them to doctor's appointments and other essential outpatient services (e.g. dialysis, chemotherapy, etc.)? ☐ Yes ☐ No

Who will accompany applicant to medical appointment? _____

Who sets up transportation? ☐ Applicant ☐ Other - Specify_____

6. Management of Medical Needs

List any diagnoses, disease state or condition that needs ongoing management, monitoring and/or treatments. (Include injections, oxygen, dressing changes, lab work, etc.) Indicate if the applicant needs any assistance, the type of assistance, and who will provide.

INITIAL SERVICE PLAN

3. **Profile of Applicant** (continued)

B. Medical/Functional Information (continued)

7. Dietary Needs

☐	Regular	☐	Low Sodium	☐	Low Fat	☐	Thickened liquids
☐	Pureed	☐	Renal	☐	Aspiration precautions	☐	Swallowing difficulties
☐	Tube feeding	☐	Cardiac	☐	Diabetic Diet	☐	Uses adaptive equipment
☐	Dentures:	☐	Upper	☐	Lower	☐	Partial

☐ Special Dietary Considerations (e.g. vegetarian, kosher, etc): (specify) _____

_____

Describe any specific information that pertains to applicant's ability to eat and drink:

8. Visual Ability (Check all that apply)

Blind: ☐ Right eye ☐ Left Eye ☐ Wears Glasses ☐ Needs Large Print

Visually Impaired ☐ Right eye ☐ Left Eye

☐ Uses Braille ☐ Cataracts ☐ Eye Prosthesis ☐ Guide Dog

☐ Other:_____

Describe any specific information that pertains to the applicant's ability to see:

9. Hearing Ability (Check all that apply)

☐ Hears adequately ☐ Hearing difficulty Uses Hearing Aid: ☐ Right ear ☐ Left ear

☐ Sign Language ☐ Other devices used _____

Describe any specific information that pertains to the applicant's ability to hear:

10. Communication Skills

Primary language is:_____

Other languages spoken/understood: _____

Describe any specific information that pertains to the applicant's ability to speak and understand: (include if a translator is needed and who provides the service):

11. Other Needs

Does the applicant use a service animal? ☐Yes ☐ No If yes, type: _____

Does the service animal have any special needs? ☐ Yes ☐ No If yes, type: _____

Where does the animal receive care/treatment, if needed? _____

Where is the service animal boarded if participant is hospitalized? _____

INITIAL SERVICE PLAN

3. **Profile of Applicant** (continued)

C. Present (Complete the following areas indicating what impact the disability or illness/injury is having on the applicant at this time)

- **Goals** (Describe the applicant's long-term and short-term goals for participating in the waiver program e.g. living at home, returning to work, education, volunteering, etc.)

- **Hobbies and Interests** (Describe how the disability or injury/illness has impacted what the applicant enjoys doing.)

Describe what activities the applicant would like to be involved in again or would like to initiate:

- **Culture and/or Religion** (List any assistance the applicant believes necessary to aid him/her in following religious, spiritual or cultural practices)

4. Applicant's Plans for Community Living

A. Living Situation

Describe the applicant's current living situation including location, type of setting (rural, urban, suburban), type of dwelling, layout of residence, individuals sharing household and relationship to applicant. (Please state if the applicant is in a Nursing Home and the name of the facility)

Describe the applicant's proposed living situation, if different from current living situation, including location, type of setting (rural, urban, suburban), layout of residence, individuals sharing household and relationship to applicant.

INITIAL SERVICE PLAN

4. Applicant's Plans for Community Living (continued)

Select type of dwelling:

☐ A home owned or leased by self/family member
☐ A leased apartment with lockable access and has own living, sleeping and eating areas
☐ A community-based residential setting with no more than 4 unrelated individuals (including applicant)
☐ Adult Care Facility
☐ Other:_____

B. Anticipated Activities Describe the applicant's anticipated daily activities (e.g. social, recreational, leisure, vocational and educational)

List any barriers identified by the applicant or others to participate in the above activities.

5. Current Supports and Services

A. Informal Supports

Family – Identify the present family supports applicant considers most significant to his/her life, the level of support and the activities the family is providing. Describe the family's willingness and/or ability to continue with their support. (List name and relationship of applicable supports)

Friend(s) – Identify the present friend(s) applicant considers most significant to his/her life, the level of support and the activities these friends are providing. Describe the friend(s) willingness and/or ability to continue with their support. List name(s) of applicable support(s).

INITIAL SERVICE PLAN

5. Current Supports and Services (continued)

Community – Identify the present level of support and services provided through community resources (e.g. neighbors, religious, fraternal, hobby groups, etc). Describe the willingness and ability of community supports and services to continue.

B. Formal Supports

List all State and Federal non-Medicaid services the applicant receives or will receive while on the waiver (e.g. Medicare services, VA, VESID, Office of Aging, etc.) Include frequency and duration.

Note: Transfer this information on to the Insurance, Resources and Funding Information Sheet.

Explain all Medicaid State Plan services the applicant will be receiving and the reason for them. (e.g. personal care services, nursing, medical day care, lab work, PT, OT, x-rays, etc). Include frequency and duration for each and the means of delivery (e.g. nursing from a CHHA, PT from a clinic, etc). Using this information, complete the Medicaid State Plan Services chart on page 22.

INITIAL SERVICE PLAN

6. Oversight/supervision and/or Assistance with Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs)

As explained in Section VI of the Program Manual - Waiver Services - arrangements may need to be made for applicants to be assessed for oversight/supervision and/or assistance with ADL/ IADL tasks, and arrangements made for informal supports or for formal supports through the waiver service of "Home and Community Support Services" (HCSS) or State Plan services such as personal care.

Instructions: Answer each question in this section. Use "N/A" where applicable.

A. For applicants needing oversight/supervision for cognitive needs

Describe the time frame during which oversight/supervision will be required and clearly explain why oversight/supervision is needed during this time (e.g. unsafe wandering due to dementia). Attach a copy of any related supportive documentation to this Service Plan (e.g. notes from the physician, hospital and/or nursing home)

Indicate the extent to which informal supports will be available to provide the applicant with needed oversight/supervision, (e.g. all needs can be met by the son and a neighbor; a son can provide oversight/supervision on Saturdays but not other needed days).
Note: If informal supports are sufficient to fully meet needs, no referral to HCSS is required.

If informal supports are not sufficient to meet all of the applicant's oversight/supervision needs and a referral was made for an HCSS assessment, indicate the extent to which HCSS will be used to meet those needs. Attach a copy of the completed HCSS evaluation with recommendations. (Proceed to page 14)

If HCSS will be provided for oversight and supervision, indicate the extent to which the applicant will also need assistance with ADL/IADL tasks through HCSS. The HCSS evaluation attached to this Service Pan should also address the necessary tasks.

INITIAL SERVICE PLAN

6. Oversight/supervision and/or Assistance with Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) (continued)

B. For applicants needing assistance with ADL/IADL tasks but not oversight/supervision

Indicate the extent to which informal supports will be available to provide the applicant with needed assistance, (e.g. all needs can be met by the son and a neighbor; a son can provide assistance on Saturdays but not other needed days).
Note: If informal supports are sufficient to fully meet needs, no referral to other services is required.

If informal supports will not be sufficient to meet all of the applicant's needs and a referral was made to the appropriate local social services district for an assessment for personal care including the Consumer Directed Personal Assistance Program (CDPAP), indicate the extent to which personal care or CDPAP was authorized and will be used to meet those needs. A full explanation should be included in Item #5B on page 11 of this Service Plan.

Indicate whether the applicant's needs were beyond the scope of a personal care aide and whether arrangements were, therefore, made for other services (e.g. certified home health agency, private duty nursing, CDPAP). Such services should be explained in Item # 5B on page 11 of this plan.

C. Alternatives Considered

Needs for oversight/supervision and/or ADL/IADL tasks can sometimes be met with other services (e.g. medical supplies, durable medical equipment, assistive technology, etc.) Indicate whether such efficiencies have been considered and are explained elsewhere in this Service Plan.

INITIAL SERVICE PLAN

7. Explanation of Need for Waiver Services

Describe why the applicant is in need of waiver services to prevent nursing home placement from occurring or to allow for transition from a nursing home into the community:

INITIAL SERVICE PLAN

8. Requested Waiver Services (Indicate "N/A" for any service(s) not requested)

Service Coordination

Explain the need for this service.

Identify the applicant's desired goals for this service including the frequency/amount of the service.

Describe specific activities targeted for the next six (6) months.

Assistive Technology

Explain the need for this service.

Identify the type(s) of Assistive Technology desired by the applicant and his/her goals for using this service(s).

Describe specific activities targeted for the next six (6) months

***Attach Assistive Technology Description and Cost Projection form and copy of bid(s), if applicable.**

INITIAL SERVICE PLAN

8. Requested Waiver Services (continued)

Community Integration Counseling (CIC)

Explain the need for this service

Identify the applicant's desired goals for this service including the frequency/amount of the service.

Describe specific activities targeted for the next six (6) months.

Community Transitional Services (CTS)

Explain the need for this service

Identify the applicant's desired goals for this service.

Describe specific activities targeted for the next six (6) months.

***Attach the Community Transition Service Description and Cost Projection form and copy of bid(s), if applicable.**

Congregate and Home Delivered Meals

Explain the need for this service

Identify the applicant's desired goals for this service including the frequency/amount of the service.

INITIAL SERVICE PLAN

8. Requested Waiver Services (continued)

Congregate and Home Delivered Meals (continued)
Describe specific activities targeted for the next six (6) months.

Environmental Modifications Services (E-Mods)
Explain the need for this service

Identify the applicant's desired goals for this service.

Describe specific activities targeted for the next six (6) months.
***Attach Environmental Modification Description and Cost Projection form and copy of bid(s), if applicable.**

Home and Community Support Services (HCSS)
Explain the need for this service

Identify the applicant's desired goals for this service including the frequency/amount of the service.

Describe specific activities targeted for the next six (6) months.

NOTE: Please attach the necessary documentation supporting the recommended frequency and duration of service(s)

INITIAL SERVICE PLAN

8. Requested Waiver Services (continued)

Home Visits by Medical Personnel

Explain the need for this service

Identify applicant's desired goals for this service including the frequency/amount of the service.

Describe specific activities targeted for the next six (6) months.

Independent Living Skills Training Services (ILST)

Explain the need for this service

Identify applicant's desired goals for this service including the frequency/amount of the service.

Describe specific activities targeted for the next six (6) months.

Moving Assistance

Explain the need for this service

Identify applicant's desired goals for this service.

Describe specific activities projected for the next six (6) months.

***Attach the Moving Assistance Description and Cost Projection form and copy of bid (s), if applicable.**

INITIAL SERVICE PLAN

8. Requested Waiver Services (continued)

Nutritional Counseling/Educational Services

Explain the need for this service

Identify applicant's desired goals for this service including the frequency/amount of the service.

Describe specific activities targeted for the next six (6) months.

Peer Mentoring

Explain the need for this service

Identify the applicant's desired goals for this service including the frequency/amount of the service.

Describe specific activities targeted for the next six (6) months.

Positive Behavioral Interventions and Supports (PBIS)

Explain the need for this service

Identify applicant's desired goals for this service including the frequency/amount of the service.

Describe specific activities targeted for the next six (6) months.

INITIAL SERVICE PLAN

8. Requested Waiver Services (continued)

Respiratory Therapy

Explain the need for this service

Identify the applicant's desired goals for this service including the frequency/amount of the service.

Describe specific activities targeted for the next six (6) months.

Respite Services

Explain the need for this service

Identify the applicant's desired goals for this service including the frequency/amount of the service.

Describe specific activities targeted for the next six (6) months.

Structured Day Program Services

Explain the need for this service

Identify the applicant's desired goals for this service including the frequency/amount of the service.

Describe specific activities targeted for the next six (6) months.

INITIAL SERVICE PLAN

8. Requested Waiver Services (continued)

Wellness Counseling Service

Explain the need for this service

Identify the applicant's desired goals for this service including the frequency/amount of the service.

Describe specific activities targeted for the next six (6) months.

INITIAL SERVICE PLAN

9. Medicaid State Plan Services* and Cost Projection

Type of Service	Provider (Name and Telephone)	Effective Date	Frequency & Duration (e.g. 2 hrs., 3X per week	Annual Amount of Units	Rate	Total Projected Medicaid Annual Cost
Medications, Medical Supplies and DME from page 6						

Total Projected Medicaid Annual Costs for All Medicaid State Plan Services $ _____

*Including but not limited to Outpatient services, Certified Home Health Aide (CHHA), Medical Day Care, Personal Care Aide (PCA), Consumer Directed Personal Assistance Program (CDPAP), nursing, physician's services, transportation, medical supplies, DME.

INITIAL SERVICE PLAN

10. Waiver Services and Cost Projection

Waiver Service	Provider (Name, Address, Telephone)	Effective Date	Frequency & Duration (e.g. 2 hrs., 3X per week)	Annual Amount of Units	Rate	Total Projected Medicaid Annual Cost
Service Coordination						

Total Projected Medicaid Annual Cost for All Waiver Services $ _____

INITIAL SERVICE PLAN

11. Projected Total Annual Costs for Initial Service Plan

1. Total Projected Medicaid Annual Cost of Medicaid State Plan Services (from page 22) _____

2. Total Projected Medicaid Annual Cost of Waiver Services (from page 23) **+** _____

Total of # 1 and #2 = **=** _____

3. Total Projected Medicaid Annual Cost of Medicaid Spend-down incurred

(from Insurance, Resources and Funding Information sheet) (Multiply one month of spend-down x 12) **-**

_____

4. Total Projected Medicaid Annual Cost of all Medicaid Services **=**

(#1 Plus #2 Minus #3) _____

5. Total Projected Medicaid Daily Rate of all Medicaid Services **=**

(#4 divided by 365) _____

INITIAL SERVICE PLAN

12. Projected Weekly Schedule of All Services (Include informal supports, waiver and non-waiver services)

Use * to indicate shared services and identify ratio of staff to applicant

Applicant Name: **Date of Initial Service Plan:**

Time	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
7:00 - AM							
8:00							
9:00							
10:00							
11:00							
NOON							
1:00 – PM							
2:00							
3:00							
4:00							
5:00							
6:00							
7:00							
8:00							
9:00							
10:00							
11:00							
12:00 AM							
1:00 AM – 7:00 AM							

INITIAL SERVICE PLAN

13. Signatures

I have participated in the development of this Initial Service Plan. I have read this Initial Service Plan or it has been read to me and I understand its contents and purpose as written. If approved as a participant in the Home and Community Based Services (HCBS) waiver, I will work in cooperation with the agencies I have selected to provide waiver services indicated in this Initial Service Plan. I will talk with my Service Coordinator if I want to make any changes to this Initial Service Plan.

In addition, as an approved participant in this Home and Community Based Services (HCBS) waiver, I understand that I have the right to pursue a Fair Hearing concerning my participation in the NHTD waiver at any time.

I understand that a copy of this Initial Service Plan will be provided to all waiver providers involved in this service plan.

☐ Mr. ☐ Mrs. ☐ Ms

Name of Applicant (First/MI/Last/Generational Suffix) Signature Date

Name of Legal Guardian (if applicable) (print) Signature Date

Name of Other/Relationship to Applicant (if applicable) (print) Signature Date

I have developed this Initial Service Plan with the above named applicant as it is written. I support the request for the waiver services detailed in this Initial Service Plan and verify that in my opinion, they are necessary to maintain the health and welfare of the applicant.

Name of Service Coordinator (print) Signature Date

Name of Service Coordinator Supervisor (print) Signature Date

Name and Address of Agency Telephone

I approve this Initial Service Plan as it is written.

RRDS Comments: _____

This Service Plan is in effect from: _____ to: _____

Name of RRDS (print) Signature Date

PROVIDER SELECTION

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

NOTE: This form must be returned to the Service Coordinator to complete Provider Selection process. Services may not begin until final notification by Service Coordinator is received.

I understand that as an applicant/participant for the above indicated waiver, I must select a Provider(s) from the attached list of approved Waiver Service Provider Agencies. I have been encouraged to interview the Provider(s) prior to making my selection. I understand that the Provider(s) will assist me with the development and implementation of a Detailed Plan which reflects my wishes and needs, maintains my health and welfare, and monitors the provision of services for quality and appropriateness.

I also understand that at any time I may change my Provider Agency and still be eligible for the waiver.

From the approved Provider Agency list, I have chosen:

Name of Provider Agency _____ Telephone _____

Provider Address _____

From this Provider agency, I am requesting the following services:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Applicant Signature _____ Date _____

Applicant's Address _____

Legal Guardian Signature (if applicable) _____ Date _____

Authorized Representative Signature (if applicable) _____ Date _____

To be completed by Provider Agency:

Provider Agency

_____ will provide all of the above listed services
_____ is unable to provide the following service(s):

because: _____

_____ will not provide any of the above listed services

because: _____

Provider Contact Signature/Title _____ Date _____

Service Coordinator Signature _____ Date _____

INITIAL SERVICE PLAN

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Insurance, Resources and Funding Information Sheet

Date: _____

Applicant Name: _____ CIN: _____

Address: _____

Phone: (H): _____ (W): _____ (C): _____

1. Insurance Information

Other Health Insurance: Company Name:_____

Telephone: _____ Policy #:_____ Group #:_____

Medicare #: _____ ☐ Medicare A Effective Date: ____/____/_____
☐ Medicare B Effective Date: ____/____/_____
☐ Medicare D Effective Date: ____/____/_____

Name of Medicare D Prescription Plan: _____

Medicare Managed Care ☐ Yes ☐ No

Company Name: _____

Telephone:_____ ID #:_____

Supplemental Insurance Company Name:_____

Telephone: _____ Policy #:_____ Group #:_____

Other Prescription Plan: Company Name:_____

Telephone: _____ Policy #: _____ Group #:_____

Medicaid Spend-down Per Month $_____

Spend-down to be applied to ☐ LDSS **or** ☐ Service:_____

Medicaid Managed Care ☐ Yes ☐ No

Company Name: _____

Telephone:_____ ID #: _____

Veteran ☐ Yes ☐ No Receives services? ☐ No ☐ Yes (List) _____

Insurance and Resource/Funding Information Sheet (continued)

2. Resources and Funding

A. Income

Income Source	Amount	Denied/ Date	Will Apply Upon Enrollment	Who Will Assist With Application?
Social Security				
Social Security Disability Insurance				
Supplemental Security Income				
Veteran's Administration				
Public Assistance				
Supplemental Needs Trust				
Other Trust				
Worker's Compensation				

B. Federal, State and Private Funded Resources/Services

Funding Source	Amount	Denied/ Date	Type and Frequency of Service	Will Apply Upon Enrollment?	Who Will Assist With Application?
HUD/Section 8					
HEAP					
Food Stamps					
Crime Victims Funding					
VESID					
OMRDD					
Worker's Compensation					
No Fault Insurance					
Veteran's Administration					
Medicare					
Other Insurance:					
NHTD Housing Subsidy					
Other:					

Insurance and Resource/Funding Information Sheet (continued)

2. Resources and Funding (continued)

C. Housing Supplement	YES	NO
Low income housing tax credits		
HOME dollars		
CDBG funds		
Housing choice vouchers (such as tenant based, project based, mainstream or homeownership vouchers)		
Housing trust funds		
Section 811		
202 funds		
USDA rural housing funds		
Veterans Affairs housing funds		
Funds for home modifications		
Funds for assistive technology as it relates to housing		
Other, specify:		

Applicant Signature Date

Service Coordinator Signature Date

PLAN FOR PROTECTIVE OVERSIGHT

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

The location where PPO in kept in the participant's home is: _____

Participant Name: _____ CIN _____

Address: _____

Phone: (H)_____ (W)_____ (C) _____

1. Contacts

Legal Guardian Name (if applicable): _____Relationship: _____
Address: _____
Street City State Zip
Phone: Home (____) _____Work (____) _____Cell (____) _____

☐ **Guardianship verified, if applicable**

Primary Contact: _____Relationship: _____

Address: _____
Street City State Zip
Phone: Home (____) _____Work (____) _____Cell (____) _____

Other Contact: _____Relationship: _____

Address: _____
Street City State Zip
Phone: Home (____) _____Work (____) _____Cell (____) _____

Out-of-Area Emergency/Disaster Contact (not same as above), if available

Name: _____Relationship: _____

Address: _____
Street City State Zip
Phone: Home (____) _____Work (____) _____Cell (____) _____

2. Advance Directives

Health Care Agent Name (if applicable): _____

Address: _____
Street City State Zip
Phone: Home (____) _____Work (____) _____Cell (____) _____

For RRDS use only:

Effective date _____to_____

PLAN OF PROTECTIVE OVERSIGHT (continued)

Participant Name: _____

2. Advance Directives (continued)

Alternate Health Care Agent Name (if applicable): _____

Address: _____
Street City State Zip
Phone: Home (____) _____ Work (____) _____ Cell (____) _____

☐ **Health Care Proxy verified, if applicable**

Is there a current Non-Hospital Do Not Resuscitate Order? ☐ **Yes** ☐ **No**

☐ **Non-Hospital DNR verified, if applicable**

3. Financial Contacts

Power of Attorney Name (if applicable): _____ Relationship: _____

Address: _____
Street City State Zip
Phone: Home (____) _____ Work (____) _____ Cell (____) _____

Specify type of assistance provided: _____

☐ **Power of Attorney verified, if applicable**

Rep. Payee Name (if applicable): _____ Relationship: _____

Address: _____
Street City State Zip
Phone: Home (____) _____ Work (____) _____ Cell (____) _____

Person/Agency who will assist with Financial Matters (if appropriate):

Name: _____ Relationship: _____

Address: _____
Street City State Zip
Phone: Home (____) _____ Work (____) _____ Cell (____) _____

4. Hospital Preference

Participant's choice of hospital: _____

5. Revisions made to page(s) 1 and/or 2

Change(s) made: _____

_____
Name of Waiver Participant Signature Date

_____
Name of Guardian (if applicable) Signature Date

_____
Name of Service Coordinator Signature Date

PLAN OF PROTECTIVE OVERSIGHT (continued)

Participant Name: _____

6. Fire/Safety Disaster Plan

Yes	No		
☐	☐	Residence has Smoke Detector	Comments: _____
☐	☐	Residence has Carbon Monoxide Detector	Comments:_____
☐	☐	Participant able to access all available exits	Comments:_____
☐	☐	Participant is bed bound	If yes, plan of action: _____ _____
☐	☐	Participant needs assistance in the case of evacuation	If yes, plan of action: _____ _____
☐	☐	Participant needs help outside of informal supports if a disaster occurs	If yes, plan of action: _____ _____
☐	☐	Evacuation Plan reviewed with participant/legal guardian and informal supports	Date reviewed: ____/____/_____ Date the local authorities were notified of assistance needed: ____/____/____
☐	☐	Discussed the need for a Disaster Preparedness Plan	Comments: _____
☐	☐	Discussed the need for a disaster kit	Dated discussed: ___/___/___
☐	☐	Participant uses oxygen	If yes, plan of action, in case of emergency: _____ _____ Vendor Name and Telephone: _____ _____
☐	☐	Participant uses ventilator	If yes, plan of action: _____ _____ Vendor Name and Telephone: _____ _____
☐	☐	Participant requires suctioning	If yes, plan of action: _____ _____ Vendor Name and Telephone: _____ _____
☐	☐	Power Company notified of all power-dependent life support equipment	Date notified: ____/____/_____ ☐ No life support used

7. Medications

Yes	No		
☐	☐	Does the participant need assistance with taking medications?	If yes, type of assistance provided: _____ By Whom:_____
☐	☐	Does the participant need assistance getting meds prescriptions filled?	If yes, type of assistance provided: _____ By whom: _____
☐	☐	Does the participant have someone to notify if there are concerns about their use of medications?	If yes, person(s) to contact: _____

PLAN OF PROTECTIVE OVERSIGHT (continued)

Participant Name: _____

8. Dietary

a. Who will be contacted if the participant experiences any changes in eating habits?

_____

9. Plan for Back-Up

a. Would the absence of waiver services or informal supports during scheduled/expected times jeopardize the participant's health and welfare?

☐ YES ☐ NO

If yes, list the waiver service and/or informal support and describe the back-up plan to be utilized:

_____

_____

_____

b. Would the absence of non-waiver services (e.g. nursing services) during scheduled times jeopardize the participant's health and safety:

☐ YES ☐ NO

If yes, list the non-waiver service(s) and describe the back-up plan to be utilized?

_____

_____

_____

_____

c. Does participant have any pets? ☐ YES ☐ NO If yes, type(s): _____

Who needs to be contacted to care for pets if participant becomes unable? _____

_____

10. Other – List all Assistive Technology, medical equipment, and emergency communication devices used by participant and contact/agency if repairs are needed:

Device Type and Description	Contact Name/Agency and Telephone Number/Ext.

PLAN OF PROTECTIVE OVERSIGHT (continued)

Participant Name: _____

11. Signatures of Individuals Participating in the Plan For Protective Oversight

Name of Waiver Participant		Signature	Date / /
Name of Legal Guardian (if applicable)		Signature	Date / /
Name of Informal Support		Signature	Date / /
Name of Informal Support		Signature	Date / /
Name of Formal Support/Title	Agency	Signature	Date / /
Name of Formal Support/Title	Agency	Signature	Date / /
Name of Service Coordinator		Signature	Date / /
Name of Service Coordinator Supervisor		Signature	Date

12. Regional Resource Development Specialist

The information provided in this Plan for Protective Oversight summarizes alternatives so that the participant's health and welfare can be maintained in the community and that he/she is not at risk for nursing home placement.

Comments: _____

Name of RRDS	Signature	Date

WAIVER PARTICIPANT'S RIGHTS AND RESPONSIBILITIES

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion Waiver (NHTD)

All individuals participating in a Home and Community Based Services (HCBS) Medicaid waiver are ensured specific rights regarding the delivery of waiver services.

Waiver Participant's Rights
As a Waiver Participant You Have the Right to:

1. Be informed of your rights prior to receiving waiver services;

2. Receive services without regard to race, religion**,** color, creed, gender, national origin, sexual orientation, marital status**,** or disability;

3. Be treated as an individual with consideration, dignity and respect including but not limited to person, residence and possessions*;*

4. Have services provided that support your health and welfare;

5. Assume reasonable risks and have the opportunity to learn from these experiences;

6. Be provided with an explanation of all services available in the Nursing Home Transition and Diversion Waiver (NHTD) waiver and other health and community resources that may benefit you;

7. Have the opportunity to participate in the development, review and approval of all Service Plans, including any changes to the Service Plan;

8. Select service providers and choose to receive additional waiver services from different agencies or different providers within the same agency without jeopardizing participation in the waiver;

9. Request a change in services (add, increase, decrease or discontinue) at any time;

10. Be fully informed of the process for requesting an Informal Conference and Fair Hearing upon receipt of a Notice of Decision or at any time while a participant of the NHTD waiver;

11. Be informed of the name and duties of any person providing services to you under the Service Plan;

12. Have input into when and how waiver services will be provided;

13. Receive services from approved, qualified individuals;

14. Receive from the Service Coordinator, in writing, a list of names, telephone numbers, and supervisors for all waiver service providers, the RRDS, QMS, and the NHTD Complaint Line***;***

WAIVER PARTICIPANT'S RIGHTS AND RESPONSIBILITIES (continued)

15. Refuse care, treatment and services after being fully informed of and understanding the potential risks and consequences of such actions;

16. Have your privacy respected, including the confidentiality of personal records, and have the right to refuse the release of the information to anyone not authorized to have such records, except in the case of your transfer to a health care facility or as required by law or Medicaid requirements;

17. Submit complaints about any violation of rights and any concerns regarding services provided, without jeopardizing your participation in the waiver and not being subject to restraint, interference, coercion, discrimination or reprisal as a result of submitting a complaint;

18. Receive support and direction from the Service Coordinator to resolve your concerns and complaints about services and service providers;

19. Receive additional support and direction from the RRDS, QMS and DOH Waiver Management Staff as desired or in the event that your Service Coordinator is not successful in resolving concerns and complaints about services and service providers;

20. Have your complaints responded to and be informed of the final resolution of the investigation***;***

21. Have your service providers protect and promote your ability to exercise all rights identified in this document;

22. Have all rights and responsibilities outlined in this document forwarded to your court appointed legal guardian or others authorized to act on your behalf; and

23. Participate in surveys inquiring about your experiences as an NHTD waiver participant. This includes the right to refuse to participate in experience surveys without jeopardizing your continued participation in the NHTD waiver program.

Waiver Participant's Responsibilities

As a Waiver Participant You Are Responsible to:

1. Work with your Service Coordinator to develop/revise your Service Plan to assure timely reauthorization of the Service Plan;

2. Work with your waiver providers as described in your current Service Plan;

3. Follow your Service Plan and notifying your Service Coordinator if problems occur***;***

4. Talk to your Service Coordinator and other waiver providers if you want to change your goals or services;

WAIVER PARTICIPANT'S RIGHTS AND RESPONSIBILITIES (continued)

5. Provide to the best of your knowledge, complete and accurate medical history including all prescribed and over-the-counter medications you are taking and understand the risk(s) associated with your decisions about care;

6. Inform the Service Coordinator about all treatments and interventions you are involved in;

7. Maintain your home in a manner which enables you to safely live in the community;

8. Ask questions when you do not understand your services;

9. Not participate in any criminal behavior. You understand that, if you do, your service provider(s) may leave, the police may be called and your continuation in the waiver program may be jeopardized;

10. Report any significant changes in your medical condition, circumstances, informal supports and formal supports to your Service Coordinator;

11. Provide accurate information related to your coverage under Medicaid (including recertification and spend-down), Medicare or other medically-related insurance programs to your Service Coordinator;

12. Notify all providers as soon as possible if the scheduled service visit needs to be rescheduled or changed;

13. Notify appropriate person(s) should any problems occur or if you are dissatisfied with services provided; and

14. Show respect and consideration for staff and their property.

I have read this Waiver Participant's Rights and Responsibilities form, or it has been read to me and I understand its contents and purpose as written. I understand that failure to adhere to the responsibilities described in this Waiver Participant Agreement and/or my signed current Service Plan may result in termination from the waiver.

Applicant/Participant Name	Signature	Date
Legal Guardian/Committee Name (if applicable)	Signature	Date
Authorized Representative Name (if applicable)	Signature	Date
Service Coordinator Name	Signature	Date

cc: All current waiver service providers

WAIVER CONTACT LIST

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
NURSING HOME TRANSITION AND DIVERSION

Date: _____

Participant: _____

Service Coordinator

Name: _____ **Telephone** _____

Supervisor: _____ **Telephone:** _____

Provider Agency: _____

Regional Resource Development Specialist (RRDS)

Name: _____ **Telephone:** _____

Supervisor: _____ **Telephone:** _____

Quality Management Specialist (QMS)

Name_____ **Telephone:** _____

Supervisor: _____

Complaint Line: _____

WAIVER CONTACT LIST (cont'd)

Service: ______________________________

Agency Name: ______________________ **Telephone:** ____________

Staff Name: ______________________ **Supervisor:** ____________

Service: ______________________________

Agency Name: ______________________ **Telephone:** ____________

Staff Name: ______________________ **Supervisor:** ____________

Service: ______________________________

Agency Name: ______________________ **Telephone:** ____________

Staff Name: ______________________ **Supervisor:** ____________

Service: ______________________________

Agency Name: ______________________ **Telephone:** ____________

Staff Name: ______________________ **Supervisor:** ____________

Service: ______________________________

Agency Name: ______________________ **Telephone:** ____________

Staff Name: ______________________ **Supervisor:** ____________

Service: ______________________________

Agency Name: ______________________ **Telephone:** ____________

Staff Name: ______________________ **Supervisor:** ____________

Other: ______________________ **Telephone:** ____________

Other: ______________________ **Telephone:** ____________

MOVING ASSISTANCE DESCRIPTION AND COST PROJECTION

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Applicant/Participant: _____CIN: _____

Current Address: _____

New Address: _____

1. Explain why the move is necessary.

2. How many times has this service been requested before or provided before? (Please be specific).

3. Moving company: _____Telephone:_____

Contact person:_____ NYSDOT License # (if applicable):_____
FMCSA License # (if applicable):_____

4. Total Moving Assistance funds requested, attach all estimates received. $ _____

Participant Signature: _____Date:_____

Service Coordinator: _____

Signature: _____Date: _____

Moving Assistance Provider: _____Provider ID#:_____

Contact Person: _____

Signature: _____

Regional Resource Development Specialist (RRDS): _____

Signature: _____Date: _____

☐ Approved ☐ Denied
Reason for denial:_____
_____
_____

DOH Waiver Management Staff (if over $5,000): _____

Signature: _____Date: _____

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

ASSISTIVE TECHNOLOGY DESCRIPTION AND COST PROJECTION

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

_____ _____
Applicant/Participant CIN

1. Describe the Assistive Technology being requested.

2. Explain how the Assistive Technology will help contribute toward the applicant/participant's health and welfare.

3. Attach all assessments and bids. Identify the selected bid.
NOTE: If this is a rental property, a signed authorization from the landlord must be attached.

Participant Signature: _____ Date: _____

Assistive Technology Provider: _____ Provider ID#: _____

Contact Person: _____

Signature: _____

Service Coordinator: _____

Signature: _____ Date: _____

Regional Resource Development Specialist (RRDS): _____

Signature: _____ Date: _____

☐ Approved ☐ Denied
Reason for denial: _____
_____
_____

DOH Waiver Management Staff (if over $15,000): _____

Signature: _____ Date: _____

COMMUNITY TRANSITIONAL SERVICES (CTS) DESCRIPTION AND COST PROJECTION

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Referral #: _____

Applicant Name: _____ CIN: _____

1. Describe each component of the Community Transitional Services being requested and explain how the Community Transitional Services will contribute toward the applicant's re-entry into the community. (Apartments for which a security deposit is being requested must have a monthly rent within Fair Market Rate (FMR) if the applicant is seeking a housing subsidy from waiver.)

2. Describe the applicant's ability to make monthly rental payments and meet other costs for maintaining the dwelling (utility, heat, telephone).

3. Total CTS funds requested (from attached page 2) $ _____

Applicant Signature: _____ Date: _____

Guardian Signature, if applicable: _____ Date: _____

CTS Provider: _____ Provider ID#: _____

Contact Person: _____

Signature: _____

Service Coordinator: _____

Signature: _____ Date: _____

Regional Resource Development Specialist (RRDS): _____

Signature: _____ Date: _____

☐ Approved ☐ Denied

Reason for denial: _____

_____

_____

COMMUNITY TRANSITIONAL SERVICES (CTS)
DESCRIPTION AND COST PROJECTION (cont'd)

1. Funds needed to secure an apartment:

Address: _____Apartment #: _____

Landlord: _____Telephone: _____

Landlord Address: _____

# of people sharing cost of residence:_____ Total Security Deposit: $_____ Please describe living situation: _____

_____

Total monthly rent: $_____ **CTS portion of security deposit** $_____

2. Utility Set-up

Utility Company (Heating): _____ Account #: _____

# of people sharing residence:____ Total Set-up Fee:$____ **CTS portion of Set-up Fee** $_____

Utility Company (Electricity):_____ Account #: _____

# of people sharing residence:____ Total Set-up Fee:$____ **CTS portion of Set-up Fee** $_____

Utility Company (Phone): _____ Account #: _____

# of people sharing residence:____ Total Set-up Fee:$____ **CTS portion of Set-up Fee** $_____

Total $_____

3. Other Expenses

Cleaning/Pest Control Company: _____

Address: _____Telephone:_____

Purpose: _____

# of people sharing residence:____ Total Set-up Fee:$____ **CTS portion of Fee** $ _____

Moving Company: _____ $ _____
Fee

Address: _____Telephone:_____

4. Total Cost

Essential Household Furnishings (from Page 3) $ _____
Amount

Total Community Transitional Services Requested $ +_____
(not to exceed $4,500 for NHTD and $2,700 for TBI)

Administrative Fee for Community Transitional Services Provider $ +_____
(10% of Total CTS Requested)

TOTAL $ _____

COMMUNITY TRANSITIONAL SERVICES (CTS)
DESCRIPTION AND COST PROJECTION (cont'd)

Essential Household Furnishings

Please list the requested items and the cost of each item. Applicants must explore all other available resources before applying for CTS funds. Only necessary household goods are covered by this service. Items **not** allowed include diversional or recreational items, such as televisions, VCR/DVDs or music systems.

ITEM:	**AMOUNT:**
Bathroom Set-Up	
Bed:	
Chair	
Chest of Drawers	
Cleaning Utensils	
Clock	
Coffee Table	
Couch	
Dishes, Bowls	
Fire Extinguisher	
First Aid Kit	
Kitchen Table and Chairs	
Lamps	
Light bulbs	
Linens	
Microwave	
Night Stand	
Pots, Pans and Kitchen Utensils	
Silverware	
Waste Baskets	
Window Blinds	
Other	

TOTAL $_____
(Transfer this amount to #4 Total Cost on Page 2)

ENVIRONMENTAL MODIFICATION (E-Mod) DESCRIPTION AND COST PROJECTION

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

_____
Applicant/Participant

_____
Address of Proposed E-Mod

1. Describe the E-Mod that is being requested.

2. Explain how the E-Mod will help contribute toward the applicant/participant's health and welfare.

3. Attach all assessments and bids. Identify the selected bid.
   NOTE: If this is a rental property, a signed authorization from the landlord must be attached.

Participant Signature: _____Date:_____

E-Mod Provider: _____Provider ID#:_____

Contact Person: _____

Signature: _____

Service Coordinator: _____

Signature: _____Date: _____

Regional Resource Development Specialist (RRDS): _____

Signature: _____Date: _____

☐ Approved

☐ Denied
Reason for denial:_____
_____
_____

DOH Waiver Management Staff (if over $15,000): _____

Signature: _____Date: _____

WAIVER SERVICES FINAL COST

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Applicant/Participant: _____CIN: _____

Final cost for: (Check One)
___ Assistive Technology ___Community Transition Services ___Environmental Modifications
___ Moving Assistance

1. Original Projected Cost $ _____ Final Cost $_____
   (if final cost is GREATER THAN 10% attach documentation of RRDS approval)

2. Describe the completed Service. (Attach itemized list and copies of receipts of all expenses incurred).

3. Justify any difference of less than 10% of the above original cost between the projected and final costs.

I certify that the above Service was provided in accordance with the above costs.

Waiver Service Provider Agency Provider Medicaid #

Provider Address Telephone

Provider Contact Signature Date

I acknowledge that the above Service was provided in accordance with the Service Plan.

Service Coordinator Signature Date

REGIONAL RESOURCE DEVELOPMENT SPECIALIST (RRDS)
APPROVAL of FINAL COST

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Service Coordinator Date

The final cost for: (Check one)

☐ Environmental Modifications ☐ Assistive Technology ☐ Community Transition Services

☐ Moving Assistance

submitted for _____
Applicant/Participant CIN

has been reviewed and is:

☐ Approved for the amount of $_____

☐ Not approved because:

RRDS Signature Date

Cc: Waiver Service Provider
Service Coordinator

REVISED SERVICE PLAN

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

---

1. Identification

Participant Name: _____ Date of Birth: _____

CIN: _____ County of Fiscal Responsibility: _____ Verified ☐ Yes ☐ No
***Attach documented proof of Medicaid eligibility**

Address: _____
Street

_____
City County State Zip

Mailing Address (if different from above): _____

_____

Phone: Home (____) _____ Work (____) _____ Cell (____) _____

2. Individuals who participated in developing this Service Plan

Name	Relationship to Participant	Telephone

Addendum completed during last Service Plan period? ☐ Yes ☐ No
Date of Addendum approval: _____

For use by RRDS only:
Date this Revised Service Plan was submitted to RRDS by SC: ___/___/___

This Service Plan will take effect from: _____ to: _____which is (check one):

☐ interim replacement for a previously approved Service Plan
☐ following the end of the previously approved Service Plan

REVISED SERVICE PLAN

3. Profile of Participant (Use "N/A" for any sections that do not apply. Do not leave blank)

A. Medical/Functional Information

For each of the following areas, describe participant's current status. Include any changes that have occurred since the last Service Plan

a) Medical:
List any hospitalization(s) or emergency room visits (include dates and reason):

b) Physical:

c) Cognitive:

d) Behavioral:

e) Psychiatric:

f) Substance Abuse:

g) Criminal Justice:

REVISED SERVICE PLAN

3. Profile of Participant (continued)

B. Medical/Functional Information (continued)

How does the participant view his/her life in the community during the last Service Plan period (e.g. satisfaction with community and living arrangements, changes in living arrangements, adjustments, etc):

Discuss any changes in significant relationships that have occurred during last Service Plan period:

Describe whether the participant's involvement in community activities (e.g. leisure time interests, volunteerism, religious or cultural activities, vocational or educational pursuits) have met the expectation of the last Service Plan and any changes anticipated for the next Service Plan period:

Describe any other Successes/Setbacks/Concerns participant has experienced including the participant's view regarding overall status, successes, goals, etc. during the last Service Plan period:

Describe the Service Coordinator's overall impression regarding the effectiveness of the last Service Plan in meeting the participant's health and welfare, and goals:

REVISED SERVICE PLAN

3. Profile of Participant (continued)

B. Medical/Functional Information (continued) List all medication, medical supplies and DME presently used.

1. Medications (use additional pages, if necessary)

Medications (prescription and over-the-counter)	Dosage	Route (injection, oral, etc.)	Purpose	Prescribed By and Phone Number	Pharmacy/Supply Co. and Phone Number	Payer Source	Projected Medicaid Monthly Cost

2. Medical Supplies and Durable Medical Equipment (use additional pages, if necessary)

Supply or Equipment Item	Pharmacy/DME Co. and Phone Number	Prescribed By and Phone Number	Payer Source	Projected Medicaid Monthly Cost

Total "A" $_____

Total "B" + $_____

Total Projected Annual Costs for All Medications, Medical Supplies and Durable Medical Equipment (Projected Monthly Cost x 12) = $_____

REVISED SERVICE PLAN

3. Profile of Participant (continued)

B. Medical/Functional Information (continued)

3. Does the medication regime differ from the last Service Plan? ☐ Yes ☐ No If yes, explain:

4. What is the current plan to assist the participant with medication administration, if needed?

5. Physician/Dentist(s)

Describe any changes in physician services during last Service Plan period and indicate reason for the change:

All Current physicians:

Physician name/Specialty: _____ Telephone:_____

Physician name/Specialty: _____ Telephone:_____

Physician name/Specialty: _____ Telephone: _____

Physician name/Specialty: _____ Telephone:_____

Dentist name: _____ Specialty:_____

When answering the following, include a description of any changes that have occurred since the last Service Plan review (If no change has occurred, write "none"):

Can the participant schedule his/her appointments? ☐Yes ☐ No
If no, who will assist the participant with scheduling appointments? _____
Changes:

Does participant need Service Coordinator to assist with finding physicians? ☐Yes ☐No
Changes:

Does participant need someone to accompany him/her to doctor's appointments? ☐ Yes ☐ No
Who will accompany participant to medical appointment? _____
Changes:

Who sets up transportation to medical appointments?
☐ Participant ☐ Other - Specify_____
Changes:

Does the participant have the ability to travel? ☐ Yes ☐ No
Method of transportation used (e.g. cab, train, bus, etc): _____
Assistance Needed? _____

REVISED SERVICE PLAN

3. Profile of Participant (continued)

B. Medical/Functional Information (continued)

6. Management of Medical Needs

List any diagnoses, disease state or condition that continues to need or needs management, monitoring and/or treatments. (Include injections, oxygen, dressing changes, lab work, etc.) Indicate if the participant needs any assistance, the type of assistance, and who will provide.

7. Dietary Needs (check all that are new or continue to apply**):**

☐ Regular	☐ Low Sodium	☐ Low Fat		☐ Diabetic Diet
☐ Pureed	☐ Renal	☐ Aspiration precautions		☐ Thickened liquids
☐ Tube feeding	☐ Cardiac	☐ Uses adaptive equipment: _____		☐ Swallowing difficulties
☐ Dentures:	☐ Upper	☐ Lower	☐ Partial	☐ Followed by Dietician Services?

☐ Special Dietary Considerations (e.g. vegetarian, kosher, etc): (specify)
_____

Describe any specific information that pertains to participant's ability to eat and drink:

Describe any changes that have occurred since the last Service Plan:

REVISED SERVICE PLAN

3. Profile of Participant (continued)

B. Medical/Functional Information (continued)

8. Visual Ability (Check all that are new or continue to apply)

☐ Blind: ☐ Right eye ☐ Left Eye ☐ Fields Cut:_____ ☐ Visually Impaired
☐ Wears Glasses ☐ Uses Braille ☐ Needs Large Print ☐ Cataracts
☐ Eye Prosthesis ☐ Guide Dog ☐ Other:_____

Describe any specific information that pertains to the participant's ability to see:

Describe any changes that have occurred since the last Service Plan:

9. Hearing Ability (Check all that are new or continue to apply)

☐ Hears adequately ☐ Hearing difficulty Uses Hearing Aid: ☐ Right ear ☐ Left ear
☐ Sign Language ☐ Other devices used _____

Describe any specific information that pertains to the participant's ability to hear:

Describe any changes that have occurred since the last Service Plan:

10. Communication Skills

Primary language is:_____
Other languages spoken/understood: _____

Describe any specific information that pertains to the participant's ability to speak and understand (include if a translator is needed and who provides the service):

Describe any changes that have occurred since the last Service Plan:

Assistive Technology used: _____

11. Other Needs

Does the participant use a service animal? ☐ Yes ☐ No If yes, type: _____
Does the service animal have any special needs? ☐ Yes ☐ No If yes, type: _____
Where does the animal receive care/treatment, if needed? _____
Where is the service animal boarded if participant is hospitalized? _____
Describe any changes that have occurred since the last Service Plan:

REVISED SERVICE PLAN

4. Current Community Living Situation

List any changes to the participants living situation since last Service Plan**.**

Currently participant resides in:

☐ A home owned or leased by self/family member
☐ A leased apartment with lockable access and has own living, sleeping and eating areas
☐ A community-based residential setting with no more than 4 unrelated individuals
☐ Adult Care Facility
☐ Other:_____

5. Current Supports and Services

a) Social/Informal Supports:
List all family, friends and/or community resources who currently provide support to the participant and will continue to do so during this Service Plan period:

b) Formal Supports:
List all State and Federal non-Medicaid services the participant will receive during this Service Plan period (e.g. Medicare services, VA, VESID, Office of Aging, etc.) Include frequency and duration for each. Using this information, complete and attach the Insurance, Resources and Funding Information sheet.

c) Describe all Medicaid State Plan services participant will be receiving and the reason for them. (e.g. personal care services, nursing, medical day care, lab work, PT, OT, x-rays, etc). Include frequency and duration for each and the means of delivery (e.g. nursing from a CHHA, PT from a clinic, etc). Using this information, complete the Medicaid State Plan Services chart.

REVISED SERVICE PLAN

5. Current Supports and Services (cont)

Does the participant receive services through CDPAP? ☐ Yes ☐ No

In the previous Service Plan, did the participant change from CDPAP Services to regular services?

☐ Yes ☐ No If yes, why?

6. Oversight/supervision and/or Assistance with Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs)

As explained in Section VI of the Program Manual - Waiver Services - arrangements may need to be made for participants to be assessed for oversight/supervision and/or assistance with ADL/ IADL tasks, and arrangements made for informal supports or for formal supports through the waiver service of "Home and Community Support Services" (HCSS) or State Plan services such as personal care.

Instructions:

1) If the participant is not currently receiving HCSS and there is no indication of need at this time, check this box ☐ and skip to page 11.
2) If the participant is currently receiving HCSS and this is anticipated to continue during this Revised Service Plan period, check this box ☐ and skip to page 11.
3) If the participant now appears to need oversight/supervision and/or personal care services, complete all questions in this section (A, B and C)

Note: Use "N/A" where applicable.

A. For participants needing oversight/supervision for cognitive needs

Describe the time frame during which oversight/supervision will be required and clearly explain why oversight/supervision is needed during this time (e.g. unsafe wandering due to dementia). Attach a copy of any related supportive documentation to this Service Plan (e.g. notes from the physician, hospital and/or nursing home)

Indicate the extent to which informal supports will be available to provide the participant with needed oversight/supervision, (e.g. all needs can be met by the son and a neighbor; a son can provide oversight/supervision on Saturdays but not other needed days).
Note: If informal supports are sufficient to fully meet needs, no referral to HCSS is required.

If informal supports are not sufficient to meet all of the applicant's oversight/supervision needs and a referral was made for an HCSS assessment, indicate the extent to which HCSS will be used to meet those needs. Attach a copy of the completed HCSS evaluation with recommendations. (Proceed to Section 7 – Explanation of Need for Waiver Services)

REVISED SERVICE PLAN

6. Oversight/supervision and/or Assistance with Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs)

If HCSS will be provided for oversight and supervision, indicate the extent to which the applicant will also need assistance with ADL/IADL tasks through HCSS. The HCSS evaluation attached to this Service Pan should also address the necessary tasks.

B. For participants needing assistance with ADL/IADL tasks but not oversight/supervision

Indicate the extent to which informal supports will be available to provide the participant with needed assistance, (e.g. all needs can be met by the son and a neighbor; a son can provide assistance on Saturdays but not other needed days).
Note: If informal supports are sufficient to fully meet needs, no referral to other services is required.

If informal supports will not be sufficient to meet all of the participant's needs and a referral was made to the appropriate local social services district for an assessment for personal care including the Consumer Directed Personal Assistance Program (CDPAP), indicate the extent to which personal care or CDPAP was authorized and will be used to meet those needs. A full explanation should be included in Item #5b on page 8 of this Service Plan.

Indicate whether the applicant's needs were beyond the scope of a personal care aide and whether arrangements were, therefore, made for other services (e.g. certified home health agency, private duty nursing, CDPAP). Such services should be explained in Item # 5b on page 8 of this plan.

C. Alternatives Considered

Needs for oversight/supervision and/or ADL/IADL tasks can sometimes be met with other services (e.g. medical supplies, durable medical equipment, assistive technology, etc). Indicate whether such efficiencies have been considered and are explained elsewhere in this Service Plan.

REVISED SERVICE PLAN

7. Explanation of Need For Waiver Services

Describe why participant continues to need NHTD Waiver services in order to remain in the community and avoid nursing home placement:

8. Service Coordinator Overview of Waiver Services

For question 1a and b of this section only: these services do not require the submission of an Individual Service Report (ISR). However, justification of use and continued need must be documented.

1a. Describe which of the following services were used in the last Service Plan and include the accomplished goals for each (Assistive Technology, Community Transition Services, Congregate and Home Delivered Meals, Environmental Modifications Services and Moving Assistance):

b. Describe which of the following services will continue to be utilized in this Service Plan including desired goals, justification of need, and the frequency/amount of each service (Assistive Technology, Congregate and Home Delivered Meals, Environmental Modifications Services and Moving Assistance):

2. List all waiver services that will continue from the last Service Plan (Include in the chart in Section #10 - Waiver Service and Cost projection) and attach an ISR for each service listed.

REVISED SERVICE PLAN

8. Service Coordinator Overview of Waiver Services (continued)

Describe any new service(s) requested in this Service Plan below and list each service in the chart in Section #10 - Waiver Service and Cost projection:

Name of New Service Requested:
Explain the need for this service

Identify the participant's desired goals for the service, the frequency/amount of the service.

Describe the specific activities targeted for the next six (6) months.

Name of New Service Requested:
Explain the need for this service

Identify the participant's desired goals for the service, the frequency/amount of the service.

Describe the specific activities targeted for the next six (6) months.

Name of New Service Requested:
Explain the need for this service

Identify the participant's desired goals for the service, the frequency/amount of the service.

Describe the specific activities targeted for the next six (6) months.

REVISED SERVICE PLAN

8. Service Coordinator Overview of Waiver Services (continued)

Name of New Service Requested:
Explain the need for this service

Identify the participant's desired goals for the service, the frequency/amount of the service.

Describe the specific activities targeted for the next six (6) months.

Name of New Service Requested:
Explain the need for this service

Identify the participant's desired goals for the service, the frequency/amount of the service.

Describe the specific activities targeted for the next six (6) months.

Name of New Service Requested:
Explain the need for this service

Identify the participant's desired goals for the service, the frequency/amount of the service.

Describe the specific activities targeted for the next six (6) months.

REVISED SERVICE PLAN

9. Medicaid State Plan Services* and Cost Projection

Type of Service	Provider (Name and Telephone)	Effective Date	Frequency & Duration (e.g. 2 hrs., 3X per week)	Annual Amount of Units	Rate	Total Projected Medicaid Annual Cost
Medications, Medical Supplies and DME from page 4						

Total Projected Medicaid Annual Cost for All Medicaid State Plan Services $ _____

*****Included but not limited to Outpatient services, Certified Home Health Aide (CHHA), Medical Day Care, Personal Care Aide (PCA), Consumer Directed Personal Assistance Program (CDPAP), nursing, physician's services, transportation, medical supplies, DME.

REVISED SERVICE PLAN

10. Waiver Services and Cost Projection

Waiver Service	Provider (Name, Address, Telephone)	Effective Date	Frequency & Duration (e.g. 2 hrs., 3X per week)	Annual Amount of Units	Rate	Total Projected Medicaid Annual Cost
Service Coordination						

Total Projected Medicaid Annual Cost for All NHTD Waiver Services $ _____

REVISED SERVICE PLAN

11. Projected Total Annual Costs for Revised Service Plan

1. Total Projected Medicaid Annual Cost of Medicaid State Plan Services (page 13) _____

2. Total Projected Medicaid Annual Cost of NHTD Waiver Services (page 14) **+** _____

Total of # 1 and #2 = **=** _____

3. Total Projected Medicaid Annual Cost of Medicaid Spend-down (from Insurance, Resources, and Funding Information sheet) (Multiply one month of spend-down x 12) **-** _____

4. Total Projected Medicaid Annual Cost of all Medicaid Services **=**
(#1 Plus #2 Minus #3) _____

5. Total Projected Daily Rate of all Medicaid Services **=**
(#4 divided by 365) _____

6. Total Change in Cost from Last Plan (indicate whether + or -) _____

REVISED SERVICE PLAN

12. Projected Weekly Schedule of All Services (Include informal supports, waiver and non-waiver services)

Use * to indicate shared services and identify ratio of staff to participant

Participant Name: **Date of Revised Service Plan:**

Time	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
7:00 - AM							
8:00							
9:00							
10:00							
11:00							
NOON							
1:00 – PM							
2:00							
3:00							
4:00							
5:00							
6:00							
7:00							
8:00							
9:00							
10:00							
11:00							
12:00 AM							
1:00 AM – 7:00 AM							

REVISED SERVICE PLAN

13. Waiver Services Comparison Chart

Complete chart to show changes in service(s) from the most recent Service Plan to the newly requested Revised Service Plan. For each service listed in column (1), complete columns (2) and (3) indicating the amount at which the service is or will be provided. In column (4), indicate whether the service has been increased (↑), decreased (↓), **no change** in service, a new service (**N**), or an Addendum **(A)** item. Once completed, the chart must be reviewed with the participant.

NOTE: For services not used in the previous Service Plan or services not requested as a new service in the Revised Service Plan, please mark (4) as "N/A".

(1) Services	(2) Most Recent Service Plan including Addendum	(3) New Service Plan	(4) Change in Service- ↑, ↓, N, no change, A
1. Service Coordination			
2. Assistive Technology			
3. Community Integration Counseling			
4. Community Transitional Services			
5. Congregate and Home Delivered Meals			
6. Environmental Modifications Services			
7. Home and Community Support Services			
8. Home Visits By Medical Personnel			
9. Independent Living Skills Training Services			
10. Moving Assistance			
11. Nutritional Counseling/Educational Services			
12. Peer Mentoring			
13. Positive Behavioral Interventions and Supports			
14. Respiratory Therapy			
15. Respite Services			
16. Structured Day Program Services			
17. Wellness Counseling Service			

REVISED SERVICE PLAN

14. Signatures

I have participated in the development of this Revised Service Plan. I have read this Revised Service Plan or it has been read to me and I understand its contents and purpose as written. As a participant in this Home and Community Based Services (HCBS) waiver, I will work in cooperation with the agencies I have selected to provide waiver services indicated in this Revised Service Plan. I will talk with my Service Coordinator if I want to make any changes to this Revised Service Plan.

As a participant in this Home and Community Based Services (HCBS) waiver, I understand that I have the right to pursue a Fair Hearing at any time.

I understand that a copy of this Revised Service Plan will be provided to all waiver providers involved in this service plan.

☐ Mr. ☐ Mrs. ☐ Ms _____

Participant's Name (First/MI/Last/Generational Suffix) Signature Date

Name of Legal Guardian (if applicable) (print) Signature Date

Name of Other/Relationship to Participant (if applicable) (print) Signature Date

I have developed this Revised Service Plan with the above named participant as it is written. I support the request for the waiver services detailed in this Revised Service Plan and verify that in my professional opinion, they are necessary to maintain the health and welfare of the participant.

Name of Service Coordinator (print) Signature Date

Name of Service Coordinator Supervisor (print) Signature Date

Name and Address of Agency Telephone

I approve this Revised Service Plan as it is written.

RRDS Comments: _____

Name of RRDS (print) Signature Date

REVISED SERVICE PLAN
HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Insurance, Resources and Funding Information Sheet

Date: _____

Participant's Name: _____ CIN: _____

Address: _____

Phone: (H): _____ (W): _____ (C): _____

1. Insurance Information

Other Health Insurance: Company Name:_____

Telephone: _____ Policy #:_____ Group #:_____

Medicare #: _____ ☐ Medicare A Effective Date: ____/____/_____
☐ Medicare B Effective Date: ____/____/_____
☐ Medicare D Effective Date: ____/____/_____

Name of Medicare D Prescription Plan: _____

Medicare Managed Care ☐ Yes ☐ No

Company Name: _____

Telephone:_____ ID #:_____

Supplemental Insurance Company Name:_____

Telephone: _____ Policy #:_____ Group #:_____

Other Prescription Plan: Company Name:_____

Telephone: _____ Policy #: _____ Group #:_____

Medicaid Spend-down Per Month $_____

Spend-down to be applied to ☐ LDSS **or** ☐ Service:_____

Medicaid Managed Care ☐ Yes ☐ No

Company Name: _____

Telephone:_____ ID #: _____

Veteran ☐ Yes ☐ No Receives services? ☐ No ☐ Yes (List) _____

Insurance and Resource/Funding Information Sheet (continued)

2. Resources and Funding

A. Income

Income Source	Amount	Denied/ Date	Will Apply Upon Enrollment	Who Will Assist With Application?
Social Security				
Social Security Disability Insurance				
Supplemental Security Income				
Veteran's Administration				
Public Assistance				
Supplemental Needs Trust				
Other Trust				
Worker's Compensation				

B. Federal, State and Private Funded Resources/Services

Funding Source	Amount	Denied/ Date	Type and Frequency of Service	Will Apply Upon Enrollment?	Who Will Assist With Application?
HUD/Section 8					
HEAP					
Food Stamps					
Crime Victims Funding					
VESID					
OMRDD					
Worker's Compensation					
No Fault Insurance					
Veteran's Administration					
Medicare					
Other Insurance:					
NHTD Housing Subsidy					
Other:					

Insurance and Resource/Funding Information Sheet (continued)

Housing Supplement	YES	NO
Low income housing tax credits		
HOME dollars		
CDBG funds		
Housing choice vouchers (such as tenant based, project based, mainstream or homeownership vouchers)		
Housing trust funds		
Section 811		
202 funds		
USDA rural housing funds		
Veterans Affairs housing funds		
Funds for home modifications		
Funds for assistive technology as it relates to housing		
Other, specify:		

Participant Signature Date

Service Coordinator Signature Date

ADDENDUM TO EXISTING SERVICE PLAN

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Date: ____/____/____

1. Identification

Participant Name: _____ Date of Birth: _____

Address: _____
Street City County State Zip

Mailing Address (if different from above): _____

_____

Phone: Home (____) _____ Work (____) _____ Cell (____) _____

CIN: _____ County of Fiscal Responsibility: _____ Verified ☐ Yes ☐ No
***Attach documented proof of Medicaid eligibility**

Current Service Plan Period From _____ To _____

Individuals who participated in developing the Addendum to the Existing Service Plan

Name	Relationship to Participant	Telephone

DO NOT WRITE BELOW THIS LINE – RRDS will complete

Date of Submission to RRDS by SC: _____
Date of Submission to QMS by RRDS (if applicable): _____
Date returned to RRDS by QMS (if applicable): _____
Date of Final Decision by RRDS: _____

ADDENDUM TO EXISTING SERVICE PLAN

2. Summary of Request for Changes in Waiver Service(s)

A. Describe the changes that the waiver participant has experienced which resulted in the need for this Addendum.

B. Describe which service(s) will be added, discontinued, and/or changed. Indicate the need for the addition, discontinuation or other change in service(s), the frequency and duration, and the participant's goals:
NOTE: Attach an Individual Service Report (ISR), where applicable for each added and/or changed service.

C. Describe what, if any, impact the requested changes in the NHTD waiver service(s) have on the Plan for Protective Oversight (PPO).
NOTE: If this Addendum impacts the current PPO, a revised PPO must be attached.

ADDENDUM TO EXISTING SERVICE PLAN

3. Medicaid State Plan Services* and Cost Projection

Type of Service	Provider (Name & Telephone)	Effective Date	Frequency & Duration (2 hrs., 3X per week)	Annual Amount of Units	Rate	Total Projected Medicaid Annual Cost
Medications, Medical Supplies and DME						

Total Projected Medicaid Annual Costs for All Medicaid State Plan Services $ _____

Current Service Plan Cost $ _____

Change in Cost from last plan $ _____

***** Included but not limited to Outpatient services, Certified Home Health Aide (CHHA), Medical Day Care, Personal Care Aide (PCA), Consumer Directed Personal Assistance Program (CDPAP), nursing, physician's services, transportation, medical supplies and DME.

ADDENDUM TO EXISTING SERVICE PLAN

4. Waiver Services and Cost Projection

Complete the chart to indicate requested changes in services. Indicate all waiver services the participant will be receiving.

Waiver Service	Provider (Name, Address, Telephone)	Effective Date	Frequency & Duration (2 hrs., 3X per week)	Annual Amount of Units	Rate	Total Projected Medicaid Annual Cost
Service Coordination						

Total Projected Medicaid Annual Cost for All NHTD Waiver Services $ _____

Current Service Plan Cost $ _____

Change in Cost from last plan $ _____

ADDENDUM TO EXISTING SERVICE PLAN

5. Projected Total Annual Costs for Service Plan

1. **Total Projected Medicaid Annual Cost for all Medicaid State Plan Services** (page 3) _____

2. **Total Projected Medicaid Annual Cost for all Waiver Services** (page 4) **+** _____

3. **Total Projected Medicaid Annual Cost of Medicaid Spend-down** **=** _____
   (From the most current Revised Service Plan)

4. **Total Projected Medicaid Annual Cost for the Addendum** (#1 plus #2 minus #3) **-** _____

5. **Total Projected Daily Rate of all Medicaid Services** (#4 divided by 365) **=** _____

6. **Total Projected Change in Annual Cost from Current Service Plan** **=** _____
   (Compare #4 to the Projected Total Annual Cost of the current Service Plan)

ADDENDUM TO EXISTING SERVICE PLAN

6. Projected Weekly Schedule of All Services (Include informal supports, waiver and non-waiver services)

Use * to indicate shared services and identify ratio of staff to participant

Participant's Name: **Date of Addendum:**

Time	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
7:00 - AM							
8:00							
9:00							
10:00							
11:00							
NOON							
1:00 – PM							
2:00							
3:00							
4:00							
5:00							
6:00							
7:00							
8:00							
9:00							
10:00							
11:00							
12:00 AM							
1:00 AM – 7:00 AM							

ADDENDUM TO EXISTING SERVICE PLAN

7. Signatures

I have participated in the development of this Addendum. I have read this Addendum or it has been read to me and I understand its contents and purpose as written. As a participant in the Home and Community Based Services (HCBS) waiver, I will work in cooperation with the agencies I have selected to provide services in this Addendum. I will talk with my Service Coordinator if I want to make any changes to this Addendum.

As a participant in this Home and Community Based Services (HCBS) waiver, I understand that I have the right to pursue a Fair Hearing at any time

I understand that a copy of this Addendum will be provided to all waiver providers involved in this service plan.

Name of Participant	Signature	Date
Name of Legal Guardian (if applicable)	Signature	Date
Name of Other/Relationship to Participant (if applicable)	Signature	Date

I have written this Addendum and support the request for the waiver services detailed in this Addendum. I verify that in my professional opinion, they are necessary to maintain the health and welfare of the participant.

The information in the current PPO has been reviewed with the above named participant and there are:

☐ changes to the current PPO. A copy of the new PPO is attached **or**
☐ no changes to the current PPO

Name of Service Coordinator	Signature	Date
Name of Service Coordinator Supervisor	Signature	Date
Name and Address of Agency		Telephone

I approve this Addendum as it is written.
The Effective Date of this Addendum is: _____

Name of RRDS	Signature	Date

INDIVIDUAL SERVICE REPORT (ISR)

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Participant Name CIN

Waiver Service Provider Agency Telephone

Date of Current Approved Service Plan From: _____ To: _____

Date of Addendum (if applicable) _____

---

1. Identify each of the participant's goal(s) for this service which have been addressed during the current Service Plan.

2. Identify the interventions used to address each goal as described in your Detailed Plan.

3. Identify any progress made for each goal.

INDIVIDUAL SERVICE REPORT (ISR) (continued)

4. Identify any barriers to progress for each goal.

5. Identify the participant's goal(s), expected interventions and outcomes for this service in the next Service Plan.

6. Provide recommendations for frequency and duration of this service in the next Service Plan.

7. Explain why this service is necessary to assure health and welfare in the next Service Plan.

Provider Signature Date

Service Coordinator Signature Date ISR Received

Nursing Home Transition and Diversion Waiver

TEAM MEETING SUMMARY

Participant's Name: _____

Date/Time of Meeting: ___/___/___ at _____ am/pm

Location: _____

Facilitator: _____

Participant's Comments: _____

Recommendations for changes in the Service Plan: _____

Issues Addressed: _____

TEAM MEETING SUMMARY
continued

Participant's Name: _____ Date: _____

Outstanding Issues/Health and Welfare Concerns: _____

Next Steps: _____

Anticipated Time Frame for Next Team Meeting: _____

TEAM MEETING SUMMARY
continued

Participant's Name: _____ Date: _____

ATTENDANCE:

Service	Attendee Signature	Agency Name	ISR Submitted? (Y) (N) (N/A)
Service Coordinator			
Assistive Technology			
Community Integration Counseling			
Community Transitional Services			
Congregate and Home Delivered Meals			
Environmental Modifications Services			
Home and Community Support Services			
Home Visits By Medical Personnel			
Independent Living Skills Training			
Moving Assistance			
Nutritional Counseling/Educational Supports			
Peer Mentoring			
Positive Behavioral Interventions and Supports			
Respiratory Therapy			
Respite Services			
Structured Day Program Services			
Wellness Counseling Service			

_____

Participant (and/or Guardian, if applicable) Signature Date

_____

Signature of Service Coordinator / Agency Date

CHANGE OF PROVIDER REQUEST

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVERS
Nursing Home Transition and Diversion (NHTD)

I, (Participant Name)_____ (CIN) _____ request to make the following change in waiver service provider agency and/or the agency staff currently providing this service to me.

I have been informed of my right to remain with this current waiver service provider agency or select a new agency from a list of all available Waiver Service Providers for this service.

Waiver Service	Current Provider Agency Name or Provider Agency Staff Name and Telephone	Requested Provider Agency Name or Provider Agency Staff Name and Telephone

_____
Participant Signature Date

_____
Legal Guardian Signature (as applicable) Date

_____
Authorized Representative Signature (as applicable) Date

NOTE: SERVICE COORDINATOR MUST CONTACT CURRENT AND REQUESTED PROVIDER OF THIS REQUEST.

_____
Current Service Coordinator Signature Agency Name Date

Transition Meeting to be held on: _____/_____/20____ at _____am / pm

To be completed by the Requested Provider:

_____ _____ will provide service(s) to the above named participant
Provider / Provider Agency _____ will not provide service(s) to the above named participant
Reason: _____

_____

_____
Provider Contact Signature/Title Date

To be completed by the Regional Resource Development Specialist:

This request for change in waiver Provider and/or waiver Provider Agency has been reviewed and:

☐approved Services to begin effective ____/____/___

☐denied (explanation): _____

_____
Regional Resource Development Specialist Signature Date

cc: Participant
Legal Guardian (if applicable)
Authorized Representative (If applicable)
Current Waiver Service Provider
New Waiver Service Provider
All current Provider Agencies

QUALITY MANAGEMENT SPECIALIST
SERVICE PLAN REVIEW FORM

Nursing Home Transition and Diversion (NHTD) Medicaid Waiver

Applicant/Participant Name: _____ CIN: _____

To be completed by RRDS:
RRDC: _____ RRDC Region: _____
Date received by RRDS: _____ Date reviewed by RRDS: _____
Proposed Daily Rate: $_____ Service Plan Effective Date: _____
RRDS Comments/Considerations:
_____
_____
_____
_____
_____
_____
RRDS Signature: _____ Date: _____

To be completed by QMS:
Date received by QMS: _____ RRDS review form attached: ___ yes ___ no
SC agency: _____
Date reviewed by QMS: _____

QA Targets	Yes	No	Comments
1. Are all necessary components of the Service Plan packet provided for this review?			
2. Does the SP meet the health and welfare needs of this applicant/participant in the community?			
3. Are the waiver services being requested justified in the Service Plan?			

4. Does the Service Plan reflect the means of increasing the applicant/participant's independence?			
5. Does this Service Plan reflect the philosophy of the NHTD waiver and person-centered planning?			
6. Is there evidence that other payer sources have been appropriately utilized prior to waiver services?			
7. Can this Service Plan be supported as written?			

QMS Concerns:

_____
_____
_____
_____
_____
_____

QMS Recommendations:

_____
_____
_____
_____
_____
_____

Quality Management Specialist : _____ QMS Region: _____

Date returned to RRDS: _____

SERIOUS REPORTABLE INCIDENT
INITIAL REPORT

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

RRDC Region: _____

Participant Name: _____ CIN: _____

Address: _____

_____ Phone: _____

Discovery Date and Time: ___/___/_____ am/pm Name of person discovering alleged incident: _____

Relationship to Participant: _____:

Date and Time alleged incident occurred: ___/___/_____ am/pm

Preliminary category of alleged incident:

☐ 1. Abuse/Neglect
☐ 2. Missing Person
☐ 3. Restraint
☐ 4. Death of Participant
☐ 5. Hospitalization
☐ 6. Possible Criminal Act
☐ 7. Sensitive Situation
☐ 8. Medication Error/Refusal
☐ 9. Medical Treatment Due to Accident or Injury

Describe the alleged incident (include the location where it occurred, any person(s) present at the time, and the circumstances). Include only known facts.

Describe waiver participant's current condition/status and current location:

List any person(s) alleged to be involved in incident:

Describe any actions taken to assist the waiver participant:

Name of Waiver Staff first notified, if not discoverer: _____ Title: _____

Report completed by: _____ Title: _____

Reporting Agency: _____ Telephone: _____

Date and Time reported to QMS: ___/___/_____ am/pm Name of QMS: _____
Date and Time Initial Provider Report faxed to QMS: ___/___/_____ am/pm
Date and Time copy of report sent to RRDS: ___/___/_____ am/pm Name of RRDS: _____
Date and Time copy of report sent to SC: ___/___/_____ am/pm Name of SC: _____

FOR QMS USE ONLY:
Form Sent to DOH WMS Date: ___/___/_____

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

SERIOUS REPORTABLE INCIDENT
24-HOUR PROVIDER REPORT

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Participant Name:_____ CIN: _____ RRDS Region: _____

Date alleged incident discovered: __/__/__ Time alleged incident discovered: _____ am / pm

Date alleged incident occurred: __/__/__ Time alleged incident occurred: _____ am / pm

Location and address of alleged incident: _____

_____

Did discovering person directly observe the alleged incident? _____ Yes _____ No

Individual(s)/witness(s) present at the time of the alleged incident:

Name	Agency/Relationship to Participant	Telephone Number	Waiver Service Provided (If Applicable)

Classification of the alleged incident: Check all that apply according to the definitions in the Serious Reportable Incident Policy.

a. Allegation of Abuse: (category)

____ Physical Abuse ____ Sexual Abuse ____ Psychological Abuse
____ Neglect ____ Seclusion ____ Violation of Civil Rights
____ Mistreatment ____ Exploitation (financial or material)
____ Unauthorized or Inappropriate Use of Restraint ____ Use of Aversive Conditioning

b. Other Serious Reportable Incidents:

_____Missing Person _____Possible Criminal Act _____Restraint
_____Sensitive Situation _____Death _____Medication Error/Refusal
_____Hospitalization _____Medical Treatment Due to Accident/Injury

SERIOUS REPORTABLE INCIDENT
24-HOUR PROVIDER REPORT (cont.)

Participant Name:_____ CIN #: _____

c. Was the Alleged Incident:

___ Participant only
___ Participant to Staff?
___ Staff to Participant?
___ Participant to Participant?
___ Participant to Other?
___ Other to Participant?

d. If there was an injury, identify type of injury sustained, and any information regarding the possible cause:

_____
_____
_____
_____
_____

e. Describe the alleged incident including anyone who may have been involved, the follow-up steps taken, and person(s) conducting the follow-up?

f. Include a statement from the participant regarding this alleged incident (use “quotes” when applicable):

g. NOTIFICATIONS:

☐ APS notified By Whom: _____
☐ Police notified By Whom: _____
☐ Other notified: (specify) _____ By Whom: _____
☐ Other notified: (specify) _____ By Whom: _____

SERIOUS REPORTABLE INCIDENT
24-HOUR PROVIDER REPORT (cont)

Participant Name:_____ CIN: _____

g. NOTIFICATIONS (continued):

Reporter's Notification to Waiver Entities:

	Person Notified, Title and Agency	Date Notified
Quality Management Specialist (QMS)		
Regional Resource Development Specialist (RRDS)		
Service Coordinator/ Supervisor		

_____
Person completing this report/Title Signature

_____
Provider Agency Telephone Date

_____
Supervisor of person completing this report/Title Signature

_____
Provider Agency Telephone Date

FOR QMS USE ONLY:
Form Sent to DOH WMS Date: ___/___/_____

SERIOUS REPORTABLE INCIDENT
SERVICE COORDINATION
24-HOUR NOTIFICATION REPORT

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Date: _____

Participant Name:_____
RRDC Region: _____CIN: _____
Incident Date: _____

Person(s) Notified by Service Coordinator or Service Coordination Supervisor:

	Name of Person Notified	Reason	Date Notified
Participant			
Legal Guardian			
Other			
Provider Agency Name:			
Provider Agency Name:			
Provider Agency Name:			

***Upon completion of form, send to Quality Management Specialist**

_____
Service Coordinator Name Signature Date

_____
Service Coordination Supervisor Name (if applicable) Signature Date

FOR QMS ONLY:
Form Sent to DOH WMS Date: ___/___/_____

SERIOUS REPORTABLE INCIDENT
QUALITY MANAGEMENT SPECIALIST
INITIAL RESPONSE

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

An **allegation** of a Serious Reportable Incident involving

Participant Name: _____ CIN: _____

was reported on: _____ by: _____
Date Discoverer

The incident number for this Serious Reportable Incident is: _____ - _____ - _____ - _____

This incident has been originally classified as: _____
Category(s) of Incident

Select one (A, B or C):

A. ☐ QMS agrees with original classification of this incident.

B. ☐ QMS does not agree with original classification of the incident and has re-classified the incident to:

☐ 1. Abuse and Neglect (select type):
- ☐ Physical Abuse
- ☐ Sexual Abuse
- ☐ Psychological Abuse
- ☐ Seclusion
- ☐ Use of Aversive Conditioning
- ☐ Violation of Civil Rights
- ☐ Mistreatment
- ☐ Neglect
- ☐ Exploitation
- ☐ Missing Person
- ☐ Restraint

☐ 2. Missing Person ☐ 3. Restraint ☐ 4. Death ☐ 5. Hospitalization
☐ 6. Possible Criminal Act ☐ 7. Medication Error/Refusal ☐ 8. Medical Treatment Due to Accident/Injury
☐ 9. Sensitive Situation

C. ☐ QMS has re-categorized this Serious Reportable Incident to a Recordable Incident status.
NOTE: QMS must also complete the QMS "Status Report" form and 'Close' this investigation.

The investigation has been assigned on: ___/___/___ to: _____
Date Provider Agency

located at: _____
Address

QMS Comments: _____

A Follow-Up Report is due:
within seven (7) calendar days of the date of this report: (Date Due) _____ **and**
within thirty (30) calendar days of the date of this report: (Date Due) _____

QMS Comments: _____

QMS Name Signature Date

Copy sent to: Reporting Provider Agency (date) _____ Investigating Provider Agency (date) _____
Regional Resource Development Specialist (date) _____ Service Coordinator (date) _____

FOR QMS USE ONLY:
Form Sent to DOH WMS Date: _____/_____/_____

SERIOUS REPORTABLE INCIDENT
PROVIDER FOLLOW-UP REPORT

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Participant Name: _____ Incident #_____-_____-_____-_____

Check One:

_____ Seven Day Report _____
Date Completed

_____ Thirty Day Report _____
Date Completed

_____ Additional Follow-Up Report(s) _____
Date Completed

1. What actions (initial or newly conducted) have been taken to investigate this incident (e.g person(s) interviewed, record review, consultations, etc)?
   NOTE: Attach all supporting documentation

2. What have been the results of these actions?

3. What follow-up actions have been taken in response to these results (e.g., changes to the Service Plan, staff changed, police called, etc.)?

4. What has been the results of these follow-up actions (e.g., NHTD waiver participant's behavior has changed, NHTD waiver participant is more satisfied with staff, safety of NHTD waiver participant has been secured, etc)?

SERIOUS REPORTABLE INCIDENT
PROVIDER FOLLOW-UP REPORT (cont.)

5. What, if any, long term activities has the provider initiated to decrease, either in frequency or intensity, the possibility of similar incidents occurring in the future?

6. What activities are necessary to complete the investigation?

7. At this time, do you expect that this incident should remain open or closed? Why?

Agency Investigator	Signature	Date
Responsible Provider Representative	Signature/Title	Date
Provider Agency		Telephone

For Investigating Agency:
Copy of this report was sent to: QMS _____ Date

For QMS:
Copy of this report was sent to: RRDS _____ Date

Service Coordinator _____ Date

FOR QMS USE ONLY:
Form Sent to DOH WMS Date: ___/___/_____

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

SERIOUS REPORTABLE INCIDENT
QUALITY MANAGEMENT SPECIALIST
STATUS REPORT

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Participant Name: _____ CIN: _____

___ This incident has been re-categorized as a Recordable Incident as indicated on the QMS Initial Response form and is considered **CLOSED.**

QMS Comments: _____

_____

QMS received a Follow-Up Report on: _____ for incident #: _____-_____-_____-_____
Date

_____
Investigating Provider Agency

_____
Address

_____
Provider Representative Agency Investigator

___ The incident has been re-classified**.** (Please change your database to reflect this revised classification). The incident was re-classified as: _____

QMS Comments: _____

_____

Check One:

___ The incident is considered **OPEN**. Further follow-up/intervention/clarification is required. A Serious Reportable Incident Follow-Up Report must be submitted by: _____

QMS Comments: _____

_____

___ The incident is considered **CLOSED**. No further action is necessary.
Final Classification: _____

QMS comments: _____

_____

_____

_____
QMS Signature Date

_____

Copy sent to: RRDS Date: _____
Service Coordinator Date: _____
Investigating Provider Date: _____

FOR QMS USE ONLY:
Form Sent to DOH WMS Date: ___/___/_____

SERIOUS REPORTABLE INCIDENT
QUALITY MANAGEMENT SPECIALIST
POST-INVESTIGATION FOLLOW-UP CONTACT WITH PARTICIPANT

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Participant Name _____ Incident Number _____

Person(s) Contacted:

___ Participant Date Notified: _____ Time Notified: ____ am/pm

___ Other Person _____ Relationship to Participant: _____
Date Notified: _____ Time Notified: ____ am/pm

___ Other Person _____ Relationship to Participant: _____
Date Notified: _____ Time Notified: ____ am/pm

Participant/Legal Guardian Comments: _____

QMS Comments: _____

QMS Name Signature Date

Copy of this form was sent to: RRDS _____ Date
Service Coordinator _____ Date
Investigating Agency _____ Date

FOR QMS USE ONLY:
Form Sent to DOH WMS Date: ___/___/_____

Hospital and Community Patient Review Instrument (HC-PRI)

RUG II Group (print name)

RHCF Level of Care:
☐ HRF ☐ SNF

Use with separate Hospital and Community PRI Instructions

I. ADMINISTRATIVE DATA

1. OPERATING CERTIFICATE NUMBER (1-8)

2. SOCIAL SECURITY NUMBER (9-17) - -

3. OFFICIAL NAME OF HOSPITAL OR OTHER AGENCY/FACILITY COMPLETING THIS REVIEW

4A. PATIENT NAME (AND COMMUNITY ADDRESS IF REVIEWED IN COMMUNITY)

4B. COUNTY OF RESIDENCE

5. DATE OF PRI COMPLETION

(18-25) - -
MO DAY YEAR

6. MEDICAL RECORD NUMBER/CASE NUMBER (26-34)

7. HOSPITAL ROOM NUMBER (35-39)

8. NAME OF HOSPITAL UNIT/DIVISION/BUILDING

9. DATE OF BIRTH

(40-47) - -
MO DAY YEAR

10. SEX (48) 1=Male 2=Female

11A. DATE OF HOSPITAL ADMISSION OR INITIAL AGENCY VISIT

(49-56) - -
MO DAY YEAR

11B. DATE OF ALTERNATE LEVEL OF CARE STATUS IN HOSPITAL (IF APPLICABLE)

(57-64) - -
MO DAY YEAR

12. MEDICAID NUMBER (65-75)

13. MEDICARE NUMBER (76-85)

14. PRIMARY PAYOR (86)
1=Medicaid
2=Medicare
3= Other

15. REASON FOR PRI COMPLETION (87)
1. RHCF Application from Hospital
2. RHCF Application from Community
3. Other (Specify:)

II. MEDICAL EVENTS

16. DECUBITUS LEVEL: ENTER THE MOST SEVERE LEVEL (0-5) AS DEFINED IN THE INSTRUCTIONS. _____

17. MEDICAL CONDITIONS: DURING THE PAST WEEK. READ THE INSTRUCTIONS FOR SPECIFIC DEFINITIONS
1=YES
2=NO

A. Comatose _____
B. Dehydration _____
C. Internal Bleeding _____
D. Stasis Ulcer _____
E. Terminally Ill _____
F. Contractures _____
G. Diabetes Mellitus _____
H. Urinary Tract Infection _____
I. HIV Infection Symptomatic _____
J. Accident _____
K. Ventilator Dependent _____

18. MEDICAL TREATEMENTS: READ THE INSTRUCTIONS FOR THE QUALIFIERS.
1=YES
2=NO

A. Trachesotomy Care/Suctioning (Daily—Exclude self-care) _____
B. Suctioning-General (Daily) _____
C. Oxygen (Daily) _____
D. Respiratory Care (Daily) _____
E. Nasal Gastric Feeding _____
F. Parenteral Feeding _____
G. Wound Care _____
H. Chemotherapy _____
I. Transfusion _____
J. Dialysis _____
K. Bowel and Bladder Rehabilitation (SEE INSTRUCTIONS) _____
L. Catheter (Indwelling or External) _____
M. Physical Restraints (Daytime Only) _____

III. ACTIVITIES OF DAILY LIVING (ADLs)

Measure the capability of the patient to perform each ADL 60% or more of the time it is performed during the past week (7 days). Read the Instructions for the Changed Condition Rule and the definitions of the ADL terms.

19. EATING: PROCESS OF GETTING FOOD BY ANY MEANS FROM THE RECEPTACLE INTO THE BODY (FOR EXAMPLE: PLATE, CUP, TUBE) 19. (113)

1=Feeds self without supervision or physical assistance. May use adaptive equipment.
2=Requires *intermittent* supervision (that is, verbal encouragement/guidance) and/or minimal physical assistance with minor parts of eating, such as cutting food, buttering bread or opening milk carton.
3= Requires continual help (encouragement/teaching/physical assistance) with eating or meal will not be completed.
4=Totally fed by hand, patient does not manually participate
5=Tube or parenteral feeding for primary intake of food. (*Not* just for supplemental nourishments)

20. MOBILITY: HOW THE PATIENT MOVES ABOUT 20. (114)

1=Walks with no supervision or human assistance. May require mechanical device (for example, a walker), but not a wheelchair.
2=Walks with intermittent supervision (that is, verbal cueing and observation). May require human assistance for difficult parts of walking (for example, stairs, ramps).
3= Walks with *constant* one-to-one supervision and/or constant physical assistance.
4= Wheels with no supervision or assistance, except for difficult maneuvers (for example, elevators, ramps). May actually be able to walk, but generally does not move.
5= Is wheeled, chairfast or bedfast. Relies on someone else to move about, if at all.

21. TRANSFER: PROCESS OF MOVING BETWEEN POSITIONS, TO/FROM BED, CHAIR, STANDING, (EXCLUDE TRANSFERS TO/FROM BATH AND TOILET). 21. (115)

1=Requires no supervision or physical assistance to complete necessary transfers. May use equipment, such as railings, trapeze.
2=Requires *intermittent* supervision (that is, verbal cueing, guidance) and/or physical assistance for difficult maneuvers only.
3=Requires one person to provide constant guidance, steadiness and/or physical assistance. Patient may participate in transfer.
4=Requires two people to provide constant supervision and/or physically lift. May need lifting equipment.
5=Cannot and is not gotten out of bed.

22. TOILETING: PROCESS OF GETTING TO AND FROM A TOILET (OR USE OF OTHER TOILETING EQUIPMENT, SUCH AS BEDPAN). TRANSFERRING ON AND OFF TOILET, CLEANSING SELF AFTER ELIMINATION AND ADJUSTING CLOTHES. 22. (116)

1=Requires no supervision or physical assistance. May require special equipment, such as a raised toilet or grab bars.
2=Requires *intermittent* supervision for safety or encouragement, or *minor* physical assistance (for example, clothes adjustment or washing hands).
3=Continent of bowel *and* bladder. Requires constant supervision and/or physical assistance with major/all parts of the task, *including* appliances (i.e., colostomy, ileostomy, urinary catheter).
4=Incontinent of bowel *and/or* bladder and is not taken to a bathroom.
5=Incontinent of bowel *and/or* bladder, but is taken to a bathroom every two to four hours during the day and as needed at night.

IV. BEHAVIORS

23. VERBAL DISRUPTION: BY YELLING, BAITING, THREATENING, ETC. 23. (117)

1=No known history
2=Known history or occurrences, but not during the past week (7 days)
3=Short-lived or predictable disruption regardless of frequency (for example, during specific care routines, such as bathing.)
4=Unpredictable, recurring verbal disruption at least once during the past week (7 days) for no foretold reason
5=Patient is at level #4 above, but does not fulfill the active treatment and assessment qualifiers (in the instructions)

24. PHYSICAL AGGRESSION: ASSAULTIVE OR COMBATIVE TO SELF OR OTHERS WITH INTENT FOR INJURY. (FOR EXAMPLE, HITS SELF, THROWS OBJECTS, PUNCHES, DANGEROUS MANEUVERS WITH WHEELCHAIR) 24. (118)

1=No known history.
2=Known history or occurrences, but not during the past week (7 days).
3=Predictable aggression during specific care routines or as a reaction to normal stimuli (for example, bumped into), regardless of frequency. May strike or fight.
4=Unpredictable, recurring aggression at least once during the past week (7 days) for no apparent or foretold reason (that is, not just during specific care routines or as a reaction to normal stimuli).
5=Patient is at level #4 above, but does not fulfill the active treatment and assessment qualifiers (in the instructions).

25. DISRUPTIVE, INFANTILE OR SOCIALLY INAPPROPRIATE BEHAVIOR: CHILDISH, REPETITIVE OR ANTISOCIAL PHYSICAL BEHAVIOR WHICH CREATES *DISRUPTION WITH OTHERS*. (FOR EXAMPLE, CONSTANTLY UNDRESSING SELF, STEALING, SMEARING FECES, SEXUALLY DISPLAYING ONESELF TO OTHERS). EXCLUDE VERBAL ACTIONS. READ THE INSTRUCTIONS FOR OTHER EXCLUSIONS. 25. (119)

1=No known history
2=Displays this behavior, but is not disruptive to others (for example, rocking in place).
3=Known history or occurrences, but not during the past week (7 days).
4=Occurences of this disruptive behavior at least once during the past week (7 days)
5=Patient is at level #4 above, but does not fulfill the active treatment and psychiatric assessment qualifiers (in instructions).

26. HALLUCINATIONS: EXPERIENCED AT LEAST ONCE DURING THE PAST WEEK. VISUAL, AUDITORY OR TACTILE PERCEPTIONS THAT HAVE NO BASIS IN EXTERNAL REALITY. 26. (120)

1=Yes 2=No 3=Yes, but does not fulfill the active treatment and psychiatric assessment qualifiers (in the instructions)

V. SPECIALIZED SERVICES

27. PHYSICAL AND OCCUPATIONAL THERAPIES: READ INSTRUCTIONS AND QUALIFIERS. EXCLUDE REHABILITATIVE NURSES AND OTHER SPECIALIZED THERAPISTS (FOR EXAMPLE, SPEECH THERAPIST). ENTER THE LEVEL, DAYS AND TIME (HOURS AND MINUTES) DURING THE PAST WEEK (7 DAYS).

A. Physical Therapy (P.T.)

P.T. Level (121)

P.T. Days (122)

P.T. Time (123-126) HOURS MIN/WEEK

B. Occupational Therapy (O.T.)

O.T. Level (127)

O.T. Days (128)

O.T. Time (129-132) HOURS MIN/WEEK

LEVEL
1=Does not receive.
2= Maintenance program-Requires and is currently receiving physical and/or occupational therapy to help stabilize or slow functional deterioration.
3=Restorative Therapy-Requires and is currently receiving physical and/or occupational therapy for the past week.
4=Receives therapy, but does not fulfill the qualifiers stated in the instructions. (For example, therapy provided for only two days).

DAYS AND TIME PER WEEK: ENTER THE CURRENT NUMBER OF DAYS AND TIME (HOURS AND MINUTES) DURING THE PAST WEEK (7 DAYS) THAT EACH THERAPY WAS PROVIDED. ENTER ZERO IF AT #1 LEVEL ABOVE. READ INSTRUCTIONS AS TO QUALIFIERS IN COUNTING DAYS AND TIME.

28. NUMBER OF PHYSICIAN VISITS: DO NOT ANSWER THIS QUESTION FOR HOSPITALIZED PATIENTS, (ENTER ZERO), UNLESS ON ALTERENATE LEVEL OF CARE STATUS. ENTER ONLY THE NUMBER OF VISITS DURING THE PAST WEEK THAT ADHERED TO THE PATIENT NEED AND DOCUMENTATION QUALIFIERS IN THE INSTRUCTIONS. THE PATIENT MUST BE MEDICALLY UNSTABLE TO ENTER ANY PHYSICIAN VISITS, OTHERWISE ENTER A ZERO. 28. (133-134)

VI. DIAGNOSIS

29. PRIMARY PROBLEM: THE MEDICAL CONDITION REQUIRING THE LARGEST AMOUNT OF NURSING TIME IN THE HOSPITAL OR CARE TIME IF IN THE COMMUNITY. (FOR HOSPITALIZED PATIENTS THIS MAY OR MAY NOT BE THE ADMISSION DIAGNOSIS).

ICD-9 Code of medical problem 29. - (135-139)

If code cannot be located, print medical name here:

VII. PLAN OF CARE SUMMARY

This section is to communicate to providers any additional clinical information, which may be needed for their preadmission review of the patient. It does not have to be completed if the information below is already provided by your own form, which is attached to this H/C-PRI.

30. DIAGNOSES AND PROGNOSES: FOR EACH DIAGNOSIS, DESCRIBE THE PROGNOSIS AND CARE PLAN IMPLICATIONS.

Primary Prognosis

1.

Secondary (Include Sensory Impairments)

1.

2.

3.

4.

31. REHABILITATION POTENTIAL (INFORMATION FROM THERAPISTS)

A. POTENTIAL DEGREE OF IMPROVEMENT WITH ADLs WITHIN SIX MONTHS (DESCRIBE IN TERMS OF ADL LEVELS ON THE HC-PRI):

B. CURRENT THERAPY CARE PLAN: DESCRIBE THE TREATMENTS (INCLUDING WHY) AND ANY SPECIAL EQUIPMENT REQUIRED.

32. MEDICATIONS

NAME	DOSE	FREQUENCY	ROUTE	DIAGNOSIS REQUIRING EACH MEDICATION

33. TREATMENTS: INCLUDE ALL DRESSINGS, IRRIGATIONS, WOUND CARE, OXYGEN.

A. TREATMENTS	DESCRIBE WHY NEEDED	FREQUENCY

B. NARRATIVE: DESCRIBE SPECIAL DIET, ALLERGIES, ABNORMAL LAB VALUES, PACEMAKER.

34. RACE/ETHNIC GROUP: ENTER THE CODE WHICH BEST DESCRIBES THE PATIENT'S RACE OR ETHNIC GROUP 34.

1=White	4=Black/Hispanic	7=American Indian or Alaskan Native
2=White/Hispanic	5=Asian or Pacific Islander	8=American Indian or Alaskan Native/Hispanic
3=Black	6=Asian or Pacific Islander/Hispanic	9=Other

35. QUALIFIED ASSESSOR: I HAVE PERSONALLY OBSERVED/INTERVIEWED THIS PATIENT AND COMPLETED THIS H/C PRI.

☐YES ☐NO

I CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS A TRUE ABSTRACT OF THE PATIENT'S CONDITION AND MEDICAL RECORD.

_____ IDENTIFICATION NO.

SIGNATURE OF QUALIFIED ASSESSOR

LDSS-3139 (3/79)

DEPARTMENT OF HEALTH

OFFICE OF HEALTH SYSTEMS MANAGEMENT

HOME ASSESSMENT ABSTRACT

GENERAL INSTRUCTIONS:

THIS FORM MUST BE COMPLETED FOR ALL LONG TERM HOME HEALTH CARE PROGRAM PATIENTS AND ALL MEDICAID PATIENTS RECEIVING HOME HEALTH AIDE OR PERSONAL CARE SERVICES. PORTIONS AS INDICATED MUST BE COMPLETED BY RESPECTIVE PERSONNEL FOR THE ABOVE MENTIONED PURPOSES. FOR MORE INFORMATION, SEE DETAILED INSTRUCTIONS.

ABBREVIATIONS:

CHHA – CERTFIED HOME HEALTH AGENCY
LTHHCP – LONG TERM HOME HEALTH CARE PROGRAM
RN – REGISTERED NURSE
SSW – SOCIAL SERVICE WORKER
INSTRUCTION PAGE 1:
TO BE COMPLETED BY RN – PARTS 1, 2, 3
TO BE COMPLETED BY SSW – PARTS 1, 2, 3, 4, 5, 6

1. REASON FOR PREPARATION

☐ ADMISSION TO LTHHCP
☐ INITIAL EVALUATION FOR HOME HEALTH AIDE
☐ INITIAL EVALUATION FOR PERSONAL CARE
☐ REASSESSMENT FROM _____ TO _____
☐ LTHHCP ☐ CHHA ☐ PERSONAL CARE
☐ OTHER, SPECIFY _____

2. PATIENT NAME

RESIDENT ADDRESS APT. NO.

CITY STATE ZIP TEL. NO.

ADDRESS WHERE PRESENTLY RESIDING TEL. NO.

DIRECTIONS TO CURRENT ADDRESS

SOCIAL SERVICES DISTRICT FIELD OFFICE

4. NEXT OF KIN/GUARDIAN

STREET

CITY STATE ZIP

RELATION TEL NO.

3. CURRENT LOCATION/DIAGNOSIS OF PATIENT

☐ HOSP. ☐ HRF ☐ HOME
☐ SNF ☐ DCF ☐ OTHER (SPECIFY)

NAME OF FACILITY/ORGANIZATION

STREET

CITY STATE ZIP TEL NO.

DATE ADMITTED PROJECTED DISCHARGE DATE

DIAGNOSIS

5. NOTIFY IN EMERGENCY

NAME

CITY STATE ZIP

RELATION TEL NO.

PATIENT INFORMATION

6. DATE OF BIRTH _____ AGE _____

LANGUAGE(S) SPOKEN/UNDERSTANDS _____

SEX: ☐ MALE ☐ FEMALE

MARITAL STATUS: ☐ MARRIED ☐ SEPARATED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ UNKNOWN

LIVING ARRANGEMENTS:

☐ ONE FAMILY HOUSE ☐ HOTEL
☐ MULTI-FAMILY HOUSE ☐ APT.
☐ FURNISHED ROOM ☐ BOARDING HOUSE
☐ SENIOR CIT. HOUSING ☐ IF WALK-UP (# FLIGHTS ___)
☐ OTHER, SPECIFY _____

LIVES WITH: ☐ SPOUSE ☐ ALONE ☐ OTHER _____

SOCIAL SECURITY NO. _____

MEDICARE NO. PART A _____
PART B _____

MEDICAID NO. _____ ☐ PENDING

BLUE CROSS NO. _____

WORKMENS COMP. _____

VETERANS CLAIM NO. _____

VETERANS SPOUSE ☐ YES ☐ NO

OTHER (SPECIFY) _____

SOURCE OF INCOME/OTHER BENEFITS

☐ SOCIAL SECURITY
☐ PUBLIC ASSIST.
☐ VETERANS BENEFITS
☐ PENSION
☐ FOOD STAMPS
☐ S.S.I.
☐ OTHER (SPECIFY) _____

AMOUNT OF AVAILABLE FUNDS AFTER PAYMENT OF RENT, TAXES UTILITIES, ETC. _____

7. To be completed by S S W
OTHERS IN HOME/HOUSEHOLD: Indicate days/hours that these persons will provide care to patient.
If none will assist explain in narrative.

	NAME	Age	Relationship	Days/Hours at Home	Days/Hours will Assist
1.					
2.					
3.					
4.					

8. To be completed by S S W
SIGNIFICANT OTHERS OUTSIDE OF HOME: Indicate days/hours when persons below will provide care to patient.

	Name	Address	Age	Relationship	Days/Hours Assisting
1.					
2.					
3.					
4.					
5.					

9. To be completed by S S W
COMMUNITY SUPPORT: Indicate organization/persons serving patient at present or has provided a service in the past six (6) months.

	Organization	Type of Service	Presently Receiving	Contact Person	Tel No.
1.					
2.					
3.					
4.					

10. To be completed by S S W and R.N.
PATIENT TRAITS:

	Yes	No	?N/A	If you check No. ?N/A, describe
Appears self directed and/or independent				
Seems to make appropriate decisions				
Can recall med routine/recent events				
Participates in planning/treatment program				
Seems to handle crises well				
Accepts diagnosis				
Motivated to remain at home				

11. To be completed by S S W and R.N. as appropriate
FAMILY TRAITS:

	Yes	No	?	
a. Is motivated to keep patient home				If no, because
b. Is capable of providing care (physically & emotionally)				If no, because
c. Will keep patient home if not involved with care				Because
d. Will give care if support service given				How much
e. Requires instruction to provide care				In what – who will give

12. To be completed by R.N.

Home/Place where care will be provided:	Yes	No	?	If problem, describe
Neighborhood secure/safe				
Housing adequate in terms of: Space				
Convenient toilet facilities				
Heating adequate and safe				
Cooking facilities & refrigerator				
Laundry facilities				
Tub/shower/hot water				
Elevator				
Telephone accessible & usable				
Is patient mobile in house				
Any discernible hazards (please circle)				Leaky gas, poor wiring, unsafe floors, steps, other (specify)
Construction adequate				
Excess use of alcohol/drugs by patient/ caretaker; smokes carelessly.				
Is patient's safety threatened if alone?				
Pets				

ADDITIONAL ASSESSMENT FACTORS: _____

13. To be completed by R.N.

RECOVERY POTENTIAL ANTICIPATED		COMMENTS
Full recovery	☐	
Recovery with patient management residual	☐	
Limited recovery managed by others	☐	
Deterioration	☐	

14. To be completed by R.N. – S S W to complete "D" as appropriate
FOR THE PATIENT TO REMAIN AT HOME – SERVICES REQUIRED

SERVICES REQUIRED	YES	NO	TYPE/FREQ/DUR	WHO WILL PROVIDE AGENCY/FAMILY	AGENCY FREQUENCY
A. Bathing					
Dressing					
Toileting					
Admin. Med.					
Grooming					
Spoon feeding					
Exercise/activity/walking					
Shopping (food/supplies)					
Meal preparation					
Diet Counseling					
Light housekeeping					
Personal laundry/household linens					
Personal/financial errands					
Other					
B. Nursing					
Physical Therapy					
Home Health Aide					
Speech Pathology					
Occupational Therapy					
Personal Care					
Homemaking					
Housekeeping					
Clinic/Physician					
Other 1.					
2.					
C. Ramps outside/inside					
Grab bars/hallways/bathroom					
Commode/special bed/wheelchair					
Cane/walker/crutches					
Self-help device, specify					
Dressings/cath. equipment, etc.					
Bed protector/diapers					
Other					
D. Additional Services (Lab, O^2, medication)					
Telephone reassurance					
Diversion/friendly visitor					
Medical social service/counseling					
Legal/protective services					
Financial management/conservatorship					
Transportation arrangements					
Transportation attendant					
Home delivered meals					
Structural modification					
Other					

15. To be completed by S S W and R.N

DMS Predictor Score _____ Override necessary ☐ Yes ☐ No

Can patient's health/safety needs be met through home care now? ☐ Yes ☐ No

If no, give specific reason why not _____

Institutional care required now? ☐ Yes ☐ No If yes, give specific reason why.

Level of institutional care determined by your professional judgment: ☐ SNF ☐ HRF ☐ DCF

Can the patient be considered at a later time for home care? ☐ Yes ☐ No ☐ N/A

16. To be completed by S S W
SUMMARY OF SERVICE REQUIREMENTS
Indicate services required, schedule and charges (allowable charge in area)

Services	Provided by	Hrs./Days/Wk.	Date Effective	Est. Dur.	Unit Cost	Payment by			
						MC	MA	Self	Other
Physician									
Nursing									
Home Health Aide									
Physical Therapy									
Speech Pathology									
Resp. Therapy									
Med. Soc. Work									
Nutritional									
Personal Care									
Homemaking									
Housekeeping									
Other (Specify)									
Medical Supplies/Medication 1.									
2.									
3.									
Medical Equipment 1.									
2.									
3.									
Home Delivered Meals									
Transportation									
Additional Services 1.									
2.									
			SUBTOTAL						
Structural Modification									
Other (Specify) 1.									
2.									

SUBTOTAL _____

TOTAL COST _____

17. To be completed by S S W and R.N.

Person who will relieve in case of emergency

Name	Address	Telephone	Relationship

Narrative: Use this space to describe aspects of the patients care not adequately covered above.

Assessment completed by:

R.N.	Agency
Date Completed	Telephone No.
Local DSS Staff	District
Date Completed	Telephone No.
Supervisor DSS	District
Date	Telephone No.

Authorization to provide services:

Local DSS Commissioner or Designee — Date

HOME ASSESSMENT ABSTRACT
FOR THE PERSONAL CARE SERVICES PROGRAM
Instructions

Purpose:

The purpose of the Home Assessment Abstract is to assist in the determination of whether a patient's home environment is the appropriate setting for the patient to receive health and related services. This form is designed to provide a standardized method for all certified home health agencies and social services districts to determine the following questions essential to the delivery of home care services:

1. Is the home the appropriate environment for this patient's needs?

2. What is the functional ability of this patient?

3. What services are necessary to maintain this patient within this home setting?

General Information:

The assessment form includes an outline for the planning for the development of a comprehensive listing of services which the patient requires.

It is required that a common assessment procedure be used for the Long Term Home Health Care Program (LTHHCP), Home Health Aide Services and Personal Care Services. This procedure will apply to both initial assessments and reassessments. The Home Assessment Abstract must be used in conjunction with the physician's orders and the DMS-1 or its successor.

The assessment procedure will differ only in the frequency with which assessments are required. Assessments must be completed at the initial onset of care. Reassessments are required every 120 days for the LTHHCP and Home Health Aide Services. Reassessments for Personal Care Services are required on an as-needed basis, but must be done at least every six (6) months. At any time that a change in the condition of the patient is noted either by staff of the certified home health agency or the local social services district, that agency should immediately inform the other agency so that the procedures for reassessment can be followed.

The form has been designed so that certified home health agencies and local social services districts may complete assessments jointly, a practice which is highly recommended. When it is not possible to undertake assessments jointly, an indication of the person responsible for completing each section has been included on the form. If, while completing the assessment, a nurse or a social services worker believes they have information in one of the other areas of the form, for which they are not responsible, they may include that information.

It is required that the local certified home health agency complete the assessment form within fifteen (15) working days of the request from the local social services district. Completed forms should be forwarded to the local social services district. Differences in opinion on the services required should be forwarded to the local Professional Director, for review and final determination by a physician.

Instructions:

Section 1 – Reasons for Preparation (RN and SSW)

Check appropriate box depending on whether patient is being considered for admission to a LTHHCP, home health aide service provided by a certified home health agency, or personal care services.

For reassessment, include the dates covered by the reassessment and check whether the reassessment is for a LTHHCP patient, certified home health agency patient, or personal care service patient. If none is appropriate, specific under "other" why form is being completed.

Section 2 – Patient Identification (RN and SSW)

Complete patient's name and place of residence. If the patient is or will be residing at a place other than his home address, give the address where he will be receiving care. Include directions to address where the patient will be receiving care.

The item "Social Services District" requires the name of the Social Services District which is legally responsible for the cost of the care. In large Social Services districts the number or name of the field office should be indicated.

Section 3 – Current Location of patient (RN and SSW)

Check the current location/diagnosis of the patient. If the patient is in an institution, give name of facility. If he/she is at home and receiving home care, give name of organization providing the service. Complete the "Diagnosis" on all cases.

Section 4 – Next of Kin/Guardian (SSW)

Complete this section with the name of the person who is legally responsible for the patient. This may be a relative or a non-relative who has been designated as power of attorney, conservator or committee for the management of the patient's financial affairs.

Section 5 – Notify in Emergency (SSW)

Complete section with requested information on whom to call in an emergency situation.

Section 6 – Patient Information (SSW)

Complete all information pertinent to the patient. Use N/A if an item is not applicable. Specify the language(s) that the patient speaks and understands.

Check the category of living arrangements that best describes the living arrangements of the patient.

Definitions of Living Arrangements:

One family house – nuclear and extended family

Multi-family house – tow or more distinct nuclear families

Furnished room – one room in a private dwelling, with or without cooking facilities

Senior citizen housing – apartments, either in clusters or high-rise

Hotel – a multi-dwelling providing lodging and with or without meals

Apartment – a room(s) with housekeeping facilities and used as a dwelling by a family group or an individual

Boarding House – a lodging house where meals are provided

If walk-up – when the living unit requires walking up stairs, specify number of flights

Lives with – specify with whom the patient lives. Members of household should be detailed in Section 7.

Other Patient Information:

Social Security Number	To obtain correct numbers, the interviewer should ask to see the patient's identification care for each item.
Medicare Numbers	
Medicaid Number	
Blue Cross Number	
Worker's Compensation	
Veterans Claim Number	

Veterans Spouse – patient may be eligible for benefits if a veteran's spouse.

Other – Identify insurance company and claim number if the patient has coverage in addition to those listed above.

Source of Income/other benefits – Include all sources of income and benefits. When the patient is receiving Medicaid or if Medicaid is pending, the local social services district will already have all necessary information.

Amount of available funds – Since many elderly people have little money left after payment of rent, taxes and utilities, an effort should be made to determine the amount available after payment of these expenses. This is especially important in evaluating whether or not the patient has adequate funds for food and clothing.

Section 7 – Others in Home/Household (SSW)

Indicate all persons residing in the house with the patient and indicate if and when they will assist in the care of the patient. Indicate in Section 14 what service this person(s) will provide. This information must be specific as it will be used to prepare a summary of service requirements for the individual patient.

Section 8 – Significant others Outside of Home – (SSW)

A "Significant Other" is an individual who has an interest in the welfare of the patient and may influence the patient. This may be a relative, friend, or neighbor who may be able to provide some assistance in rendering care. Indicate the days/hours that this person will provide assistance.

Section 9 – community Support – (SSW)

Indicate organizations, agencies or employed individuals, including local social services districts or certified home health agencies who have, or who are presently giving service to the patient; also indicate those services that have been provided in the past six months. Agencies providing home care, home delivered meals, or other services should be included if they have been significant to the care of the patient.

Section 10 – Patient traits – (SSW and RN)

Patient traits should help to determine the degree of independence a patient has and how this will affect care to this patient in the home environment. A patient's safety may be jeopardized if he shows emotional or psychological disturbance or confusion. It is important to determine if the patient is motivated to remain at home, otherwise services provided may not be beneficial.

For all criteria check the "yes" column if the patient meets the standard of the criteria defined. If, in your judgment the patient does not meet the standard as defined, check "no". If you have insufficient evidence to make a positive or negative statement about the patient, check the box marked "?/NA" – unknown or not applicable. If you check a no or ?/NA, please explain the reason in the space to the right. Also indicate source of information used as basis for your judgment.

Definitions:

Appears self directed and/or independent – the patient can manage his own business affairs, household needs, etc., either directly or through instruction to others.

Seems to make appropriate decisions –n the patient is capable of making choices consistent with his needs, etc.

Can recall med. Routine/recent events – the patient's memory is intact, and patient remembers when to take medication without supervision or assistance. Patient knows medical regimen.

Participates in planning/treatment program – the patient takes an active role in decision-making.

Seems to handle crisis well – this means that the patient knows whom to call and what to do in the event of an emergency situation.

Accepts Diagnoses – the patient knows his diagnoses and has a realistic attitude toward his illness

Motivated to remain at home – the patient wants to remain in his home to receive needed care.

Section 11 – Family Traits (SSW and RN as appropriate)

This section should be used to indicate whether the family is willing and/or able to care for the patient at home. The family may be able to care for the patient if support services are provided, and if required instruction and supervision are given, as appropriate, to the patient and/or family.

Definitions:

a. Is motivated to keep patient home – this means that the family member(s) is (are) willing to have the patient stay at home to receive the needed care and will provide continuity of care in those intervals when there is no agency person in the home by providing care themselves or arranging for other caretakers.

b. Is capable of providing care – the family member(s) is (are) physically and emotionally capable of providing care to the patient in the absence of caretaker personnel, and can accept the responsibility for the patient's care.

c. Will keep patient home if not involved with care – the family member(s) will allow the patient space in the home but will not (or cannot) accept responsibility for providing the necessary services in the absence of Home Care Services.

d. Will give care if support services given – this means that the family member(s) will accept responsibility for and provide care to the patient as long as some assistance from support personnel is given to the family member(s).
e. Requires instruction to provide care – this item means that the family is willing and able to keep the patient at home and provide care but will need guidance and teaching in the skills to provide care safely and adequately.

Section 12 – Home/Place where care will be provided – (RN)

In order to care for a person in the home, it is necessary to have an environment which provides adequate supports for the health and safety of the patient. This section of the assessment is to determine if the home environment of the patient is adequate in relation to the patient's physical condition and diagnosis. Input from the patient and family should be considered where pertinent.

Specifically describe the problem if one exists.

Definitions:

Neighborhood secure/safe – refers to how the patient and/or family perceives the neighborhood, for example, in the assessor's perception, the neighborhood may not be safe or secure but the patient may feel comfortable and safe.

Housing adequate in terms of space – refers to the available space that the patient will be able to have in the home. The space should be in keeping with the patient's home health care needs, without encroaching on other members of the family.

Convenient toilet facilities – refers to the accessibility and availability of toilet facilities in relation to the patient's present infirmities.

Heating adequate and safe – refers to the type of heating that will produce a comfortable environment. Safety and accessibility factors should be considered.

Laundry facilities – refers to appliances that are available and accessible to the patient and/or family.

Cooking facilities and refrigerator – refers to those appliances that are available and accessible for use by the patient or family.

Tub/shower/hot water – refers to what bathing facilities are available and if the patient is able to use what is available. Modifications may have to be made to make the facilities accessible to the patient.

Elevator – refers to the availability of a working elevator and if the patient is able to use it.

Telephone accessible and usable – refers to whether or not there is a telephone in the home, or if one is available. Specify whether or not the patient is able to reach and use the telephone.

Is patient mobile in house – refers to the ability of the patient to move about in the home setting. Modifications may have to be made to allow mobility, for example, widening doorways and adding ramps for a patient in a wheelchair.

Any discernible hazards – refers to any hazard that could possibly have a negative impact on the patient's health and safety in the home.

Construction adequate – refers to whether or not the building is safe for habitation.

Excess use of alcohol/drugs by patient or caretaker – refers to whether or not the patient or caretaker uses those materials enough to endanger the patient's health and safety because of inadequate judgment, poor reaction time, etc.; smokes carelessly.

Is patient's safety threatened if alone – refers to situations that may cause injury to the patient. This includes situations such as physical incapacitation, impaired judgment to the point where the patient will allow anyone to enter the home, wandering away from home, and possibility of the patient causing harm to himself or others.

Pets – refers to if the patient has a pet(s) and if so, what problems does it present, for example, is the patient able to take care of the pet, is the pet likely to endanger the patient's caretaker, and what plans, if any, must be made for the care of the animal.

Additional Assessment factors – include items that would influence the patient's ability to receive care at home that are not considered previously.

Section 13 – Recovery Potential (RN)

The anticipated recovery potential is important for short and long range planning.

Full recovery – the patient is expected to regain his optimal state of health.

Recovery with patient managed residual – the patient is expected to recover to his fullest potential with residual problem managed by himself, e.g., a diabetic who self-administers insulin and controls his diet.

Limited recovery managed by others – the patient is expected to be left with a residual problem that necessitates the assistance of another in performing activities of daily living.

Deterioration – it is expected that the patient's condition will decline with no likelihood of recovery.

Section 14 – Services Required (RN, SSW to complete "D" as appropriate)

This section will serve as the basis for the authorization for service delivery. Fill in all services required, describing type, frequency and duration as pertinent. Specify whether the family or an agency will be providing services and frequency that the agency will be involved. It is necessary to determine the amount of services required to enable the local Social Services district to develop the summary of service requirements and to arrive at a total cost necessary to the Long Term Home Health Care Program. The local Social Services district will make the final budgetary determinations.

A. This section determines that activities the patient can/cannot do for himself, also the frequency which the patient needs help in performing these activities.

B. The RN should determine what level of services are needed or anticipated.

Example:

	Yes	No	Type/Freq. Dur.	Agency/Family Agency Freq.
Registered Nurse	X		1 hr.2xWk/1 mo.	V.N.S.
Physical Therapy		X		
Home Health Aide	X		4 hr/3xWk/ 1mo.	V.N.S.
Speech Pathology		X		
Occupational Therapy		X		
Personal Care	X		4 hr./5xWk/1 mo.	Homemaker Upjohn
Clinic	X		1xWk-Mondays 1 pm	

C. Equipment/Supplies

The nurse should determine what medical supplies and equipment are necessary to assist the patient. Consideration should be for the rehabilitation and safety needs of the patient. Circle the specific equipment required and described in type/freq./dur. column, etc.

Example:

Dressing, cath equipment----#18 Foley/1xmo/6mo

D. Other Services

The RN should indicate any other health service needed for the total care of the patient. The SSW should complete the balance of the service needs.

Service needs will not be changed by the local social services district without consulting with the nurse. If there is disagreement, the case will be referred to the local professional director for review and final determination by a physician.

Section 15 – (SSW and RN)

DMS-1 Predictor Score

The predictor score must be completed. To be eligible for the LTHHCP, the patient's level of care needs must be determined and must be at the Skilled Nursing Facility (SNF) or Health Related Facility (HRF) level. The predictor score must be completed for home health aide and personal care services to assure adequate information for placement of personnel.

If the patient is institutionalized the predictor score should be obtained from the most recent DMS-1 completed by the discharge planner of that facility. If the patient is at home, it may be necessary for the nurse from the LTHHCP or certified home health agency to complete a DMS-1 form during the home assessment to ascertain the predictor score. Refer to the instructions for completing the DSM-1, if necessary.

Override necessary

An override is necessary when a patient's predictor score does not reflect the patient's true level of care. For example, a patient with a low predictor score may require institutional care due to emotional instability or safety factors. Either the institution's Utilization Review physician or physician representing the local professional director must give the override.

Can needs be met through home care?

Indicate if the patient can remain at home if appropriate services are provided. If the patient should not remain at home for health or safety reasons, be specific in your reply.

Institutional Care

Give specific reason why institutionalization is required. Check the level of institutional care the patient requires. Indicate if the patient can be considered for home care in the future.

Section 16 – Summary of Service Requirements – (SSW)

This information is to be used in correlation with services required for the patient to remain at home (Section 14). This section is to determine the cost of each individual service, source of payment, data services are effective and total monthly budget.

The SSW should complete this section including unit cost and source of payment. Subtotal and total costs will be determined by the local social services department.

Section 17 – Person who will relieve in an emergency – (SSW and RN)

This should be an individual who would be available to stay with the patient, if required, in a situation where the usual, planned services are not available. An example would be, when an aide did not appear on schedule, and the patient could not be left alone.

Narrative – (SSW and RN)

The narrative should be used to describe details of the patient's condition, not covered in previous sections, that will influence the decision regarding placement of the patient.

Assessment completed by

Each professional should sign and date this form. Include agency and telephone number.

Authorization to provide services for the LTHHCP, Home Health Aide or Personal Care Services will be provided by the Local District Social Services Commissioner or his designee.

NEW YORK STATE HEALTH DEPARTMENT NUMERICAL STANDARDS MASTER SHEET
NUMERICAL STANDARDS FOR APPLICATION FOR THE LONG TERM CARE PLACEMENT FORM
MEDICAL ASSESSMENT ABSTRACT
(DMS-1)

3.a.

Nursing Care and Therapy (Specify details in 3d, 3e or attachment)	Frequency			Self Care		Can Be Trained	
	None	Day Shift	Night/Eve. Shift	Yes	No	Yes	No
Parenteral Meds	0	25	60	-15	0	0	0
Inhalation Treatment	0	38	37	-20	0	0	0
Oxygen	0	49	49	-4	0	0	0
Suctioning	0	50	50	-1	0	0	0
Aseptic Dressing	0	42	48	0	0	+1	0
Lesion Irrigation	0	49	49	-20	0	0	0
Cath/Tube Irrigation	0	35	60	-1	0	+4	0
Ostomy Care							
Parenteral Fluids	0	50	50				
Tube Feedings	0	50	50				
Bowel/Bladder Rehab.	0	48	48				
Bedsore Treatment	0	50	50				
Other (Describe)	0	0	0				

b.
Incontinent

Urine: Often* [ ] 20 Seldom** [ ] 10 Never [ ] 0 Foley [ ] 15
Stool: Often* [ ] 40 Seldom** [ ] 20 Never [ ] 0

c.
Does patient need a special diet? No [ ] Yes [ ]

If yes, describe_____

4.

Function Status	Self Care	Some Help	Total Help	Cannot
Walks with or w/o aids	0	35	70	105
Transferring	0	6	12	18
Wheeling	0	1	2	3
Eating/Feeding	0	25	50	
Tolieting	0	7	14	
Bathing	0	17	24	
Dressing	0	40	80	

5.

Mental Status	Never	Sometimes	Always
Alert	40	20	0
Impaired Judgement	0	15	30
Agitated (nightime)	0	10	20
Hallucinates	0	1	2
Severe Depression			*
Assaultive	0	40	80
Abusive	0	25	50
Restraint Order	0	40	80
Regressive Behavior	0	30	60
Wanders			
Other (Specify)			

6.

Impairments	None	Partial	Total
Sight	0	1	2
Hearing	0	1	2
Speech	0	10	20
Communications			
Other (Contractures, etc.)			

7.

Short Term Rehab. Therapy Plan (To be completed by Therapist)

a.	Describe Condition (not Dx) Needing Intervention	Short Term Plan of Treatment & Eval. and Progress in last 2 weeks	Achievement Date

b. Circle Minimum number of days/week of skilled therapy from each of the following:

REQUIRES		RECEIVES
0 1 2 3 4 5 6 7	PT	0 1 2 3 4 5 6 7
0 1 2 3 4 5 6 7	OT	0 1 2 3 4 5 6 7
0 1 2 3 4 5 6 7	SPEECH	0 1 2 3 4 5 6 7

+ 37 for skilled rehab/therapy (received & required both>0)

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF LONG TERM CARE

Nursing Home Transition and Diversion Waiver Program

Regional Resource Development Center (RRDC) List

Region/County	Regional Resource Development Center	RRDS & Phone Number
Adirondack: Fulton, Montgomery, Saratoga, Washington, Warren, Hamilton, Essex, Franklin and Clinton	Glens Falls Independent Living Center d/b/a Southern Adirondack Independent Living (SAIL) 71 Glenwood Avenue Queensbury, NY 12804 www.sail-center.org	**Karen Thayer, RRDS** kannthayer@aol.com (518) 792-1584 (518) 792-0979 (FAX)
Binghamton/Southern Tier: Broome, Steuben, Schuyler, Tioga, Delaware, Tompkins, Cortland, Chenango, Cayuga, Chemung, Cattaraugus, Allegany and Otsego	Southern Tier Independence Center (STIC) 24 Prospect Avenue Binghamton, NY 13901 www.stic-cil.org	**Al Jennings, RRDS** alj@stic-cil.org nhtd@stic-cil.org (607) 724-2111 (607) 772-3671 (FAX)
Buffalo: Erie, Chautauqua, Wyoming, Orleans and Niagara	Headway of Western New York, Inc. 976 Delaware Avenue Buffalo, NY 14209 www.headwayofwny.org	**Ronald Fernandez, RRDS** nhtdwaiver@headwayofwny.org (716) 629-3636 (716) 629-3639 (FAX)
Capital: Albany, Schenectady, Greene, Rensselaer, Schoharie and Columbia	Sunnyview Hospital and Rehabilitation 1270 Belmont Avenue Schenectady, NY 12308 www.sunnyview.org	**Barbara McCarthy**, **RRDS** mccarthyb@nehealth.com (518) 386-3555 (518) 386-3664 (FAX)
Long Island: Nassau and Suffolk	Self Initiated Living Options, Inc. (Suffolk Independent Living Organization (SILO) 3680 Route 112, Suite 4 Coram, NY 11727 www.suffolkilc.org	**Bonnie Hope, RRDS** bhope@suffolkilc.org (631) 880-7929 (631) 946-6377 (FAX)
Lower Hudson Valley: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester	Westchester Independent Living Center 200 Hamilton Avenue 2nd Floor White Plains, NY 10601 www.wilc.org	**Margaret Nunziato, RRDS** mnunziato@wilc.org (914) 682-3926 (914) 681-7105 (FAX)
New York City:	Center for Independence of the Disabled, NY (CIDNY) 841 Broadway, #301 New York, NY 10003 www.cidny.org	**Stuart Kaufer, RRDS** skaufer@cidny.org (212) 674-2300 (646) 442-4188 (212) 254-5953 (FAX)
Rochester: Monroe, Wayne, Ontario, Seneca, Genesee, Livingston and Yates	Unity Health System 89 Genesee Street Rochester, NY 14611 www.unityhealth.org	**Terri Mercado, RRDS** tmercado@unityhealth.org (585) 368-3562 (585) 368-3567 (FAX)
Syracuse: Onondaga, Madison, Herkimer, Oneida, Oswego, Lewis, Jefferson and St. Lawrence	Southern Tier Independence Center (STIC) 24 Prospect Avenue Binghamton, NY 13901 www.stic-cil.org	**Al Jennings, RRDS** alj@stic-cil.org **Stanley Johns, RRDS** nhtd@stic-cil.org (607) 724-2111 (607) 772-3671 (FAX)

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF LONG TERM CARE

Nursing Home Transition and Diversion Waiver Program

Quality Management Specialist (QMS) List

EASTERN	School and Community Support, Inc. 17 British American Blvd. Latham, NY 12110	Christina Alverez-Ross Work Phone (518) 782-7100 Fax Number (518) 782-7101 calvarezross@scssconsulting.com
WESTERN	School and Community Support, Inc. South Hill Business Campus 950 Danby Road Ithaca, NY 14850	Rhonda Bennett Work Phone 607-330-4816 Fax Number 607-330-4817 rbennett@scssconsulting.com
METRO	School and Community Support, Inc. 64 Division Ave. Suite 103 Levitton, NY 11756	Natalia Gonzalez Work Phone (518) 372-2026 Fax Number (518) 372-2028 ngonzalez@scssconsulting.com

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF LONG TERM CARE

Nursing Home Transition and Diversion Waiver Program

Waiver Management Staff (WMS) List

NYS DOH Nursing Home Transition and Diversion (NHTD) Program Staff	For questions concerning participants, contact: **Carol Hodecker** **Andrea Swire** For questions concerning providers, contact: **Cheryl Udell** **Leah Sauer** **Patricia Smith** NHTD Director: **Bruce Rosen**	NYS Department of Health Office of Long Term Care Division of Home and Community Based Services One Commerce Plaza, Suite 826 Albany, NY 12260 Tel: 518-486-3154 Fax: 518-474-7067 Email: NHTDWaiver@health.state.ny.us