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: ___/___/___
Region: _____

Referral #: _____
(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

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:

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:

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

Provider Agency Name:________________________
RRDC:________________________

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