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. Personal History (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.

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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. <u>Anticipated Activities</u> 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. <u>Informal Supports</u>

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: _____

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