New York State Department Of Health
Division of Long Term Care

RRDS APPLICATION PACKET REVIEW FORM

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Date: ___ Referral number: __

Applicant Name: ☐ Mr ☐ Mrs. ☐ Ms._____
(First/MI/Last/Generational Suffixes)

DOB:_____ CIN:_____ Region: ___

SC Coordinator Name:___SC Agency:_____

Has the applicant submitted the Application Packet? ☐ Yes ☐ No (If no, go to Page 7)

Status: received, approved, denied, withdrawn, corrections needed RRDS review, QMS reviewed

*Application Packet Received By RRDS	Date:
*Applicant/Legal Guardian signed/dated ISP	Date:
*SC signed ISP	Date:
*SC Supervisor signed ISP	Date:
*ISP Returned to SC for corrections	Date:
*Attachments Returned to SC for Corrections	Date: N/A
*Review Completed by SC	Date: N/A
*Received by RRDS from SC with corrections	Date:
Submission to QMS (if applicable) over $300/day Submission to QMS for consultation	Date: n/a Date: n/a
Returned to RRDS from QMS	Date: n/a
*Final Decision by RRDS	Date:

Attachments	**Signed and Completed**	**Comments**
Freedom of Choice form	**Date**_____ ☐ **Y** ☐ **N**	_____
Service Coordinator Selection form	**Date**_____ ☐ **Y** ☐ **N**	_____
Documentation of disability is present	☐ **Y** ☐ **N** ☐ **N/A**	_____
Age requirement met	☐ **Y** ☐ **N**	_____
Medicaid eligibility verification Co.	**Date**_____ ☐ **Y** ☐ **N**	_____
PRI	**Date**_____ ☐ **Y** ☐ **N**	_____
Screen	**Date**_____ ☐ **Y** ☐ **N**	_____
Community Based Assessment (CBA)	**Date**_____ ☐ **Y** ☐ **N** ☐ **N/A**	_____
PRI, Screen, CBA, and other documentation was reviewed and LOC requirement for NHTD has been met?	☐ **Y** ☐ **N**	_____
Application for Participation form	**Date**_____ ☐ **Y** ☐ **N**	_____
Participant Rights/Responsibilities	**Date**_____ ☐ **Y** ☐ **N**	_____
Provider Selection form(s) –	**Date**_____ ☐ **Y** ☐ **N** ☐ **N/A**	_____
Provider Selection form(s) –	**Date**_____ ☐ **Y** ☐ **N** ☐ **N/A**	_____
Plan for Protective Oversight	**Date**_____ ☐ **Y** ☐ **N**	_____
Insurance, Resource, Funding Info. form	**Date**_____ ☐ **Y** ☐ **N**	_____
Home Abstract	**Date**_____ ☐ **Y** ☐ **N** ☐ **N/A**	_____
Waiver Contact List	☐ **Y** ☐ **N**	____
MFP Survey	**Date**_____ ☐ **Y** ☐ **N** ☐ **N/A**	_____

INSTRUCTIONS: **For each of the following sections, please indicate whether the ISP has been completed correctly by checking YES or NO. If NO is selected, use the COMMENTS area to document corrections that are needed. For questions that are not applicable to the participant, document "N/A" under Comments column.**

SERVICE PLAN:

1. Personal Identification Information	**YES**	**NO**
All identification items are completed including Transition/Diversion		
Comments:		

2. Individuals Selected by the Applicant to Participate in ISP Development	**YES**	**NO**
All individuals selected by applicant are listed		
Comments:		

3. Profile of Applicant			
3.A. Personal History includes the following description of:	**YES**	**NO**	**COMMENTS**
•Developmental History			
•Family History			
•Educational History			
•Work History			
•Mental Health History			
•Substance Abuse History			
•Criminal Justice History			

3.B. Medical/Functional Information	YES	NO	COMMENTS
1. •Diagnosis and Medical Status			
•Management of Medical Needs			
•Impact of disability or illness/injury on applicant	YES	NO	COMMENTS
a. Communication Ability			
b. Cognitive Status			
c. Physical Status and Ability			
1. Visual Ability			
2. Hearing Ability			
3. Dietary Needs			
4. ADL/IADL Ability			
5. Behavioral Status			
•Applicant's response to the disability, illness or injury			
•Present	YES	NO	COMMENTS
1. Unique Characteristics and Strengths			
2. Goals			
3. Hobbies and Interests			
4. Preferred Activities			
5. Culture and/or Religion			
Comments:			

4. Applicant's Plans for Community Living	YES	NO	COMMENTS
A. Living Situation			
Type of Dwelling			
B. Anticipated Activities			
Comments:			

5. Current Supports and Services			
A. Informal Supports	YES	NO	COMMENTS
•Family			
•Friends			
•Community			
B. Formal Supports	YES	NO	COMMENTS
•Federal/State Agency Supports			

•Physician(s)/Specialist(s)/Dentist(s)			
C. Medications			
Comments:			

6. Alternatives Considered	**YES**	**NO**
-Alternatives for oversight/supervision and/or ADL/IADL tasks have been considered		
Comments:		

7. Explanation of Need for Waiver Services	**YES**	**NO**
Clear description of need for waiver service(s) to prevent Nursing Home placement or transition from Nursing Home		
Comments:		

<u>Instructions</u>: For section 8, check "yes" or "no" to indicate whether each service requested has been justified, the applicant's desired needs have been identified, the frequency/amount of service clearly indicated, and specific activities targeted. Use N/A (not applicable) to indicate whenever a particular service was not requested.**

8. Requested Waiver Services	**YES**	**NO**	**N/A**	**COMMENTS**
•Service Coordination				
•Assistive Technology				
•Community Integration Counseling (CIC)				
•Community Transitional Service (CTS)				
•Congregate and Home Delivered Meals				
•Environmental Modifications (E-Mods)				
•Home and Community Support Services (HCSS)				
•Home Visits by Medical Personnel				
•Independent Living Skills Training (ILST)				
•Moving Assistance				
•Nutritional Counseling/Educational Services				
•Peer Mentoring				
•Positive Behavioral Interventions and Supports (PBIS)				
•Respiratory Therapy				
•Respite Services				
•Structured Day Program Services				
•Wellness Counseling Services				

9. Medication/Medical Supply/DME Information	**YES**	**NO**
A. Medications		
B. Medical Supplies and Durable Medical Equipment		
Total Projected Medicaid Annual Costs for All Medications, Supplies and DME		
Comments:		

10. Medicaid State Plan Services and Cost Projection		YES	NO
•Medications, Medical Supplies and DME transferred			
•All expected Medicaid Services are listed			
•Provider(s) information is complete			
•Effective Date			
•Frequency and Duration			
•Annual Amount of Units			
•Rate of each service			
•Total Projected Medicaid State Plan Annual Cost	$		
Comments:			

11. NHTD Waiver Services and Cost Projection		YES	NO
•Waiver Service(s)			
•Provider(s)			
•Effective Date			
•Frequency and Duration			
•Annual Amount of Units			
•Rate of each service			
•Total Projected Waiver Annual Cost	$		
Comments:			

12. Projected Total Annual Costs for Initial Service Plan		YES	NO
•Total Medicaid Costs of Medicaid State Plan Services	$		
•Total Medicaid Costs of Waiver Services	$		
•Total Medicaid Annual Cost of Medicaid Spend-down incurred	$ 0		
•Total Medicaid Annual Cost of all Medicaid Services	$		
•Total Medicaid Daily Rate of all Medicaid Services	$		
Comments:			

13. Projected Weekly Schedule of All Services	YES	NO
•All Services are documented appropriately		
Comments:		

RRDS Recommendation:

☐ Corrections needed
☐ Submit to QMS

Comments: _____

_____

_____

RRDS Reviewer Signature Date

Final Decision by RRDS

☐ Approved
☐ Denied
DOH WMS Notified: ____/____/____
Date NOD – Denial of Waiver Program Sent: ____/____/____
☐ Withdrawn by Applicant

If Application has been denied or withdrawn, please specify reason:
☐ Too physically ill
☐ Too cognitively impaired
☐ Mental Illness
☐ Guardian refused participation
☐ Could not locate appropriate housing arrangement
☐ Could not secure affordable housing
☐ Individual changed his/her mind
☐ Individual would not cooperate in Initial Service Plan development
☐ Service needs greater than what could be provided in the community
☐ Other, specify: _____

I have received and accept all corrections and/or additional information provided and approve this Initial Service Plan (ISP) and Application Packet.

I have determined that without the provision of the NHTD waiver services indicated in this service plan review, this individual may not be successfully maintained in the community and would be at risk for placement in a Residential Health Care facility (**check one**): ☐ **Yes** ☐ **No**
NOD Issue Date: _____

NOD Effective Date (if applicable): _____

NOD type: _____

Initial Service Plan (ISP) Effective Date: from _____ to _____

_____

RRDS Reviewer Signature Date