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

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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:

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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:

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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) = $_____

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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? _____

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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:

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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:

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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.

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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)

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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.

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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.

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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.

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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.

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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 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.

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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 $ _____

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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 -) _____

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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 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							

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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			

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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