# RRDS REVISED SERVICE PLAN (RSP) REVIEW FORM
# HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER

Nursing Home Transition and Diversion (NHTD)

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Date: _

Participant's Name:__CIN:_____ Region: ___

SC Coordinator Name: ____ SC agency:___

**Status: received, approved, denied, corrections need RRDS review, QMS reviewed**

| | |
|---|---|
| *RSP Packet Downloaded By RRDS | Date: |
| | |
| *Participant/Legal Guardian signed/dated RSP | Date: |
| *SC signed RSP | Date: |
| *SC Supervisor signed RSP | Date: |
| | |
| *RSP Returned to SC for corrections | Date: |
| *Attachments Returned to SC for Corrections | Date: |
| *Review Completed by SC | Date: n/a |
| *Received by RRDS from SC with corrections | Date: |
| | |
| Submission to QMS (if applicable) over $300/day<br>Submission to QMS for consultation | Date: N/A<br>Date: N/A |
| | |
| Returned to RRDS from QMS | Date: N/A |
| *Final Decision by RRDS | Date: |

| **Attachments** | **Signed and Completed** | **Comments** |
|---|---|---|
| Medicaid eligibility verification Co.: | **Date** _____ ☐ **Y** ☐ **N** | _____ |
| PRI | **Date** _____ ☐ **Y** ☐ **N** ☐ **N/A** | _____ |
| Screen | **Date** _____ ☐ **Y** ☐ **N** ☐ **N/A** | _____ |
| Community Based Assessment (CBA) | **Date** _____ ☐ **Y** ☐ **N** ☐ **N/A** | _____ |
| UAS, PRI, Screen, CBA, and other documentation was reviewed and LOC requirement for NHTD has been met? | ☐ **Y** ☐ **N** | _____ |
| Participant Rights/Responsibilities | **Date** _____ ☐ **Y** ☐ **N** ☐ **N/A** | _____ |
| Provider Selection form(s) | **Date** _____ ☐ **Y** ☐ **N** ☐ **N/A** | _____ |
| Plan for Protective Oversight | **Date** _____ ☐ **Y** ☐ **N** | _____ |
| Insurance, Resource and Funding form | **Date** _____ ☐ **Y** ☐ **N** | _____ |
| Contact List | ☐ **Y** ☐ **N** | ____ _____ |

Additional Comments:_____

**INSTRUCTIONS: For each of the following sections, please indicate whether the RSP 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.** YES NO N/A Comments

**SERVICE PLAN:**

| **I. Identification** | **YES** | **NO** |
|---|---|---|
| All identification items are completed | | |
| **Comments:** | | |

| **II. Individuals Selected by the Participant to Participate in RSP Development** | **YES** | **NO** |
|---|---|---|
| All individuals selected by participant are listed | | |
| **Comments:** | | |

| **III. Profile of Participant** | **YES** | **NO** | **N/A** | **COMMENTS** |
|---|---|---|---|---|
| **A. Medical/Functional Information** | | | | |
| •Medical | | | | |
| •Physical | | | | |
| •Cognitive | | | | |
| •Behavioral | | | | |
| •Psychiatric | | | | |
| •Substance Abuse | | | | |
| •Criminal Justice | | | | |

**III. Profile of Participant**

| **B. Medical/Functional Information (cont)** | **YES** | **NO** | **N/A** | **COMMENTS** |
|---|---|---|---|---|
| How does the participant view his/her life in the community during the last Service Plan period | | | | |
| Discuss any changes in significant relationships that have occurred during last Service Plan period | | | | |
| Describe whether the participant's involvement in community activities 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 | | | | |
| 1. Medications | | | | |
| • All prescriptions and/or over-the-counter medications | | | | |
| 2. Medical Supplies/Durable Medical Equipment (DME) | | | | |
| •Total Projected Medicaid Monthly Cost (x12) provided | | | | |
| 3. Does medication regime differ from last Service Plan? | | | | |
| 4. What is current plan to assist participant with medication administration? | | | | |
| 5. Physicians/Dentist | | | | |
| 6. Management of Medical Needs | | | | |
| 7. Dietary Needs | | | | |
| 8. Visual Ability | | | | |
| 9. Hearing Ability | | | | |
| 10.Communication Skills | | | | |
| 11.Other Needs | | | | |

## IV. Current Community Living Situation

| | | |
|---|---|---|
| ***List any changes to participant's living situation since last service plan** | | |
| ***Type of Dwelling Participant Currently Resides In** | | |
| **Comments:** | | |

| **IV. Current Supports and Services** | **YES** | **NO** |
|---|---|---|
| **a. Social/Informal Supports** | | |
| •Family | | |
| •Friends | | |
| •Community | | |
| **b. Formal Supports** | | |
| **c. Medicaid State Plan Services** | | |
| • CDPAP | | |
| **Comments:** | | |

| **V. Oversight/Supervision and/or Assistance with ADLs and/or IADLs** | **YES** | **NO** |
|---|---|---|
| **A. Applicants needing Oversight/Supervision for cognitive needs** | | |
| **B. Applicants needing assistance with ADLs/IADLs tasks but no Oversight/Supervision** | | |
| **C. Alternatives Considered** | | |
| **Comments:** | | |

| **VI. 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:** | | |

| **VII. Service Coordination Overview of Waiver Services** | **YES** | **NO** | **N/A** | **COMMENTS** |
|---|---|---|---|---|
| 1a. Describe which of the following services were used in the last Service Plan and include the accomplished goals for each | | | | |
| 1b. 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 | | | | |
| 2. List all waiver services that will continue from the last Service Plan | | | | |

| VII. Service Coordination Overview of Waiver Services | YES | NO | N/A | COMMENTS |
|---|---|---|---|---|
| •An ISR is attached to this Service Plan for each service listed | | | | |
| 3. Describe any new service(s) requested in this Service Plan | | | | |
| •Each service has been listed in the corresponding chart | | | | |
| **For each new service requested in this Service Plan, list each service in the following boxes and indicate if all information provided is appropriate:** | | | | |
| Service: | | | | |
| Service: | | | | |
| Service: | | | | |
| Service: | | | | |

| VIII. Medicaid State Plan Services and Cost Projection | YES | NO | N/A |
|---|---|---|---|
| •All Medicaid State Plan Services items listed | | | |
| **Comments:** | | | |

| IX. 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 Medicaid Annual Cost | $ | | |
| **Comments:** | | | |

| X. Projected Total Annual Costs for RSP | | 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:** | | | |

| XI. Projected Weekly Schedule of All Services | YES | NO |
|---|---|---|
| •All Services are documented appropriately | | |
| Comments: | | |

| XII. Waiver Services Comparison Chart | YES | NO |
|---|---|---|
| •Chart is completed according to instructions | | |
| Comments: | | |

| Money Follows the Person (MFP) Housing Supplement | YES | NO |
|---|---|---|
| Low income housing tax credits | | |
| HOME dollars | | |
| CDBG funds | | |
| Housing choice vouchers (such as tenant based, project based, mainstream or homeownership vouchers) | | |
| Housing trust funds | | |
| Section 811 | | |
| 202 funds | | |
| USDA rural housing funds | | |
| Veterans Affairs housing funds | | |
| Funds for home modifications | | |
| Funds for assistive technology as it relates to housing | | |
| Other, specify: | | |

**RRDS Recommendation:**

- ☐ Approved
- ☐ Denied
- ☐ Corrections needed
- ☐ Submit to QMS

Comments: _____

_____

_____

_____

RRDS Reviewer Signature Date

I have received and accept all corrections and/or additional information provided and approves this Revised Service Plan (RSP).

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 (if applicable): _____

NOD Effective Date (if applicable): _____

NOD type (if applicable): _____

Revised Service Plan (RSP) Effective Date: from _____ to _____

_____

RRDS Reviewer Signature Date