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Status: received, approved, denied, withdrawn, corrections needed RRDS review, QMS reviewed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