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: _____

_____

_____

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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