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

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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)

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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.)

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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:

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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):

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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)**

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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.

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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? _____

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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).

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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.

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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.

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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.

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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:

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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.**

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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.

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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)

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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.**

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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.

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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.

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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.

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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 $ _____

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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) _____

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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							

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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