

### 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 \_\_\_\_\_ 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

	<b>Total "A"</b>		\$ _____
	<b>Total "B"</b>	+	\$ _____
<b>Total Projected Annual Costs for All Medications, Medical Supplies and Durable Medical Equipment</b>		=	\$ _____
<b>(Projected Monthly Cost x 12)</b>			

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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):

- |   |                                     |   |  |  |
|---|-------------------------------------|---|--|--|
| <input type="checkbox"/> Regular  | <input type="checkbox"/> Low Sodium | <input type="checkbox"/> Low Fat                  | <input type="checkbox"/> Diabetic Diet           |  |
| <input type="checkbox"/> Pureed   | <input type="checkbox"/> Renal      | <input type="checkbox"/> Aspiration precautions   | <input type="checkbox"/> Thickened liquids       |  |
| <input type="checkbox"/> Tube feeding   | <input type="checkbox"/> Cardiac    | <input type="checkbox"/> Uses adaptive equipment: | <input type="checkbox"/> Swallowing difficulties |  |
| <input type="checkbox"/> Dentures:  | <input type="checkbox"/> Upper      | <input type="checkbox"/> Lower                    | <input type="checkbox"/> Partial                 | <input type="checkbox"/> Followed by Dietician Services? |
| <input type="checkbox"/> 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 Plan 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.

**9. Medicaid State Plan Services\* and Cost Projection**

Type of Service	Provider (Name and Telephone)	Effective Date	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.

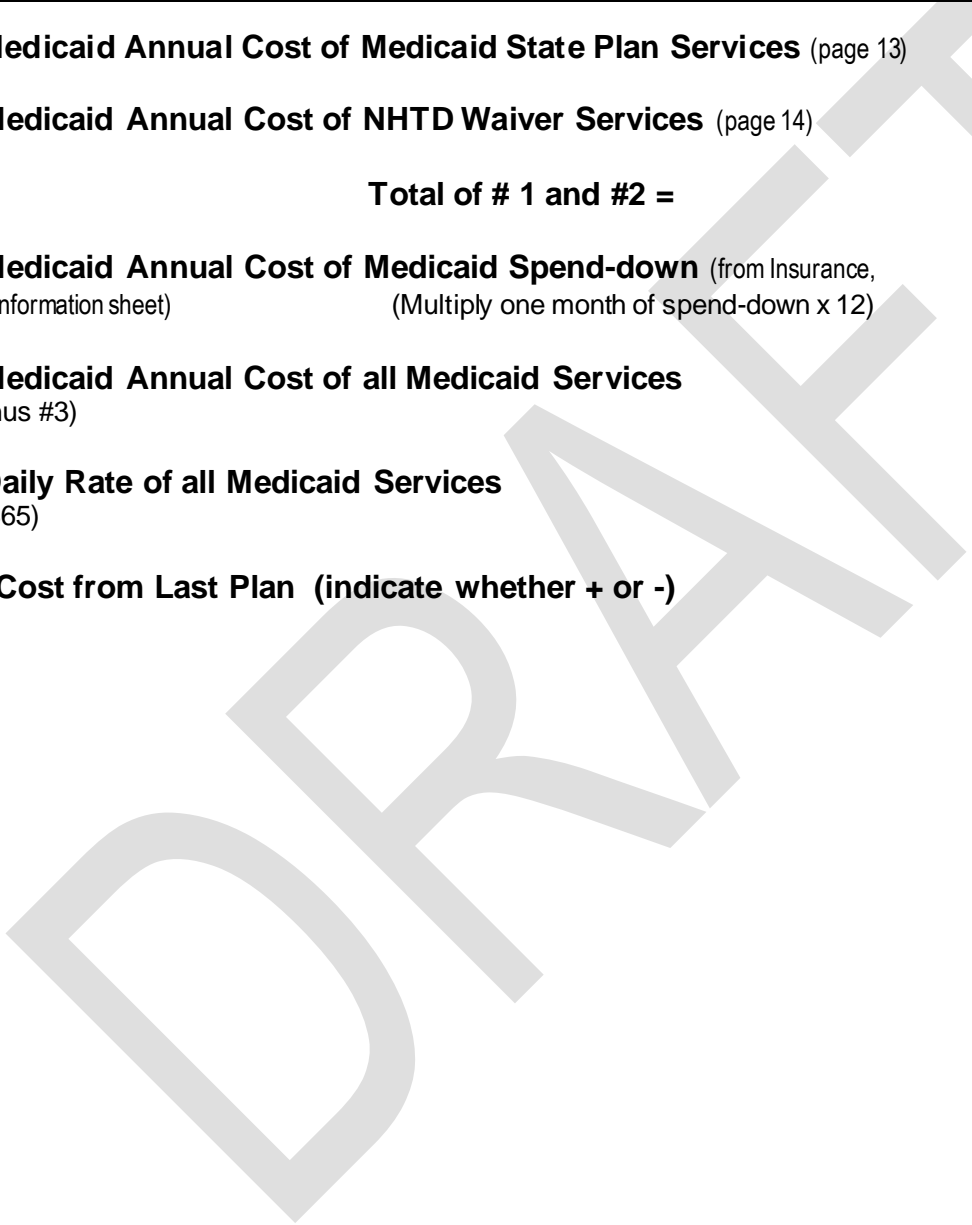
**10. Waiver Services and Cost Projection**

Waiver Service	Provider (Name, Address, Telephone)	Effective Date	Annual Amount of Units	Rate	Total Projected Medicaid Annual Cost
Service Coordination					

**Total Projected Medicaid Annual Cost for All NHTD Waiver Services \$ \_\_\_\_\_**

**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 -) \_\_\_\_\_



**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							

### 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			

