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: __________

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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.

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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.

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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 $ ___________________

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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)

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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							

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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