NEW YORK STATE DEPARTMENT OF HEALTH
Division of Long Term Care

Initial Service Plan

Home And Community Based Services Medicaid Waiver
Nursing Home Transition and Diversion (NHTD) and Traumatic Brain Injury (TBI)

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.

Street Address ______________________

City ____________ County ____________ State ______ ZIP ______

Mailing Address if different from above ______________________

City ____________ County ____________ State ______ ZIP ______

Phone ____________ HOME (xxx) xxx-xxxx ____________ WORK (xxx) xxx-xxxx ____________ CELL (xxx) xxx-xxxx

Check all 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	Phone
		(xxx) xxx-xxxx

3. Profile of Applicant

A. Personal History

DEVELOPMENTAL HISTORY (Include any significant events) ☐ Within Normal Limits

☐ Developmental concerns (describe):

EDUCATIONAL HISTORY (Include the highest level of education achieved, degrees, special education, etc.);

WORK HISTORY (Describe the most significant employment experience(s); volunteer positions):

MENTAL HEALTH HISTORY

☐ No history of mental health issues or concerns
☐ Indicated history of mental health issue/concerns but declined to provide any further information

List current psychiatric diagnosis(es):

History of psychiatric intervention (list all treatments and hospitalizations in order):

Current psychiatric concerns identified by applicant, including best methods of support

Current psychiatric concerns are managed by:

☐ Counseling Receives Counseling: ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other (specify): ____________

☐ Medication Medication Prescribed by: ☐ Psychiatrist ☐ Primary Care Physician ☐ Other (specify): ____________

☐ Psychiatric intervention has been recommended, but individual has deferred this option.

Other Mental Health information including how applicant describes the impact of their mental health on daily living:

SUBSTANCE ABUSE HISTORY

☐ No history of substance abuse issues or concerns
☐ Indicated history of substance abuse issue/concerns but declined to provide any further information

History of substance abuse with:

☐ Alcohol ☐ Prescription Drugs ☐ Over the Counter Legal Drugs

☐ illegal drugs (specify): ____________________ ☐ Other (specify): ____________________

History of substance abuse treatment (list all treatments and hospitalizations in order):

Current substance abuse issues are managed by: ☐ Counseling ☐ Medication

The applicant attends: ☐ Outpatient Treatment ☐ Daily ☐ Weekly ☐ Other (specify): ____________________

The applicant attends: ☐ Narcotics Anonymous ☐ Alcoholics Anonymous ☐ Other (specify): ____________________

The applicant has an AA/NA mentor: ☐ Yes ☐ No Length of sobriety/abstinence: ____________________

Other Substance Abuse information including how applicant describes the impact of their substance use on daily living:

CRITICAL JUSTICE HISTORY

CRIMINAL JUSTICE HISTORY (Describe any history that impacts the applicant's life including current involvement in the criminal justice system, if applicable);

☐ No history of involvement in the criminal justice system
☐ Indicated history of involvement in the criminal justice system but declined to provide any further information

History of criminal justice involvement (list all arrests and incarcerations in order):

The applicant is currently on ☐ Probation ☐ Parole for the following charge: ____________________

List any specific conditions of parole/probation:

Probation/parole is expected to end on: ____________________

Other Criminal Justice information:

B. Medical/Functional Information

DIAGNOSES AND MEDICAL STATUS

Primary Diagnosis: ____________________

Other Diagnoses: ____________________

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.):

MANAGEMENT OF MEDICAL NEEDS

List skilled care needs, supports needed for activities of daily living, and who will provide:

List tools, strategies, medical equipment, environmental modifications or assistive technology that the participant identifies they are currently using or feel they would benefit from:

DESCRIBE IF AND HOW THE APPLICANT'S DISABILITY OR ILLNESS/INJURY HAS IMPACTED THEIR COGNITIVE, PHYSICAL AND BEHAVIORAL STATUS (include the applicant's strengths in each area)

a. Communication Ability

Primary Language is: ☐ English ☐ Other (specify): ____________________

Primary Mode of Communication: ____________________

Other languages spoken/understood: ____________________

Communication:
- ☐ Effectively communicates wants/need
- ☐ Can carry on a conversation
- ☐ Utilizes alternative communication (specify): ____________________
- ☐ Needs a translator (specify person/agency): ____________________
- ☐ Needs prompting/cueing to initiate communication
- ☐ Has difficulties with articulation/speech
- ☐ Needs prompting/cueing to engage in conversation

Participant preferences for effective communication:

Supports requested:

b. Cognitive Status (check all that apply for each)

Orientation, oriented to:
- ☐ Time
- ☐ Person
- ☐ Day/Week
- ☐ Easily confused
- ☐ Place
- ☐ Activities
- ☐ Needs prompting/cueing for orientation
- ☐ Not oriented

Attention/Concentration:
- ☐ Able to stay on task independently
- ☐ Needs occasional verbal cues/prompts to stay on task
- ☐ Easily distracted
- ☐ Requires constant cueing/prompting

Initiation:
- ☐ Initiates activities
- ☐ Needs cues/prompts to initiate tasks/activities
- ☐ Requests assistance when needed
- ☐ Cannot initiate tasks/activities
- ☐ Ability varies for ADLs

Memory:
- ☐ Memory is functional for day-to-day activities
- ☐ Short term memory difficulties
- ☐ Long term memory difficulties

Organization:
- ☐ Good organizational skills
- ☐ Needs prompting/cueing for organizational skills
- ☐ Ability varies based on task/activity
- ☐ needs others to provide organization

Problem-Solving/Judgment:
- ☐ Aware of current skills/limitations
- ☐ Needs cues/prompts for problem-solving
- ☐ Makes reasonable decisions
- ☐ Unable to engage in problem-solving activities

Other Information Regarding Cognitive Status:

Overall Cognitive Status:
- ☐ Self-directing
- ☐ Needs periodic oversight/supervision
- ☐ Needs constant oversight/supervision

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1. Visual Ability (check all that apply) ☐ Vision is adequate for daily activities

- ☐ Visually Impaired ☐ Right eye ☐ Left eye ☐ Wears glasses ☐ Needs large print
- ☐ Cataracts ☐ Right eye ☐ Left eye
- ☐ Blind ☐ Right eye ☐ Left eye ☐ Uses Braille
- ☐ Eye prosthesis ☐ Right eye ☐ Left eye
- ☐ Guide dog ☐ Other:

Describe any specific information that pertains to the applicant's vision:

2. Hearing Ability (check all that apply) ☐ Hears adequately

- ☐ Hearing difficuly
- ☐ Uses hearing aid ☐ Right ear ☐ Left ear
- ☐ Sign language
- ☐ Other devices used:

Other method(s) used:

c. Physical Status and Ability (continued)

3. Dietary Needs (check all that apply) ☐ Regular

☐ Low sodium ☐ Cardiac diet ☐ Nutritional supplement ☐ Ground consistency ☐ Thickened liquids
☐ Low fat ☐ Diabetic diet ☐ Swallowing difficulties ☐ Chopped consistency ☐ Tube feeding
☐ Low cholesterol ☐ Renal diet ☐ Pureed foods ☐ Aspiration precautions ☐ Adaptive equipment

Dentures: ☐ Upper ☐ Lower ☐ Partial

Special Dietary Considerations (e.g. vegan, kosher, etc) specify: ____________________

Describe any specific information that pertains to the applicant's ability to eat and drink:

4. ADL/IADL Ability (check all that apply) ☐ Independent

Mode of Ambulation: ☐ Cane ☐ Walker ☐ Wheelchair ☐ Scooter ☐ Unable

Ability to Ambulate:
☐ Independent ☐ One person assist
☐ Needs periodic supervision/oversight ☐ Two person assist
☐ Needs ongoing supervision/oversight ☐ Unable

Ability to Transfer:
☐ Independent ☐ One person assist ☐ Mechanical lift
☐ Needs periodic supervision/oversight ☐ Two person assist
☐ Needs ongoing supervision/oversight ☐ Unable ☐ Other ____________________

Basic ADLs (Eating, Dressing, Toileting, etc.):
☐ Independent ☐ Needs hands-on assistance
☐ Needs verbal cues/prompts ☐ Must be completed by others
☐ Needs physical cues/prompts

Basic ADLs (Shopping, Banking, etc.):
☐ Independent ☐ Needs hands-on assistance
☐ Needs verbal cues/prompts ☐ Must be completed by others
☐ Needs physical cues/prompts

Endurance/Strangth:
☐ Able to engage in routine activities ☐ Requires frequent rest periods
☐ Experiences periodic fatigue ☐ Needs physical assistance to engage in routine activities
☐ Fatigues easily

Other Information Regarding Physical Ability:

d. Behavioral Status

Exhibits behavior(s) that may not be accepted in community (Provide a full description and include frequency and duration, effective interventions, etc.):

Describe the applicant’s interest in and willingness to use available strategies/tools:

How does applicant describe their current emotional adjustment related to their disability?

Applicant goals related to adjustment to their disability:

Describe impact of applicant's disability on significant family members and informal supports:

Goals for significant family members and informal supports:

- **Present** (Complete the following areas indicating what impact the disability or illness/injury is having on the applicant at this time)

1. **Strengths and challenges** identified by the applicant or their supports:

2. **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):

3. **Hobbies and Interests** (Describe how the disability or injury/illness has impacted what the applicant enjoys doing):

4. Describe what **activities the applicant would like to be involved in again or would like to initiate**:

5. **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

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:

THE RESIDENCE:

Is integrated in and supports full access to the greater community	☐ Yes	☐ No
Was selected from among options by the individual ensures the applicant's rights of privacy, dignity and respect, and freedom from coercion and restraint	☐ Yes	☐ No
Optimizes autonomy and independence in making life choices	☐ Yes	☐ No
Facilitate choice about services and who provides them	☐ Yes	☐ No
Is a community-based residence with no more than 4 unrelated individuals	☐ Yes	☐ No

ANTICIPATED ACTIVITIES

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. FAMILY/FRIEND/COMMUNITY SUPPORTS identified as significant by applicant:

Name	Age	Relationship	Support/Activities Provided	Support is
				☐ intermittent/periodic ☐ consistent/ongoing ☐ emergency only
				☐ intermittent/periodic ☐ consistent/ongoing ☐ emergency only
				☐ intermittent/periodic ☐ consistent/ongoing ☐ emergency only
				☐ intermittent/periodic ☐ consistent/ongoing ☐ emergency only
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				☐ intermittent/periodic ☐ consistent/ongoing ☐ emergency only
				☐ intermittent/periodic ☐ consistent/ongoing ☐ emergency only

Additional Information:

B. FORMAL SUPPORTS

Federal/State Agency 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). **Note:** Transfer this information to the Insurance, Resources and Funding Information Sheet.

☐ **SSI:** Amount ____ ☐ SSDI Amount ____ ☐ SSA Amount ____

☐ **Medicare:** ☐ Part A ☐ Part B ☐ Managed Care ☐ Part D ☐ QMBY ☐ SLMBY

☐ **VA Pension:** ☐ VA Medical ☐ VA Aide and Attendant Services ☐ VA Equipment

☐ **HUD:** ☐ Section-8 ☐ Other subsidized housing (specify): ____

☐ **EPIC** ☐ Other Pharmacy Program (specify): ____

☐ **Food Stamps**

☐ **HEAP** ☐ Meals-on-Wheels

☐ **Office for the Aging (specify):** ____

☐ **Other (specify):** ____

Physician(s)/Specialist(s)/Dentist(s):

Primary Payor: ☐ Private Health Insurance ☐ Medicare ☐ VA Medical ☐ Medicaid
☐ Other (specify): ____

Secondary Payor: ☐ Private Health Insurance ☐ Medicare ☐ VA Medical ☐ Medicaid
☐ Other (specify): ____

Tertiary Payor: ☐ Private Health Insurance ☐ Medicare ☐ VA Medical ☐ Medicaid
☐ Other (specify): ____

List all medical providers currently treating the individual:

Primary Physician name: ____ Phone: ____

Physician name/Specialty: ____ Phone; ____

Physician name/Specialty: ____ Phone: ____

Dentist name: ____ Phone; ____

Are referrals to any other doctors 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 physicians? ☐ Yes ☐ No

Does the 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 the applicant to medical appointments? ____

Who sets up transportation? ☐ Applicant ☐ Other (specify): ____

C. MEDICATIONS (Note: Use the chart on page 20 to list all medications)

Medications are primarily funded through:

☐ Private Health Insurance ☐ Medicare ☐ VA Medical ☐ Medicaid

☐ Other (specify):

Applicant is fully independent with medication setup and administration ☐ Yes ☐ No

The applicant is requesting assistance with obtaining and/or administering medications ☐ Yes ☐ No

Supports requested by the applicant:

Who will provide requested supports?

6. 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:

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?

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:

8. Requested Waiver Services

If informal supports are not sufficient to meet all of the applicant's oversight/supervision needs and a referral was made for HCSS assessment, indicate the extent to which HCSS will be used to meet those needs.

If service requested is for **Assistive Technology**, **Community Transition**, **Environmental Modification**, or **Moving Assisstance** attach Description and Cost Projection form and copy of bid(s), if applicable.

If service requested is for **Home Visits by Medical Personnel** or **Independent Living Skills Training** include proposed number of Team Meetings for the next six (6) months.

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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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:

8. Requested Waiver Services (continued)

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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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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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:

8. Requested Waiver Services (continued)

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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Identify the applicant's desired goals for this service including the frequency/amount of the service:

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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:

9. Medication/Medical Supply/DME Information

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	Total Projected Medicaid Monthly Cost

A. TOTAL = $ ____________

B. Medical Supplies and Durable Medical Equipment (use additional pages, if needed)

Supply or Equipment Item	Prescribed By and Phone Number	Pharmacy/DME Co. and Phone Number	Total Projected Medicaid Monthly Cost

B. TOTAL = $ ____________

Total Projected Medicaid Annual Costs for All Medications, Medical Supplies and Durable Medical Equipment: **A + B.** TOTAL **x 12** = $ ____________

▲ Transfer this total to Page 22

10. Medicaid State Plan Services* and Cost Projection

Type of Service	Provider Name and Telephone	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: $ ____________

Transfer this total to Page 22

*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.

11. Waiver Services and Cost Projection

Waiver Service	Provider Name, Address and Telephone	Effective Date	Annual Amount of Units	Rate	Total Projected Medicaid Annual Cost
Medications, Medical Supplies and DME from page 6		Upon NOD - Authorization	1		

Total Projected Medicaid Annual Cost for All Waiver Services: $ ______________

▲ Transfer this total to Page 22

12. Projected Total Annual Costs for Initial Service Plan

1. **Total Projected Medicaid Annual Cost of Medicaid State Plan Services** from page 16 ____________

2. **Total Projected Medicaid Annual Cost of Waiver Services** from page 17 ____________

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)

13. 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: __________

	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							
Midnight							
1:00 AM - 7:00 AM							

14. 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 at any time a Notice of Decision is issued to me concerning my services under the HCBS Waiver and I disagree with the decision.

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.

Applicant

PRINT FIRST/MI/LAST/GENERATIONAL SUFFIXES

SIGNATURE DATE

Legal Guardian (if applicable)

PRINT FIRST/MI/LAST

SIGNATURE DATE

Other/Relationship to Applicant (if applicable)

PRINT FIRST/MI/LAST

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.

PRINT NAME OF SERVICE COORDINATOR SIGNATURE DATE

PRINT NAME OF SERVICE COORDINATOR SUPERVISOR SIGNATURE DATE

PRINT NAME NAME AND ADDRESS OF AGENCY TELEPHONE

I approve this Initial Service Plan as it is written.

RRDS Comments:

This Initial Service Plan is in effect from: ______ to ______

PRINT NAME OF RRDS SIGNATURE DATE