RRDS ADDENDUM REVIEW FORM
HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER

Nursing Home Transition and Diversion (NHTD)

Date: _____

Participant's Name: CIN: __ Region: Binghamton/Southern Tier

SC Coordinator Name:_____SC agency:_____

Current Service Plan period ____to_____

Status: received, approved, denied, withdrawn, corrections needed RRDS review, QMS reviewed

*Addendum received by the RRDS	Date:
*Participant/Legal Guardian signed/dated Addendum	Date:
*SC/SC Supervisor signed Addendum	Date:
*Returned to SC for corrections	Date:
*Received by RRDS from the SC with corrections	Date:
Submission to QMS (if applicable) over $300/day Submission to QMS for consultation	Date: Date :
Returned to RRDS from QMS	Date:
*Final Decision by RRDS	Date:

Attachments	**Signed and Completed**	**Comments**
Functional Assessment, if needed	**Date** __Y __N	_____
Revised Waiver Contact List	__Y __N	_____
Insurance, Resource, Funding form	**Date** __Y __N	_____
Provider Selection form(s)	**Date** __/__/__ __Y __N	_____
Plan for Protective Oversight	**Date** _____ __Y __N	_____

Additional Comments: _____

_____

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:

I. Individuals who participated in developing the Addendum	**YES**	**NO**
All individuals selected by participant are listed		

Comments:		

II. Summary of Request for changes in Waiver Services	**YES**	**NO**	**COMMENTS**
A. Describe the changes that the participant has experienced which resulted in the need for this Addendum			
B. Describe which services will be added and/or changed Note: ISR attached			
C. Describe what, if any, impact the requested changes in the NHTD waiver service(s) have on the Plan of Protective Oversight			

III. Medicaid State Plan Services	**YES**	**NO**	**COMMENTS**
•All Medicaid State Plan Services items listed			
Comments:			

IV. Waiver Services and Cost Projection		**YES**	**NO**
•Waiver Service(s)			
• Provider(s) name, address, telephone number			
•Effective Date			
•Frequency and Duration			
•Annual Amount of Units			
•Daily Rate of each service	$		
•Total Projected Medicaid Annual Cost	$		

V.. Projected Total Annual Costs for ISP		**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	$		
•Total Medicaid Annual Cost of all Medicaid Services	$		
•Total Medicaid daily Rate of all Medicaid Services	$		
Comments:			

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

RRDS Recommendation:

____ Corrections needed
____ Submit to QMS

Comments_____

_____

_____

_____

Final Decision by RRDS

____ Approved
____ Denied

I have received and accept all corrections and/or additional information provided and approve this Addendum.

NOD Notice Date: _____

NOD Effective Date: _____

NOD type: _____

Addendum Effective Date: ____/____/____

Current Service Plan period: from _____/____/____ to _____/____/____

_____

RRDS Reviewer Signature Date