

N.Y.S. Department of Health
Office of Long Term Care
Division of Home and Community Based
Services

**NURSING HOME TRANSITION
and DIVERSION MEDICAID
WAIVER**

Program Manual
2008

Program Manual - Purpose and Layout

This Program Manual was created to provide information about the policies and procedures of the Nursing Home Transition and Diversion (NHTD) Medicaid Waiver program. This manual is written for Service Coordinators and other waiver service providers, Regional Resource Development Centers (RRDC), Regional Resource Development Specialists (RRDS), Nurse Evaluators (NE), and Quality Management Specialists (QMS). It can also be shared with applicants and waiver participants upon request.

Sections one (I) through ten (X) of this Program Manual outline the policies and procedures of the NHTD waiver. Section eleven (XI) contains Appendices A through G, which are the forms used in the various areas/components of the waiver program. Section twelve (XII) is the Glossary of Terms relevant to the waiver program. Section thirteen (XIII) contains the maps outlining the regions for the Regional Resource Development Centers (RRDC) and the Quality Management Specialists (QMS).

Special Note: Whenever the term ‘applicant’ or ‘participant’ is used in this Program Manual, it also includes reference, if applicable to the presence of a court appointed Legal Guardian or Committee, or other legal entity designated to act on behalf of the applicant/participant, unless specifically stated otherwise.

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Section I

INTRODUCTION AND PHILOSOPHY OF THE NHTD WAIVER

Introduction to the Home and Community-Based Services Nursing Home Transition and Diversion (NHTD) Medicaid Waiver

The Nursing Home Transition and Diversion (NHTD) Medicaid Waiver is a Home and Community Based Services (HCBS) program, administered by the New York State Department of Health (DOH) through contractual agreements with Regional Resource Development Centers (RRDC) and Quality Management Specialists (QMS). The RRDC employs the Regional Resource Development Specialist (RRDS) and Nurse Evaluator (NE), who serve specific counties throughout the State (refer to Section XIII).

The NHTD waiver uses Medicaid funding to provide supports and services to assist individuals with disabilities and seniors toward successful inclusion in the community. Waiver participants may come from a nursing facility or other institution (transition), or choose to participate in the waiver to prevent institutionalization (diversion).

Waiver services may be considered when informal supports, local, State and federally funded services and Medicaid State Plan services are not sufficient to assure the health and welfare of the individual in the community, or when waiver services are a more efficient use of Medicaid funds.

Philosophy of the NHTD Waiver

The NHTD Medicaid waiver was developed based on the philosophy that individuals with disabilities and/or seniors have the same rights as others. This includes the right to be in control of their lives, encounter and manage risks and learn from their experiences. This is balanced with the waiver program's responsibility to assure the waiver participants' health and welfare.

Waiver services are provided based on the participant's unique strengths, needs, choices and goals. The individual is the primary decision-maker and works in cooperation with providers to develop a Service Plan. This process leads to personal empowerment, increased independence, greater community inclusion, self-reliance and meaningful productive activities. Waiver participant satisfaction is a significant measure of success of the NHTD waiver.

Section II

BECOMING A WAIVER PARTICIPANT

Introduction

NHTD waiver services can only be provided to eligible individuals whose application has been approved. This section will explain the eligibility criteria, issues that impact eligibility, referral, intake, application and determination processes.

A. Eligibility Criteria

An individual applying to participate in the waiver must meet all of the following criteria in order to be approved for the NHTD waiver:

1. Be a recipient of Medicaid coverage that supports community-based long-term care services. Such coverage includes:

All Services except Nursing Facility Service
Community Coverage with Community-Based Long Term Care
Outpatient Coverage with Community-Based Long Term Care
Outpatient Coverage with no Nursing Facility Services

Note: Type of coverage must be verified by providing a copy of Medicaid verification from the New York State system with the submission of the application packet. (The Service Coordinator attaches this to the Initial Service Plan).

2. Be between age 18 and 64 with a physical disability, or age 65 and older upon application to the waiver; If under age 65, the physical disability will be documented by:
 - a. award letters/determination of:
 - Supplemental Security Income (SSI);
 - Social Security Disability Insurance (SSDI); or
 - Railroad Retirement letter for total permanent disability for SSI benefits.

Note: Because eligibility is restricted to individuals with physical disabilities, additional information may be needed to verify the existence of such a disability.

- b. a letter from the Local Department of Social Services or local disability team (form LDSS 4141) stating the individual has been determined to have a physical disability;
 - c. documentation from the individual's physician, hospital summaries or Nursing Home records verifying the physical disability.
3. Be assessed to need a nursing home level of care. Nursing home eligibility is determined by the Hospital and Community Patient Review Instrument (H/C PRI) and SCREEN (refer to Appendix F). The forms must be dated within ninety (90) calendar days of the individual's application to the waiver and be completed by an individual certified by the State of New York to administer the tool;

4. Sign the Freedom of Choice form indicating that he/she chooses to participate in the NHTD waiver (refer to Appendix B – form B.4);
5. Be able to identify the actual location and living arrangements in which the waiver participant will be living when participating in the waiver;
6. Complete and submit an Application Packet which includes the Initial Service Plan (refer to section C below - Application) in cooperation with the Service Coordinator. This Initial Service Plan must describe why the individual is at risk for nursing home placement without the services of the waiver and indicate how the available supports and requested waiver services identified in the Plan and how the use of the waiver services will prevent institutionalization. The potential applicant must need at least one waiver service (see section C below - Referral, Intake, Application and Determination processes);
7. Have a completed Plan for Protective Oversight (PPO) (refer to Appendix C – C.4). Be capable of directing his/her Service Plan or has a legal guardian available to direct the participant's Service Plan;
8. Services agreed upon in the Initial Service Plan (ISP) must meet regional and statewide cost neutrality; and
9. Be able to live in the community where health and welfare can be maintained as determined by the RRDS.

B. Issues That Impact Eligibility

Federal policy prohibits participation in two HCBS waivers at the same time. Some examples of other HCBS waiver programs include:

- Long Term Home Health Care Program (LTHHCP)
- Office of Mental Retardation and Developmental Disabilities/Home and Community Based Services Waiver (OMRDD/HCBS)
- Traumatic Brain Injury Program (TBI)

If an individual is already receiving services from one of these federal waiver programs and wishes to be considered for participation in the NHTD waiver program, he/she must be informed that if approved, they must be discontinued from their current program to participate in the NHTD waiver.

An individual currently residing in or planning to reside in a facility under the Assisted Living Program (ALP) is not eligible for the NHTD waiver.

In addition, Medicaid regulations will not allow for duplication of services. Therefore, individuals enrolled in a Managed Long Term Care Program (MLTC), a Program of all Inclusive Care for the Elderly (PACE) or receiving Comprehensive Medicaid Case Management (CMCM) through a targeted case management program are **not** eligible for the NHTD waiver unless they are disenrolled from these programs.

C. Referral, Intake, Application and Determination Processes

The following describes the processes for becoming a waiver participant:

Referral: A potential participant or an individual acting on his/her behalf contacts the RRDC in the region where he/she chooses to reside or where they are currently living. The RRDS completes the Referral form (refer to Appendix B) and makes a determination whether to proceed to the Intake process. If the individual is considered not to meet the basic criteria for the waiver or indicates his/her preference not to pursue admission into the NHTD waiver, the RRDS will provide available options for referrals to other programs/services.

Note: It is expected that within two (2) weeks of receiving the referral the RRDS will make contact with the individual and schedule an Intake. If it is immediately apparent that the Referral will not proceed to Intake (e.g. the individual is under age 18), the RRDS has two (2) business days to contact the individual and give them information for other community resources.

Intake: If the potential participant has a Legal Guardian the RRDS will request a copy of the Guardianship document be provided at the time of Intake. The RRDS meets with the potential participant, his/her Legal Guardian, if applicable and anyone the potential participant chooses to be present and describes the waiver philosophy and available services.

The RRDS reviews the Initial Applicant Interview Acknowledgment form (refer to Appendix B – form B.3) with the potential participant and has him/her sign it. The RRDS makes a preliminary determination of probable eligibility for the waiver. If the potential participant is considered ineligible for the waiver or indicates his/her preference not to pursue admission into the NHTD waiver, the RRDS will provide available options for referrals to other programs/services. The RRDS closes the Intake process.

If the RRDS determines probable eligibility for the waiver and the potential participant indicates his/her interest in pursuing admission into the NHTD waiver, the RRDS reviews the Freedom of Choice form with the potential participant and has him/her sign it.

The individual completes and signs the Application for Participation form.

The RRDS provides the potential participant with a list of approved Service Coordination providers and encourages him/her to interview potential Service Coordinators.

The potential participant selects a Service Coordination Agency from the list of approved providers, completes the Service Coordinator Selection form (refer to Appendix B – form B.5) and returns it to the RRDS. The RRDS forwards the Service Coordinator Selection form to the selected

Service Coordinator provider for their signature along with a copy of the Intake form. The Service Coordination Agency will return the completed Service Coordination Selection form to the RRDS, indicating that they are willing and able to accept the applicant. The RRDS completes the Intake form (refer to Appendix B – form B.2). The RRDS will then forward a copy of the Freedom of Choice form, and the Service Coordination Selection form to the Service Coordination Agency. If the potential participant has a Legal Guardian, the RRDS will assure that a copy of the Guardianship documentation is given to the selected Service Coordinator prior to the development of the Service Plan.

If the Service Coordination Agency is unable to provide this service then the potential participant is notified by the RRDS. The potential participant must select another Service Coordination Agency.

Note: The RRDS and Service Coordination agency must follow their Health Insurance Portability and Accountability Act (HIPAA) compliance policies. If the intake meeting does not occur within sixty (60) calendar days after the scheduled date for the Intake meeting, the Intake is cancelled for it did not proceed to the application process. If after this time period the individual decides to proceed with the Intake process, the RRDS must start a new Referral process.

Application: It is at this point the individual becomes a formal applicant. The applicant and anyone he/she may choose, works with their chosen Service Coordinator to develop an ISP (refer to Appendix C – form C.1) and PPO. This process includes the applicant and Service Coordinator working together to develop the ISP and PPO.

Note: It is expected that once the Service Coordinator agency has accepted the applicant the Service Coordinator has sixty (60) calendar days to complete the Application Packet and submit it to the RRDS (refer to Section V – The Service Plan).

The ISP is signed by the applicant indicating they had choice of waiver services and providers of these services. If the waiver service provider agency is unable to provide the service(s) requested, then the applicant is notified by the Service Coordinator. The applicant must then select another waiver provider agency.

Note: All NHTD Waiver Provider agencies must follow their HIPAA compliance policies.

The Service Coordinator assembles the Application Packet, which includes the following forms:

1. Application for Participation- completed with the RRDS
2. Participant Rights and Responsibilities
3. H/C PRI and SCREEN
4. Initial Service Plan (ISP)-including Medicaid coverage

- Verification (Medicaid Eligibility Verification System)
5. Provider Selection form(s)
 6. Insurance, Resource and Funding Information Sheet;
 7. Plan of Protective Oversight (PPO)
 8. Proof of physical disability determination (if under age 65)
 9. Freedom of Choice- completed with the RRDS
 10. Service Coordination Selection- completed with the RRDS

The Service Coordinator sends his/her part of the completed Application Packet to the RRDS which includes Participant Rights and Responsibilities, H/C PRI and SCREEN , PPO, Initial Service Plan, Provider Selection forms, Insurance, Resource and Funding Information Sheet, Proof of disability determination (if under age 65) (refer to Section V - The Service Plan).

Determination: The RRDS reviews the entire Application Packet, which includes the ISP, and either approves the Packet or sends the RRDS ISP Review form (refer to Appendix B – form B.10) to the Service Coordinator and requests in writing, revisions and/or additional information needed for approval. All Service Plans over \$300 per day must be reviewed by the RRDS and forwarded to the QMS for recommendations. The QMS will review, make recommendations and return the Service Plan to the RRDS within three (3) business days of receipt. The RRDS is responsible for the final decision.

Note: The RRDS has fourteen (14) calendar days from receipt of the Application Packet to review and make a determination.

A Notice of Decision (NOD) – Authorization is issued to the applicant by the RRDS for the approved Application Packet indicating the applicant's transition to participant status. This Notice of Decision indicates the start date for the initial six (6) month approval period of the waiver program for the participant. Subsequent six (6) month approvals are based on the participant's choice to remain in the waiver, continued eligibility, and an approved Service Plan. The RRDS also forwards a copy of the NOD to the Local Department of Social Services (LDSS) and to the Service Coordinator. Upon receipt of the NOD, the LDSS inputs program code 60 (NHTD) into the Welfare Management System (WMS).

A Notice of Decision (NOD) - Denial is issued to the applicant when the RRDS determines that the individual is not eligible for the waiver or the Service Plan does not describe a sufficient level of supports and/or services to maintain the individual's health and welfare in the community.

Note: During the referral and intake process when an individual chooses to relocate to a region covered by another RRDS, the current RRDS is responsible for making the initial contact with the RRDS in the relocation region. The RRDS from the new region will contact the individual to provide the list of approved Service Coordination providers in that region.

D. Waiver Participant's Rights and Responsibilities

Every waiver participant is assured certain rights and must agree to certain responsibilities related to the waiver program.

As part of the approval process, the potential participant is presented with a copy of the Waiver Participant's Rights and Responsibilities for the NHTD waiver by the Service Coordinator.

The Service Coordinator is responsible for explaining the rights and responsibilities of being a waiver participant to the individual and/or legal guardian. These rights and responsibilities should be reviewed during the development of the application and at least annually, and any time the Service Coordinator is aware that the participant does not understand his/her rights or responsibilities. The Service Coordinator gives a copy to the participant.

The Waiver Participant's Rights and Responsibilities (refer to Appendix C – form C.5) must be signed and dated by the applicant and/or legal guardian during the application process and at least annually there after. The signed original document is maintained with the Application Packet in the Service Coordinator's record. A copy is given to the participant to be maintained in an accessible location in the participant's home.

The Waiver Participant Has The Right To:

1. Be informed of his/her rights prior to receiving waiver services;
2. Receive services without regard to race, religion, color, creed, gender, national origin, sexual orientation, marital status, or disability;
3. Be treated as an individual with consideration, dignity and respect including but not limited to person, residence and possessions;
4. Have services provided that support his/her health and welfare;
5. Assume reasonable risks and have the opportunity to learn from these experiences;
6. Be provided with an explanation of all services available in the NHTD waiver and other health and community resources that may benefit him/her;
7. Have the opportunity to participate in the development, review and approval of all Service Plans, including any changes to the Service Plan;
8. Select service providers and choose to receive additional waiver services from different agencies or different providers within the same agency without jeopardizing participation in the waiver;
9. Request a change in services (add, increase, decrease or discontinue) at any time;
10. Be fully informed of the process for requesting an Informal Conference and Fair

Hearing upon receipt of a Notice of Decision or at any time while on the waiver.

11. Be informed of the name and duties of any person providing services to him/her under the Service Plan;
12. Have input into when and how waiver services will be provided;
13. Receive services from approved, qualified individuals;
14. Receive from the Service Coordinator in writing a list of names, telephone numbers, and supervisors for all waiver service providers, the RRDS, the QMS and NHTD Complaint Hotline;
15. Refuse care, treatment and services after being fully informed of and understanding the potential risks and consequences of such actions;
16. Have his/her privacy respected, including the confidentiality of personal records, and have the right to refuse the release of the information to anyone not authorized to have such records, except in the case of his/her transfer to a health care facility or as required by law or Medicaid requirements;
17. Submit complaints about any violation of rights and any concerns regarding services provided, without jeopardizing his/her participation in the waiver and not being subject to restraint, interference, coercion, discrimination or reprisal as a result of submitting a complaint;
18. Receive support and direction from the Service Coordinator to resolve his/her concerns and complaints about services and service providers;
19. Receive additional support and direction from the RRDS, QMS, and DOH Waiver Management staff as desired or in the event that his/her Service Coordinator is not successful in resolving concerns and complaints about services and service providers;
20. Have his/her complaints responded to and be informed of the final resolution of the investigation;
21. Have his/her service providers protect and promote his/her ability to exercise all rights identified in this document;
22. Have all rights and responsibilities outlined in this document forwarded to his/her court appointed legal guardian or others authorized to act on his/her behalf; and
23. Participate in surveys inquiring about your experiences as an NHTD waiver participant. This includes the right to refuse to participate in experience surveys without jeopardizing your continued participation in the NHTD waiver program.

Waiver Participant's Responsibilities

The participant is responsible for:

1. Working with the Service Coordinator to develop/revise his/her Service Plan to assure timely reauthorization of the Service Plan;
2. Working with his/her waiver providers as described in his/her Service Plan;
3. Following his/her Service Plan and notifying his/her Service Coordinator if problems occur;
4. Talking to his/her Service Coordinator and other waiver providers if he/she wants to change his/her goals or services;
5. Providing to the best of his/her knowledge complete and accurate medical history including all prescribed and over-the-counter medications he/she is taking and understanding of the risk(s) associated with his/her decisions about care;
6. Informing the Service Coordinator about all treatments and interventions he/she is involved in;
7. Maintaining his/her home in a manner which enables him/her to safely live in the community;
8. Asking questions when he/she does not understand his/her services;
9. Not participating in any criminal behavior. He/she understands that, if he/she does, his/her service provider(s) may leave, the police may be called and his/her continuation in the waiver program may be jeopardized;
10. Reporting any significant changes in his/her medical condition, circumstances, informal supports and formal supports to his/her Service Coordinator;
11. Providing accurate information related to his/her coverage under Medicaid, Medicare or other medically-related insurance programs to your Service Coordinator;
12. Notifying all providers as soon as possible if the scheduled service visit needs to be rescheduled or changed;
13. Notifying appropriate person(s) should any problems occur or he/she is dissatisfied with services provided; and
14. Showing respect and consideration for staff and their property.

Notice of Decision (NOD)

Introduction

A Notice of Decision (NOD) is a written document that notifies an applicant/participant of an action being taken by the waiver program, including an explanation of the reasons for the action.

The RRDS is responsible for assuring the correct NOD is completed and sent out to each applicant/participant, Legal Guardian (if applicable), Authorized Representative (if applicable), Service Coordinator, NHTD Waiver Management staff, and LDSS as specified on the bottom of each form.

The Service Coordinator provides follow-up in this process by contacting the applicant/participant to discuss the reasons for the NOD and to assure his/her understanding of the right to request an Informal Conference and/or Fair Hearing (with aid continuing, if appropriate).

Types of Notice of Decision forms

The following describes each type of Notice of Decision form used in the NHTD waiver program (refer to Appendix B – forms NOD.1 to NOD.9):

- 1) Authorization is sent to an applicant when he/she has been approved to participate in the waiver program. This NOD includes the effective date of services. When a participant is authorized for the NHTD waiver he/she is entered into WMS until a NOD is provided to LDSS indicating the individual is no longer a participant.
- 2) Denial of Waiver Program is sent when an applicant will not become a NHTD waiver participant for the following reasons:
 - (a) The applicant chooses not to receive waiver services;
 - (b) The applicant is not:
 - assessed to require a nursing home level of care based on the PRI/SCREEN;
 - 18 years of age or older;
 - in possession of appropriate documentation verifying a physical disability, if under age 65; or
 - capable of living in the community with the assistance of informal supports, non-Medicaid supports, State Plan Medicaid services, and/or waiver services.
 - (c) The services and supports available through the waiver and all other sources are not sufficient to maintain the individual's health and welfare in the community;
 - (d) The applicant chooses to receive services from another Home and Community Based Services Medicaid Waiver or State Plan Services;

- (e) The cost of the Service Plan is above the level necessary to meet the federally mandated requirement that waiver services must be cost neutral in the aggregate when compared to Statewide nursing home costs;
 - (f) The applicant is not in need of one or more waiver services; and/or
 - (g) The applicant is not Medicaid eligible. When an applicant/participant is denied for this reason, a notice of denial is sent to the applicant/participant by LDSS. The process for pursuing a Fair Hearing regarding their determination may be pursued through the Fair Hearing process as identified in the Notice of Decision received by the /applicant/participant from LDSS system.
- 3) Intent to Discontinue From the Waiver Program (1) is sent to a participant when he/she chooses to no longer participate in the waiver program.
 - 4) Intent to Discontinue From the Waiver Program (2) is sent to a participant when the following occurs:
 - (a) The participant is no longer eligible for a nursing home level of care, per PRI and SCREEN;
 - (b) Waiver Services cannot safely maintain the participant in the community;
 - (c) An agreement can not be reached between participant and waiver entities regarding the Service Plan;
 - (d) The participant no longer needs waiver services to assure health and welfare in the community;
 - (e) Other appropriate reason as documented on the form.
 - 5) Reduction and/or Discontinuation of Waiver Service(s) is sent to a participant when there is a reduction in the hours/frequency of a waiver service(s) and/or discontinuation of waiver service(s).
 - 6) Denial Of A Waiver Provider/Denial Of A Waiver Service is sent to a participant when his/her request for a particular waiver provider or a request for an additional service(s) is denied by the RRDS.

Note: When a request for a particular provider is denied by the RRDS because the agency is under Vendor Hold status and therefore can not accept any new participants, an NOD is not issued by the RRDS.

Additionally, when it is the waiver provider agency who is unable/unwilling to accept a participant, an NOD is not issued to the participant.

- 7) Addition and/or increase of Waiver Service(s) is sent to a participant when there is an increase in the hours/frequency of a waiver service(s) and/or when a new waiver services is added to a participant's Service Plan.
- 8) Suspension is sent when all waiver services are being held due to the participant's

temporary absence from participation in the NHTD waiver (e.g. travel in/out of NYS, hospitalization or nursing home placement, incarceration, etc). The Service Coordinator is responsible for distributing this Notice to all waiver providers. A suspension 'holds' a participant's place in the NHTD waiver for up to thirty (30) calendar days at which time the participant's situation is re-evaluated by the Service Coordinator. If additional time is deemed appropriate by the Service Coordinator and RRDS, the Suspension can be extended for up to an additional thirty (30) calendar days.

Upon resuming waiver services following a period of suspension, the RRDS issues written notification to the participant that the suspension has been cancelled. The Service Coordinator must determine whether the participant is in need of an Addendum or a Revised Service Plan and provide timely follow up.

If the participant is unable to resume participation in the waiver by the end of the suspension period, the RRDS issues an NOD-Discontinuation from Waiver Program to the participant.

- 9) Notification of Death of a Waiver Participant to Local Department of Social Services is sent when a participant has died.

Note: This notice is not sent to the participant's home, legal guardian, or to any family/designated representatives. It is only intended for the Service Coordinator, NHTD Waiver Management staff and LDSS in county of residence and with fiscal responsibility as noted on the bottom of the form.

Informal Conference/Fair Hearings

Introduction

Individuals receiving a Notice of Decision (NOD) for issues related to the waiver are eligible for an Informal Conference and/or a Fair Hearing. When a applicant/participant has concerns regarding the NOD, the program tries to work with the applicant/participant to reach a resolution. However, when that can not occur, the program assures the applicant/participant knows his/her rights about requesting an Informal Conference and/or Fair Hearing, and aid continuing, if applicable. All NODs must include information regarding an individual's Informal Conference and Fair Hearing rights; how to apply for an Informal Conference and/or Fair Hearing; and, how to maintain his/her benefits throughout the Fair Hearing process (aid continuing), if appropriate.

Informal Conference

If a participant receives a NOD from the RRDS, an Informal Conference may be conducted prior to or while pursuing a formal Medicaid Fair Hearing. A review by the RRDS may be requested by the participant, legal guardian, advocate, Service Coordinator or anyone involved in the development of the Service Plan. Requesting an Informal Conference does not affect the participant's ability or right to request a Fair Hearing.

The Informal Conference is an opportunity for the participant and/or Legal Guardian to review with the RRDS the reasons for the NOD and address information they feel is not properly represented. Through discussion and negotiation, it may be possible to resolve issues without a Fair Hearing.

Fair Hearings

A Fair Hearing is a hearing held in the presence of a Hearing Officer, a specially trained administrative law judge from the New York State Office of Temporary and Disability Assistance (OTDA). The judge hears arguments from the applicant/participant or Legal Guardian who wishes to appeal a NOD issued by the RRDS. In addition, providers may assist in clarifying issues and attend the hearing upon the request of the RRDS or DOH.

An individual has the right to seek a Fair Hearing for many reasons including issues related to the NHTD waiver. Decisions regarding Medicaid eligibility are addressed through the Fair Hearing process with the Local Department of Social Services.

Issues related to the waiver that can be addressed through the Fair Hearing process include:

- (1) Was the applicant offered the choice of waiver service(s) as an alternative to a nursing home?
- (2) Was the applicant or participant denied the waiver service(s) of his or her choice?
- (3) Was the applicant or participant denied the waiver services of an approved waiver service provider that was willing to serve the applicant/participant?
- (4) Was the decision to reduce or eliminate waiver services correct? and/or
- (5) Was the decision of Denial or Intent to Discontinue correct?

Issues about the waiver that are NOT addressed through the Fair Hearing process include:

- (1) Was the applicant or participant in need of a nursing home level of care (as determined by the PRI/SCREEN)?
- (2) Does the waiver have any openings based on the number of participants approved for the waiver as specified by the federal government? and/or
- (3) Does the applicant have evidence of a physical disability if between ages 18 and 64 or, is a senior over the age of 65?

Aid continuing

Aid continuing offers the participant an opportunity to continue Medicaid benefits previously received while he/she pursues a Fair Hearing until a final determination is made.

When aid continuing is an option included in the NOD form sent to the participant,

he/she has the right to pursue or decline continuation of Medicaid benefits. If the participant wants aid continuing until the Fair Hearing decision is received, this request must be done within ten (10) calendar days of the Notice Date on the form, indicated as the Effective Date. If this ten (10) day time period elapses, the participant can no longer request aid continuing but may still request a Fair Hearing, as long as it is done within sixty (60) calendar days of the Notice Date on the form. If aid continuing is requested, in most instances Medicaid benefits will stay the same until the Fair Hearing decision is made. However, if a participant receives aid continuing and loses the Fair Hearing, he/she may have to pay back the cost of any Medicaid benefits he/she should not have received while waiting for the Fair Hearing decision.

Fair Hearing Process

Upon receiving a copy of a NOD from the RRDS, the Service Coordinator and the participant discuss the impact of the NOD. Information must include discussion of participant's right to pursue an Informal Conference, Fair Hearing or both, and aid continuing policies. The participant is directed to follow the instructions provided in the NOD.

When OTDA receives notification from the participant and/or Legal Guardian of his/her intent to pursue a Fair Hearing, OTDA notifies DOH and the RRDS.

If the request for Fair Hearing also includes the participant's request for aid continuing, the RRDS notifies the Service Coordinator so that appropriate notification can be made to the waiver providers.

To prepare for the Fair Hearing the RRDS:

1. Works in conjunction with DOH Waiver Management staff to prepare for the hearing;
2. Prepares an Evidentiary Packet containing copies of all required documentation and examples that explain the reasons for the NOD and address the participant's concerns;

An Evidentiary Packet includes copies of the following:

- a. Verification of current Medicaid coverage/eligibility, indicating LTC eligibility;
- b. Notice of Decision(s) sent to participant resulting in the request for Fair Hearing ;
- c. Current H/C PRI and SCREEN, completed by an individual(s) certified to administer the tools;
- d. Freedom of Choice form, signed by the applicant/participant;
- e. Case notes;
- f. Current ISP, RSP and/or Addendum approved and signed by RRDS;
- g. Plan for Protective Oversight;
- h. Service provider notes/records which serve as documentation of recurring issues, if applicable;

- i. Neurobehavioral assessments and notes, if applicable;
 - j. Pages from the NHTD Program Manual applicable to the case with section and page number(s) noted; and
 - k. Record of attempts made by the RRDS and Service Coordinator to work with the participant to resolve any issues which have contributed to the issuance of the NOD which is the basis for the Fair Hearing.
3. Responds in a timely manner to a participant's request for access to and/or copies of documents from the participant's record;
4. Attends the Fair Hearing and presents information to the Administrative Law Judge. (DOH may request that its legal counsel or another waiver entity, e.g. waiver provider attend the Fair Hearing and present information as appropriate); and
5. Keeps DOH Waiver Management staff informed of any issues that occur during the Fair Hearing process.

Generally within 90 days, OTDA sends a formal written response to the participant, DOH and LDSS with the final decision of the hearing. DOH provides a copy of this response to the RRDS.

The RRDS:

- Notifies the Service Coordinator of the outcome of the hearing so that appropriate follow-up can occur;
- Assures that any changes to the Service Plan are made accordingly; and
- Assures that if discontinuation from the waiver is indicated for the participant, the Service Coordinator establishes a safe and appropriate discharge plan.

Section III

BECOMING A WAIVER PROVIDER

Waiver Provider

Introduction

The NHTD Waiver program is committed to providing high quality and cost effective services offered through qualified waiver providers. This section describes the provider's qualifications, the provider's responsibilities, steps in the application process, subcontracts, vendor hold, termination of contracts and housing.

A. Qualifications for Provider Agencies

All waiver providers, including those already approved to provide services under the Medicaid State Plan or another Medicaid waiver are required to also be approved as a NHTD waiver provider.

Waiver providers must be located in and able to provide services in New York State.

Providers must meet all licensure and other qualifications of the service(s) included on the application they are applying for as specified in this Program Manual (refer to Section VI-Waiver Services).

Providers are responsible to know, understand and implement the waiver in accordance with the policies and procedures established in this Program Manual and any updates or changes to it.

Providers may request approval for any number of waiver services. Providers may apply to provide additional services or become a provider in additional Regional Resource Development Center regions at any time. The approval process to add services or Regions is the same as the initial application process.

If at any time a provider is unable to maintain qualified staff, it will not be able to provide that service/services. The waiver provider must report any changes in status to the appropriate RRDC.

Providers must adhere to all Medicaid confidentiality and Health Information Portability and Accountability Act (HIPAA) requirements and ensure the privacy of the waiver participant. Providers must adhere to all responsibilities and conditions delineated in the Provider Agreement (refer to Appendix A – form A.2).

B. Provider Responsibilities

- I. Providers applying for Assistive Technology (AT), Community Transitional Services (CTS), Congregate and Home Delivered Meals, Environmental Modifications Services (E-mods), Home Visits by Medical Personnel, Moving Assistance and Respiratory Therapy must satisfy the following conditions:

1. Assure participant's right of choice;
 2. Establish and maintain current safety and emergency policies and procedures;
 3. Have personnel files on every employee including resumes and job descriptions; if a provider has more than one office and the personnel files are housed in the main office when the other office(s) is surveyed by DOH, the personnel files need to be provided to the surveyor(s) at that location per their request;
 4. Have knowledge of the NHTD Waiver's Incident Reporting Policy regarding Serious Reportable Incidents (SRI) (refer to Section X – Incident Reporting Policy and Complaint Procedure) including the obligation to report to the Service Coordinator (SC), and to cooperate with the Quality Management Specialist (QMS) in relation to the investigation of SRI, i.e. staff interviews;
 5. Establish and maintain a tracking system to ensure staff will provide the expected amount/type of service in accordance with the participant's Service Plan (SP);
 6. Establish and maintain an accurate system for documenting when services are provided and billed;
 7. Establish and maintain a process for surveying participant satisfaction of its service; this process includes obtaining information from the participant on his/her satisfaction of the service provided, was the staff able to make appointments, be on time and provided services as agreed upon;
 8. Establish and maintain a policy for handling complaints raised by participants, family members or advocates and concerns addressed by the SC, Regional Resource Development Specialist (RRDS) or QMS and documenting outcomes;
 9. Establish and maintain a file for each participant regarding the waiver participant's individual information provided by the SC including: a copy of the Notice of Decision (NOD), the first page of the SP and the page(s) describing the need for the requested waiver service(s); and
 10. Cooperate with New York State Department of Health, Office of Medicaid Inspector General (OMIG) and other government agencies with jurisdiction to conduct surveys and audits.
- II. All other providers applying to become a waiver provider must satisfy the following conditions:
1. Assure participant's right of choice;

2. Establish and maintain current safety and emergency policies and procedures;
3. Establish and maintain personnel files on every employee including resumes and job descriptions; if a provider has more than one office and the personnel files are housed in the main office, when the other office(s) is surveyed by DOH, the personnel files need to be provided to the surveyor(s) at that location per their request;
4. Follow the NHTD Serious Reportable Incident Policy and Procedure (refer to Section X – Incident Reporting Policy and Complaint Procedure);
5. Establish and maintain policy and procedure for documenting Recordable Incidents; (refer to Section X – Incident Reporting Policy and Complaint Procedure);
6. Establish and maintain a tracking system to ensure that staff is providing expected amount of service in accordance with the participant's SP;
7. Establish and maintain a method for self-appraisal of service provision including suggestions and methods for improvements;
8. Establish and maintain a process for surveying participant satisfaction of its service. This process includes obtaining information from the participant on his/her satisfaction of the service provided, was the staff able to keep appointments made, be on time and provided services as agreed upon;
9. Establish and maintain a method for recording and addressing complaints made by the waiver participants, families, legal guardians and others; this information is included in an annual report stating the number and types of complaints made/received, including an analysis of these complaints and the provider's response to them;
10. Establish and maintain a method for recording and addressing concerns expressed by the SC, RRDS, QMS and/or DOH Waiver Management staff (WMS);
11. Establish and maintain participant records which include functional assessments, detailed plans, notation of every encounter and contact with the participant, a copy of all Individual Service Reports (ISR), documentation of all communication with the SC, documentation of the times of visits, billing records, current copy of the NOD, a copy of the current approved SP, and a copy of the current Waiver Participant Rights and Responsibilities (refer to Appendix C – form C.5);

12. Provide training utilizing DOH established curriculum and where an agency's curriculum exists regarding the subject matter, have that written training curriculum approved by DOH WMS to meet the DOH training requirements (refer to Section VIII – Required Training for Waiver Service Providers); and
13. Cooperate with New York State Department of Health, OMIG and other government agencies with jurisdiction to conduct surveys and audits.

Note: Providers approved under B-II above are expected to attend the RRDS provider meetings. At times, these meetings cover policies and procedures relevant to the health and welfare of the participants. These meetings are a critical opportunity for the providers to remain current regarding NHTD policies and procedures. Not attending these meetings could result in noncompliance with policies and procedures, which will ultimately lead to restrictions to the provision of waiver services.

C. Application Process

The following eight (8) steps describe the application process for becoming a waiver provider:

STEP 1 Provider Inquires

The potential waiver service provider for the NHTD Waiver will obtain a copy of the Program Manual from the DOH website or the RRDS, which includes the application forms for becoming a waiver provider (refer to Appendix A – forms A.1 and A.2).

STEP 2 Application

The potential waiver service provider submits the Provider Application Packet to the RRDC in the region/regions it wants to serve. The packet includes:

- a. Letter of Intent describing:
 1. The agency's history of providing services to individuals with disabilities and/or seniors. If this experience is limited, a description of how the agency proposes to develop the expertise to effectively provide services must be included;
 2. A list of service(s) for which the provider is seeking approval; and
 3. Identification of the RRDC region(s) and/or counties within the RRDC region where service(s) would be provided.
- b. Employee Verification of Qualifications form (refer to Appendix A – form A.1) and resume for at least one individual providing the waiver service requested.

- c. Signed original Provider Agreement Form.
- d. Signed original eMedNY Provider Enrollment Form. The Category of Service 0260 needs to be completed by potential providers of Home Visits by Medical Personnel and Respiratory Therapy. All other potential providers need to complete the Category of Service 0263.
- e. Signed original Disclosure of Ownership and Control Form, including:
 1. A list of the Board of Directors, including any relationships that exist between Board members (e.g. spouses, children, etc.), or individuals with the same last name; and
 2. The location of the agency including street address, even if the mailing address does not include a street or road.
- f. Copy of the Federal Employee Identification Number (FEIN).
- g. A copy of provider's licensure, certification and other requirements, as applicable, which support the requested services and satisfies the requirements of being a provider of the waiver service specified in the prospective provider application.
- h. A copy of provider policies and procedures which include:
 - HIPAA compliance;
 - Safety and emergency procedures;
 - Human Resource (personnel) records;
 - Serious Reportable and Recordable Incident Reporting;
 - Service provision tracking system;
 - Plan for self-appraisal of service provision including suggestions and methods for improvements;
 - Participant satisfaction survey;
 - Recording and addressing waiver participant complaints and grievances;
 - Recording and addressing concerns of RRDS, QMS, SC, and DOH WMS; and
 - Record keeping/ documentation.

The completed Provider Application packet must be submitted to the RRDS(s) for review and recommendations in the region/regions they will be serving. If a prospective provider is interested in providing services in more than one region, the Application Packet must be sent to each RRDC for review by the RRDS(s).

STEP 3 RRDS Preliminary Review

Prior to arranging an interview with the potential provider, each RRDS will review the Provider Enrollment Application Packet for potential providers in his/her region and determine preliminary eligibility. This includes reviewing and verifying the provider meets the licensure, certification and staff qualifications which support the services requested. When two or more RRDCs are involved, the RRDSs will contact each other to discuss preliminary reviews and then set up a joint interview with the potential provider.

STEP 4 RRDS Interview and Review

The RRDC administering the waiver in the region(s) for which the provider is requesting approval is responsible for the review and decision about the application. A primary component in this determination is the RRDS(s) interview with the potential provider. In this interview the RRDS(s) will:

- a. Explain the NHTD waiver, its philosophy and services;
- b. Interview the potential provider and complete the Waiver Service Provider Interview form (refer to Appendix B – form B.8);
- c. Review resumes of proposed staff and Employee Verification of Qualifications forms (refer to Appendix A – form A.1);
- d. Review training materials developed by the provider (refer to Section VIII - Required Training for Waiver Service Providers);
- e. Review provider policies and procedures that were submitted (refer to Step 2-h).

The RRDS must visit the proposed site for a Structured Day Program Services and obtain a copy of the Certificate of Occupancy.

STEP 5 RRDS Recommendations

The RRDS is responsible for making recommendations to the Department of Health regarding approval of the proposed service(s) based on: personnel qualifications which meet all the requirements described above; the capacity of the agency to develop and maintain high quality services; and the provider's understanding of and willingness to adhere to the philosophy and policies of the waiver.

The RRDS must submit to DOH WMS the completed Provider Enrollment Application Packet and the Waiver Service Provider Interview form, which includes and describes the RRDS decision to DOH WMS including the RRDS(s) recommendations for whether to approve the potential provider and which waiver services to approve.

If there is a difference of opinion between the potential provider and the RRDS about whether the provider should be approved or what services the provider will be able to provide, DOH WMS will be responsible for the final decision.

STEP 6 DOH Waiver Management Staff Decisions

If any additional information or clarification is needed, DOH WMS will contact the RRDS or the potential provider agency, as appropriate. DOH WMS will send written notification to the potential provider indicating which, if any, services are approved and the starting date of the approval. If the provider disagrees with the decision, the potential provider may discuss concerns with DOH WMS.

DOH WMS is responsible for making a judgment about the character and competence of each potential provider as it impacts the provider's ability to deliver waiver services. DOH WMS must obtain reasonable assurances that the applying agency is capable of delivering services in accordance with the operational standards and intent of this waiver. DOH WMS may contact other New York State agencies or their counterparts in other states to gather information about the current status and background of the potential provider including any past experience in providing Home and Community-Based Services waiver services.

STEP 7 Billing

DOH WMS will forward the necessary provider information to the appropriate DOH office for processing to become approved to bill Medicaid. This office informs the approved provider about eMedNY and ePACES for billing instructions. The Billing Manual will be available at www.eMedNY.org.

STEP 8 Lists of Approved Providers

DOH WMS notifies the appropriate RRDS(s) of the Medicaid approval and services approved. The RRDS adds the provider to the list of approved providers for the RRDC region.

D. Subcontracting for Waiver Services

Subcontracting is defined as the approved provider's use of another agency to fulfill the responsibilities and services delegated to the approved provider in the Service Plan.

Subcontracting in the NHTD waiver is allowed for the following services **only**:

- Environmental Modifications (E-mods);
- Assistive Technology (AT);
- Community Transitional Services (CTS);
- Moving Assistance; and
- Congregate and Home Delivered Meals.

For these services, subcontracting may occur when the approved provider cannot complete the specified tasks with their resources. However, the provider is responsible for supervising the completion of the specified task in accordance with the Service Plan (SP), assuring that all workers are skilled or appropriately licensed, and determining that the completed task meets State and Federal codes, if appropriate.

E. Vendor Holds and Disenrollment Initiated by DOH Waiver Management Staff

When DOH WMS is informed by the RRDS of an issue(s) regarding the provision of services by a waiver provider, DOH WMS may choose to restrict a provider's opportunity level (Vendor Hold). This is done by sending the provider a letter via certified mail advising the provider that it will be placed on Vendor Hold, specifying the reason(s) for the restriction, the effective date and time period of the Vendor Hold and request for a correction plan.

The provider will be informed that it is ineligible to receive new referrals of waiver participants. This restriction may be for one specific service or for all services that the waiver provider offers. Reasons for this may include:

- late SPs (refer to Section V - The Service Plan);
- late ISR (refer to Section V - The Service Plan);
- unacceptable provider practices;
- questionable quality of services;
- provider's inability to deliver the specific services; and
- the provider's inability to follow the NHTD waiver policies and procedures.

The waiver provider must submit to DOH WMS a plan describing actions to address the specific issue within seven (7) calendar days of receiving the certified letter so the Vendor Hold can be lifted. If this is successful, a letter will be issued to the waiver provider by DOH Waiver Management staff indicating the Vendor Hold has been ended.

If the matter is not corrected by the waiver provider within the allotted seven (7) calendar days, DOH WMS will initiate the provider disenrollment process.

DOH WMS initiates the disenrollment process by sending a Provider Disenrollment Notification letter via certified mail to the waiver provider agency Executive Director indicating that the sixty (60) day disenrollment process has begun and the date the provider agreement will be terminated. The letter also informs that waiver provider that Vendor Hold restrictions remain in effect. It further provides information regarding the process for waiver participants to select a new waiver provider agency(s).

To stop disenrollment, the waiver provider must submit a plan of action to DOH WMS. Upon review and approval of this plan, DOH WMS will decide whether to stop the disenrollment process. If the plan of action is approved,

DOH WMS will issue a notice to the waiver provider executive director indicating this.

If DOH WMS does not approve the plan of action the SC must assist the participant(s) in choosing a new provider and with completing the Request for Change of Provider form (refer to Appendix C – form C.18). The SC will assist the participant(s) and the terminating waiver provider through the period of transition from current to new provider(s). The terminating waiver provider is responsible for sending the applicable new waiver provider(s) the following copies of all evaluations, ISR, a copy of the detail plan and an update on the participant's accomplished goals.

In situations where the service being terminated is Service Coordination, the notice must direct the participant to contact the RRDS to select another Service Coordination provider agency. The RRDS must assist the participant in completing the Request for Change in Service Coordinator Form (refer to Appendix B – form B.15). The RRDS must assure that all applicable documents (e.g. ISP, current SP, evaluations, current PRI/SCREEN, ISRs, Detailed Plans, etc.) are transferred from the current SC to the new SC.

F. Waiver Provider Request to Terminate Provider Agreement

An approved waiver provider may choose to terminate one or all of the approved waiver service(s) with a written notice of termination to DOH WMS and a copy to the RRDS, at least sixty (60) calendar days prior to the date of termination in accordance with the Provider Agreement.

The provider must also send a written notice of termination to all participants receiving the service(s) to be terminated at least sixty (60) calendar days prior to the date of termination. The notice must direct the participant to contact his/her SC to select another provider.

The SC must assist the participant(s) in choosing a new provider and filling out the Request for Change of Provider form. The SC will assist the participant(s) and the terminating waiver provider through the period of transition from current to new provider(s). The terminating waiver provider is responsible for sending the applicable new waiver provider(s) the following copies of all evaluations, ISR, a copy of the detail plan and an update on the participant's accomplished goals.

In situations where the service being terminated is Service Coordination, the notice must direct the participant to contact the RRDS to select another provider. The RRDS must assist the participant in completing the Request for Change in Service Coordinator form. The RRDS must assure that all applicable documents (e.g. ISP, current Service Plan, evaluations, current PRI/SCREEN, ISRs, Detailed Plans, etc) are transferred from the current SC to the new SC.

G. Provider Termination of Waiver Services to an Individual Waiver Participant

An approved waiver provider may choose to no longer serve an individual waiver participant by sending a letter to the waiver participant, the participant's SC and the RRDS at least ten (10) calendar days prior to stopping the provision of service(s). The letter must be sent via certified mail or delivered directly to the participant. The reasons for terminating services must be included (e.g. inability to meet participant's service needs, staff safety or loss of staff).

The letter must advise the participant to contact his/her SC for assistance with selecting another approved waiver provider.

The current provider must follow the Change of Provider Process (refer to Section V – The Service Plan).

When the service being stopped is Service Coordination, the participant must be directed to contact the RRDS for assistance in selecting another approved Service Coordination provider. The RRDS will oversee the process for transitioning to a new SC. In addition, the RRDS must assure that all applicable documents (e.g. ISP, current SP, evaluations, PRI/SCREEN, ISRs, Detailed Plans, etc.) are transferred from the current Service Coordinator to the new SC.

Licensed professionals and/or provider agencies may have other standards or regulations that dictate procedures they must follow in stopping services to an individual. This waiver policy is not intended to override or replace those standards or regulations.

H. Housing

Provider agencies which choose to function as landlords for waiver participants must allow participants to select waiver services from all approved providers and support access to bundled services. Provision of housing must not be contingent upon the selection of services from the provider. Waiver participants choosing to reside in a provider owned living arrangement must have a choice of where they live, whom they live with, and must be issued a one year lease.

Section IV

ROLES and RESPONSIBILITIES

- Regional Resource Development Center-
Regional Resource Development Specialist
and Nurse Evaluator
- Quality Management Specialist

Introduction

The Department of Health contracts with several entities who play a vital role in the success of the NHTD waiver. These entities include the Quality Management Specialist (QMS), and the Regional Resource Development Center (RRDC) which employs the Regional Resource Development Specialist (RRDS) and the Nurse Evaluator. As discussed earlier in this Program Manual, these entities are located throughout New York State and work collaboratively to ensure the high quality service provision to all participants of the NHTD waiver. This section of the Program Manual is devoted to clarifying the roles and responsibilities of each entity.

Regional Resource Development Center (RRDC)

The NHTD waiver contracts with RRDCs, located in nine (9) designated regions across New York State (refer to Section XIII - RRDC Regions map).

Each RRDC administers the NHTD waiver program initiatives at the regional level under the direction of the DOH Waiver Management staff (DOH WMS). The RRDC is responsible for managing the waiver with an emphasis on ensuring participant choice, availability of waiver service providers, and cost effectiveness of waiver services within its contracted region.

Qualifications of the RRDC

The RRDC must:

- Be a non-profit organization or agency capable of supporting the work of the RRDS, Nurse Evaluator (NE), and the philosophy of the waiver;
- Be Health Insurance Portability and Accountability Act (HIPAA) and Medicaid confidentiality compliant to assure the privacy of all waiver participants;
- Have expertise working with individuals with disabilities and seniors, and be able to demonstrate commitment to integrated community-based services to these individuals, their family members and other informal supports; and
- Possess extensive knowledge of providers of community based long term services in the geographic area they serve, financial stability and organizational capacity to administer RRDC responsibilities.

Roles and Responsibilities of the RRDC

The RRDC will:

- Employ an RRDS, NE and other staff who meet the qualifications and experience specified in its contract;
- Function as an initial point-of-contact for potential applicants, their families, legal guardians, and/or authorized representatives;
- Administer the day-to-day activities of the waiver and make recommendations based on such activities to DOH for improvements to NHTD waiver policies and procedures;

- Develop and maintain waiver resources and supports in the contracted region;
- Not provide any NHTD waiver services;
- Manage the Service Plan (SP) review process, regional budgeting requirements, and other monitoring functions using a database compatible with DOH needs;
- Maintain a database to ensure efficient management of the Service Plan review process, regional budgeting requirements and other information determined by DOH;
- Maintain participant Application Packets, SPs, reports and other required documentation as specified by the NHTD waiver and in a manner consistent with State standards for e-file transfers and information sharing;
- Develop collaborative relationships with regionally based stakeholders including Local Departments of Social Services (LDSS) and other local government entities, providers, advocacy organizations and others necessary to assure a comprehensive coordinated approach to the targeted population;
- Reduce the incidence of unnecessary institutionalization through:
 - Transition: Assisting eligible individuals currently living in nursing homes to move to appropriate community-based settings.
 - Diversion: Preventing in-state and out-of-state facility placements through individual and systems advocacy and the development of needed supports for eligible individuals.
 - Repatriation: Assisting individuals who have been in out-of-state facilities return home to New York State.
- Cooperate with State and Federal audits; and
- Manage other roles and responsibilities as defined by DOH and supported by the RRDC contract with DOH.

Regional Resource Development Specialist (RRDS)

The RRDS is responsible for the development, management, administration, and monitoring of the NHTD waiver for the RRDC on a regional level. The RRDS promotes participant choice, ensures the delivery of high quality services, assists in the development of needed waiver services and oversees waiver cost-effectiveness.

The RRDS communicates regularly with DOH, collaborates with local government entities, service providers and advocacy groups to be an active member of the network of services and supports in the community.

Skills

The RRDS will have:

- Demonstrated expertise working with individuals with disabilities and seniors and extensive familiarity with the operation of 1915 (c) waivers and community-based services;
- Knowledge, skills, and/or abilities to assess, identify and address gaps in services;
- Excellent screening and interviewing skills;
- Excellent communication and presentation skills;
- Ability to develop and maintain collaborative relationships with regionally based stakeholders, including LDSS, other local government entities, providers, advocacy organizations and others necessary to assure a comprehensive coordinated approach to services for individuals with disabilities and seniors;
- Working knowledge of community-based resources for individuals with disabilities and/or seniors;
- Excellent problem-solving and investigating skills;
- Working knowledge of Medicaid, Medicare and/or other third party payers;
- Skill in coordinating activities, evaluating data and establishing priorities; and
- Meet all additional qualifications outlined in the RRDC contract.

Roles and Responsibilities of the RRDS

It is the responsibility of the RRDS to assist DOH in ensuring that waiver participants in New York State, who are individuals with disabilities and seniors, are able to live as independently as possible in the community. The RRDS works closely with DOH to provide data and input as needed regarding the administration of the NHTD waiver in their region.

The RRDS has the right to meet with the participant at any time or place and has the right to access all records regarding a participant's or a provider's activities related to the waiver.

RRDS responsibilities include:

1. Information, Resource and Referral

- Work closely with DOH to disseminate public information regarding the waiver's ability to meet the needs of individuals with disabilities and seniors;
- Respond to calls from individuals with disabilities and seniors, family members, advocates, professionals and others requesting information regarding waiver

services;

- Provide resource information and education regarding the community-based needs of individuals with disabilities and seniors;
- Interview all prospective participants who have indicated interest in returning to the community;
- Meet with prospective waiver participants to explain the waiver philosophy and services and make a preliminary non-financial determination of appropriateness for the waiver;
- Make referrals to available resources in the community if an individual is determined not eligible for the waiver;
- Track referrals and intakes; and
- Maintain an informational database vital to the analysis of the effectiveness of the NHTD waiver.

2. Development of Community Resources

- Assess and identify regional waiver and non-waiver service capacity to meet the demands for waiver participation in the contracted area and report to DOH;
- Provide data to DOH regarding regional needs, outcomes, quality assurance and improvement and cost savings as part of quarterly reports and at other times upon request;
- Develop and implement a comprehensive outreach campaign to recruit waiver service providers;
- Promote the quality and availability of services sufficient to allow waiver participants the real opportunity of choosing providers;
- Develop strong linkages with inpatient rehabilitation units and long term care facilities to identify potential participants and to facilitate community re-entry from these institutions;
- Develop linkages with community-based health care providers to promote quality and availability of services;
- Develop and maintain relationships with existing local and state entities, including Point of Entry, advocacy groups and providers of community-based services for people with disabilities and seniors and their families;
- Maintain an open, collaborative relationship with LDSSs to understand historical information regarding the individual's prior use community based services and, coordinate and utilize Medicaid State Plan and waiver services, as well as other services that impact the health and welfare of the individual in the community (e.g. Adult Protective Services);

- Serve as a liaison between the NHTD waiver and the community by joining the Regional Task Force focusing on individuals with disabilities and seniors, or develop one if one does not exist; and
- Recommend to DOH any waiver service providers that should be surveyed and/or audited.

3. Manage Provider Enrollment and Training

- Interview potential waiver service providers using the RRDS Provider Interview form (refer to Appendix B – form B.8);
- Make provider enrollment recommendations to DOH based on factors such as the provider’s understanding of the waiver philosophy, the provider’s staff qualifications, the provider’s established policies and procedures, participant choice and control, and the provider’s ability to deliver high quality, services (refer to Section VI –Waiver Services; and
- Provide training to potential waiver service providers regarding the philosophy, policies and procedures of the waiver; participant needs; development and implementation of comprehensive waiver SPs, and standard documentation and reporting requirements

NOTE: NHTD has developed standardized trainings using the ‘Training of Trainer’ model for the following: Overview of NHTD waiver program; Service Coordination 101; ILST 101; and HCSS 101.

4. Interview and Preliminary Assessment of Potential Waiver Participants

- Meet with all prospective waiver participants to complete an Intake interview Initial Applicant Interview and Acknowledgement (refer to Appendix B – form B.3), explain the waiver’s philosophy, goals and available services and determine if the individual is a probable candidate for the waiver;
- Offer individuals the choice of participation in the NHTD waiver and, when the individual chooses the waiver, offer him/her a choice of Service Coordination providers. Obtain signed Application for Participation form, Freedom of Choice form, and the Service Coordination Selection form (refer to Appendix B – form B.5);
- Assure each potential waiver participant receives a Level of Care (LOC) determination through the completion of the PRI and SCREEN assessment tools (refer to Appendix F);
- Verify Medicaid eligibility by collaborating with LDSS;
- Coordinate with the LDSS regarding the appropriate utilization of Medicaid State Plan and NHTD waiver services;
- Maintain contact with a potential waiver participant until a Service Coordinator (SC) is selected;

- Forward all preliminary information to the SC selected by the potential waiver participant; and
- Maintain a current list of all approved providers in their region.

5. Review of All Service Plans

- Review all completed Application Packets, including the Initial Service Plan (refer to Appendix C – form C.1) submitted by the SC to determine initial appropriateness for participation in the waiver;
- Review all SPs (Initial, Revised and Addendum) for completeness focusing on the needs and goals of the waiver participant, the ability of waiver services to support the health and welfare of the participant in the community, the timely provision of services, participant rights and choices, and the efficiency and cost effectiveness of the Plan;
- Complete the RRDS Service Plan Review form and determine whether the Plan, Application Packet, or subsequent RSP or Addenda is approved or disapproved. If needed, provide a written evaluation of the review to the SC indicating any necessary revisions or additions needed to the SP or Application packet;
- Forward all SPs over \$300/day along with the appropriate RRDS review form to the QMS for review and recommendations;
- Track time elapsed from receipt of referral through setting up Intake appointment, and conducting of Intake;
- Track time elapsed from applicant's selection of Service Coordination agency/Coordinator through distribution of Notice of Decision (NOD);
- Track timeliness of submission of all SPs and follow up as needed to assure compliance; and
- Send notification to the SC of late submission of SPs using the appropriate Late Notice (refer to Appendix B – forms B.13 and B.14).

6. Administer Notice of Decisions (NOD)

- Provide the potential waiver participant with information regarding NODs and his/her rights regarding Informal Conferences and Fair Hearings during the initial interview process;
- Notify participants of his/her program status through utilization of the standard DOH NOD forms as outlined in the Program Manual;
- Provide each applicant/participant an appropriate NOD. Forward a copy to all entities listed on the NOD form (refer to Appendix B – forms NOD.1 to NOD.9);
- Maintain open communication with DOH regarding NODs that lead to an Informal Conference or Fair Hearing process and all discontinuation notices issued by LDSS due to loss of Medicaid coverage;

- Attend Informal Conferences and Fair Hearings as a representative of the NHTD Waiver program (refer to Section II – Becoming a Waiver Participant); and
- Keep DOH informed of any concerns affecting the status of the Fair Hearing process.

7. Maintain Regional Budgets

- Review all SPs in their region to ensure that the targeted aggregate average cost for all waiver participants does not exceed that of serving such individuals in an institutional setting without prior consent from DOH;
- Maintain information and data regarding the annual cost for each waiver participant;
- Maintain information and data regarding the average aggregate cost for all participants in their region; and
- Track and report expenditures to maintain regional cost neutrality.

8. Incident Reporting

- Meet responsibilities described in the Incident Reporting policy and procedure (refer to Section X – Incident Reporting Policy and Complaint Procedure);
- Support the efforts of the QMS in determining whether a Serious Reportable Incident (SRI) should be closed or whether further action is needed through collaborative discussion and prompt response to requests from QMS for consultation; and
- Assure that the SC has made needed changes to SPs as a result of SRI outcomes are implemented timely and effectively.

9. Technical Assistance to Participants, Family Members and Others

- Be available to participants, family members/informal supports and legal guardians to answer questions and address concerns regarding the NHTD waiver;
- Support a participant's right to be the decision-maker regarding life goals, activities, services and providers; and
- Provide information, regarding the NHTD waiver program to meet the needs of individuals with disabilities and/or seniors, their family members/informal supports and the community in their region.

10. Technical Assistance to Providers

- Attend Team Meetings as appropriate or upon request of Participant, SC or Team, (refer to Section V – The Service Plan);
- Provide training and technical assistance to waiver service providers on all

- Conduct scheduled provider meetings 8-10 times per year in the region to review waiver policies and updates, and provide waiver-related training; and
- Provide on-going technical assistance and receive feedback from providers regarding the policy and procedures of the waiver.

11. Technical Assistance to QMS, Other RRDS, Community Agencies and the State

- Attend and participate in Regional Forums set up by the QMS;
- Provide cross training and technical assistance and share areas of expertise with RRDCs in other regions and the QMSs as needed; and
- Provide information and assistance to the State and community agencies.

12. Develop and Submit Reports to DOH

- Prepare and submit quarterly and annual reports on behalf of the RRDC summarizing services provided and progress made toward contractual obligations and detailing the use of grant funds for a full range of program activities undertaken. Reports are sent to DOH and to the regional QMS;
- Work closely with DOH to provide information, records and statistical and narrative reports regarding regional needs, outcomes, quality assurance and improvement and cost savings;
- Communicate regularly with DOH, including attending meetings, to review policies affecting the waiver and to receive ongoing technical assistance through phone calls and e-mails;
- Attend quarterly RRDS meetings in Albany and other meetings upon the request of DOH;
- Make recommendations, based on experience with waiver activities and ongoing administration of the program to DOH for improvements to NHTD waiver policies and procedures; and
- Assess quality of services in the region and report findings to DOH.

13. Other Roles and Responsibilities as Defined by DOH and Supported by the RRDC Contract with DOH

Nurse Evaluator (NE)

The RRDC will employ, either directly or under contract, a Registered Nurse (referred to as “Nurse Evaluator”) to assist the RRDC in the administration and monitoring of the NHTD waiver program. The role of the NE is not to duplicate the role of the RRDS, but to use his/her level of clinical expertise to support the RRDS and the successful implementation of the NHTD waiver.

Skills

The NE must:

- Possess excellent clinical assessment skills;
- Have excellent screening and interviewing skills;
- Have excellent problem-solving and investigating skills;
- Have professional experience working with people with disabilities and/or seniors;
- Possess excellent organizational and training skills;
- Have excellent communication skills and ability to resolve conflicts;
- Be able to coordinate activities, evaluate data and establish priorities;
- Have working knowledge of community-based resources for individuals with disabilities and/or seniors;
- Possess experience with developing relationships with institutional and/or community-based organizations;
- Maintain a working knowledge of services and supports available through Medicaid, Medicare and/or other third party payers; and
- Meet all additional qualifications outlined in the Nurse Evaluator contract.

Roles and Responsibilities of the NE

NE responsibilities include:

1. Technical Assistance and Support to the RRDC/RRDS

- Assist the RRDS in reviewing SPs that are medically complex to assure information is accurate and utilizes resources and available services to meet the health and welfare needs of the participant;
- Review and administer the PRI and SCREEN when there is a concern that the current PRI and SCREEN does not reflect LOC needs of the individual;
- Conduct annual LOC assessments for waiver participants as requested by the RRDS;
- Provide resource information and education regarding individuals with

disabilities and seniors as requested by the RRDC;

- Assist the RRDC when requested with attracting quality new providers to offer needed services;
- Participate in local consortium on issues involving individuals with disabilities and seniors relevant to the NHTD waiver; and
- Attend Regional Forums as requested by RRDS.

2. Resource to Providers

- Attend Team Meetings where the participant's clinical needs may warrant further interpretation; and
- Provide training and technical assistance to waiver service providers on clinical aspects of the waiver program as needed.

3. Technical Assistance to QMS and Nurse Evaluator

- Provide training and technical assistance and share areas of expertise with QMSs and other NEs.

4. Technical Assistance to Participants, Family Members and Others

- Be available to participants family members/informal supports and legal guardians to answer questions and address concerns of a clinical nature; and
- Support the participant's right to be the decision maker regarding life goals, activities, services and providers.

5. Incident Reporting

- Provide feedback to RRDS and QMS during investigations of SRI as requested.

6. Develop and Submit Reports to DOH

- Maintain required documentation including visits, assessments, consultations recommendations, technical assistance, etc; and
- Prepare reports summarizing services provided and progress made toward attaining waiver program objectives in cooperation with RRDC requirements for submission of quarterly and annual reports to the regional QMS and DOH. (refer to Appendix B).

7. Other Roles and Responsibilities as Defined by DOH and Supported by the RRDC Contract with DOH

Quality Management Specialist (QMS)

The QMS is a contracted entity with DOH and reports directly to DOH Waiver Management staff. The contractor for the services of the QMS is separate from that of the RRDC. The QMSs are located in three (3) designated regions across New York State (refer to Section XIII – QMS Regions map).

The QMS promotes the Quality Management Program in the NHTD waiver program to ensure the delivery of high quality services to the participants. The QMS is a liaison between DOH, RRDCs, RRDSs, NEs, SCs and other waiver providers, and waiver participants regarding the NHTD waiver. The QMS can not provide waiver services.

The QMS has the right to access all records regarding a participant's or a provider's activities related to the waiver and has the right to meet with the participant at any time or place with his/her permission. The QMS works closely with DOH Waiver Management staff to provide data and input as needed regarding the administration of the NHTD waiver in their region.

Skills

The QMS must have:

- Knowledgeable about the operation of 1915 (c) waivers and community-based services;
- Professional experience working with people with disabilities and/or senior;
- Experience in developing and implementing quality management programs;
- Knowledgeable regarding issues concerning individuals with disabilities and seniors;
- Experience supervising professional staff;
- Experience in person/centered planning and team building;
- Ability to review and analyze records;
- Working knowledge of community-based resources for individuals with disabilities and/or seniors;
- Skill in analyzing reports or surveys to determine trends;
- Skill in program development;
- Working knowledge of benefits provided by Medicaid, Medicare and/or other third party payers;
- Excellent communication and presentation skills; and
- Meet all additional qualifications outlined in the QMS contract.

Roles and Responsibilities of the QMS

QMS responsibilities include:

1. Incident Reporting

- Oversee the SRI process, assuring compliance with the reporting process and the timely completion and submission of all required documentation associated with the investigatory process;
- Notify DOH in all appropriate situations of alleged abuse or neglect, or when a participant dies or at any time DOH involvement in the investigation process is warranted;
- Determine whether a SRI is closed or deemed open for further investigation, utilizing the RRDS in consultation as needed;
- Conduct follow-up contacts with the participant and/or legal guardian to assure satisfaction with outcome of investigation; and
- Track all pertinent information pertaining to SRIs for analysis to identify any regional trends and emerging issues.

2. Quality Monitoring

- Assist in the annual random retrospective review of a sample of Participant records as part of the NYS Quality Management Program and to confirm adherence to proper authorization procedures and satisfaction of federal review requirements;
- Perform trend analysis identifying problematic areas, and develop activities that will support positive outcomes;
- Assure the completion of annual Participant Satisfaction Surveys of waiver participants using the DOH designated form to assess participant satisfaction with the NHTD waiver and to monitor quality assurance activities;
- Arrange and facilitate annual Regional Forums to gather and discuss waiver related issues in the QMS region;
- Attend quarterly DOH meetings in Albany and at other times/places upon the request of DOH; and
- Attend Quality Advisory Board meetings to determine areas of intervention, training, participant satisfaction and programmatic changes.

3. Review of Service Plans

- Review all Service Plans over a specified dollar amount (\$300 per/day) determined by DOH and provide recommendations to the RRDCs; and

- Assist RRDS in reviewing Service Plans upon request to assure information is accurate and meets the health and welfare needs of the participant.

4. Development of Community Resources

- Refer any potential provider(s) to the RRDS;
- Provide trend analysis to DOH regarding provider capacity and capabilities in their regions; and
- Promote the quality and availability of services.

5. Information and Resource

- Assist the RRDCs with outreach and dissemination of information to the community when requested or as appropriate to his/her role; and
- Refer all calls received from individuals, family members, advocates, professionals and others requesting information regarding the NHTD waiver to the appropriate RRDS for timely response.

6. Develop and Submit Reports to DOH

- Review quarterly reports from RRDCs in the QMS region;
- Review all reports submitted by provider agencies' Serious Incident Review Committee; and
- Submit quarterly and annual reports to DOH summarizing QMS activities which include: findings from Participant Satisfaction Surveys, SRIs and Recordable Incidents, SP reviews, regional trends and needs analysis, quality assurance activities and improvements, cost savings, and progress made toward attaining the program objectives articulated in the QMS contract; and
- Make recommendations to DOH based on experience for improvements to NHTD waiver policies and procedures.

7. Technical Assistance to other QMSs, RRDC, RRDS, Providers, and the DOH

- Provide cross training and technical assistance and share areas of expertise with other QMS's and the RRDC's in their region as requested;
- Provide training to waiver provider agencies as requested by RRDS; and
- Provide information and assistance to DOH as requested.

8. Other Roles and Responsibilities as Defined by DOH

- Conduct evaluations upon request of DOH that reflect a possible system-wide concern. Provide outcomes and recommendations to DOH.

Section V

THE SERVICE PLAN

Introduction

The Service Plan is a document where vital information about the applicant/participant's personal and medical history, lifestyle choices, strengths, and limitations, and service needs are gathered and maintained for access by the participant, waiver providers and other entities of the NHTD waiver. The Service Plan is a reflection of the individual's wishes focusing on maintaining his/her health and welfare in the community. The Service Plan is ever changing as the needs and wishes of the individual evolve.

A. Types of Service Plans

The following is an explanation of the different types of Service Plans used in the NHTD waiver.

1. Initial Service Plan (ISP) – The ISP (refer to Appendix C – form C.1) is developed when an individual is applying to become a waiver participant. The ISP is a collection of personal, historical, medical/functional and social information about the applicant gathered through interview and assessment of the individual by the Service Coordinator (SC) and others. It is the primary component of the Application Packet (refer to Section II – Becoming a Waiver Participant). The ISP provides justification for the individual's participation in the NHTD waiver. It describes the reason NHTD services are needed to assure the individual's health and welfare while in the community.

The focus of the ISP is on the individual, reflecting his/her choices and needs that support the individual's health and welfare while in the community. This includes information regarding significant relationships, current informal and community supports, desired living situation, and recreation or community inclusion-time activities. The ISP must also contain a description of the individual's strengths and limitations, including any cognitive, behavioral or physical concerns.

The ISP also details services necessary to maintain the individual in the community. A description justifying why the services are needed to allow for transition from a nursing home into the community or to prevent nursing home placement from occurring is also included. For an applicant presently in an institution, the ISP must include current assessments and/or summaries of all services provided by the facility, including relevant medical reports.

2. Revised Service Plan (RSP) – The RSP (refer to Appendix C – form C.13) is developed through a collaborative effort between the participant, individual(s) selected by the participant to participate in the development of the RSP, the SC, current NHTD waiver service providers, non-waiver providers, and others as appropriate. The focus of the RSP remains on the individual, reflecting his/her needs and choice of services that continue to support safe and successful community living.

The RSP is required in the following situations:

- At least every six months, if the participant chooses to continue waiver services;
- When a participant is absent from the community (e.g. extended institutionalization) where upon return to the community the individual's needs have significantly changed, requiring revision of the Service Plan;
- Any time there is a need for a significant change in the level or amount of services (e.g. a decrease/increase in the participant's abilities, a change in the participant's living situation, a participant wants to make a significant change in his/her Service Plan, or there is a major change in the availability of informal supports); and
- When a participant relocates from one region to another.

The RSP must contain a review of the participant's previous months in the waiver and identify the plans and goals for the next six (6) months. The RSP details services necessary to maintain the individual in the community and prevent nursing home placement.

3. Addendum to the Service Plan – The Addendum to the Service Plan (refer to Appendix C – form C.15) is developed by the SC in collaboration with the participant and individual(s) selected to participate in the process and specific service provider(s) when there is only a minor change needed in the amount, type, or mix of waiver services to an existing Service Plan. (e.g. a participant wishes to increase/decrease the amount of time at a Structured Day Program)

B. Insurance, Resources and Funding Information Sheet

The Insurance, Resources and Funding Information Sheet (refer to Appendix C – forms C.3 and C.14) is completed by the SC at the time of development of the Initial and Revised Service Plan, and whenever changes in the information occur. Information regarding the applicant/participant's current insurance, income and resources is obtained from the applicant/participant and verified by the SC. In addition, newly identified income and funding sources are determined.

This form is provided to the RRDS for review by the SC with the submission of the ISP and RSP packet. To maintain the financial privacy of the individual, the form is not distributed to waiver service providers as part of the participant's Service Plan. However, the form must be maintained in the applicant/participant's record by the SC. Information needed to provide specific services to the participant are obtained by the individual waiver service provider through direct request to the SC.

C. Plan for Protective Oversight (PPO)

The PPO (refer to Appendix C – form C.4) indicates all key activities that directly impact the health and welfare of the participant and clearly identifies the individual(s) responsible for providing the needed assistance to the participants

in the event of an emergency or disaster.

The PPO must be completed by the SC with the applicant during the development of the ISP. The PPO must be signed and dated by the applicant and SC and all individuals listed as Informal Supports to the waiver applicant. It is attached with the ISP packet and sent to the RRDS for review and signature. A copy of the PPO must be provided to the participant by the SC to be maintained in an easily accessible location of the participant's choice within his/her home. A copy is also provided to each waiver service provider listed in the ISP.

The PPO must be redone by the SC with the participant each time an RSP is developed for submission with the RSP packet to the RRDS for review. The SC, participant, and all individuals listed as Informal Supports to the participant must sign the PPO. A final copy of the PPO is distributed by the SC to the participant to maintain in an easily accessible location of the participant's choice within his/her home. A copy is also provided by the SC to each waiver service provider listed in the RSP.

The PPO must be reviewed by the SC with the participant at each Addendum. If there are no changes to the PPO, the participant and the SC sign the last page of the Addendum indicating that the PPO was reviewed and there were no changes. If there are any changes, a new PPO must be completed and signed by the participant, SC and any individuals listed as Informal Supports to the participant. The PPO must be attached to the Addendum for submission to the RRDS for review.

Should any information in the PPO change in the interim, the SC is responsible for making updates at that time and acquiring signatures from the participant and any individuals listed as Informal Supports to the participant. The PPO must be sent to the RRDS for review and signature. If the participant's situation has changed and he/she now has a legal guardian, the SC will request and obtain the guardian documentation. A copy of this guardian documentation is forwarded to the RRDS. The SC is responsible to communicate with the waiver service providers that the participant now has a legal guardian who they need to communicate with as needed. The SC does not forward the guardian documentation to waiver service providers only to the RRDS as stated above.

Once reviewed and signed by the RRDS, the PPO is returned to the SC, who distributes it to the participant and any waiver service provider listed in the current Service Plan.

D. Development of the ISP

The development of the ISP is a complex process and a key responsibility of the SC. The development of the ISP begins upon acceptance of the applicant by his/her chosen Service Coordination provider.

All Service Plans must be person-centered and support the applicant's dignity, right to take risks and the right to fail while maintaining his/her health and welfare

living in the community. Through direct interview and assessment, the SC must be able to acquire information needed to build an individualized and comprehensive plan. To accomplish this, multiple visits with the applicant by the SC may be required. The applicant may choose to include family, friends and others he/she selects to participate in the process. If the individual has a legal guardian he/she are present for the ISP development. (Refer to Section II - Becoming a Waiver Participant).

The Service Plan must reflect the applicant's strengths and abilities. It details all of the services and supports (e.g. informal supports such as family and friends) necessary to maintain the applicant in the community and prevent institutionalization, and the coordination of these services and supports. As information is collected for the Service Plan, the SC taking into account the efficiency of service utilization, must determine whether services are available through informal supports, non-Medicaid local, state and federally funded programs, Medicaid State Plan services, and/or waiver services.

The SC must collaborate with Local Department of Social Service (LDSS) staff to have an understanding of the applicant's history, if any, of participation in Medicaid State Plan community-based services or adult protective services. This collaboration will further the SC understanding of the strengths and needs regarding the applicant's health and welfare if he/she is approved for the NHTD waiver.

The SC discusses the need for non-waiver options with the applicant to assure appropriate referrals are made. If the applicant is already receiving non-waiver services with the anticipation of continuing them if approved for the NHTD waiver, the SC must obtain appropriate information from and regarding each of these services for inclusion in the ISP.

If the applicant's ISP indicates the need for Home and Community Support Services, Assistive Technology, Community Transitional Services, Environmental Modifications, and/or Moving Assistance the Service Coordinator must obtain, complete, and attach all applicable supporting documentation (e.g. HCSS assessment tools).

The SC works with the applicant to establish what services are needed. Upon selection of waiver service providers by the applicant, the SC is responsible to contact each waiver service provider to assure the availability and ability necessary to provide the service(s). In addition, the SC coordinates the inclusion of non-waiver services. The SC must work collaboratively with the applicant, NHTD and non-waiver providers and others to prepare the most accurate and complete Service Plan for submission to the RRDS. Open communication assists the SC in establishing a projected weekly schedule of all services (including days, times and who will provide) with input from the applicant. The schedule also includes the availability of informal supports.

Once the ISP is reviewed with/by the applicant, he/she is asked to sign the document indicating understanding of its contents and purpose as written. The

SC then submits the completed ISP as part of the Application Packet to the RRDS for review (refer to Section II – Becoming a Waiver Participant).

Service Plans are expected to evolve as the participant experiences life in the community, requests revisions, experiences significant changes in his/her condition, or as new service options become available.

E. Coordination of non-waiver services

In addition to the scheduling of waiver services, the SC must also identify and coordinate all non-waiver services deemed appropriate and necessary for the applicant. If the applicant is not currently receiving non-waiver services, the SC must work with him/her and all necessary partners to obtain any necessary referrals, assessments and approvals/authorizations.

If the applicant is currently receiving non-waiver services, the SC must work with him/her and all necessary parties to obtain any necessary referrals, re-assessment and re-approvals/re-authorizations for the potential continuation of these services.

It is the SC's responsibility to maintain a current understanding of the processes required to obtain necessary referrals, re-assessments and re-approvals for non-waiver services.

This includes understanding which services under Medicaid require a physician's order (e.g. personal care or private duty nursing) and re-approvals/re-authorizations (e.g. authorization from LDSS for personal care and/or prior approval from State DOH or the LDSS for private duty nursing). The RRDS and/or SC may identify that the applicant/participant requires the provision of skilled tasks. These tasks are not provided by NHTD waiver services. They are potentially provided to Medicaid recipients under State Plan services through Certified Home Health Agencies (CHHA), Private Duty Nursing or the Consumer Directed Personal Assistance Program (CDPAP). When Service Plans include State Plan services, the SC must work closely with LDSS assuring there is no duplication of services and that roles and responsibilities are clearly defined.

Once all non-waiver services are identified, the SC must include them in the Projected Weekly Schedule of the ISP to ensure the coordination of services, preventing unnecessary overlap and/or gaps in services. The SC must clearly articulate the provision of service the provider is responsible for.

F. Scheduling of Waiver Services

Part of the work to develop an ISP is the scheduling of anticipated services that the applicant will receive. The Projected Weekly Schedule of All Services is a one (1) week schedule for twenty four (24) hours-a-day indicating the type of the service being provided (e.g. ILST, CIC, informal supports, etc) and the day(s), time(s) and frequency of each service in the Service Plan. The name of each provider agency must be documented in the Waiver Service and Cost Projection chart in the ISP. The name of Informal Supports and specific assistance

provided are documented in the Current Supports and Services section of the ISP. The schedule should be flexible to allow for preferences and limitations of the applicant such as a limited attention span or reduced stamina, balanced with the availability of formal and informal supports. It should be designed to meet the goals and needs of the applicant, support the waiver's philosophy of choice, and provide for the health and welfare of the participant.

Once the ISP is approved by the RRDS and the applicant becomes a participant, the established frequency and duration of waiver services must be adhered to unless prior approval is given by the SC following a request to increase or decrease services.

Negotiations for changes in time will include the waiver participant, SC, and impacted providers of waiver and non-waiver services.

The Service Plan must document any situations where two services will be provided at the same time to ensure consistent and effective service provision; situations must be clinically justified and time limited. Example: When an Independent Living Skills Training (ILST) provider is training Home and Community Support Services (HCSS) provider to assist a participant in a specific task or when the Director of the Positive Behavioral Interventions and Supports (PBIS) in the process of developing the PBIS Detailed Plan must observe a participant's behavior at the Structured Day Program (SDP). The overlap of services must be justified and documented in the Service Plan in order for both services to be reimbursed.

Services may be rescheduled if the participant is unable to participate or the provider is not available. When the participant requests that a service be suspended for a day or more, it is the responsibility of that participant and/or informal support to notify the SC who, in turn notifies the providers. If the participant notifies the provider(s), he/she must also notify the SC.

A provider should notify the SC when a participant repeatedly refuses a service. The SC should review the Service Plan with the participant and provider to determine if it needs to be revised to more accurately reflect the goals and abilities of the participant. Revisions to the schedule should allow enough time for the provider to make the necessary arrangements. When a participant refuses significant services, it may be necessary to discontinue the individual from the waiver.

G. Submission of the Application Packet and ISP

Once the potential participant selects a SC who agrees to work with him/her, the SC has sixty (60) calendar days to submit a completed Application Packet, including the ISP, to the RRDS.

Once the ISP is completed, the SC must review it with the applicant and asks the applicant to sign the document.

The SC must have the SC supervisor review and sign the completed Service

Plan prior to submission to the RRDS for review. This provides another level of professional review identifying any inconsistencies or problems in the Service Plan which could impede the approval process. If the SC supervisor is the SC for the participant whose ISP is being submitted to the RRDS for review, the SC supervisor is not required to obtain an additional supervisory signature. In this situation, the SC supervisor must sign the Signature page of the ISP as both SC and SC Supervisor.

The SC submits the Application Packet with the ISP to the RRDS for review. In addition to the ISP, the Application Packet includes the following documents:

- Freedom of Choice form (refer to Appendix B – form B.4) (copy) – signed by the applicant during Intake with RRDS;
- Application for Participation form (refer to Appendix B – form B.6) (copy) – signed by the applicant during Intake with RRDS;
- Documentation of a disability (examples: Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) award letter, Railroad retirement letter for total permanent disability or a letter from the LDSS stating the individual has been determined to have a physical disability), if under 65 years old;
- Verification of age (examples: birth certificate, passport, drivers license);
- Written verification from the Medicaid Eligibility Verification System (MEVS) regarding Medicaid coverage that supports community based long term care services;
- Service Coordinator Selection form (refer to Appendix B – form B.5) (copy) – signed by the applicant and completed by RRDS;
- Provider Selection forms- signed by the Applicant and provider;
- A PRI and SCREEN (refer to Appendix F) completed by a certified assessor within ninety (90) days prior to the submission of the Application Packet and ISP to the RRDS;
- Plan for Protective Oversight (PPO) (refer to Appendix C – form C.4), completed by the SC and signed by applicant;
- Insurance, Resource and Funding Information Sheet completed by the SC and signed by the applicant;
- Waiver Participant's Rights and Responsibilities form (refer to Appendix C – form C.5) (copy), signed by applicant during Application process; and
- Any Description and Cost Projection form(s) (refer to Appendix C – forms C.7, C.8, C.9, and C.10) and HCSS assessment form, if applicable completed by the provider agency and submitted by the SC.

There may be instances when a delay is expected in submitting an Application Packet to the RRDS. The SC must maintain consistent and open communication with the RRDS if this is indicated. Depending on the circumstances of the delay, the RRDS may choose to grant an extension of the sixty (60) calendar day deadline. Some examples of this are: establishing a residence, unexpected hospitalization, nursing home admission, or indecisiveness on the part of the

participant regarding receipt of waiver services. In addition, length of time residing in a nursing home may require a longer period of time to establish a safe discharge and set up appropriate services.

If the SC does not meet the sixty (60) calendar day time frame for submission of the ISP packet or does not meet the conditions of the approved extension period, the SC and Service Coordination agency supervisor receives written notification from the RRDS indicating that the Application Packet is past due and must be submitted within the next thirty (30) calendar days. If the SC does not comply with the thirty (30) calendar day time line, the RRDS will send the SC agency supervisor written notification stating that due to non-compliance, the agency may no longer serve that applicant. The RRDS meets with the applicant to select another Service Coordination agency.

If late submission of Application Packets becomes a repeated problem for an agency, the RRDS will notify DOH of this problem. DOH will send a Letter of Vendor Hold via certified mail to the Service Coordination agency Executive Director indicating the intent to close referrals of new participants until a written plan of action is submitted and approved by DOH. If this problem is not corrected, DOH will begin the provider disenrollment process by sending the Service Coordination agency's Executive Director a Notice of Pending Disenrollment via certified mail (refer to Section III – Becoming A Waiver Provider).

H. Review and Determination Process for the ISP

Upon receipt of the Application Packet, and ISP, the RRDS has fourteen (14) calendar days to review the information and make a final determination.

The RRDS completes the RRDS Initial Service Plan Review form (refer to Appendix B - form B.10) while reviewing the ISP to determine that:

1. the individual is in need of waiver services;
2. Medicaid eligibility has been verified;
3. the individual meets the appropriate age requirement;
4. the individual has a disability determination, if under age 65;
5. the PRI/SCREEN is current, and identifies the applicant as needing a nursing home level of care;
6. the ISP is reasonable given the context of the participant's stated goals and needs;
7. all available informal supports and non-waiver services are utilized wherever appropriate;
8. waiver services will be used appropriately, and in a reasonable and effective manner;
9. the services described in the ISP will maintain the individual's health and welfare;
10. the overall plan and goals for each waiver service describes the activities that each service will provide towards the accomplishment of the participant's goals;

11. the PPO is completed, signed and reasonable;
12. the Insurance, Resource and Funding Information Sheet is completed and signed;
13. all other forms included in the Application Packet are completed and signed by the applicant;
14. the waiver applicant has signed the Initial Service Plan; and
15. projected costs for Medicaid services fit within the regional aggregate Medicaid cap established by DOH.

The RRDS will request review of an Application Packet, included in the ISP by the Nurse Evaluator if the needs of that applicant appear to be medically complex.

The RRDS must send all Service Plans over a projected \$300 per day to the QMS, with a copy of the RRDS Service Plan Review form attached for further review and recommendations. The QMS must return the Service Plan with recommendations to the RRDS within three (3) business days.

If there are any discrepancies/concerns regarding the Service Plan, the RRDS must return it to the SC for correction or additional information. This is documented on the RRDS Initial Service Plan Review form.

The SC has fourteen (14) calendar days to respond to the RRDS's request for additional information or corrections and resubmit the Service Plan to the RRDS for final review and determination. Prior to resubmission of the ISP, the SC must present the revised plan to the applicant for review and signature.

Total turn around time for waiver eligibility determination is expected to be less than ninety (90) days from the time of Service Coordination selection to final determination by the RRDS.

Upon final determination, the RRDS signs the RRDS Service Plan Review form, ISP and PPO.

If approved, the applicant is acknowledged as a 'participant'. The RRDS must complete the Notice of Decision (NOD) – Authorization and distributes it to the participant and all others listed on the NOD (refer to Section II - Becoming a Waiver Participant). The RRDS will return the Application Packet to the SC who must provide a copy of the ISP and PPO to the participant. The SC communicates the authorization and the effective date to the facility (e.g. nursing home, hospital, etc., if applicable) and all non-waiver providers involved in the ISP. The SC also sends a copy of the approved ISP and PPO to all NHTD waiver service providers responsible for delivery of the services and items identified in the ISP.

If the RRDS believes that the applicant will be denied for the NHTD waiver program, he/she must contact DOH Waiver Management Staff (WMS) to discuss the reasons for this decision. Following this discussion, if the applicant is denied, the RRDS completes and sends a NOD– Denial of Waiver Program to the applicant and SC. The SC in consultation with the RRDS will provide alternative

referral options (e.g. names and phone numbers of other LTC programs, etc) to the denied applicant. The SC will notify the nursing home, if applicable, and all waiver and non-waiver providers involved in the development of the ISP of the denial decision.

I. Waiver Contact List

The SC will provide to each participant a Waiver Contact List (refer to Appendix C – form C.6), containing a current listing of his/her waiver service providers as listed in the ISP. This list includes the services provided, names of the provider agencies, names of the persons providing the services and their phone numbers, names of their supervisor, and the supervisor's phone number. Also included is contact information for the RRDS, QMS and NHTD Complaint Line.

Waiver Service Providers are responsible for contacting the SC when contact information pertinent to the participant changes. The SC provides a copy of the updated list of services and phone numbers to the participant and to all waiver service providers listed in the ISP.

The SC retains a copy of the most updated contact list in the participant's file.

This process must be repeated each time a new waiver service is started and when there is a permanent change in the person providing the service or provider agency; with the submission of a Revised Service Plan; or at the time of submission of an Addendum. The SC must review the Contact List to assure it is correct and up-to-date. If changes are warranted, the SC will make needed updates and redistribute the contact list.

J. Implementation of the Approved Service Plan

In consultation with the SC, the RRDS must establish the effective date for services to begin and notify the SC. The SC must then contact the participant, waiver service providers, non-waiver providers, and other necessary parties as appropriate and arrange for services to begin.

Each approved waiver service provider must meet with the participant and anyone else selected by the participant to complete a Detailed Plan (refer to Section VII – Record Keeping).

The Detailed Plan includes:

- all assessment(s) conducted by the waiver service provider;
- participant's goals as it relates to the waiver service that is the subject of the Detailed Plan;
- milestones needed to meet the goals of the Detailed Plan;
- interventions needed by the waiver service provider to assist the participant in meeting his/her goals; and
- timeframes in obtaining the participant's individualized goals.

Waiver service providers must communicate with each other, informal supports

and non-waiver providers at all times, especially when there is an overlap in the provision of services to the participant in achieving his/her milestone and/or goal. An example of this is the provider of Positive Behavioral Interventions and Supports (PBIS) communicating with other waiver service providers on methods of working with a participant with behavioral issues.

If at anytime a waiver participant or waiver service provider determines the need to change the amount, frequency or duration of services approved in the ISP, the SC must be notified. No changes may be made by the waiver service provider until receiving notification from the SC following approval of an Addendum or RSP by the RRDS, as appropriate.

Waiver service providers must recognize that Detailed Plans are ever-changing as the needs of the participant change. Therefore, re-assessments are a critical element of the Detailed Plan.

K. Ongoing Review of the Service Plan

The SC should regularly review the Service Plan with the participant. This review is a natural component of the meetings between the participant and SC. For new participants to the waiver, the SC must meet with him/her face-to-face at a minimum once a month for the first six (6) months. The frequency of visits thereafter will be determined by the participant and SC and described in subsequent Service Plans. It is expected that at least one face-to-face visit per six (6) months is made in the participant's home.

These reviews should focus on all aspects of the participant's life, including:

- Satisfaction with the performance of providers and informal supports;
- Satisfaction with living situation;
- Adequacy of supports and services;
- Provision of the waiver services per the Approved Service Plan ensuring that at a minimum one waiver service is provided per month;
- Sufficient opportunities to participant in community activities;
- Achievement of goals related to waiver services;
- Changes in function and behavior; and
- Changes in priorities or goals.

Any issues identified must be addressed by the SC with the provider, other necessary parties and/or RRDS, as appropriate.

Other events that may trigger a Service Plan review include:

- The participant requests a change in services or service providers;
- There are significant changes (improvement or decline) in the participant's physical, cognitive, or behavioral status;
- A new provider is approved for the NHTD waiver and the participant is interested in either changing to that provider or adding a newly available service;
- The expected outcomes of the services are either realized or need to be

- altered; or
- Notification from a non-waiver provider of the need to change amount, frequency and/or duration of services.

In addition, review of the Service Plan is conducted through Team Meetings held with the participant and others involved in the Service Plan (refer to Submission of Revised Service Plans/Team Meeting below).

For plans that include one or more non-waiver services, the review of the plan must include timely outreach to and coordination with all involved parties (e.g. review of plans including personal care, certified home health agency, or private duty nursing must be considered with those providers and the agencies responsible for approving/authorizing services).

L. Development of the Addendum

Requests for changes to the Service Plan may come from the participant, the SC, other waiver service providers or other involved parties. The SC is responsible for working with the participant and anyone chosen by the participant to participate in the development of the Addendum (refer to Appendix C – form C.15).

In the case of an emergency, the SC must contact the RRDS for immediate approval to increase or add a waiver service. In these emergency cases the RRDS may give verbal approval to the SC. All communication between the RRDS and the SC must be documented. The SC then has two (2) business days to develop the Addendum and submit it to the RRDS.

Once the Addendum has been written by the SC, it must be reviewed and signed by the participant for submission to the RRDS for review and determination.

M. Submission of the Addendum

The SC will submit to the RRDS the completed and signed Addendum and a copy of each of the following documents:

- Waiver Contact List, if revision were necessary;
- A new PPO, if revisions were made which impact the PPO;
- ISR, only if a waiver service is stopped;
- Insurance, Resources and Funding Information Sheet (if any information has changed); and
- Functional assessment if it is the basis of the Addendum (e.g. ILST, PBIS, etc);

N. Review and Approval Process for the Addendum

The RRDS must review the Addendum to determine the need for changes in the service(s). If the Addendum increases the daily rate of the Service Plan to exceed \$300/day, the Addendum must be reviewed by the QMS. The QMS sends recommendations back to the RRDS within three (3) business days.

The RRDS will complete the RRDS Addendum Review form (refer to Appendix B – form B.12). Upon determination on the Addendum, the RRDS will distribute the appropriate NOD (refer to Appendix B – forms NOD.1 to NOD.9) to the participant and other entities listed on the NOD form. The six (6) month approval period of the Service Plan remains in effect.

If an Addendum to the Service Plan is denied by the RRDS, the SC must work with the participant to find an alternative solution, if possible. Technical assistance from the RRDS may be requested at any time.

A copy of the Addendum is provided to the participant and waiver service providers involved in the change.

O. Development of the RSP

The SC works with the participant and anyone he/she selects to participate and other necessary parties in the development of the RSP. It is a time when the activities of the current service plan period are reviewed to assess the participant's current status and to determine whether goals have been met successfully. The continued need for participation in the waiver program to avoid nursing home placement is also determined by the SC.

At least eight (8) weeks prior to last day of current Service Plan period, the SC establishes a date, time and location for the Team Meeting with the participant. The SC completes and distributes a written notice to the participant, all required waiver service providers, and other necessary parties with Team Meeting information. Included in this notice is a reminder regarding the submission of timely Individual Service Reports (ISR) (refer to Appendix C – form C.16). A copy of this notice is maintained in the participant's record by the Service Coordinator.

It is essential that all proposed RSPs be submitted to the RRDS by the SC at least thirty (30) calendar days prior to the end of the current Service Plan period for review and final decision. This is necessary to prevent delays in service which would adversely affect the health and welfare of the participant.

To ensure this is done, the SC must:

1. work with the participant to arrange for and facilitate a Team Meeting that must be held approximately six (6) weeks prior to the end of the current Service Plan period to develop the proposed RSP. Attendees include the participant, legal guardian and anyone invited by the participant, waiver service providers and other non-waiver providers involved in the Service Plan. The Team Meeting provides an opportunity to discuss issues that cut across services and discuss/resolve concerns regarding health and welfare; and
2. receive all current required waiver service provider's ISR prior to or at the time of the Team Meeting. For the SC to appropriately develop the RSP, it

is imperative that all current required waiver service provider ISRs are complete and submitted timely.

Information is gathered from ISRs submitted by each current required waiver service provider (refer to Section VII – Record Keeping). Each ISR contains the information:

- Identifying each of the participant's goal(s) for this service which have been addressed during the current Service Plan;
- Identifying the interventions used to address each goal as described in the Detailed Plan;
- Identifying any progress made for each goal;
- Identifying any barriers to progress for each goal;
- Identifying the participant's goal(s), expected interventions and outcomes for this service in the next Service Plan;
- Providing recommendations for amount, frequency and duration of this service in the next Service Plan; and
- Explaining why this service is necessary to assure health and welfare in the next Service Plan.

The SC also uses information from the current Service Plan, including Addenda submitted during the Service Plan period. For new services, the SC must collaborate with the provider(s) selected by the participant to assure appropriate documentation of information into the RSP, including the justification for the new service.

For plans that include non-waiver service providers, the review of the plan must include timely outreach to and coordination with all non-waiver providers identified in the Service Plan (e.g. review of plans including personal care, certified home health agency, or private duty nursing must be considered with those providers and the agencies responsible for approving/authorizing services).

The SC must discuss any proposed changes to the Service Plan with the participant and the individual(s) who participated in the development of the Revised Service Plan.

Once the RSP is completed, the SC must review it with the participant. The RSP must be signed by the participant or participant's legal guardian to indicate that the participant understands its contents and purpose as written.

The SC must have the SC supervisor review and sign the completed Service Plan prior to submission to the RRDS for review. This provides a level of professional review identifying any inconsistencies or problems in the Service Plan which could impede the approval process. If the SC supervisor is the SC for the participant whose RSP is being submitted to the RRDS for review, the SC supervisor is not required to obtain an additional supervisory signature. In this instance, the SC supervisor must sign the Signature page of the RSP as both SC and SC Supervisor.

As previously stated, the SC submits the completed and signed RSP and any required documentation to the RRDS for review at least thirty (30) calendar days prior to the end of the current Service Plan period.

P. Delinquent Individual Service Reports (ISR) From Waiver Service Providers

Waiver service providers are responsible to submit their ISR at least six (6) weeks prior to the end of the current Service Plan or at the Team Meeting to the SC to avoid interruption of service to the participant (with exceptions as noted in Section VII – Record Keeping). The SC is also required to submit a complete and timely ISR as part of the development of the RSP.

At the Team Meeting, if a waiver service provider determines that changes need to be made to the ISR to better reflect the participant's needs, that waiver service provider may request one (1) additional business day to revise and resubmit the ISR to the SC. In some situations an ISR can only be completed after decisions are reached during the Team Meeting.

Each waiver service provider is responsible to develop and submit ISRs in accordance with timelines established in this Section of the Program Manual. Therefore, when a waiver service provider does not submit a timely ISR or does not communicate with the SC the need for additional time to submit an ISR, the SC must notify the RRDS within one (1) business day after the Team Meeting for technical assistance. The RRDS will send a Late Notice (refer to Appendix B – form B.14) to the waiver service provider agency supervisor informing him/her that the ISR is delinquent, giving the provider agency seven (7) calendar days to complete and submit the ISR to the SC.

If at the end of the seven (7) calendar days the waiver service provider agency has not complied with the submission of the ISR, the SC must contact the RRDS for further technical assistance. The RRDS notifies DOH WMS of the continued delinquency. DOH WMS sends a Letter of Vendor Hold via certified mail to the waiver service provider agency's Executive Director and SC Supervisor giving him/her seven (7) calendar days to submit the ISR. The letter includes notification that continued failure to submit the ISR will initiate the sixty (60) day Provider disenrollment process. Upon receipt of the ISR, the SC notifies the RRDS. Upon review and approval of the ISR by the RRDS, the RRDS notifies DOH WMS who may send the provider agency Executive Director a Letter of Vendor Hold termination.

If the waiver service provider agency fails to comply within the seven (7) calendar days the SC notifies the RRDS that no ISR has been received. The RRDS contacts DOH WMS. DOH WMS will issue the sixty (60) calendar day Notice of Pending Provider Disenrollment indicating the effective date of disenrollment.

Upon receipt of the ISR, DOH will determine whether a notice will be issued by DOH terminating the disenrollment process. However, if there is an ongoing pattern of late Service Plan submission, DOH WMS has the right to continue the

disenrollment process.

In circumstances where the waiver service provider may not be able to submit the ISR on time, it is imperative that the waiver service provider maintains open communication with the SC regarding the reasons for late submission. The SC must contact the RRDS and communicate this delay. The RRDS makes a determination regarding a reasonable plan of action for submission of the ISR by the waiver service provider. The RRDS will send a Late Notice via certified mail to the waiver service provider agency supervisor including documentation of the expected action plan for submission of the ISR.

The SC should proceed with the development of the Service Plan to maintain the timeline for submission to the RRDS for review.

If the delinquent waiver service provider agency fails to comply with the action plan for submission of the ISR to the SC, the SC contacts the RRDS. The RRDS notifies DOH WMS of the waiver service provider's continued delinquency. DOH WMS will proceed with sending a Letter of Vendor Hold to the waiver service provider agency's Executive Director. If the agency fails to comply further, the RRDS will contact DOH WMS to begin Provider disenrollment procedures of the delinquent waiver service provider agency.

Q. Submission of the RSP

The SC must submit the completed RSP packet to the RRDS for review. The RSP packet includes the RSP and the following:

- Written verification from the Medicaid Eligibility Verification System (MEVS) regarding the participant's Medicaid status;
- PRI/SCREEN (a copy), if due;
- ISRs from all appropriate waiver service providers;
- Provider Selection forms (if applicable);
- Documentation of reauthorizations/re-approvals of pertinent non-waiver services;
- Plan of Protective Oversight (PPO) – newly written and signed;
- Insurance, Resources and Funding Information Sheet completed and signed;
- Waiver Participant Rights and Responsibilities form, completed annually; and
- Description and Cost Projection forms and HCSS Assessment (if applicable).

R. Delinquent Submission of the RSP by the SC

Late submission of a RSP by the SC can result in the interruption of services to a participant and potentially lead to Vendor Hold or Disenrollment of the Service Coordination provider agency. A complete, acceptable RSP Packet must be submitted to the RRDS for approval at least thirty (30) calendar days prior to the end date of the current Service Plan.

When the SC is facing unforeseen circumstances that affect the submission of the Service Plan within the required timeframe, the SC makes immediate contact with the RRDS for technical assistance. A plan must be established that will prevent disruption of services to the participant, potential penalties to the Service Coordination agency, and billing concerns for all waiver service providers.

When a RSP Packet is not submitted to the RRDS by the SC at least thirty (30) calendar days prior to the end date of the current Service Plan, the following protocol must be followed:

1. Late Letter

A Late Letter will be sent to the Service Coordination agency supervisor by the RRDS via certified mail any time a RSP packet is not submitted by the required timeframe (thirty (30) calendar days prior to the end of the current Service Plan period). It informs the Service Coordination agency supervisor that communication with the RRDS is necessary and a plan to submit the RSP packet within seven (7) calendar days is expected. It further informs the supervisor that failure to comply will lead to the initiation of Vendor Hold process.

2. Vendor Hold

Vendor Hold restricts the Service Coordination agency from accepting any new NHTD referrals. If the SC does not submit the RSP packet to the RRDS within seven (7) calendar days, the RRDS notifies DOH WMS. DOH will send a certified Letter of Vendor Hold to the Service Coordination agency supervisor and Executive Director informing him/her of continued non-submission of the RSP packet. The letter informs the agency that a completed and signed RSP packet must be submitted within seven (7) calendar days along with a plan of action to prevent further submission of late service plans. Failure to submit an acceptable RSP packet within this time frame constitutes breach of the Provider Agreement, leading to provider disenrollment.

It is the responsibility of the SC to contact all waiver service providers involved in the RSP that billing for waiver services is now prohibited until the RRDS receives and approves the RSP packet.

If the Service Coordination agency submits an acceptable RSP packet to the RRDS within the seven (7) calendar day period, DOH may terminate the Vendor Hold process with a written notification to the agency.

3. Pending Provider Disenrollment

If the Service Coordination agency fails to comply with the terms of the Vendor Hold notification, the RRDS notifies DOH WMS. DOH WMS sends the Service Coordination agency Executive Director, Service Coordination Supervisor and SC a Notice of Pending Disenrollment via certified mail.

This notice informs the agency that due to continued non-compliance with the request for submission of the RSP packet, the agency will be disenrolled from the NHTD waiver sixty (60) calendar days from the notice date. During this time Vendor Hold status remains in effect.

If at any time during this process the Service Coordination agency complies with the submission of the RSP packet and establishes a satisfactory plan of action to prevent delinquencies, DOH WMS may stop the disenrollment process.

Repeated late submissions of RSP packets will result in the initiation of the Provider disenrollment process whereby the Service Coordination agency will no longer be able to serve NHTD waiver participants.

4. Provider Disenrollment

A Notice of Disenrollment is sent via certified mail by DOH WMS to the Service Coordination agency's Executive Director when the agency has failed to provide the requested information (e.g. RSP or ISR) and/or has not provided an acceptable plan of action. The letter specifies the final date of disenrollment. It informs the agency of the requirements for transitioning all waiver participants to new waiver service provider agency(s).

S. Review and Approval Process for RSP

The RSP review process must be completed by the RRDS within four (4) weeks. This includes RRDS review, Nurse Evaluator and/or QMS review, if indicated, return of the RSP to the SC for corrections and then resubmission to the RRDS for final review, issuance of the appropriate Notice of Decision, if applicable, and sufficient time for implementation of RSP.

Upon receipt of the RSP packet, the RRDS uses the RRDS Revised Service Plan Review form (refer to Appendix B – form B.11) while reviewing the RSP to determine if:

1. the individuals' health and welfare were maintained in the previous Service Plan and , if not what changes need to occur;
2. the participant continues to need waiver services;
3. Written verification from the Medicaid Eligibility Verification System (MEVS) regarding Medicaid coverage that supports community based long term care services is attached;
4. the PRI/SCREEN is current, and reflects a nursing home level of care;
5. the RSP is reasonable given the context of the participant's stated goals;
6. all available informal supports and non-waiver services have been appropriately arranged and are utilized;
7. waiver services are being used in a reasonable and effective manner;
8. the services described in the RSP will maintain the participant's health and welfare;
9. the goals and preferences described in previous Service Plans have been the focus of the activities in the last six months;
10. the PPO is complete, signed and reasonable;
11. the Insurance, resources and Funding Information Sheet is completed and signed;
12. all other required forms (e.g. Cost Description and Projection forms,

- HCSS assessment form etc if applicable) are completed, signed by the participant, and attached to the Revised Service Plan; and
13. the participant has signed the Revised Service Plan.

If the needs of the participant appear to be medically complex in nature, the RRDS will request additional review of the RSP by the Nurse Evaluator.

In addition, if the RSP exceeds \$300/day, the RRDS must provide the RSP along with a copy of the RRDS RSP Review form to the QMS for review and recommendations. The QMS will send the recommendations to the RRDS within three (3) business days.

If there are any discrepancies in the information provided in the RSP, or if it appears that that RSP may not be approved, the RRDS discusses this with the SC. This is documented on the RRDS Revised Service Plan Review form which is sent with the RSP packet to the SC for correction. The SC discusses the issues and/or any alternative options with the participant.

Note: If at any time the RRDS feels the information provided in the ISR from any waiver service provider requires further explanation, they may request that the SC obtain and submit a copy of the Detailed Plan for that service.

The SC returns the corrected/amended RSP packet to the RRDS for re-review.

Upon approval, the RRDS signs the RSP and PPO and returns them to the SC. The SC provides a copy of the RSP and PPO to the participant, all waiver service providers included in the RSP and others as appropriate. The SC may also need to notify other key parties who may not necessarily receive a copy of the RSP.

The RRDS completes and issues the NOD– Authorization to the participant and others listed on the form. The SC distributes a copy of the NOD form to the approved waiver service providers. The NOD informs the participant of his/her rights regarding the decision, including Informal Conference and Fair Hearings (refer to Section II – Becoming a Waiver Participant).

Upon denial of the RSP the RRDS must relay this to the SC and issue the NOD– Denial of Waiver Program to the applicant and others listed on the NOD form.

The SC discusses the concerns with the participant to determine if any alternative options are available for consideration. If appropriate alternatives are not found to meet the participant's health and welfare needs, the SC communicates this to the RRDS.

If the RRDS's determination results in a denial of continued participation in the waiver, the RRDS sends the NOD – Discontinuation of Waiver Program to the participant and others designated on the form. The SC will work with the participant to establish an appropriate discharge plan.

T. Process for Changing a Provider

The participant's ability to change a waiver service provider is an essential

component of assuring participant choice. It also allows a waiver service provider the opportunity to recognize that it can no longer meet the participant's service needs.

a. Participant Request

If the participant chooses to change their waiver service provider, the SC must comply utilizing the following procedure:

1. The participant or his/her current SC informs the current waiver service provider of the participant's intention to change providers;
2. The SC will provide the participant with a list of approved and available waiver service providers for the participant to interview and choose from;
3. Upon selection of a new waiver service provider, the participant will inform the SC of his/her preference. The Service Coordinator will complete the Change of Provider Request form (refer to Appendix C – form C.18) with the participant and send the completed and signed form to the selected waiver service provider agency;
4. The requested waiver service provider must review the form and complete the statement of Requested Provider indicating the approval of the participant's request or the denial of the participant's request with reason. The form must then be returned to the Service Coordinator;
5. When the requested waiver service provider declines the participant's request for services, the SC must inform the participant and ask him/her to select another waiver service provider agency from the list. The selection process proceeds. The Service Coordinator maintains all completed Change of Provider forms in the participant's record;
6. When the requested provider accepts the participant's request, the SC submits the Change of Provider Request form to the RRDS for review and determination. The RRDS's decision is documented on the Change of Provider Request form and sent back to the SC;
7. If the RRDS approves, the SC will establish a date and time for the Transition Meeting and documents this on the Change of Provider Request form.

Note: The Transition Meeting provides an opportunity for current provider(s) to meet with newly selected providers to exchange information ensuring the success of the new provider(s) with the least amount of disruption to the participant. The SC documents this information on the Change of Provider Request form;

8. The RRDS reviews the request and upon approval, sets an effective date for the change. The RRDS will send the approved Change of

Provider form to the participant, SC, and all current and new waiver service providers;

9. If the RRDS can not approve the request for change in waiver service provider, the RRDS will indicate the reason why (e.g. Vendor Hold status or the waiver service agency is no longer an approved provider of NHTD services) on the Change of Provider Request form and immediately notify the SC, sending the form back to the SC to be maintained in the participant's record. No NOD is issued by the RRDS in this case. However, for all other instances where the RRDS can not approve a request for change in waiver service provider, the RRDS will complete and send the NOD– Denial of Waiver Provider/Waiver Service form to the participant and others designated on the form;
10. The SC must work with the participant to select another waiver service provider restarting the Change of Provider process;
11. When the request for Change in Provider is approved by the waiver service provider agency and the RRDS, the SC must facilitate the Transition Meeting where participant information is reviewed and transferred to the new provider, assuring a smooth transition occurs;
12. Once this process is completed, the SC must update the Waiver Contact List and provide a copy to the participant and other current waiver service providers as appropriate;
13. If the participant chooses to change the Service Coordination agency, the RRDS must work directly with the participant through the above process (refer to Appendix B – form B.15); and
14. The participant, SC or any provider should contact the RRDS if this procedure is not followed.

b. Provider Request

When a waiver service provider is unable to or wishes to no longer provide services to a participant, the following procedures must be followed:

1. The waiver service provider agency must inform the participant of its intent to terminate service provision. This must be done at a minimum of ten (10) calendar days prior to stopping the provision of service(s);
2. Notification must be sent via certified letter or directly delivered to the participant. A copy of the letter must also be sent to the Service Coordinator and the RRDS;
3. Reasons for the termination must be included in the letter;
4. The SC must provide the participant with a list of available waiver service providers from which to interview and select;

5. If it is the SC agency requesting termination, then the RRDS is responsible for providing the participant with a list of available SCs/agencies from which to select;
6. Upon selection of the new waiver service provider, the participant must inform the SC (or RRDS as appropriate) who will assist the participant through the completion of the Change of Provider Request form;
7. The current provider agency must work closely with the newly requested provider agency and the SC (or RRDS, as appropriate) to assure a smooth transition occurs and that all appropriate documentation is provided to the new agency; and
8. The SC must amend the Service Plan to reflect the change in waiver service provider.

Note: The above procedures do not replace any professional requirements which a provider must follow in accordance with professional credentialing or licensing rules.

c. As a Result of Staff Leaving

When a staff member of a waiver service provider agency will no longer be providing services to a participant, the following procedures must be followed:

1. The staff member or agency supervisor must notify the participant of the employee's intent to leave his/her current agency and directs the participant to discuss the impact of their leaving with his/her SC. The participant can remain with the agency or choose to change providers. If it is the SC who is leaving the agency, the participant will be directed to the RRDS to select a new SC.
2. The staff member or the agency supervisor notifies the SC of the staff member leaving the agency.
3. The SC meets with the participant to determine if a new provider agency is desired. If the participant desires a new waiver service provider agency, the SC will assist him/her through the Change of Provider process (refer to Changing Waiver Provider section above).
4. If the participant chooses to remain with the current waiver provider agency, the SC must work with the participant and agency supervisor to assure no lapse in staff coverage occurs.
5. The SC will amend the current Service Plan to reflect the change, if needed.
6. When it is the SC leaving the agency, the RRDS will talk with the participant about his/her continued interest in remaining with this Service Coordination agency. If the participant desires to change Service Coordination agencies, the RRDS will assist him/her through

the change of Service Coordination process.

7. If the participant chooses to remain with the current Service Coordination agency, the agency will work with the participant and agency supervisor to assure no lapse in staff coverage occurs.

d. Establishing the Date of Termination

As a final step in the process of changing waiver service providers, the RRDS will establish the date of termination to assure no lapse in service provision occurs to the participant. In doing so, the following must occur:

- Service Coordination must change on the first of the month (refer to Section VI – Waiver Services); and
- Other waiver services may be changed within ten (10) business days from the RRDS receipt of the signed Change of Provider form. The RRDS may make the change of providers effective upon receipt of the Change of Provider Request form if it is determined that the health and welfare of the participant is at risk. This may be accomplished verbally or in writing.

During the transition period, the SC will arrange for a Transition Meeting between the current and new providers and the participant to exchange information. In the event the SC is the staff member leaving, the RRDS will arrange for a Transition Meeting between current and new provider to exchange information. The current provider is responsible for providing the new provider with copies of all evaluations, Individual Service Reports, and an update of what has been accomplished since the last Service Plan. This process must comply with all laws, such as the Health Insurance Portability and Accountability Act (HIPAA), regarding confidentiality and the release of medical and NHTD waiver services material.

U. Transferring Regions

The participant may choose or need to relocate to a different region of NYS. To preserve continuity of services, meaningful exchange of information between the RRDS and waiver service providers is imperative. The following must occur to support the participant's relocation:

1. The participant must inform the SC of his/her desire/need to relocate;
2. The SC will meet with the participant to obtain information regarding the new residence, needed services in the new location, and anticipated date of transfer;
3. The SC must notify the current RRDS and provides details of the participant's request to relocate;
4. The current SC must assure a Release of Information is in place to assist in the transfer of information process;
5. The current RRDS must contact the RRDS in the new region to initiate transfer of services and provide a copy of the Initial Service

- Plan, and the current Service Plan and PPO;
6. The new RRDS must make a face-to-face visit with the participant to discuss service options and providers in the new area and make a preliminary determination as to whether the participant can be appropriately served in the new region;
 7. Upon preliminary approval by the new RRDS, the participant will select a new SC from the list of approved and available SCs provided by the new RRDS;
 8. The participant maintains his/her right to interview SCs or designate someone on their behalf to do so, whenever possible.

Note: It is always suggested that a face-to-face visit between the SC and participant is made whenever possible. In the event this can not be accomplished, it is imperative that the new SC work closely with the participant and current SC);

9. The participant works with the new RRDS to complete the Service Coordination Selection form indicating his/her selection;
10. The new SC acquires needed additional documentation (e.g. PRI/SCREEN, original Application Packet, PPO, etc). for the development of the RSP;
11. The new SC assists the participant through the Provider Selection process;
12. The participant maintains his/her right to interview waiver service providers or designate someone on their behalf to do so whenever possible;
13. The new SC develops the RSP with the participant and submits it to the new RRDS for review and approval;
14. Upon approval of the RSP by the new RRDS, the current SC must inform the participant of his/her responsibility to contact the current LDSS and inform them of his/her intent to transfer to a new county as a continued participant of the NHTD waiver and with the anticipated date of transfer. If requested by the participant, the SC can assist in the contact to LDSS; and
15. The new SC must contact the LDSS in the new county to assure information regarding transferring the participant's Medicaid eligibility status to the new region has occurred.

Note: If there is indication that the participant can not be appropriately served in the new RRDS region, this is communicated to the current RRDS for discussion with the participant. If the participant still desires to relocate to the new region but can not be served by the waiver in that region, the current RRDS sends a completed NOD – Discontinuation of Waiver Program. The current SC discusses the NOD and Fair Hearing rights with the Participant. The current SC works with the participant to develop a discharge plan.

Section VI

WAIVER SERVICES

Introduction

The NHTD Waiver Services are designed to address the unique needs of the participants. All other services including informal supports, non-Medicaid services, federally funded services and Medicaid State Plan services are explored before utilizing waiver services. The provision of waiver services must be cost effective and necessary to avoid institutionalization.

This section describes each of the waiver services, provider qualifications and reimbursement for the service.

Service Coordination

Definition

Service Coordination is an individually designed intervention which provides primary assistance to the waiver applicant/participant in gaining access to needed waiver and Medicaid State Plan services, as well as other local, state and federally funded educational, vocational, social, medical and any other services. These interventions are expected to result in assuring the waiver participant's health and welfare and increasing independence, integration and productivity. The Service Coordinator (SC) will assist the applicants/participants in obtaining and coordinating the services that are necessary to return to or remain in the community.

Roles and Responsibilities

The applicant/participant is the primary decision-maker in the development of goals, and selection of supports and individual service providers. The SC is responsible for assuring that the SP is implemented appropriately and supports the participant to become an effective self-advocate and problem solver. Together they work to develop and implement the SP, which reflects the participant's goals.

The SC assists the applicant/participant in the development of the individualized SP and will include those individuals chosen by the applicant/participant to also participate in the process. Following the approval of the SP, the SC will assist the waiver participant in implementing the plan, as well as reviewing its effectiveness. Throughout his/her involvement with the waiver participant, the SC will support and encourage the waiver participant to increase his/her ability to problem-solve, be in control of life situations, and be independent. The SC will also assist the applicant/participant to complete the Plan of Protective Oversight (PPO) (refer to Appendix C – form C. 4).

Questions that a SC should explore with the participant include:

- What are the participant's goals?
- What can be done to help the participant fulfill his/her goals?
- How can the participant be assisted to become a member of the community?
- What can be done to assist the participant to be more independent?

The SC must also be an effective advocate for the participant, so the participant obtains needed benefits for which he/she is eligible and receives appropriate and adequate services.

The SC is responsible for assuring that all waiver service providers receive a copy of the most up-to-date SP.

Types of Service Coordination

Service Coordination has two basic components:

- 1) Initial; and
- 2) Intensive

1. Initial Service Coordination

This component has three types of Service Coordination available to the waiver applicant:

- Initial Service Coordination Diversion - This type of Service Coordination is provided to individuals who are new to the waiver and presently living in the community. This will occur only once per waiver enrollment.
- Initial Service Coordination Transition - This type of Service Coordination is provided to individuals who are new to the waiver and presently living in a nursing home for less than six months. This will occur only once per waiver enrollment.
- Initial Service Coordination Transition - This type of Service Coordination is provided to individuals who are new to the waiver and presently living in a nursing home for six months or more. This will occur only once per waiver enrollment.

Initial Service Coordination encompasses those activities involved in developing the individual's Application Packet. After the individual selects a SC, it is the SC's responsibility to gain a full understanding of who this person is now, his/her life experiences, and his/her goals for the future. It is essential to interview those individuals who are of primary importance to the applicant. Information from community services and medical facilities/practitioners providing services to the individual including information from a discharging facility should be obtained.

In assisting the individual to develop the ISP (refer to Appendix C – form C.1), the SC should look to sources of support – informal caregivers (family, friends, neighbors, etc.), non-Medicaid federal and state funded services, such as VESID, Medicare and other third party payers and Medicaid funded services (physician, personal care, nursing, etc). The waiver services are designed to complement other available supports and services available to Medicaid recipients. Waiver services can be substituted for Medicaid State Plan services when there are greater efficiencies, such as the use of Congregate and Home Delivered Meals in lieu of a personal care assistant preparing a meal.

Another important task of the SC is to assist the participant in locating a place to live in the community. The NHTD waiver supports the individual's right to choose where to live and to have access to integrated and accessible housing that falls within the individual's economic means.

There are no certified residences specifically/directly associated with the waiver;

participants may live with up to three (3) other non-related individuals, unless they are in a living situation which is certified or licensed by the State (e.g. an Office of Mental Hygiene supported Residential Program for Adults or an Adult Care Facility). The SC is to assist the waiver participant to secure housing.

2. Intensive Service Coordination

This component has one type of Service Coordination available to the waiver applicant:

- Intensive Service Coordination - This type of Service Coordination is provided to participants on an ongoing basis.

Intensive Service Coordination is ongoing and begins after the individual is approved to become a waiver participant and has been issued a Notice of Decision (NOD). The SC is responsible for the timely and effective implementation of the approved SP. The SC is responsible for assuring that there is adequate coordination, effective communication, and maximum cooperation between all sources of support and services for the participant.

During the first six (6) months of the ISP, the SC will conduct face-to-face meetings with the waiver participant at least monthly to provide closer monitoring of the participant's health and welfare needs as he/she adjusts to the waiver program. It is expected that at least one of these visits will be conducted in the participant's home. In addition, these meetings can provide monitoring opportunities for the SC to assure that all approved services are being provided. Thereafter, the SC will conduct face-to-face meetings with the waiver participant as determined through discussion with the participant and as authorized in the SP. These meetings must occur, at a minimum, once every six (6) months. The SC will assure that the participant is aware that he/she may contact the SC if issues/problems occur.

The ultimate responsibility for assuring that the SP is appropriately implemented rests with the SC.

A SC must be knowledgeable about all waiver services, Medicaid State Plan Services, and available non-Medicaid services. Informal supports are often a crucial factor if the participant is to live a satisfying life and remain in the community. The SC's ability to make use of these informal supports is essential, and offers the SC and other providers the greatest opportunity for creativity. In addition, the SC must be knowledgeable of the processes necessary to obtain needed referrals/orders, assessments and approvals for non-waiver service.

The SC will also be responsible for:

1. Formally reviewing, updating and submitting all SPs to the Regional Resource Development Specialist (RRDS) for review in a timely manner (refer to Section V – The Service Plan);
2. Assuring that Team Meetings are held at least six (6) weeks prior to the

- end of the most recently approved SP period and/or on an as needed basis;
3. Providing all waiver providers, the participant and others, as appropriate, with written summaries of the Team Meetings (refer to page 8 for more information on Team Meetings);
 4. Maintaining records for at least six (6) years after termination of waiver services;
 5. Maintaining a tracking system for level of care evaluations and assuring that the PRI and SCREEN (refer to Appendix F) is completed:
 - a. at least every twelve months; or
 - b. when the participant experiences a significant improvement in his/her ability to function independently in the community;
 6. Assuring that a signed Release of Information is obtained to disclose the ISP, Addendum or RSP and other documents generated in the provision of service to the participant. This information will be shared as needed with waiver service providers and others as directed by the participant;
 7. Maintaining knowledge of all approved waiver service providers in their region;
 8. Conducting face-to-face meetings with the participant and at a minimum:
 - 1) Review the SP with the participant to determine if the services are meeting the participant's needs;
 - 2) Discuss the provision of services with the participant to determine the participant's level of satisfaction with the services he or she is receiving; and
 - 3) Review the Service Coordination Detailed Plan with the participant to discuss the participant's progress towards meeting his or her goals.
 9. Conducting in-home visits with the waiver participant at least once every six (6) months, prior to the development of the Service Plan;
 10. Reviewing all NODs with the participant and assuring that the participant understands his/her rights to an Informal Conference and/or Fair Hearing;
 11. Ensuring that the participant understands and signs the Waiver Participant's Rights and Responsibilities (refer to Appendix C – form C. 5) annually;
 12. Assuring that the participant is provided with information regarding abuse/neglect prevention and how to report any incidents of abuse/neglect if it does occur;
 13. Working with the participant to develop and maintain a Detailed Plan

for Service Coordination which includes coordination of team in the provision of services, and overall activities and goals of the SC;

14. Documenting all visits, contacts, meetings, etc. involving the participant in the SC's record;
15. Working with the participant on a safe discharge/discontinuation plan if he/she is leaving the NHTD waiver. In many cases, this will include collaboration with Local Department of Social Services (LDSS) to establish alternative services; and
16. Administering the Quality of Life (QoL) Survey for applicants who have resided in a nursing home for at least six (6) months prior to transitioning into the community. The QoL Survey must be administered within two (2) weeks of the anticipated discharge of the individual from the nursing home.

Although the SC is an employee of a provider agency, the SC must always act as the participant's advocate and provide unbiased assistance to the participant with the selection of providers.

Ratio of Waiver Participants to SC

- Full time SC for NHTD waiver participants may not exceed a caseload of twenty (20) waiver participants.
- SCs providing services to NHTD waiver participants on less than a full time basis must limit their caseload proportionately. For example, a SC working 50 percent may not exceed a caseload of ten (10) waiver participants.

Provider Qualifications

Not-for-profit or for profit health and human services agencies may provide Service Coordination. The agency must be approved by DOH as a NHTD waiver provider.

I. Qualifications for a SC are:

- (A)
 - (1) Master of Social Work;
 - (2) Master in Psychology;
 - (3) Registered Physical Therapist – Licensed by the NYS Education Department;
 - (4) Registered Professional Nurse –Licensed by the NYS Education Department;
 - (5) Certified Special Education Teacher – Certified by the NYS Education Department;
 - (6) Certified Rehabilitation Counselor – Certified by the Commission of Rehabilitation Counselor Certification;
 - (7) Licensed Speech-Language Pathologist - Licensed by

- the NYS Education Department; or
- (8) Registered Occupational Therapist – Licensed by the NYS Education Department.

The individual shall have, at a minimum, one (1) year of experience providing service coordination and information, linkages and referrals regarding community-based services for individuals with disabilities and/or seniors; OR

- (B) Be an individual with a Bachelor's degree and two (2) years experience providing service coordination for individuals with disabilities and/or seniors and knowledge about community resources; or
- (C) Be an individual with a High School Diploma with three (3) years' experience providing service coordination for individuals with disabilities and/or seniors and knowledge about community resources; or
- (D) Be an individual who has successfully served as a Regional Resource Development Specialist for one (1) year.

II. The following individuals may be hired and must be supervised by individuals identified in Section I (A) above to perform Service Coordination Services:

- (A) Individuals with educational experience listed in I (A) but who do not meet the experience qualification;
- (B) Individuals with a Bachelor's degree with one (1) year of experience providing service coordination for individuals with disabilities and/or seniors and knowledge about community resources; and
- (C) Individuals with a High School Diploma and two (2) years of experience providing service coordination to individuals with disabilities and/or seniors and knowledge about community resources.

The supervisor of the above listed staff is expected to:

1. Meet any potential participants prior to the completion of the ISP developed by a SC under their supervision;
2. Have supervisory meetings with staff on at least a bi-weekly basis and maintain notes on these meetings;
3. Document progress of staff and conduct regular performance evaluations; and
4. Review and sign-off on all Service Plans.

A supervisor may maintain an active caseload of waiver participants in accordance with ratio guidelines.

The Service Coordination agency must have available a communication system for 24 hours/seven days per week coverage to assure any issues regarding a participant's services can be addressed.

Team Meetings

The SC must be a strong and effective team leader. After the participant has selected all service providers, the SC organizes the team to provide individualized services for the participant. The SC needs to coordinate communication among all team members, including the participant. This becomes especially important when cognitive deficits affect the participant's memory. Maintaining good communication contributes towards effective coordination of services to support the participant in the community.

Team Meetings are scheduled based on the service needs of the participant but must be held at a minimum of every six (6) months when the RSP is being developed. A new waiver participant may benefit from monthly meetings initially with the entire team.

The SC coordinates and facilitates the Team Meeting. The participant, his/her legal guardian if applicable, and all waiver service providers for the individual must attend each Team Meeting. (Exceptions to Team Meeting attendance may be made at the discretion of the SC for providers of Assistive Technology (AT), Community Transition Services (CTS), Congregate and Home Delivered Meals, Environmental Modifications(E-mods), Moving Assistance, Home Visits by Medical Personnel, and Respite Services. Failure to attend may jeopardize the ability of the waiver provider to continue to provide waiver services. Providers of essential non-waiver services and anyone identified in the Plan for Protective Oversight should also be invited to Team Meetings. Other potential members of the Team Meeting include advocates, family members, local department of social services staff, etc. If the waiver participant is receiving the same service from different waiver providers, both providers should attend the Team Meeting.

The SC is responsible for facilitating effective communication between the participant and all service providers. To assure services are provided in the most integrated and efficient manner, it is necessary for providers to attend regularly scheduled Team Meetings to discuss progress toward the participant's goals, identify any impediments to achieving projected milestones and address any issues affecting the participant. Regularly scheduled Team Meetings with the participant and service providers are an essential part of assuring the participant's health and welfare.

Team meetings are scheduled by the SC six (6) weeks prior to the end of the most recently approved SP period and/or on an as needed basis. Prior to or at the time of the Team Meeting, all waiver providers required to submit an updated ISR must do so to assure the development of the RSP. Timely submission of

Individualized Service Reports (ISR) (refer to Appendix C – form C.16) is imperative to maintain continuity of services to the participant. In addition, the SC may need to obtain information from non-waiver providers or other parties prior to the meeting. The RRDS may consult with the SC to determine if Team Meetings are being used appropriately.

On limited occasions, service providers may indicate the need to meet without the participant (e.g. the participant's behavior or other factors jeopardize the participant's ability to remain in the community). The SC is responsible for informing the RRDS of the team's interest in holding a meeting without the participant. Following the meeting, the SC and other members of the team must meet with the participant to explain the results of the meeting. This exception does not apply when the team is meeting to develop a RSP.

Team Meetings must be documented in the SP by the SC. Participation in Team Meetings must be documented in the notes of each active waiver service provider, including date, time and location, and projected activities (refer to Section VII – Record Keeping).

In addition, the SC completes the Team Meeting Summary form (refer to Appendix C – form C.17 which includes:

- Date, time and location of Team meeting;
- Participant's (or designated representative's) input and comments;
- Issues Addressed;
- Recommendations for changes in the Service Plan (e.g. addition, decrease, increase or discontinuation of service(s));
- Who was in attendance; and
- Submission and acceptance of all required ISRs or documentation of reasons for any delay or resubmission.

The SC distributes a copy of the completed Team Meeting Summary to all active waiver service providers for review and acceptance. A final copy is then provided to the participant. Any concerns regarding the content of the Team Meeting Summary should be directed to the SC. All active waiver service providers must maintain a copy of the Team Meeting Summary in the participant's record.

Team Meetings may not be used by the SC for required face-to-face visits.

Team Meetings are organized and facilitated by the SC as part of his/her responsibility to oversee services. Reimbursement for this activity is included in the monthly rate for Service Coordination. All other waiver service providers participating in a Team Meeting will be reimbursed at the usual rate for their service (e.g. Community Integration Counseling (CIC) will be able to bill as a face-to-face session with the participant).

Reimbursement for Service Coordination

Service Coordination must be provided by a DOH approved provider and must be included in the SP to be reimbursed.

There are two (2) types of reimbursement for Service Coordination:

1. Initial Service Coordination is reimbursed on a one-time only basis for each participant after the individual is an approved participant in the waiver. Reimbursement is for the work, time and travel expended in developing the Application Packet, including the Initial Service Plan.

There are three (3) rates for Initial Service Coordination. These are based on whether the person is in the community and how long an individual has been in a nursing home. These are:

- Diversion
- Transition - six (6) months or less in a nursing home
- Transition - greater than six (6) months in a nursing home

2. Intensive Service Coordination is reimbursed in monthly units. As with all waiver services, Service Coordination must be included in the SP and can only be billed after the service is delivered. For reimbursement purposes, at a minimum, the SC must have at least one face-to-face meeting with the participant in the month for which bills are being submitted.

Assistive Technology (AT)

Definition

The purpose of this service is to supplement the Medicaid State Plan Service for Durable Medical Equipment and supplies, which provides a broad range of special medical equipment and supplies. The Medicaid State Plan and all other resources must be explored and utilized before considering AT. Durable Medical Equipment covered by the Medicaid State Plan can be found at www.emedny.org under 'Provider Manuals'.

An Assistive Technological device may include an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or to improve the functional capabilities of the waiver participants. AT service is a service that directly assists a waiver participant in the selection, acquisition, or use of an assistive technology device. This service will only be approved when the requested equipment and supplies improve or maintain the waiver participant's level of independence, ability to access needed supports and services in the community or, maintain or improve the waiver participant's safety.

Documentation must describe how the waiver participant's expected use, purpose and intended place of use have been matched to features of the products requested in order to achieve the desired outcome in an efficient and cost effective manner.

AT may be obtained at the time the individual becomes enrolled as a participant, no more than thirty (30) days prior to the initial NOD, or during the development of any SP. Requests for AT must be less than \$15,000 per 12-month period. For example: If a participant needs more than one type of AT device during the twelve (12) month period, the combined cost for this period may not exceed \$15,000. A contract for AT resulting in an amount of \$15,000 or more per 12-month period must be approved by DOH.

Provider Qualifications

AT Services are purchased through vendors who sell the needed medical, communication and adaptive equipment or supplies.

Providers of Assistive Technology must be:

1. Approved by DOH under Section 504 of Title 18 NYCRR;
2. Providers of AT services to the HCBS waiver administered by OMRDD;
3. A licensed pharmacy; or
4. For Personal Emergency Response Systems (PERS), an approved provider of PERS which have existing contracts with the LDSS.

Providers of AT must ensure that all devices and supplies meet standards established by Underwriters Laboratory and/or comply with FCC Regulations, if appropriate.

The provider of this service is responsible for training the waiver participant, natural (informal) supports and paid staff who will be assisting the waiver participant in using the equipment or supplies.

Approval Process for AT Services

Step 1 The participant, his/her legal guardian, the SC, and anyone selected by the participant determine if any AT is needed during the development of any SP.

This must be done in conjunction with an assessment by either an Independent Living Skills Trainer (ILST) or other professional who is knowledgeable about the full range of devices and/or technology to assist individuals with disabilities or seniors.

Step 2 The participant and SC explore and utilize all possible funding sources including: private insurance; community resources; non-Medicaid federal and state funding (e.g. Medicare); and/or other federal/State programs. These funding sources must be accessed with documentation of denial prior to requesting AT Services.

Step 3 If NHTD funding is required for the device(s), the SC initiates the process for submission of the AT request to the RRDS using the Assistive Technology Description and Cost Projection form (refer to Appendix C – form C.9). Information that must be submitted includes but is not limited to:

- Justification for the AT, indicating how the specific equipment will meet the needs and goals of the participant in an efficient and cost effective manner;
- Copies of all assessments made to determine the necessary AT, including an assessment of the participant's unique functional needs and the intended purpose and expected use of the requested AT. The assessment must include a description of the ability of the equipment to meet the individual's needs in a cost effective manner;
- When the AT will require modifications to the participant's residence, information must also include the name of the home owner or landlord and their permission for the modifications/adaptations; and
- Date the AT is needed.

- Step 4** The SC obtains bids from approved AT providers. The SC must select an approved provider based on reasonable pricing and obtain a written bid stating all terms and conditions of sale.
- For an item of AT costing up to \$1,000 per 12 month period, only one bid is required.
 - For an item of AT costing \$1,000 or more per 12 month period, three bids are required.
- The lowest bid for comparable equipment will be selected.
- Step 5** The SC completes the Assistive Technology Description and Cost Projection form and attaches all bids obtained. The SC reviews the form with the applicant/participant and both the SC and applicant/participant signs.
- Step 6** The SC submits the complete Assistive Technology Description and Cost Projection form along with the Initial or Revised Service Plan, or Addendum to the RRDS.
- Step 7** The RRDS reviews the Assistive Technology Description and Cost Projection form and may request more information. Approval is contingent upon available funding. The RRDS notifies the SC of the approval.
- Step 8** The SC notifies the AT provider.
- Step 9** The AT provider completes and signs the Waiver Services Final Cost form (refer to Appendix C – form C.11) with the participant;
- Step 10** The AT provider sends the Waiver Services Final Cost form to the SC who signs off and submits the form to the RRDS;
- Step 11** The RRDS reviews the Waiver Services Final Cost form and completes the RRDS Approval of Final Cost form. The RRDS provides a copy of the RRDS Approval of Final Cost form to the AT provider and SC;
- Step 12** The AT provider seeks reimbursement after receiving a copy of the NOD from the SC.

Repairs

Repairs to AT which are cost effective may be allowed. Items that have worn out through normal everyday use (keyboards, switches, etc.) may be replaced using the same procedures that were followed to initially acquire the item. There are situations where replacement or repair will be contingent on establishing a plan that would minimize repeated loss or damage. The SC is responsible for working with the team to develop and implement a plan to prevent repeated loss or damage.

Reimbursement

AT must be provided by a DOH approved provider and included in the SP to be reimbursed.

AT is reimbursed based on the lowest of two costs: wholesale plus 50% or the retail cost. Repairs and replacement of parts are reimbursed at the retail cost. AT obtained no more than thirty (30) days prior to the initial NOD are reimbursed after the NOD is issued.

Community Integration Counseling (CIC)

Definition

Community Integration Counseling (CIC) is an individually designed service intended to assist waiver participants who are experiencing significant problems managing the emotional responses inherent in adjusting to a significant physical or cognitive disability while living in the community. It is a counseling service provided to the waiver participant who is coping with altered abilities and skills, a revision of long term expectations, or changes in roles in relation to significant others. This service is primarily provided in the provider's office or the waiver participant's home. It is available to waiver participants and/or anyone involved in an ongoing significant relationship with the waiver participant when the issues to be discussed relates directly to the waiver participant. It is expected that CIC will be conducted on a short-term basis. The need for CIC could occur at the time of transition from a nursing home or at various times during the participant's involvement in the NHTD waiver.

While CIC Services are primarily provided in a one-to-one session to either the waiver participant or a person involved in an ongoing relationship with the participant, there are times when it is appropriate to provide this service to the waiver participant or other in a family counseling or group counseling setting.

Regarding client confidentiality, the sharing of information obtained during a CIC session can only be disclosed in accordance with federal standards and accepted professional standards regarding client confidentiality.

CIC must not be used to assist the participant to become physically integrated into his/her environment. This function is the responsibility of other service providers, such as SCs, ILST and Home and Community Support Services (HCSS).

Provider Qualifications

CIC may be provided by any not-for-profit or for profit health and human services agency.

A CIC must be a:

- (A) 1. Licensed Psychiatrist - Licensed by the NYS Education Department;
2. Licensed Psychologist - Licensed by the NYS Education Department;
3. Master of Social Work;
4. Master of Psychology;
5. Mental Health Practitioner – Licensed by the NYS Education Department;
6. Certified Rehabilitation Counselor – Certified by the Commission on Rehabilitation Counselor Certification; or

7. Certified Special Education Teacher- Certified by the NYS Education Department.

Each of these individuals must have, at a minimum, two years of experience providing adjustment related counseling to individuals and/or seniors with physical and/or cognitive disabilities and their families. A significant portion of the provider's time which represents this experience must have been spent providing counseling to individuals with disabilities and/or seniors and their families in order to be considered qualifying experience.

Individuals listed in (A) may supervise the following individuals to perform CIC services:

- (B) 1. Licensed Psychiatrist - Licensed by the NYS Education Department;
2. Licensed Psychologist Licensed by the NYS Education Department;
3. Master of Social Work;
4. Master of Psychology;
5. Mental Health Practitioner – Licensed by the NYS Education Department;
6. Certified Rehabilitation Counselor - Certified by the Commission on Rehabilitation Counselor Certification; or
7. Certified Special Education Teacher - Certified by the NYS Education Department.

Individuals in section (B) may have less than two years of experience providing adjustment related counseling to individuals and/or seniors with physical, cognitive, developmental or psychiatric disabilities.

Supervisors are responsible for providing ongoing supervision and training to staff. Supervision must occur no less than once a month when reviewing the caseload and must be more frequent when there is a new participant, a new provider or there has been a significant change in the participant's emotional, psychiatric or life situation.

Reimbursement

CIC services must be provided by a DOH approved provider and must be included in the SP to be reimbursed.

CIC is reimbursed in one hour units. Participation in Team Meetings is reimbursed at the hourly rate for this service.

If CIC is provided in a group setting, the hourly rate is divided evenly among the participants. For instance, if the participant is one of four people in the group, only one quarter of an hour is billable to that participant. Providers must accumulate billable units until a whole hour is reached before billing for the service.

Community Transitional Services (CTS)

Definition

Community Transitional Services (CTS) are defined as individually designed services intended to assist a waiver participant to transition from a nursing home to living in the community. CTS is a one time service per waiver enrollment. If the waiver participant has been discontinued from the program and now is a resident of the nursing home, they can access this service again, if needed. This service is only provided when transitioning from a nursing home. These funds are not available to move from the participant's home in the community to another location in the community. The funding limits for this service are separate and apart from the limits applied to Moving Assistance, and the two services will not be used at the same time in any approved Service Plan.

CTS provide funding for the reasonable costs of one-time set-up expenses for individuals transitioning from a nursing home to their own home or apartment in the community. Reasonable costs are defined as necessary expenses for an individual to establish his/her living space.

These services must be included in the ISP and may not exceed \$5,000 per waiver enrollment, including the 10% administrative fee payable to the CTS provider. Approved costs will be covered by CTS up to thirty (30) days prior to the individual's discharge into the community.

This service includes:

- The cost of moving essential furniture and other belongings;
- Security Deposits, including broker's fees to obtain a lease on an apartment or home;
- Purchasing essential furnishings;
- Set up fees or deposits for utility or service access (e.g. telephone, electricity, heating);
- Health and safety assurances, such as pest removal, allergen control or one-time cleaning prior to occupancy.

This service will not be used to purchase diversional or recreational items, such as television/ VCRs/ DVDs/ or music systems.

Provider Qualifications

All CTS providers must be approved providers of Service Coordination in the NHTD waiver. When the participant chooses the provider of CTS it does not have to be the same agency providing Service Coordination to the participant. Someone other than the participant's SC must be the individual responsible for arranging CTS. The provider of this service must designate an individual who has sufficient knowledge and skills to work with subcontractors and to assist the participant in utilizing this service.

Approval Process for CTS

- Step 1** The applicant, SC, and anyone selected by the applicant, determines if any CTS is required prior to discharge from the nursing home into the community.
- Step 2** If appropriate, a comprehensive list of the items needed or anticipated expenses is developed by the applicant and SC.
- Step 3** The applicant and SC explore all possible resources including informal supports and community resources for these items.
- Step 4** After all other resources are explored and utilized, the SC compiles a detailed list of items and anticipated expenses using the Community Transitional Services Description and Cost Projection form (refer to Appendix C – form C.9);
- Step 5** The SC and applicant select an approved CTS provider and include the contact information on the Community Transitional Services Description and Cost Projection form.
- Step 6** After completing the Community Transitional Services Description and Cost Projection Form, the applicant and SC sign the form.
- Step 7** The SC sends the Community Transitional Services Description and Cost Projection Form to the CTS provider for their signature and Medicaid provider number.
- NOTE:** For moving costs and for services for health and safety assurances (e.g. cleaning) – if the cost of either one of these services is greater than \$1,000, three (3) bids must be obtained and submitted by the CTS provider, along with the CTS Description and Cost Projection form.
- Step 8** The CTS provider returns the completed Community Transitional Services Description and Cost Projection form to the applicant's SC.
- Step 9** The SC submits the complete Community Transitional Services Description and Cost Projection form with the ISP to the RRDS.
- Step 10** The RRDS reviews and approves the costs detailed for CTS.
- Step 11** The RRDS notifies the SC of approval for CTS.
- Step 12** The SC notifies the CTS provider that the applicant has been approved for CTS.
- Step 13** The CTS provider makes the approved payment directly to the broker, utility company and/or the landlord for a security deposit. The CTS provider purchases the approved essential furnishings

with prior approval by the RRDS. All receipts and any remaining balance must be maintained by the CTS provider.

- Step 14** The CTS provider completes the Waiver Services Final Cost form, which certifies that the CTS was provided in accordance with the ISP. The CTS provider must maintain original receipts. A copy of the original receipts is attached to an itemized list of items purchased to the Waiver Services Final Cost form and submitted to the SC.
- Step 15** The SC signs the complete Waiver Services Final Cost form and submits it to the RRDS for approval.
- Step 16** The RRDS completes the RRDS Approval of Final Cost form and provides a copy to the CTS provider and SC.
- Step 17** The CTS provider seeks reimbursement after receiving a copy of the NOD – Authorization from the SC.

Reimbursement

CTS must be provided by a DOH approved provider and included in the Initial SP to be reimbursed. Prior to making the purchases, if the cost is greater than 10% more than the estimate then another Community Transitional Services Description and Cost Projection form has to be submitted to justify the request. Reimbursement will not be provided if the actual cost of the CTS exceeds ten (10) percent of the projected cost and the CTS provider did not obtain prior approval.

This Service is reimbursed on a cost basis. Total one-time reimbursement for CTS must not exceed \$5,000 per waiver enrollment, which may include a 10% administrative fee payable to the CTS provider.

Congregate and Home Delivered Meals

Definition

Congregate and Home Delivered Meals is an individually designed service which provides meals to waiver participants who cannot prepare or obtain nutritionally adequate meals for themselves, or when the provision of such meals will decrease the need for more costly supports to provide in-home meal preparation. These meals will assist the waiver participant to maintain a nutritious diet. These meals do not constitute a full nutritional regimen. Therefore the maximum number of meals the participant may receive per day is two (2). It is not to be used to replace the regular form of "board" associated with routine living in an Adult Care Facility. Individuals eligible for non-waiver nutritional services would access those services first.

Provider Qualifications

Providers of Congregate and Home Delivered Meals are either contracted through Area Agencies on Aging (AAA) or those entities contracted through the Area Agency on Aging for Congregate and Home Delivered Meals.

Reimbursement

Congregate and Home Delivered Meals must be documented in the SP and provided by agencies approved by DOH.

This service is reimbursed on a per meal basis.

Attendance at Team Meetings for Congregate and Home Delivered Meal providers will be determined by the SC.

Environmental Modifications Services (E-mods)

Definition

Environmental Modifications (E-mods) are internal and external physical adaptations to the home, which are necessary to ensure the health, welfare and safety of the waiver participant. These modifications enable the waiver participant to function with greater independence and prevent institutionalization.

E-mods must be provided where the waiver participant lives. If a waiver participant is moving to a new location which requires modifications, the modifications may be completed prior to the waiver participant's move. If an eligible individual is residing in an institution at the time of the application, the modifications may be completed no more than thirty (30) days prior to the waiver participant moving into the modified dwelling. All modifications must meet State and local building codes.

Modifications may also be made to a vehicle if it is the primary means of transportation for the waiver participant (referred to as vehicle modifications). An E-mod may alter the basic configuration of the waiver participant's home only if this alteration is necessary to successfully complete the modification. All environmental and vehicle modifications must be included in the SP and provided by agencies approved by DOH.

E-mods, including vehicle modifications, have a limit of up to \$15,000 per twelve (12) month period. For example: if a participant needs more than one type of E-mod during the twelve (12) month period, the combined cost for this period may not exceed \$15,000. E-mods in the amount of \$15,000 or more per twelve (12) month period must be approved by DOH.

E-mods do not include improvements to the home (carpeting, roof repair, central air conditioning), which are not medically necessary or are not necessary to the waiver participant's independence in the home or community.

Allowable E-mods

E-mods in the home include the purchase and/or installation of:

- Ramps
- Lifts: hydraulic, manual or electric, for porch, bathroom or stairs (Lifts may also be rented if it is determined that this is more cost-effective.)
- Widened doorways and hallways
- Hand rails and grab bars
- Automatic or manual door openers and doorbells

Bathroom and kitchen modifications, additions or adjustments to allow accessibility or improved functioning, include:

- Roll-in showers
- Sinks and tubs

- Water faucet controls
- Plumbing adaptations to allow for cutouts, toilet/sink adaptations
- Turnaround space changes/adaptations
- Worktables/work surface adaptations
- Cabinet and shelving adaptations

Other home adaptations include:

- Medically necessary heating/cooling adaptations required as part of a medical treatment plan. (Any such adaptations utilized solely to improve a person's living environment are not reimbursable under the waiver.)
- Electrical wiring to accommodate other adaptations or equipment installation.
- Specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that have been determined medically necessary.
- Other appropriate E-mods, adaptations or repairs necessary to make the living arrangements accessible or accommodating for the participant's independence and daily functioning and provide for emergency fire evacuation and necessary to assure the waiver participant's health, welfare or safety.

Provider Qualifications

Any not-for-profit or for profit health and human services agency may provide E-mods or may subcontract with a qualified person or entity to provide E-mods. Agencies approved to provide E-mods by the Office of Mental Retardation and Developmental Disabilities (OMRDD) may be approved by DOH to provide this service for the NHTD waiver.

The E-mod provider must ensure that individuals working on the E-mods are appropriately qualified and/or licensed to comply with any State and local rules. All materials and products used must also meet any State or local construction requirements.

Providers must adhere to safety issues addressed in Article 18 of the New York State Uniform Fire Prevention and Building Code Act as well as all local building codes.

Approval Process for E-mods for a home

- STEP 1** The participant, SC, and anyone selected by the participant determines if any E-mods are required during the development of any SP;
- STEP 2** A comprehensive assessment must be completed to determine the specifications of the E-mod;

STEP 3 The participant, the SC and anyone selected by the participant must explore all other available resources to pay for E-mods (i.e. informal supports, community resources and State/Federal agencies);

STEP 4 When all other resources have been explored and/or utilized, the SC begins the bid procurement and selection process;

There are two options for obtaining bids:

1. The SC and participant select a waiver approved E-mod provider to be responsible for planning, oversight and supervision of the project. The provider is then responsible for obtaining three bids from skilled professionals and selecting the contractor; OR
2. The SC and participant obtain three bids from providers who are responsible for planning, oversight and supervision of the project and have the personnel and expertise to complete the E-mod.
 - For E-mods of less than \$1,000, only one bid is necessary.
 - For E-mods of \$1,000 or more, three bids are necessary.

Any combination of these two options can be used to obtain three bids. The lower bid must be selected, unless there is an indication that the contractor did not understand the full scope of the work or is unable to deliver the needed service. Every reasonable effort must be made to acquire the required three bids.

When the SC determines that the continued delay due to lack of the required number of bids is jeopardizing the participant's health and welfare or is preventing an applicant from leaving an institution, the SC must contact the RRDS. The RRDS will consult with DOH and will notify the SC if they can proceed without the required three bids.

STEP 5 The SC completes and submits the E-mod proposal using the E-mod Description and Cost Projection form (refer to Appendix C – form C.10) to the RRDS for review and approval along with the SP. Information that must be submitted includes but is not limited to:

1. Justification for the E-mod.
2. All comprehensive assessments completed to determine the specifications of the E-mod.
3. Information regarding the residence where the E-mod is proposed, including the name of the home owner or landlord.

The owner's approval for the renovations, including any lease or rental contract, must be included (DOH is not responsible for the cost of restoring a site to its original configuration or condition).

4. If the participant or family is having other renovations or repairs done to the house along with the E-mods, the scope of work should clearly delineate the waiver covered E-mods from modifications being funded by the family;

STEP 6 The RRDS reviews the Environmental Modification Description and Cost Projection form and may request more information. Approval is contingent upon available funding. The RRDS completes and signs the E-mod Description and Cost Projection form. The RRDS sends a copy of the form to the SC with the final determination.

STEP 7 The SC notifies the E-mod provider of the approval and obtains a signed contract from the E-mod provider. The E-mod provider is responsible for coordination of the E-mod, including obtaining necessary permits, supervising the construction, beginning and ending dates, and satisfactory completion of the project.

Signed contracts must be forwarded to the RRDS and must result in a total of less than \$15,000 per twelve (12) month period. Any changes in cost must be prior approved by the RRDS through an Addendum to the SP. A contract for E-mods in the amount of \$15,000 or more must be approved by DOH.

STEP 8 Upon completion of the E-mod, a summary of the work with actual costs, is documented on the Waiver Services Final Cost form by the E-mod provider. The complete form is submitted to the SC who signs off and submits the form to the RRDS.

STEP 9 The RRDS reviews the Waiver Services Final Cost form, and upon approval completes and signs the RRDS Approval of Final Cost form. The RRDS sends a copy of this form to the E-mod provider and SC.

STEP 10 The E-mod provider seeks reimbursement after receiving a copy of the NOD from the SC.

Repairs

Repairs for home modifications which are cost effective may be allowed. Modifications that have worn out through normal use (faucet controls, ramps, handrails, etc.) may be replaced using the same E-mod approval process as for new E-mods. Repair and/or replacement may be contingent upon developing and implementing a plan to minimize repeated damage.

Reimbursement

E-mods must be provided by a DOH approved provider and included in the SP to be reimbursed. E-mods initiated up to thirty (30) days prior to the initial NOD are reimbursed after the Notice is issued.

This service is reimbursed according to the final cost of the project approved by the RRDS and must be less than \$15,000 per twelve (12) month period. If a participant needs more than one type of E-mod during the twelve (12) month period, the combined cost for this period may not exceed \$15,000. A contract for E-mods in the amount of \$15,000 or more must be approved by DOH.

E-mods for Vehicles **This Section is currently under review for revisions**

Home and Community Support Services (HCSS)

Definition

Home and Community Support Services (HCSS) are utilized when oversight and/or supervision as a discrete service is necessary to maintain the health and welfare of the participant living in the community. Oversight and/or supervision may be needed for safety monitoring to prevent an individual from harmful activities (for example wandering or leaving the stove on unattended). Oversight and/or supervision can be accomplished through cueing, prompting, direction and instruction. If the applicant/participant does not require oversight and/or supervision, HCSS would not be appropriate.

HCSS can also be provided to participants needing oversight and/or supervision who also require assistance with personal care services. Personal Care services is defined as some or total assistance with Activities of Daily Living (ADL) such as dressing, bathing, hygiene/grooming, toileting, ambulation/mobility, transferring and eating, and/or Instrumental Activities of Daily Living (IADL) such as housekeeping, shopping, meal preparation, laundry, transportation and telephone use essential to the maintenance of the participant's health and welfare in the community. HCSS can support this as long as the discrete oversight and/or supervision component is needed.

Since HCSS staff must be trained to the Personal Care Aide (PCA) Level, they will be able to perform the scope of personal care tasks and functions necessary for an individual who also requires oversight and/or supervision. The HCSS worker is never allowed to exceed this scope of practice.

HCSS is complementary but not duplicative of other services. HCSS is not to be used as a companion service.

NOTE: If a participant's oversight/supervision needs warrant HCSS during the night, the HCSS staff must remain awake throughout the duration of time assigned to the participant to assure the appropriate level of oversight/supervision is provided.

Once it is determined that a referral for HCSS will be pursued, the applicant/participant should select an HCSS provider from the list of qualified agencies provided by the SC. The SC contacts the selected HCSS provider to request an assessment.

NOTE: If the applicant/participant does not require oversight and/or supervision, he/she may still need to be assessed for assistance with personal care or higher skilled needs. Such assistance may be available from informal supports or a referral to State Plan services may be needed. If the individual appears to need assistance with ADLs and IADLs, the applicant/participant with needs that can not be met through informal supports, must be assessed for personal care services. The SC will need to work with the applicant/participant's physician and LDSS to assure the necessary evaluation is completed and needed services

arranged.

If an applicant/participant's personal care needs are being met through the provision of HCSS under the waiver, that individual cannot receive LDSS prior authorized Personal Care Services. This is true for both the traditional model of LDSS authorized personal care or the Consumer Directed Personal Assistance Program (CDPAP) model.

The RRDS and/or SC may identify that the applicant/participant requires the provision of skilled tasks such as those provided under Certified Home Health Agency services or Private Duty Nursing. These tasks are not included in this waiver service. They are potentially provided to Medicaid recipients through Certified Home Health Agencies (CHHA), Private Duty Nursing or the CDPAP. CDPAP may be used for the delivery of skilled services. In cases involving a combination of HCSS and CDPAP for skilled services, the SC must clearly articulate in the SP the justification of the need for CDPAP and the task(s) CDPAP is providing to the participant.

If an applicant/participant requires HCSS due to the need for discrete oversight and/or supervision, this is an indicator that the individual is not self-directing and requires an appointed self-directed other to manage the CDPAP services. To avoid conflict of interest the individual's HCSS worker, current NHTD waiver service providers, and/or NHTD contract staff (e.g. RRDS, NE and QMS) can not serve as a self-directing other. In addition, any individual associated with an agency delivering Medicaid reimbursed services to the participant can not serve as the self-directing other.

Assessment Process

If the SC determines that the applicant/participant may be in need of HCSS, the SC discusses the need for an assessment by a provider of HCSS with the applicant/participant. The SC provides the applicant/participant with a list of available HCSS providers to select from. Upon selection of the HCSS provider, the applicant/participant completes the Provider Selection form. The SC contacts the selected HCSS provider and forwards the Provider Selection form to that agency. The HCSS provider completes and returns the Provider Selection form to the SC.

The SC completes the designated sections of the Home Assessment Abstract (DSS-3139) (refer to Appendix F) and forwards the tool to the selected HCSS provider's supervising Registered Professional Nurse for completion. Upon receipt of the Home Assessment Abstract (DSS-3139) from the SC, the HCSS provider's Registered Professional Nurse must complete the appropriate nursing-related sections of the Home Assessment Abstract (DSS-3139) and return the completed tool to the SC within (14) calendar days. The Registered Professional Nurse must include in the Home Assessment Abstract (DSS-3139) documentation supporting the need for oversight and/or supervision. In addition, there must be clearly documented recommendations for the amount, frequency

and duration of HCSS for the participant and identification of any additional areas of support needed. The completed assessment tool must be provided to the SC for review with the applicant/participant and to be included in the SP. As per usual practice, the RRDS has the final determination regarding the amount, frequency and duration of HCSS to be provided.

For an applicant/participant who is in a nursing home or hospital at the time the assessment is conducted, the NHTD SC and the selected agency's supervising Registered Professional Nurse will need to complete the Home Assessment Abstract (DSS-3139) tool. For the section of the tool regarding the home environment, it is necessary to access the participant's residence. However, if this can not be done prior to discharge from the hospital or nursing home, it must be completed on the first day HCSS is scheduled to begin. In this situation, HCSS may be approved to begin by the RRDS based on the information available in the preliminary HCSS assessment.

The provider of HCSS must assure that orders from the participant's medical practitioner have been acquired in support of the need for HCSS as approved in the SP. This order must include documentation of the need for oversight and/or supervision as a discrete service based on medical diagnosis.

Other Considerations

Under the NHTD waiver, the selected provider's supervising Registered Professional Nurse will be responsible for supervising HCSS staff. The selected provider's supervising Registered Professional Nurse must conduct an initial home visit on the day and time HCSS staff begins providing services to the participant. The focus of this visit is for the selected provider's supervising Registered Professional Nurse to introduce the staff to the participant, assure services established during the initial assessment continue to be sufficient and, if necessary complete the environmental portion of the preliminary assessment tool. Any changes indicated will be communicated to the NHTD SC and/or MD as appropriate. If a particular activity requires on-the-job training, the selected provider's supervising Registered Professional Nurse will provide it during this visit.

Often times, when HCSS is being utilized, there may be other services involved, for example ILST, and/or Positive Behavioral Intervention and Support (PBIS) and other waiver service providers assisting the participant to work toward his/her goals. For example, if ILST is utilized, an assessment will be completed and a Detailed Plan developed for cueing, prompting or supervising the participant in ADLs and IADLs. The ILST will work cooperatively with the selected provider's supervising Registered Professional Nurse and HCSS staff to assure implementation of the Detailed Plan and provide needed guidance and/or additional training. Another example is the PBIS Specialist who may also train the HCSS staff in behavioral interventions based on a Detailed Plan. The provision of these types of complementary trainings will serve to enhance the level of consistency, cooperation, communication and team work between

providers and the participant.

It is important to consider the interests and needs of the waiver participant when assigning HCSS support. The ability of the HCSS staff to support the strengths, interests and needs of the participant will promote a better working relationship and help to meet the established goals for the service. It is the right of the participant to request a change in HCSS staff. Attempting to find the best match between the HCSS staff and participant from the start decreases the occurrence of staff turnover and Serious Reportable Incidents (SRI) while increasing participant satisfaction and success in the community.

Given the critical need for continuity in oversight and/or supervision, HCSS providers are reminded of their responsibility for assuring sufficient back-up for the HCSS staff.

Provider Qualifications

HCSS may only be provided by a Licensed Home Care Services Agency (LHCSA). All regulations governing the LHCSA will be in effect for the provision of this service, e.g. patient rights, patient service policies and procedures, plan of care, medical orders, clinical supervision, patient care records, governing authority, contracts, personnel, and records and reports.

Key requirements for HCSS staff members include that such staff must:

- Be at least 18 years old;
- Be able to follow written and verbal instructions;
- Have the ability and skills necessary to meet the waiver participant's needs that will be addressed through this service;
- Have a certificate to indicate that they have successfully completed a forty (40)-hour training program for Level II PCAs that is approved by DOH;
- Attend the approved DOH curriculum entitled "Home and Community Support Services 101" prior to providing billable services, and any additional training required by DOH;
- Attend six (6) hours of in-service education per year which includes NHTD waiver-specific training; and
- Be in good physical health; including health and immunization requirements as per LHCSA regulations.

The selected provider's supervising Registered Professional Nurse must:

- (a) be licensed by the NYS Education Department pursuant to Article 139 of the NYS Education Law and is currently certified to practice as a registered professional nurse in New York State;
- (b) be in good physical health that the Department of Health requires for employees of certified home health agencies that includes documentation of a yearly physical exam, immunizations, a yearly

Mantoux skin test and a declaration that one is free from health impairments which pose potential risks to patients or personnel;
and

- (c) meet one of the following qualifications:
 - (1) have at least two years satisfactory recent home health care experience; or
 - (2) have a combination of (a) and (b), with at least one year of home health care experience and acts under the direction of an individual who meets the qualifications listed in (a) and (b) and (1) of this section.

The HCSS agency must have available a communication system for 24 hours/ seven days per week coverage to assure any issues regarding a participant's services can be addressed.

Reimbursement

HCSS services, including both direct care and selected provider's supervising Registered Professional Nurse Visits, must be provided by a DOH approved provider and included in the SP to be reimbursed.

HCSS services are reimbursed on an hourly basis. When HCSS is provided to more than one person at a time, the ratio of provider to participants must be stated in the SP and the billing must be prorated. Example: HCSS is providing services to two individuals living together for six hours. The SP for each individual reflects a 1:2 ratio and billing reflects three hours per person.

HCSS staff must attend Team Meetings. However, the provider may claim reimbursement for only one agency representative attending a Team Meeting.

The assessment of the applicant/participant for the need for HCSS and providing recommendations for HCSS is considered an administrative cost and, therefore, is not discretely billable. The selected provider's supervising Registered Professional Nurse Visit made on the day the HCSS begins is billable on a per visit basis. This visit will result in the development of the Detailed Plan and if necessary, provide an opportunity for the completion of the environmental section of the preliminary assessment.

Subsequent visits made by the selected provider's supervising Registered Professional Nurse for supervision or on-the-job training of the HCSS staff are considered administrative costs and, therefore, are not billable.

A selected provider's supervising Registered Professional Nurse Visit made six (6) weeks prior to the development of a RSP to re-evaluate the participant for the continued need for HCSS and to complete the Individual Service Report (ISR) is a billable visit.

Home Visits by Medical Personnel

Definition

Home Visits by Medical Personnel are individually designed services to provide diagnosis, treatment and wellness monitoring in order to preserve the waiver participant's functional capacity to remain in his/her own home. Wellness monitoring is critical to the overall health of the waiver participant. Wellness monitoring includes disease prevention, the provision of health education and the identification of modifiable health risks. Through increased awareness and education, the waiver participant is more apt to make healthy lifestyle choices which will decrease the likelihood of unnecessary institutionalization. The frequency of wellness monitoring will be contingent on the waiver participant's needs.

Home visits by Medical Personnel must be needed to decrease the likelihood of exacerbations of chronic medical conditions and unnecessary and costly emergency room visits, hospitalizations and nursing facility placement. In addition to assessing the waiver participant, this service will also include the evaluation of the home environment from a medical perspective and the waiver participant's natural (informal) supports' ability to maintain and/or assume the role of caregiver. The provider's assessment of the natural (informal) supports/caregivers will not be one in which a physical exam is performed; instead the assessment will focus on the natural (informal) supports'/caregivers' relationship to the waiver participant in terms of the physical, social and emotional assistance that is currently provided or may be provided in the future. Based on the outcome of this assessment, the provider of this service can make referrals for or request that the SC make referrals for additional assistance as appropriate, thus promoting the ability of the waiver participant to remain at home. The provision of this service allows the waiver participant to remain in the least restrictive setting. This service will enhance the quality of medical care and the quality of life of the waiver participant.

Home Visits by Medical Personnel differs from what is offered under the State Plan as this waiver service is used for wellness monitoring, the assessment of the natural (informal) supports'/caregivers' ability to provide assistance to the waiver participant, and/or the evaluation of the waiver participant's home environment from a medical perspective.

This service is especially beneficial for those waiver participants who have significant difficulty traveling or are unable to travel for needed medical care provided by a physician, physician's assistant or nurse practitioner because of:

- (1) severe mobility impairments;
- (2) terminal illness;
- (3) when travel is contraindicated due to the person's chronic condition;
- (4) severe pain;
- (5) when medical providers at a physician's office and/or transportation

- providers refuse to provide services due to an individual's disruptive behavior;
- (6) the home visit is cost-effective; or
 - (7) where transportation to medical appointments is limited due to geographical considerations.

The Medical Personnel will perform a comprehensive assessment of the physical, psychosocial, environmental and economic factors in the waiver participant's own environment that could affect the waiver participant's health and welfare and the ability to remain in the community. This comprehensive assessment and medical follow-up in the waiver participant's home is intended to improve the waiver participant's functioning. As a result of this improved functioning, and by having the Medical Personnel complete a comprehensive assessment in the waiver participant's home, the Medical Personnel is more apt to detect conditions in the home environment that negatively affect the waiver participant's health and welfare and respond accordingly. This preventive activity is expected to decrease the likelihood of accidents in the home, lower the waiver participant's and caregiver's stress level, increase the quality of medical care provided to the waiver participant and increase the efficiency of medication management which will promote the waiver participant's ability to remain at home.

As part of the home visit, the medical personnel will evaluate safety issues and other conditions in the home from a medical perspective. Medical Personnel will conduct a basic assessment of the home environment in relation to the waiver participant's health and welfare. Any concerns about the home environment that may affect the waiver participant's health and welfare will be shared with the SC and other relevant members of the team.

The Medical Personnel are an integral part of the waiver participant's service provider team. It is the responsibility of the Medical Personnel to inform the SC of any recommendations for services that will meet the waiver participant's medical needs and other significant findings. The SC will utilize this information in revising the waiver participant's SP.

Provider Qualifications

Home Visits by Medical Personnel must be provided by a Physician in Private Practice or a corporation licensed pursuant to Public Health Law Article 28. Persons providing Home Visits by Medical Personnel shall be a:

1. Physician – Licensed pursuant to NYS Medicine Education Law;
2. Licensed Nurse Practitioner – Licensed pursuant to NYS Education Law; or
3. Licensed Physician's Assistant – Licensed pursuant to Medicine Education Law.

Reimbursement

Home Visits by Medical Personnel must be provided by a DOH approved provider and must be included in the SP to be reimbursed.

Home Visits by Medical Personnel are provided on an individual basis and billed in twenty (20) minute units with a maximum of three (3) units per visit.

Home Visits by Medical Personnel providers participating in Team Meetings will be reimbursed at regular rate for attendance at these meetings.

Independent Living Skills Training (ILST)

Definition

Independent Living Skills Training Services (ILST) are individually designed to improve or maintain the ability of the waiver participant to live as independently as possible in the community. ILST assists in recovering skills that have decreased as a result of onset of disability. Also, ILST will primarily be targeted to those individuals with progressive illnesses to maintain essential skills. ILST may be provided in the waiver participant's home and in the community. This service will primarily be provided on an individual basis; only in the unique situation where the waiver participant will receive greater benefit from other than a 1:1 situation, will a group method of providing service be approved.

It is the responsibility of the ILST provider to conduct a comprehensive functional assessment of the waiver participant, identifying the participant's strengths and weaknesses in performing ADL and IADL related to his/her established goals. The Provider will use the results of the assessment to develop an ILST Detailed Plan. The Detailed Plan will identify milestones to be met during the six (6) month period. The assessment must also include a determination of the participant's best manner of learning new skills and responses to various interventions. This comprehensive and functional assessment must be conducted at least annually from the date of the last assessment.

ILST services may include assessment, training, and supervision of an individual with self-care, medication management, task completion, communication skills, interpersonal skills, socialization, sensory/motor skills, mobility, community transportation skills, reduction/elimination of maladaptive behaviors, problem solving skills, money management, pre-vocational skills and skills to maintain a household.

ILST must be provided in the environment and situation that will result in the greatest positive outcome for the waiver participant. It is expected that this service will be provided in the waiver participant's environment; for example, in the participant's kitchen as opposed to a provider's kitchen. This expectation is based on the difficulty many participants experience with transferring or generalizing knowledge and skills from one situation to another. However, it is recognized that there is need for some practice of skills before using them in the waiver participant's environment.

ILST services may also be used to assist a participant in returning to, or expanding the waiver participant's involvement in meaningful activities, such as paid or unpaid (volunteer) employment. The use of ILST for vocational purposes must occur only after it is clear that the waiver participant is not eligible for these services through either the Vocational and Educational Services for Individuals with Disabilities (VESID) or the Commission for the Blind and Visually Handicapped (CBVH); that VESID and CBVH services have been exhausted; or the activity is not covered by VESID or CBVH services.

It is expected that ILST providers will train the waiver participant's informal/natural supports, paid staff and waiver providers to provide the type and level of supports that allows the waiver participant to act and become as independent as possible in ADLs and IADLs. This service may continue only when the waiver participant has reasonable goals. It is used for training purposes and not ongoing long term care supports. Reasons to provide or continue this service must be clearly stated in the SP within the context of clearly defined and reasonable goals.

Provider Qualifications

ILST may be provided by any not-for-profit or for profit health and human services agency.

An ILST must be a:

- (A)
 - (1) Registered Occupational Therapist-licensed by the NYS Education Department;
 - (2) Registered Physical Therapist-licensed by the NYS Education Department;
 - (3) Licensed Speech-Language Pathologist-licensed by the NYS Education Department;
 - (4) Registered Professional Nurse-licensed by the NYS Education Department;
 - (5) Certified Special Education Teacher-certified by the NYS Education Department;
 - (6) Certified Rehabilitation Counselor-certified by the Commission on Rehabilitation Counselor Certification;
 - (7) Master of Social Work; or
 - (8) Master of Psychology.

These individuals must have, at a minimum, one (1) year of experience completing functionally based assessments, developing a comprehensive treatment plan and teaching individuals with disabilities and/or seniors to be more functionally independent; OR

- (B) An individual with a Bachelor's degree and two (2) years of experience completing functionally based assessments, developing a comprehensive treatment plan and teaching individuals with disabilities and/or seniors to be more functionally independent; OR
- (C) An individual with a High School Diploma and three (3) years experience completing functionally based assessments, developing a comprehensive treatment plan and teaching individuals with disabilities and/or seniors to be more functionally independent.

The following individuals must be supervised by individuals identified in section (A) to perform ILST services:

- Individuals with the educational experience listed in section (A) but who do not meet the experience qualifications;
- Individual with a Bachelor's degree and one (1) year of experience;
- Individuals with a High School Diploma and two (2) years of experience; and
- Individuals who have successfully completed two (2) years of providing Home and Community Support Services or Residential Habilitation under the Office of Mental Retardation and Developmental Disabilities HCBS waiver.

The supervisor is responsible for:

- Meeting any potential waiver participants prior to the completion of the Detailed Plan developed by the ILST under their supervision;
- Working with the ILST on completing the functional assessment of the participant;
- Working with the ILST to reevaluate the participant as needed, but not less than at the completion of the Revised Service Plans and whenever Addenda to the SP are written;
- Have supervisory meetings with staff on at least a bi-weekly basis;
- Provide ongoing supervision and training to staff; and
- Review and sign-off on all Detailed Plans.

Reimbursement

ILST services must be provided by a DOH approved provider and must be included in the SP to be reimbursed.

ILST is reimbursed in one hour units. Participation in Team Meetings is reimbursed at the hourly rate for this service.

If ILST is provided in a group setting, the hourly rate is divided evenly among the participants.

Moving Assistance

Definition

Moving Assistance Services are individually designed services intended to transport a waiver participant's possessions and furnishings. This service can be used when the waiver participant must be moved from an inadequate or unsafe housing situation to a viable environment which more adequately meets the waiver participant's health and welfare needs and alleviates the risk of unwanted nursing home placement. Moving Assistance may also be utilized when the waiver participant is moving to a location where more natural supports will be available, and thus allows the waiver participant to remain in the community in a supportive environment.

Moving Assistance is only available to waiver participants who do not reside in nursing homes. It differs from CTS as CTS is only available to waiver participants who are transitioning from a nursing home. The funding limits for this service are separate and apart from the limits applied to CTS, and the two services must not be used at the same time in any approved SP.

Moving Assistance must be included in the SP and may not exceed \$5,000 per twelve (12) month period. The SC must obtain three bids from licensed moving companies if the bids are over \$1,000. In a unique situation, any requests over \$5,000 per twelve (12) month period must be approved by DOH.

Provider Qualifications

A not-for profit or for profit health and human service agency that provides Service Coordination can be approved to provide Moving Assistance. This does not have to be the same agency providing Service Coordination to the participant. Someone other than the SC may be the individual responsible for arranging Moving Assistance. The Service Coordination agency must designate an individual with the necessary competencies to work with subcontractors who will be utilized for Moving Assistance. The Service Coordination agency will subcontract with licensed certified (by NYS Dept. of Transportation) moving companies to provide this service. A participant may choose from the list of Moving Assistance companies from which they will receive the bids.

Approval Process for Moving Assistance

- Step 1** The participant, SC, and anyone selected by the participant, discuss if a move is necessary;
- Step 2** If necessary, then the participant may choose an approved provider of Moving Assistance;
- Step 3** The Moving Assistance provider works with the participant to select a moving company;

- Step 4** The moving company submits an estimate to the Moving Assistance provider;
- Step 5** If the estimate is under \$1,000, the Moving Assistance provider submits the estimate to the participant's SC;
- NOTE:** If the cost of this service is greater than \$1,000, three (3) bids must be obtained and submitted by the Moving Assistance provider to the participant's SC, along with the Moving Assistance Description and Cost Projection form.
- When the SC determines that the continued delay due to lack of the required number of bids is jeopardizing the participant's health and welfare the SC must contact the RRDS. The RRDS will consult with DOH and will notify the SC if they can proceed without the required three bids;
- Step 6** The SC completes the Moving Assistance Description and Cost Projection form (refer to Appendix C – form C.7), reviews the form with the participant and both the participant and SC sign the form;
- Step 7** If necessary, the SC sends the form to the Moving Assistance provider for their signature and Medicaid provider number;
- Step 8** The Moving Assistance provider returns the completed form to the participant's SC;
- Step 9** The SC submits the completed Moving Assistance Description and Cost Projection form with an Initial or Revised Service Plan, or an Addendum to the RRDS for approval;
- Step 10** The RRDS reviews and approves the costs for the move or makes suggestions before the move is approved;
- Step 11** The RRDS sends a copy of the approved form back to the SC;
- Step 12** The SC notifies the Moving Assistance provider that the participant has been approved for the move;
- Step 13** The Moving Assistance provider completes and signs the Waiver Services Final Cost form (refer to Appendix C – form C.11) with the participant;
- Step 14** The Moving Assistance provider sends the Waiver Services Final Cost form to the SC who signs off and submits it to the RRDS;
- Step 15** The RRDS reviews the Waiver Services Final Cost form and completes the RRDS Approval of Final Cost form. The RRDS provides a copy of the RRDS Approval of Final Cost form to the Moving Assistance provider and SC;

Step 16 The Moving Assistance provider seeks reimbursement after receiving a copy of the NOD from the SC.

Reimbursement

Moving Assistance must be documented in the SP and provided by agencies approved by DOH.

This Service is reimbursed on a cost basis. Total reimbursement for Moving Assistance must not exceed \$5,000 per twelve (12) month period. This may include a ten percent (10%) administrative fee payable to the Moving Assistance provider. Requests above \$5,000 per twelve (12) month period must be approved by DOH.

Nutritional Counseling/Educational Services

Definition

Nutritional Counseling/Educational Services is an individually designed service which provides an assessment of the waiver participant's nutritional needs and food patterns, and the planning for the provision of food and drink appropriate for the waiver participant's conditions, or the provision of nutrition education, and counseling to meet normal and therapeutic needs.

In addition, these services may include:

- Assessment of nutritional status and food preferences;
- Planning for the provision of appropriate dietary intake within the waiver participant's home environment and cultural considerations;
- Nutritional education regarding therapeutic diets as part of the development of a nutritional treatment plan;
- Regular evaluation and revision of nutritional plans; and
- The provision of in-service education to the waiver participant, family, advocates, waiver and non-waiver staff as well as consultation on specific dietary problems of the waiver participants.

Provider Qualifications

Nutritional Counseling/Educational Services may be provided by any not-for-profit or for profit health and human services agency.

Staff providing Nutritional Counseling/Educational Services must be a:

- (1) Licensed as a Registered Dietician – Licensed by the NYS Education Department; or
- (2) Licensed as a Registered Nutritionist – Licensed by the NYS Education Department.

Nutritional Counseling/Educational Services can not be provided to a participant without a physicians' written order which is obtained by the Nutritional Counseling/Educational Services provider. The Nutritional Counseling/Educational Services provider must obtain and maintain all physician's orders in the waiver participant's file at the agency according to existing regulations for Nutritional Counseling.

Reimbursement

Nutritional Counseling/Educational Services must be provided by a DOH approved provider and must be included in the SP to be reimbursed.

Nutritional Counseling/Educational Services are provided on an individual, per visit basis. In-service education and consultation provided to informal supports or waiver or non-waiver service providers must be included in the SP in order to be reimbursed.

Nutritional Counseling/Educational Services providers participating in Team Meetings will be reimbursed at the per visit rate for their time at the Team Meeting.

Peer Mentoring

Definition

Peer Mentoring is an individually designed service intended to improve the waiver participant's self-sufficiency, self-reliance, and ability to access needed services, goods, and opportunities in the community. This is to be accomplished through education, teaching, instruction, information sharing, and self-advocacy training.

The service is based on the belief that often people with disabilities who are struggling to regain a self satisfying life may best benefit from relating to another person with a disability who has been successful in this effort. Since there may be attitudinal and physical barriers placed in the way of individuals with disabilities, a Peer Mentor is able to examine these barriers and assist the waiver participant to overcome them. This service is not intended to meet the waiver participant's needs for a mental health professional's services, which may be necessary due either to a condition which existed prior to the onset of the disabilities or which may have occurred following the onset of the disability. The provider of this service should develop an ongoing relationship with a local provider of mental health services for mutual training, and when appropriate, referral by one entity to the other to assure that waiver participants receive the most appropriate services. The supervisor of the Peer Mentoring service is responsible for assuring that this service is used within the limits described above.

A waiver participant may receive this service as well as CIC or other mental health services as long as the need for both is clearly documented in the Service Plan. This service is provided on an individual basis and specific goals must be established for the individual. Peer Mentoring will primarily be available to waiver participants who have recently transitioned into the community from a nursing home or as needed during times of crisis.

Provider Qualifications

Peer Mentoring may be provided by any not-for-profit or for profit health and human services agency. Persons providing Peer Mentoring must have:

- a significant physical or cognitive disability;
- successfully demonstrated the ability to maintain a productive life in the community; and
- at least one (1) year of paid or unpaid experience providing peer mentoring.

Reimbursement

Peer Mentoring must be provided by a DOH approved provider and must be included in the SP to be reimbursed.

Peer Mentoring is provided on an individual, face to face visit on a hourly basis. Participation in Team Meetings is reimbursed at the hourly rate for this service.

Positive Behavioral Interventions and Supports (PBIS)

Definition

Positive Behavioral Interventions and Supports (PBIS) services are individually designed and are provided to waiver participants who have significant behavioral difficulties that jeopardize their ability to remain in the community of choice due to inappropriate responses to events in their environment. The PBIS should be provided in the situation where the significant maladaptive behavior occurs.

PBIS services include but are not limited to:

- A comprehensive assessment of the individual's behavior (in the context of their medical diagnosis and disease progression as determined by the appropriate health or mental health professional), skills and abilities, existing and potential natural and paid supports and the environment;
- The development and implementation of a holistic structured behavioral treatment plan (Detailed Plan) including specific realistic goals which can also be utilized by other providers and natural supports;
- The training of family, natural supports and other providers so they can effectively use the basic principles of the behavioral plan;
- Regular reassessments of the effectiveness of the behavioral treatment plan, making adjustments to the plan as needed.

The primary focus of the Detailed Plan for this service is to decrease the intensity and/or frequency of the targeted behaviors and to teach safer or more socially appropriate behaviors. None of these activities shall fall within the scope of the practice of mental health counseling set forth in Article 163 of the NYS Education Law.

The Detailed Plan must include a clear description of successive levels of intervention starting with the simplest and least intrusive level. All plans must be written in a manner so that all natural and paid supports will be able to follow the plan.

An emergency intervention plan is warranted when there is the possibility of the waiver participant becoming a threat to him or herself or others.

Provider Qualifications for Director of the Positive Behavioral Interventions Support Program

PBIS services may be provided by any not-for-profit or for profit health and human services agency. The two key positions in PBIS service are the Program Director and the Behavioral Specialist. Each PBIS provider must employ a Program Director.

The Program Director is responsible for assessing the waiver participant and developing the PBIS plan for each waiver participant. The Director may work as a Behavioral Specialist or may provide ongoing supervision to a Behavioral Specialist who will implement the plan.

If a provider has more than one individual who meets the qualifications for Program Director, each of these qualified individuals can develop PBIS plans.

The Program Director must be a:

- (A) Licensed psychiatrist licensed by the NYS Education Department with one year experience providing behavioral services; OR
- (B) Licensed psychologist licensed by the NYS Education Department with one year experience in providing behavioral services; OR
- (C)
 - 1. Master of Social Work;
 - 2. Master of Psychology;
 - 3. Registered Occupational Therapist – Licensed by the NYS Education Department;
 - 4. Registered Physical Therapist - Licensed by the NYS Education Department;
 - 5. Licensed Speech-Language Pathologist - Licensed by the NYS Education Department;
 - 6. Registered Professional Nurse - Licensed by the NYS Education Department;
 - 7. Mental Health Practitioner – Licensed by the NYS Education Department;
 - 8. Certified Rehabilitation Counselor – Certified by the Commission on Rehabilitation Counselor Certification; or
 - 9. Certified Special Education Teacher - Certified by the NYS Education Department.

Each of the individuals in (C) must have, at a minimum, two years of experience providing neurobehavioral services; or

- (D) Individual who has been a Behavioral Specialist for two years and has successfully completed an apprenticeship program offered by the Statewide Neurobehavioral Resource Project.

Provider Qualifications for Behavioral Specialists

The Behavioral Specialist is responsible for implementation of the Detailed Plan under the direction of the Program Director and must be a:

- (A) Person with a Bachelor's Degree;
- (B) Licensed Practical Nurse licensed by the NYS Education Department;
- (C) Certified Occupational Therapy Assistant, certified by the NYS Education Department; or
- (D) Physical Therapy Assistant, certified by the NYS Education Department.

The Behavioral Specialist must have at least one year of experience working with individuals and/or seniors with disabilities or behavioral

difficulties. The Behavioral Specialist must successfully complete forty (40) hours training in behavioral analysis, and crisis intervention techniques which is provided by the Positive Behavioral Interventions and Supports Program. Until the Behavioral Specialist successfully completes the forty (40) hours of training, the PBIS provider may not bill for the Behavioral Specialist's time. The Behavioral Specialist must be supervised by the Program Director. The Program Director will provide ongoing training and supervision to the Behavioral Specialist.

Supervision must occur no less than biweekly to review the caseload and must be more frequent when there is a new participant, new provider or when significant behavioral issues arise.

Reimbursement

Positive Behavioral Interventions and Supports services must be provided by a DOH approved provider and must be included in the SP to be reimbursed.

This service is reimbursed on an hourly basis. Participation in Team Meetings is reimbursed according to the hourly rate for this service.

Respiratory Therapy

Definition

Respiratory Therapy is an individually designed service, specifically provided in the home, intended to provide preventative, maintenance, and rehabilitative airway-related techniques and procedures. Respiratory Therapy services include:

- application of medical gases, humidity and aerosols;
- intermittent positive pressure;
- continuous artificial ventilation;
- administration of drugs through inhalation and related airway management;
- individual care; and
- instruction administered to the waiver participant and natural supports.

Provider Qualifications

Respiratory Therapy may be provided by a Certified Home Health Agency licensed under Article 36 of the New York Public Health Law or a provider of Respiratory Therapy and Equipment, and approved as a provider of this waiver service by DOH.

Respiratory Therapy services can not be provided to a participant without a physicians' written order which is obtained by the Respiratory Therapy agency. The Respiratory Therapy provider must obtain and maintain all physician's orders in the waiver participant's file at the agency according to existing regulations for Respiratory Therapy.

Staff providing Respiratory Therapy must be a Respiratory Therapist currently registered and licensed pursuant to Article 164 of the NYS Education Department.

Reimbursement

Respiratory Therapy must be provided by a DOH approved provider and must be included in the SP to be reimbursed.

Respiratory Therapy is provided on an individual, per visit basis.

Respiratory Therapy providers participating in Team Meetings will be reimbursed at the per visit rate for their time at the Team Meeting.

Respite Services

Definition

Respite Services is an individually designed service intended to provide relief to natural (informal), non-paid supports who provide primary care and support to a waiver participant. This is usually provided for participants who are in need of oversight and supervision as a discrete task. The primary location for the provision of this service is in the waiver participant's home. Respite Services are provided in a 24-hour block of time.

Services may be provided in another home in the community if this is acceptable to the waiver participant and the people living in the other dwelling. If a waiver participant is interested in seeking a brief respite in a nursing home, this can be accomplished through a Scheduled Short Term Admission, and is not considered a Waiver Service.

Provider Qualifications

Providers of Respite Services must meet the same standards and qualifications as the direct care providers of HCSS. If the services needed by the waiver participant exceed the type of care and support provided by the HCSS, then other appropriate providers must be included in the plan for Respite Services and will be reimbursed separately from Respite Services.

Reimbursement

Respite Services must be provided by a DOH approved provider of HCSS and included in the SP to be reimbursed.

Respite Services are provided in blocks of 24 consecutive hours, billed on a daily-rate basis. Since Respite Services is provided on an intermittent basis, the SC must determine when participation in Team Meetings is appropriate.

Structured Day Program Services

Definition

Structured Day Program services are individually designed services, provided in an outpatient congregate setting or in the community, to improve or maintain the waiver participant's skills and ability to live as independently as possible in the community. Services may include assessment, training and supervision to an individual with self-care, task completion, communication skills, interpersonal skills, problem-solving skills, socialization, sensory/motor skills, mobility, community transportation skills, reduction/elimination of maladaptive behaviors, money management skills, and skills to maintain a household.

Structured Day Program services may be used to augment some aspects of other NHTD services and Medicaid State Plan services when reinforcement of skills is necessary. This is permitted due to the difficulty many individuals have with transferring or generalizing skills learned in one setting to other settings and the need for consistent reinforcement of skills. The SP should address how the services are complimentary but not duplicative and ensure consistency. This service is intended to provide an opportunity for the waiver participant to continue to strengthen skills that are necessary for greater independence, improved productivity and/or increased community inclusion.

The Structured Day Program may be provided within a variety of settings and with very different goals. Waiver participants may choose to participate in a Structured Day Program that emphasizes basic work skills, such as punctuality, problem solving and effectively communicating with co-workers and supervisors. Other Structured Day Programs may focus on specific job skills, such as computer operation, cooking, etc. Other participants, for whom employment is not an immediate or long-term goal, may be more interested in community inclusion or improving their socialization skills.

The Structured Day Program is responsible providing appropriate and adequate space to meet the functional needs of those served. The Program must provide adequate protection for the personal safety of the program participants, including fire drills twice a year and maintain documentation of those drills. The Structured Day Program must be located in a building that meets all provisions of the New York State Uniform Fire Prevention and Building Codes. In addition, access to the Program must meet and adhere to the requirements of the Americans with Disabilities Act. If the RRDS or DOH identifies questionable situations, appropriate referrals will be made for necessary corrective action. The RRDS or DOH may determine the appropriateness of the physical space for the NHTD waiver participants.

Whatever type of Structured Day Program(s) the participant chooses it is essential that there be coordination between providers, assuring consensus in the type of supports and structures that are used in all settings and avoiding

duplication of services. This is particularly important when the participant is receiving waiver services such as ILST, PBIS, and HCSS.

Provider Qualifications for the Director of Structured Day Programs

Structured Day Programs may be provided by any not-for-profit or for profit health and human services agency. All Structured Day Programs must be identified in the SP and provided by agencies approved as a provider of this waiver service by DOH.

The Structured Day Program Director must be:

- (A) (1) Registered Occupational Therapist – Licensed by the NYS Education Department;
- (2) Registered Physical Therapist – Licensed by the NYS Education Department;
- (3) Licensed Speech-Language Pathologist – Licensed by the NYS Education Department;
- (4) Registered Professional Nurse – Licensed by the NYS Education Department;
- (5) Certified Special Education Teacher – Certified by the NYS Education Department;
- (6) Certified Rehabilitation Counselor – Certified by the Commission on Rehabilitation Counselor Certification;
- (7) Master of Social Work; or
- (8) Master of Psychology.

Structured Day Program Directors must have, at a minimum, one (1) year of experience providing functional assessments, Intensive Behavioral Services or Structured Day Program services to individuals with disabilities and/or seniors;
OR

- (B) Individual with a Bachelor's degree and two (2) years of experience providing functional assessments, Intensive Behavioral Services or Structured Day Program services to individuals with disabilities and/or seniors.

In addition to a required Program Director, a Structured Day Program may employ program staff. Program staff must be at least 18 years old; be able to follow written and verbal instructions; and have the ability and skills necessary to meet the waiver participant's needs that will be addressed through this service. It is expected that Structured Day Program staff will be available to provide hands-on assistance to participants, and therefore, must have previous training as a PCA.

Reimbursement

Structured Day Program services must be provided by a DOH approved provider and must be included in the SP to be reimbursed.

Structured Day Program services are reimbursed on an hourly basis. Participation in Team Meetings organized by the SC is reimbursed at the hourly rate.

The provision of Structured Day Program services must not occur in a sheltered workshop environment. If a participant decides to make use of the services of a sheltered workshop, the reimbursement for that service must be provided through VESID.

Wellness Counseling Service

Definition

Wellness Counseling Service is an individually designed service intended to assist the medically stable waiver participant in maintaining optimal health status. It is intended to be available to a waiver participant who does not otherwise have access to nursing services. Through Wellness Counseling, a Registered Professional Nurse assists the waiver participant to identify his/her health care needs and provides guidance to the waiver participant to minimize, or in some cases prevent, exacerbations of disease. This service differs from Medicaid State Plan Nursing Service as it provides wellness counseling as a discrete service to medically stable individuals.

Through Wellness Counseling, a Registered Professional Nurse can reinforce or teach healthy habits such as the need for daily exercise, weight control, or avoidance of smoking. Additionally, the Registered Professional Nurse will be able to offer support for control of any diseases or disorders such as high blood pressure, diabetes, morbid obesity, asthma or high cholesterol.

In addition to these services, the Registered Professional Nurse can assist the waiver participant to identify signs and symptoms that may require intervention so as to prevent further complications from the disease or disorder. If potential complications are identified, the Registered Professional Nurse will counsel the waiver participant about appropriate interventions including the need for immediate medical attention or contact the waiver participant's physician for referral to traditional Medicaid State Plan services. This service will assess the waiver participant's chronic care needs to assure the participant's health status remains stable and at an optimal level to avoid acute episodes and utilize health care resources efficiently and effectively.

Wellness Counseling Service will be limited to no more than twelve visits in a calendar year and will occur on an as needed basis.

Provider Qualifications

Wellness Counseling Service may be provided by a Certified Home Health Agency or a Licensed Home Care Service Agency. Staff providing Wellness Counseling Service must be a Registered Professional Nurse licensed by the NYS Education Department.

Wellness Counseling Service can not be provided to a participant without a physicians' written order, which is obtained by the Wellness Counseling Service agency. The Wellness Counseling Service provider must obtain and maintain all physician's orders in the waiver participant's file at the agency.

Reimbursement

Wellness Counseling Service must be provided by a DOH approved provider and

must be included in the SP to be reimbursed.

Wellness Counseling Service is provided on an individual, per visit basis. It is limited to no more than twelve visits in a calendar year and will occur on an as needed basis.

Wellness Counseling Service providers participating in Team Meetings will be reimbursed at the per visit rate for their time at the Team Meeting.

Section VII

RECORD KEEPING

Record Keeping

Introduction

Record keeping is required both for clinical reasons and documentation of the expenditures of Medicaid funds.

Clinically structured record keeping assists the provider in documenting the participant's desired goals and the accomplishment of these goals. The participant and waiver provider work together to develop a Detailed Plan that reflects the participant's goals, identifies strategies for intervention, and reviews the effectiveness of these interventions. This provides a better understanding of whether the goals have been met and when interventions and/or goals need to be revised.

Accurate and up-to-date record keeping is required of all Medicaid providers to substantiate Medicaid billing. The need to maintain the necessary records is described in the Provider Agreement, the eMedNY Provider Manual and in this Program Manual. It is the responsibility of the provider to have clear and accurate documentation to support all Medicaid claims.

Providers must adhere to all Medicaid confidentiality and Health Information Portability and Accountability Act (HIPAA) requirements and ensure the privacy of the waiver participant.

In addition, all waiver providers must maintain a policy and procedure that assures the appropriate safeguard of all records containing any identifiable information regarding waiver applicants and participants. These policies and procedures must be disseminated to all staff.

The policy must include, but is not limited to:

- Maintaining records in a secured environment (e.g. locked files or locked Room) when they are not in use;
- Preventing exposure of information when records are in use;
- Identifying all information transmitted from one location to another as "confidential" in an appropriately secured manner;
- Obtaining prior authorization from the appropriate supervisory staff before records are taken outside the agency, and the return of records within one (1) business day;
- Properly informing applicants/participants of record collection procedures, access, utilization and dissemination of information;
- Specify procedures related to employee access to information; and
- Specify the disciplinary actions for violations of confidentiality statutes, regulations and policies.

All waiver providers must maintain waiver participant records for **at least six (6) years after termination** of waiver services.

Record-Keeping Components

The three major components of the record-keeping responsibilities of the waiver providers are:

1. Detailed Plans
2. Documentation of Encounters/Case Notes
3. Individual Service Reports (ISR)

Note: Waiver service providers of Assistive Technology (AT), Community Transitional Services (CTS), Congregate and Home Delivered Meals, Environmental Modifications Services (E-mods), and Moving Assistance are exempt from these three major components of record keeping but are required to have other types of documentation (Refer to “Record Keeping for Specific Waiver Providers” later in this section).

1. Detailed Plans

Each waiver provider must develop a Detailed Plan for each waiver participant they are serving. The Detailed Plan identifies the participant’s goals for each waiver service and describes the interventions to be provided to assist the participant to achieve his/her goals. The Detailed Plan is an essential component of a participant’s efforts to remain in his/her community of choice.

The development of the Detailed Plan begins with the provider interviewing the participant to establish the specific goals he/she wants to achieve through this service. Once these goals are established, information must be obtained regarding the participant’s current level of functioning. This will occur through discussions between the provider, the participant and others. If the individual has been in a facility or has been receiving services in the community, it is essential to obtain any formal assessments which have been completed including discharge summaries. This may require discussions with staff from nursing homes, hospitals, certified home health agencies and licensed home care service agencies. The method for gathering baseline information may vary according to the particular waiver service. In addition, the provider may utilize information received from these assessments to complete the Detailed Plan. The provider is responsible for completing a thorough evaluation of the participant’s basic skills and abilities related to the selected goals.

Even after the Detailed Plan has been developed, there must be an ongoing process where providers must objectively and constantly review the Plan’s goals with the participant. This allows the provider to fully evaluate the participant’s progress, address any areas of concern and make needed revisions to the Detailed Plan.

The Detailed Plan should include three components:

a. Milestones

Milestones are defined as component, intermediate steps which must be

accomplished to achieve a larger goal. For example, a participant's goal is to resume participation in preparing meals for his/her family. A milestone would be established through the planning, preparing and serving of dinner for three consecutive days.

b. Interventions

Once milestones are established, the provider determines what interventions will assist the participant to achieve the milestones and, eventually, the selected goal. A thorough understanding of the participant's unique strengths, deficits, interests and abilities will help guide the provider in the development of interventions. For example, ILST would work with the participant on the steps needed to plan a meal. This would include creating a menu, making a shopping list for items needed to make the meal, and purchasing needed items.

c. Timeframes

Timeframes include the frequency and length of the interventions and how long the participant and provider expect it will take for the participant to reach the selected goal. It is essential to set realistic timeframes to determine the success of an intervention and the stated goal. It can be equally important to assist a participant to recognize that a particular goal may not be obtainable but that the outcome of the goal can be accomplished through another means. For example, if a participant is not successful in achieving the milestone of planning and preparing one meal within the designated timeframe, re-evaluation of the milestone, interventions and/or timeframe must occur. This includes determining what other means can be utilized to help the participant accomplish the goal of participating in meals with his/her family.

2. Documentation of Encounters

The provider must document each face-to-face encounter with the participant as required by Medicaid for reimbursement. This documentation should provide a measure of how effective the intervention has been in supporting the participant in meeting their goals. It should contain a clear description of the staff's action, the participant's response to that action and progress toward the goals /milestone. Documentation of this encounter must include:

- the date,
- the location,
- the time and
- a description of the services provided, which are related to the goals established in the Detailed Plan.

This information must be recorded as soon as possible after each contact and reviewed for completeness each month.

In addition to documenting encounters, providers must keep case notes that reflect:

- communication with participants' family, friends, waiver and non-waiver providers;
- health and welfare issues and follow-up; and
- concerns expressed by the participant or others and the actions taken to address them.

All providers are responsible for maintaining open communication with other providers when concerns or changes with the participant occur that potentially affect the provision of services. However, each provider must be respectful of the participant's right to privacy and confidentiality regarding the sharing of information and have in place policies and procedures that support this.

3. Individual Service Reports (ISR)

The ISR (refer to Appendix C – form C.16) is an opportunity for the provider to describe its activities during the past six months and to describe the participant's future goals.

Waiver service providers are required to submit an ISR to the Service Coordinator (SC) for inclusion in each Revised Service Plan (RSP) (refer to Appendix C – form C.13). The ISR must be submitted to the participant's SC at least six (6) weeks prior to the end of each Service Plan (SP) period or at the Team Meeting held to discuss the development of each RSP. Failure to provide a timely ISR may result in provider Vendor Hold or Disenrollment (refer to Section V – The Service Plan of this Program Manual).

The following waiver service providers are required to submit ISR(s):

- Community Integration Counseling;
- Home and Community Support Services;
- Home Visits by Medical Personnel;
- Independent Living Skills Training Services;
- Nutritional Counseling/Educational Services;
- Peer Mentoring;
- Positive Behavioral Interventions and Supports;
- Respiratory Therapy;
- Respite Services;
- Service Coordination;
- Structured Day Program Services; and
- Wellness Counseling Services.

The ISR is directly related to the Detailed Plan and ongoing documentation of encounters with the participant. The Detailed Plan sets the overall design of the interventions to be implemented. The notes regarding ongoing interactions with the participant provide the information necessary to complete the ISR.

The ISR documents the progress of the participant in relation to the provided service, describes if there is a need for the continuation of the service and represents the provider's request for continued approval to provide the service. The completion of the ISR relies on a thorough review of the Detailed Plan by the provider with the participant.

To justify re-approval/continuation of a service, the ISR must clearly describe how the continuation of this service is needed to assure health and welfare of the participant in the community.

The ISR must identify responses to the following questions:

- a. What were the participant's goals identified in the current SP?
- b. What interventions were used to address goals?
- c. How successful were the interventions utilized and what progress has been made towards the goals?
- d. Did any barriers occur in the progress towards meeting the goals?
- e. What will be the goals, expected interventions and outcomes for the next six (6) months?
- f. What are the recommendations for frequency and duration of this service?
- g. Why is this service needed to assure health and welfare in the next service plan?

Providers of the following waiver services are not required to complete an ISR for these services:

- Assistive Technology (AT);
- Community Transitional Services (CTS);
- Congregate and Home Delivered Meals;
- Environmental Modifications Services (E-mods); and
- Moving Assistance.

However, the SC must complete an ISR for each of these services with the participant and input from the waiver provider. The SC must clearly describe the anticipated costs and need for each of these services in the Service Plan. The approval process as outlined in Section VI - Waiver Services of this Program Manual and the required forms must be completed and submitted with each RSP.

Record Keeping for Specific Waiver Providers

1. Requirements for Service Coordinators

In addition to the three components of the record keeping responsibilities listed above (i.e. Detailed Plans, documentation of encounters/case notes and ISR), the SC shall maintain a file for each participant that includes:

- a. The Application Packet including the ISP;
- b. All completed Insurance, Resources and Funding Information

- forms;
- c. The original and all subsequent PRI and SCREENS;
 - d. All RSP(s), including all required documentation attached and ISR(s) submitted from other waiver service providers;
 - e. All Addendums;
 - f. All copies of Notices of Decision (NOD) forms and documentation that the participant has been informed about the NOD(s), including the right to an Informal Conference and/or Fair Hearing (as appropriate);
 - g. Summaries of all Team Meetings (refer to Appendix C – form C.17);
 - h. Initial and annual Waiver Participant's Rights and Responsibilities form (refer to Appendix C – form C.5) with the original signature and date;
 - i. Current Waiver Contact List (refer to Appendix C – form C.6);
 - j. All Plan for Protective Oversight (PPO) (refer to Appendix C – form C. 4);
 - k. Documentation of proof of the participant's current Medicaid eligibility each time the SP is submitted to the RRDS;
 - l. Documentation of Release of Information forms;
 - m. Documentation of the provision of Service Coordination services; and
 - n. Documentation of all other contacts with:
 - The participant;
 - Family and informal supports;
 - Local Departments of Social Services (LDSS);
 - Providers of waiver services;
 - Providers of non-waiver services;
 - Regional Resource Development Specialists (RRDS);
 - Nurse Evaluator (NE);
 - Quality Management Specialist (QMS);
 - DOH Waiver Management Staff (WMS); and
 - Any other significant contacts which affect the SP or reflect a change in the participant's situation.

In addition, providers of Service Coordination must maintain the following separate from the participant's record:

- a. Provider Satisfaction Surveys regarding the participant's satisfaction with service(s) provided;
- b. Documentation of any complaints or grievances received and the outcome of these situations; and
- c. Documentation reflecting any involvement in the Serious Reportable and Recordable Incident processes.

Note: If the current Service Coordination agency was not the agency involved in

the development of the Application Packet, a copy of the Application Packet must be obtained from the previous Service Coordination agency or the RRDS and maintained by the current Service Coordination agency in the participant's record. For all other information, the SC is responsible for maintaining information which was obtained and/or written since involvement as the Service Coordination agency with the participant.

The SC is responsible for distributing the approved Service Plans to all waiver providers and ensuring each provider receives information that impacts the delivery of his/her services.

2. Requirements for AT, CTS, Congregate and Home Delivered Meals, E-mods, and Moving Assistance

These waiver service providers are responsible to maintain the following in the participant's record:

- a. Bid(s) submitted to the SC, corresponding documentation regarding acceptance of bid(s), and RRDS final approval;
- b. Services provided to any waiver participant;
- c. Copy of page one of the SP and the pages regarding the need for the waiver service that is sent from the Service Coordinator;
- d. The Notice of Decision (NOD) (refer to Appendix B – NOD.1 to NOD.9) sent from the SC;
- e. Copy of the Initial and annual Participant's Rights and Responsibilities form, as applicable;
- f. Documentation of Release of Information forms; and
- g. Documentation of all contacts (through an encounter, or verbal/written communication) with:
 - The Participant;
 - Family and informal supports;
 - Providers of waiver services;
 - RRDS;
 - NE;
 - QMS;
 - DOH WMS; and
 - Any other significant contacts which affect the SP or reflect a change in the participant's situation involving the waiver service provider.

In addition, these waiver service providers must maintain the following separate from the participant's record:

- a. Provider Satisfaction Surveys regarding the participant's satisfaction with service(s) provided;
- b. Documentation of any complaints or grievances received and

- the outcome of these situations; and
- c. Documentation reflecting any involvement in the Serious Reportable and Recordable Incident process.

3. Requirements for All Other Waiver Service Providers

As noted earlier in this section, waiver service providers are responsible to maintain the three major components of Record Keeping (i.e. Detailed Plans, documentation of encounters/case notes and ISR). In addition to the documentation required by those components, providers must maintain in participant record:

- a. ISP (refer to Appendix C – form C.1);
- b. All RSP(s);
- c. All Addendum(s) (refer to Appendix C – form C.15), if applicable;
- d. All copies of Notices of Decision (NOD) forms;
- e. Documentation of all Team Meetings attended and a copy of the completed Team Meeting Summary received from the SC;
- f. Initial, as applicable and Annual Participant's Rights and Responsibilities form;
- g. Current Waiver Contact List;
- h. All Plan for Protective Oversight (PPO) forms received during provision of service(s);
- i. Release of Information forms, as appropriate;
- j. Documentation of the provision of services;
- k. Documentation of all other contacts with:
 - The participant;
 - Family and informal supports;
 - Local Departments of Social Services;
 - Providers of waiver services;
 - Providers of non-waiver services;
 - RRDS;
 - NE;
 - QMS;
 - DOH WMS; and
 - Any other significant contacts which affect the SP or reflect a change in the participant's situation.
- l. Service-specific assessments conducted or acquired, if applicable; and
- m. Physician Orders (for providers of HCSS, Respiratory Therapy, Wellness Counseling, and Nutritional Counseling/Educational Services only).

In addition, other waiver service providers must maintain the following separate from the participant's record:

- a. Provider Satisfaction Surveys regarding the participant's

- satisfaction with service(s) provided;
- b. Documentation of any complaints or grievances received and the outcome of these situations; and
- c. Documentation reflecting any involvement in the Serious Reportable and Recordable Incident process.

Note: If a current waiver service provider was not the original waiver service provider agency involved at the time the ISP was approved, a copy of the ISP, current PPO, current RSP, any Addendum issued during the current RSP period, and NOD form(s) must be obtained from the Service Coordination agency and maintained in the waiver service provider's record for the waiver participant. For all other information, the waiver service provider is responsible for maintaining information which has been obtained and/or written since becoming involved as a waiver service provider agency for the participant.

Section VIII

REQUIRED TRAINING FOR WAIVER SERVICE PROVIDERS

Introduction

This section of the Program Manual will describe the training requirements for waiver service provider staff and how best to meet those training requirements.

The NHTD waiver has divided the waiver service providers into three (3) groups regarding requirements for staff training, assuring minimum training requirements for providers are met, and at the same time, assuring all waiver service providers are properly trained and able to provide appropriate services. The creation of three (3) groups was based on the complexity of service and the amount of interaction between waiver service providers. The provision of high quality services on a consistent basis will result in providing the waiver participant with the greatest opportunity to achieve his/her individual goals for living in the community.

Required training for all waiver service providers includes three components:

1. Basic Orientation Training
2. Service Specific Training
3. Annual Training

DOH Waiver Management staff and/or its contractors may request to review any training materials used by a waiver provider and make recommendations for changes or improvements. DOH Waiver Management staff and/or its contractors may request to attend waiver service provider trainings as necessary.

The three (3) groups of waiver service providers are as follows:

GROUP A

- Service Coordination
- Community Integration Counseling
- Home and Community Support Services
- Independent Living Skills Training
- Peer Mentoring
- Positive Behavioral Interventions and Supports Services
- Respite Care
- Structured Day Program Services

GROUP B

- Nutritional Counseling/Educational Services
- Respiratory Therapy
- Home Visits By Medical Personnel
- Wellness Counseling

GROUP C

- Assistive Technology
- Community Transitional Services
- Congregate and Home Delivered Meals

- Environmental Modification Services
- Moving Assistance

GROUP A

Required Training for Group A

Waiver service providers in this group (Service Coordination, Community Integration Counseling, Home and Community Support Services, Independent Living Skills Training, Peer Mentoring, Positive Behavioral Interventions and Supports Services, Respite Care, and Structured Day Program Services) are responsible for:

- Developing a written training curriculum if one has not been developed by DOH to meet the requirements identified in this section;
- Ensuring individuals providing the training meet the qualifications specified in this section; and
- Documenting all training in staff's files, including all related NHTD training, seminars and conferences attended, whether offered by the provider or other entities.

1. Basic Orientation Training

Definition

Qualified waiver service provider staff for this group must complete Basic Orientation training prior to any unsupervised contact with a waiver participant and within thirty (30) days of beginning service provision to a NHTD participant.

The training consists of one-on-one and/or group training to instruct new employees of waiver service providers about general needs of individuals with disabilities and/or seniors, the philosophy and policies of the NHTD waiver, waiver services and waiver participant's rights and responsibilities.

The requirement for Basic Orientation training will be met by utilizing the approved DOH curriculum entitled "Overview of NHTD-TBI Waiver Programs".

The Regional Resource Development Specialist (RRDS) will provide Training-Of-Trainer (TOT) programs to the trainers of the waiver service provider agencies so they, in turn can conduct the overview training to their agency staff. The individuals that have attended the TOT program will then be able to train agency staff in this curriculum. Upon completion of the TOT program, the RRDS will give the employee a Certificate of Attendance which will be kept in his/her employee file verifying that he/she has attended the training. This curriculum can be obtained by contacting the Regional Resource Development Center (RRDC) following the successful completion of the training.

2. Service Specific Training

Definition

Service specific training prepares the waiver service provider staff for the roles and responsibilities specific to the waiver service he/she is qualified to provide. This training must be completed prior to any unsupervised contact with a waiver participant and within thirty (30) days of initial employment.

Service specific training consists of one-on-one and/or group training to instruct individual staff of their roles as providers of a specific service. All staff must understand the description of each waiver service written in the Program Manual (refer to Section VI - Waiver Services).

All waiver service providers for this group must include the following information in the curriculum for Service Specific Training:

1. Definition and goals of the service and a detailed job description;
2. Roles and responsibilities of the provider of the specific service;
3. Procedures for completing service-specific assessments;
4. Procedures for effective communication and coordination between staff and Service Coordinator and all waiver and non-waiver service providers;
5. Basic understanding of NHTD waiver services and other available community services and funding sources;
6. The prior approval process;
7. Record keeping responsibilities of the specific waiver service providers including NHTD Service Plans, Detailed Plans, documentation of encounters, and Individual Service Reports (refer to Appendix C – form C.16);
8. Team Meeting requirements;
9. Waiver Participant Rights and Responsibilities (refer to Appendix C – form C.5);
10. Effective interventions during crisis, including behavioral and medical, natural disasters, severe weather, and lack of replacement staff;
11. Basic safety and emergency procedures (e.g. choking, loss of consciousness, breathing difficulties); and
12. Identifying and reporting any changes in the participant's routine use of medication, usual behaviors, mood, personality, sleep patterns, functional and cognitive abilities, appearance and/or lifestyle.

Home and Community Support Services and Positive Behavioral Interventions and Supports Services have more clearly defined training requirements which must be adhered to (refer to Section VI - Waiver Services).

3. Annual Training

Definition

Annual Training is provided to keep waiver service provider staff up to date regarding

their roles and responsibilities specific to the waiver service he/she is qualified to provide. Waiver service provider staff must complete an Annual Training program. Annual Training consists of one-on-one and/or group training.

Annual Training requirements for this group include at a minimum:

- A review of NHTD Participant Rights and Responsibilities;
- A review of the NHTD Incident Reporting Policy and Complaint Procedure;
- A review of all new policies and/or procedures required by the NHTD Waiver which impact the services provided; and
- Additional topics relating to findings of satisfaction surveys, incident reports and trend analyses.

Qualifications of Trainers for Group A Providers

Training must be provided by individuals who are:

- Knowledgeable about the needs of individuals with disabilities and/or seniors or knowledgeable regarding one of the specific areas of required training;
- Familiar with the philosophy, policies and procedures of the NHTD Waiver;
- Knowledgeable regarding the waiver service which is the subject of the service specific training; and
- Have completed the required DOH "Training-of-Trainer (TOT)" program for the "Overview of NHTD-TBI Waiver program" and any approved curriculum relevant to NHTD services provided.

Documentation of all Training for Group A Providers

For all waiver service providers of Group A, this includes:

- Documentation in each waiver service provider employee's file of all NHTD related trainings provided by the waiver service provider or other entities.

This documentation must include:

- Name of the trainer and affiliation/qualifications;
- Verification of staff's attendance at trainings;
- Date and place of training;
- Goals and objectives of training;
- Evaluation instruments that measured the success of the training; and
- Certificate of Attendance.

Agencies are responsible for ensuring that individuals providing waiver services

complete Basic Orientation Training and Service Specific Training. Individuals with documented successful completion of prior training in the content area(s) specified in Basic Orientation Training and/or Service Specific Training may be exempt from such training at the discretion of the provider. If the DOH Certificate of Attendance is more than two (2) years old, the employee must complete and pass the post questionnaire of the Basic Orientation Training, and if applicable, Service Specific Training. The reason for the exemption as well as the post questionnaire results must be documented by the employer in the staff's file so it may be reviewed upon request and during the survey process.

GROUP B

Required Training for Group B

Waiver services providers in this group (Nutritional Counseling/Educational Services, Respiratory Therapy, Home Visits By Medical Personnel, and Wellness Counseling) are responsible for:

- Developing a written training curriculum if one has not been developed by DOH to meet the requirements identified in this section;
- Ensuring individuals providing the training meet the qualifications specified in this section; and
- Documenting all training in staff's files, including all related NHTD training, seminars and conferences attended, whether offered by the provider or other entities.

1. Basic Orientation Training

Definition

Qualified waiver service provider staff for this group must complete an approved DOH condensed Basic Orientation Training curriculum prior to any unsupervised contact with a waiver participant and within thirty (30) days of beginning service provision to a NHTD participant.

The training can consist of one-on-one and/or group training to instruct new waiver service provider staff.

The Regional Resource Development Specialist (RRDS) will provide Training-Of-Trainer (TOT) programs to the trainers of the waiver service provider agencies so they, in turn can conduct the overview training to their agency staff. The individuals that have attended the TOT program will then be able to train agency staff in this curriculum. Upon completion of the TOT program, the RRDS will give the employee a Certificate of Attendance which will be kept in his/her employee file verifying that he/she has attended the training. This curriculum can be obtained by contacting the Regional Resource Development Center (RRDC) following the successful completion of the training.

2. Service Specific Training

Definition

Service Specific Training prepares the waiver service provider staff for the roles and responsibilities specific to the waiver service he/she is qualified to provide. This training must be completed prior to any unsupervised contact with a waiver participant and within thirty (30) days of beginning service provision to a NHTD participant.

Service Specific training consists of one-on-one and/or group training to instruct individual staff of their roles as providers of a specific service and as well as their responsibilities to interact with the Service Coordinator and other waiver service providers.

All waiver service providers for this group must include the following information in the curriculum for Service Specific Training:

1. Definition and goals of the service and a detailed job description;
2. Roles and responsibilities of the provider of the specific service; and
3. Requirements for prior approval, including in some cases, physician orders before the provision of Nutritional Counseling/Educational Services, Respiratory Therapy and Wellness Counseling.

3. Annual Training

Definition

Annual Training is provided to keep waiver service provider staff up to date regarding their roles and responsibilities specific to the waiver service he/she is qualified to provide. Waiver service provider staff must complete an Annual Training program. Annual Training consists of one-on-one and/or group training.

Annual Training requirements for this group include at a minimum:

- A review of all new policies and/or procedures required by the NHTD Waiver which impacts the services provided;
- Review of NHTD Participant Rights and Responsibilities;
- Review of NHTD Waiver and the specific waiver provider's service in relationship to the other members of the NHTD Waiver; and
- Additional topics relating to findings of satisfaction surveys and incident report trend analyses.

Qualifications of Trainers for Group B

Training must be provided by individuals who are:

- Knowledgeable about the needs of individuals with disabilities and/or seniors or knowledgeable regarding one of the specific areas of

- required training;
- Familiar with the philosophy, policies and procedures of the NHTD Waiver;
- Knowledgeable regarding the waiver service which is the subject of the service specific training; and
- Trained through the completion of the required DOH “Training-of-Trainer (TOT)” program for the condensed curriculum of the “Overview of NHTD-TBI Waiver” program.

Documentation of Training for Group B Providers

For all waiver service providers of Group B, this includes:

- Documentation in each waiver service provider staff’s file of all NHTD related trainings provided by the waiver service provider or other entities.

This documentation must include:

- Name of the trainer and affiliation/qualifications;
- Verification of staff’s attendance at trainings;
- Date and place of training;
- Goals and objectives of training;
- Evaluation instruments that measured the success of the training; and
- Certificate of Attendance.

Agencies are responsible for ensuring that individuals providing waiver services complete Basic Orientation Training and Service Specific Training. Individuals with documented successful completion of prior training in the content area(s) specified in Basic Orientation Training and/or Service Specific Training may be exempt from such training at the discretion of the provider. If the DOH Certificate of Attendance is more than two (2) years old, the employee must complete and pass the post questionnaire of the Basic Orientation Training, and if applicable, Service Specific Training. The reason for the exemption as well as the post questionnaire results must be documented by the employer in the employee file so it may be reviewed upon request and during the survey process.

GROUP C

Required Training for Group C

Waiver services providers in this group (Assistive Technology, Community Transitional Services, Congregate and Home Delivered Meals, Environmental Modification Services, and Moving Assistance) are responsible for:

- Developing a written training curriculum if one has not been developed by DOH, to meet the requirements identified in this section;
- Ensuring individuals providing the training meet the qualifications

- Documenting all training in staff files, including all related NHTD training, seminars and conferences attended, whether offered by the provider or other entities.

1. Basic Orientation Training

Definition

The qualified waiver service provider will appoint a designee to complete an approved DOH condensed Basic Orientation Training curriculum prior to the agency's provision of services to any NHTD participant. This designee may include, but is not limited to, the Executive Director, owner, direct supervisor or staff assigned to be responsible for oversight of the service.

The training can consist of one-on-one and/or group training to instruct the new waiver service designee.

This curriculum must be obtained by contacting the RRDC. The RRDS will provide a Training-Of-Trainer (TOT) program to the waiver service provider designee. The individuals that have attended the TOT program will then be able to train agency staff in this curriculum, if deemed necessary. A DOH Certificate of Attendance will be issued by the RRDS and must be kept in the agency employee personnel file.

2. Service Specific Training

Definition

Service Specific Training prepares the waiver service designee for the roles and responsibilities specific to the waiver service he/she is qualified to provide. This training must be completed prior to any unsupervised contact with a waiver participant and within thirty (30) days of beginning service provision to a NHTD participant. The RRDS will intimately provide this training to the waiver provider's designee.

Service Specific training consists of one-on-one and/or group training to instruct individual staff of their roles as providers of a specific service and as well as their responsibilities to interact with the Service Coordinator and other waiver service providers.

All waiver service providers for this group must include the following information in the curriculum for Service Specific Training:

1. Definition and goals of the service and a detailed job description;
2. Roles and responsibilities of the provider of the specific service;
3. Requirements for prior approval; and
4. For providers of Assistive Technology, Community Transitional Services, Environmental Modifications Services and Moving Assistance, the bidding process and final cost report associated with obtaining approval.

3. Annual Training

Annual Training is provided to keep waiver service provider designee up to date regarding their roles and responsibilities specific to the waiver service he/she is qualified to provide. Waiver service provider designee must complete an Annual Training program. Annual Training consists of one-on-one and/or group training.

Annual Training requirements for this group include at a minimum:

- A review of NHTD Participant Rights and Responsibilities;
- A review of the NHTD Incident Reporting Policy and Complaint Procedure;
- A review of all new policies and/or procedures required by the NHTD Waiver which impact the services provided; and
- Additional topics relating to findings of satisfaction surveys, incident reports and trend analyses.

Qualifications of Trainers for Group C Providers

The waiver service designee must be an individual who is:

- Knowledgeable regarding one of the specific areas of required training;
- Familiar with the philosophy, policies and procedures of the NHTD Waiver;
- Knowledgeable regarding the waiver service which is the subject of the service specific training; and
- Trained through the completion of the required DOH "Training-of-Trainer (TOT)" program for the condensed curriculum of the "Overview of NHTD-TBI Waiver" program.

Documentation of Training for Group C Providers

For the designee of each waiver provider agency in Group C, the following documentation must be included in the staff's file:

- Name of the trainer and affiliation/qualifications;
- Verification of staff's attendance at trainings;
- Date and place of trainings;
- Goals and objectives of trainings; and
- Evaluation instruments that measured the success of the training.

Agencies are responsible for ensuring that individuals providing waiver services complete Basic Orientation Training and Service Specific Training. Individuals with documented successful completion of prior training in the content area(s) specified in Basic Orientation Training and/or Service Specific Training may be exempt from such training at the discretion of the provider. If the Certificate of Attendance is more than

two (2) years old, the employee must complete and pass the post questionnaire of the Basic Orientation Training, and if applicable, Service Specific Training. The reason for the exemption as well as the post questionnaire results must be documented by the employer in the employee file so it may be reviewed upon request and during the survey process.

Section IX

QUALITY MANAGEMENT

Introduction

An effective, comprehensive Quality Management Program (QMP) combines quality assurance and quality improvement strategies to assure there is a system in place that continuously measures performance, identifies opportunities for improvement and monitors outcomes. For this program to be successful, participants, waiver providers, DOH and all contracted entities must work collaboratively to identify and address problems. This can only be done through open and effective communication between all entities.

By following the activities provided in the QMP outlined in this section, each provider can achieve the greatest probability of success serving participants in a manner that reflects the highest level of quality. This can be measured through participant success and overall satisfaction pursuing desired goals.

Framework for a Quality Management Program

CMS has developed a Quality Framework which provides an excellent model for constructing a viable and practical approach to dealing with the quality aspects of a waiver. This Quality Framework contains three distinct functions: Discovery, Remediation and Improvement. Just as the NHTD waiver has adopted this approach, it is expected waiver providers will also. By incorporating these three functions into its quality activities, providers can better meet the responsibility of identifying problems, understanding the extent of each problem and developing appropriate interventions to resolve the problem.

The **Discovery** function focuses on the ability and willingness to become aware of those events that may compromise the waiver's pursuit of meeting its assurances to the federal government. On a more concrete level, are there policies and procedures in place that will identify issues of concern to the participant, provider, community or program? Do we know when a participant experiences neglect or other critical incident? Do we know when waiver policies and procedures have a negative impact on providers' ability to meet the standards established for hiring qualified staff? Do we have a way of documenting and sharing best practices? These are the types of questions that must be positively responded to if the NHTD waiver is to understand whether it is successful in fulfilling its primary goals.

Once Discovery processes are in place, the QMP must respond to individual situations via **Remediation** and, when necessary, to initiate Improvements on a system-wide level. The Remediation processes established to provide amelioration of an individual's problem must be ones that can be carried out in a timely and efficient manner. Overwhelmingly, situations requiring Remediation would be considered Serious Reportable Incidents (SRI) (refer to Section X - Incident Reporting Policy and Complaint Procedure). Such events must be catalogued by both the waiver (through the QMS) and provider to understand whether they are isolated events or if a pattern has developed.

Improvement on a system-wide basis is also essential in order for the waiver to respond to changes in healthcare and other environments. Resource and reimbursement concerns, along with the shifting interests and needs of participants and providers, must be considered as the waiver continues to mature and grow. New barriers and concerns may evolve and must be managed. System-wide improvements, clarifications or changes to existing policies and procedures will impact the other two components of the QMP – Discovery and Remediation. These improvements may also be reflected in changes to the basic waiver design or to its policies and procedures. Often, the system-wide improvements being sought are based on the recognition that there are faults within the Discovery or Remediation functions that cannot be corrected in any other way. This type of self-correcting closed loop model of improvement -where feedback from the system is used to initiate changes in that system-provides the opportunity for an ongoing quality improvement process.

NHTD Quality Management Program

Through a robust system of Discovery, information is gathered, when there are problems and analyzed to determine where the locus of the problem primarily lies, for example at provider or program level. Once appropriate action is taken to remedy the problem, the system of Discovery is used continuously to assure the proposed solution has been successful. Embracing the “participant-centered approach” to service provision, the Department of Health (DOH), Quality Management Specialists (QMS), Regional Resource Development Centers (RRDC), Regional Resource Development Specialists (RRDS), Nurse Evaluators (NE), Service Coordinators (SC) and other provider agencies work collaboratively with waiver participants with a focus on choice and satisfaction.

The NHTD QMP uses a five-level approach. Each level has a responsibility and an opportunity for identifying problems (Discovery), creating solutions at the provider level (Remediation) and assisting in changes in program policy (Improvement).

Level One is the waiver participant and natural (informal) supports. Waiver participants work with waiver providers to develop a Service Plan that reflects personal goals and strategies to assure successful outcomes.

The QMP assures waiver participants receive ongoing support and monitoring of their health and welfare throughout their participation in the waiver through:

- waiver participant education;
- Team Meetings;
- visits with the SCs;
- access to all waiver providers and the NHTD Complaint Line;
- annual Participant Satisfaction Surveys; and
- timely response to concerns or SRI.

Waiver participants play an active role in the Discovery process through communicating problems or issues to waiver providers. Working with the DOH, QMS, RRDC and waiver providers, waiver participants are part of the remediation process and provide input into solutions to assure successful outcomes.

Level Two is the SCs and other waiver service providers. Providers must employ self-monitoring strategies that assure the agency's policies and procedures regarding service provision to waiver participants meet the standards of the waiver (Discovery). When problems are identified, waiver providers must evaluate whether the difficulty is staff-specific and/or related to provider-specific or programmatic policies and procedures. If the provider's policies and procedures are the source of the problem, then the provider must assure changes in policies and procedures are made that continue to support the waiver participants and maintain compliance with the standards of the waiver.

Using the NHTD Program Manual as a guide, each provider will have the tools needed to understand and measure the quality of service provision. These tools include:

- policies regarding Service Plan (SP) development;
- changing procedures;
- Participant Satisfaction Surveys;
- Complaint procedures and SRI protocols;
- Serious Incident Review Committee (SIRC);
- Team Meetings; and
- outcomes of DOH surveys and Office of Medicaid Inspector General (OMIG) audits.

Level Three is the RRDC which employs the RRDS and NE. The RRDC has a lead role in the transition and diversion of waiver participants. It is responsible for:

- outreach, education and training;
- resource identification and referral, networking, assuring level of care, maintaining an aggregate budget and approving SPs;
- the RRDS acts as a gatekeeper and a point of contact for the NHTD waiver. He/she interviews all potential waiver providers;
- interviews all potential waiver participants;
- reviews every Application Packet and SP, and assures cost neutrality in the region; and
- the RRDS also compiles and reviews data collected from waiver providers and waiver participants in his/her region for quality assurance.

The NE must be a Registered Nurse certified to conduct PRI and SCREEN (refer to Appendix F) assessments to evaluate, as necessary, new waiver participants and participants returning to the community following a significant medical event that may have altered the individual's cognitive or physical abilities. The NE will

evaluate

- SPs at the direction of the RRDS, as appropriate; and
- provide the results of his/her evaluation to the SC selected by the waiver participant, as well as to other appropriate parties at the direction of the RRDS.

The RRDC personnel maintain regular contact with the QMS and DOH Waiver Management staff (WMS) regarding quality management issues. Through these activities, the RRDC staff plays an essential role in the Discovery, Remediation and Improvement processes.

Level Four is the QMS, another key resource in the waiver. The QMS is responsible for

- overseeing the SRI process;
- providing technical assistance to the RRDS as requested;
- analyzing data obtained from RRDS reports, participant complaints and retrospective record reviews, monitoring for regional trends;
- working with the RRDS and waiver providers to remedy any issues discovered and makes recommendations to DOH WMS for systemic improvements;
- reviewing SPs over \$300 per day to assure the health and welfare needs of the waiver participant are met in a cost effective manner; and
- assuring Participant Satisfaction Surveys are conducted through face-to-face visits with participants to assess satisfaction.

The QMS personnel maintain regular contact with the RRDC personnel and DOH WMS regarding quality management issues.

Level Five is the DOH WMS, who has the overall responsibility for the waiver. The DOH WMS consists of skilled professionals who have knowledge regarding diverting and transitioning individuals from nursing homes and maintaining them in the community. This team works collaboratively with the OMIG and other State agencies to share information useful to the waiver's success.

DOH WMS conduct ongoing reviews of Discovery information received through:

- SRIs;
- Regional Forums;
- RRDS, QMS and waiver provider reports;
- fair Hearings;
- Complaint Line calls;
- quarterly meetings with QMS and RRDS;
- random retrospective record reviews;
- financial audits; and
- surveys.

Through the team's ongoing collaborative efforts, data is shared and analyzed for use in implementing remediation at the provider and/or regional level and

developing strategies for implementation on a state or system-wide level. DOH WMS may initiate remediation actions including additional provider training, restriction of the provider opportunity level (vendor hold) for providing services to participants, or termination of a provider agreement. The staff maintains open communication through a variety of forums with all entities involved with the waiver, providing feedback and direction for change or improvement. DOH WMS meets at least quarterly with the RRDS and QMS to identify concerns and examine remedial actions.

DOH WMS continuously monitors the outcomes of these changes or improvements through ongoing Discovery measures to assure the standards of the waiver program are maintained through all levels of the QMP. That staff works with the RRDS and QMS to identify trends that need response by Remediation and/or Improvement activities to assure the underlying philosophy and assurances of this waiver are maintained. DOH WMS also monitors the QMS and RRDC by conducting on-site visits and annual evaluations to assure they are meeting contractual obligations.

Another forum important for data sharing is a Quality Advisory Board, designed to keep waiver participants, stakeholders, advocates and community representatives informed and involved in the process for change or improvement to the NHTD waiver program. This Board works with DOH WMS at least twice a year to review trends and provide feedback.

The QMP is an ongoing process whose strategies change over time in response to the changing needs of the NHTD waiver and New York State. The success of the QMP strategies are reviewed minimally at every quarterly RRDS and QMS meeting, with the submission of RRDS and QMS quarterly reports, annually and at other times at the discretion of DOH WMS. An annual summary and report is sent to CMS describing the ability of the waiver to meet the assurances described in the application.

CMS Waiver Assurances

Through the dynamic QMP, New York State will be able to continuously ensure the waiver assurances and other federal requirements are met.

This section explains the waiver assurances required by CMS and the NHTD activities related to Discovery, Remediation and Improvement, including performance measures and the entity(s) responsible for each activity.

A. Level of Care (LOC) – Nursing Home Eligibility

- 1. Waiver applicants for whom there is reasonable indication that waiver services may be needed in the future are provided an individual LOC evaluation.**

Activities:

- a. The RRDS is responsible for assuring individuals are informed

about the waiver application process including the need for a LOC evaluation, using the PRI and SCREEN.

- b. As part of the application process, the SC assures a current PRI and SCREEN has been completed and that the individual meets the LOC requirement.
- c. The SC submits the Application Packet, including the PRI and SCREEN, to the RRDS who reviews 100% of all applications received to assure compliance with waiver eligibility criteria, including LOC.
- d. If the finding of a LOC evaluation poses any concerns or questions for the RRDS, the NE reviews the PRI and SCREEN and/or completes a new PRI and SCREEN for LOC determination.
- e. If the individual does not meet the nursing home level of care criteria, the RRDS assures that the individual is referred to other community resources and tracks all referrals.
- f. The QMS monitors for regional trends and suggests any additional training to the RRDS regarding the LOC process and waiver eligibility.
- g. During an annual random retrospective record review of at least five-percent (5%) in Year One of the waiver, two-percent (2%) in Year Two, and one-percent (1%) in Year Three, QMS and DOH WMS evaluate the LOC evaluations.
- h. The data gathered regarding this assurance must be included in the RRDS and/or QMS Quarterly Reports for review by DOH WMS. That staff, in consultation with the QMS and RRDS evaluates the need to change and/or improve policies/procedures.

2. The LOC of enrolled participants are reevaluated at least annually or as specified in the approved waiver

Activities:

- a. Waiver participants are reevaluated at least annually for LOC through completion of the PRI and SCREEN. This is done from the anniversary date of the last LOC determination. The RRDS reviews 100% of all Revised Service Plans (RSP) (refer to Appendix C – form C.13) to assure ongoing compliance with waiver standards regarding LOC determinations.
- b. The SC creates and maintains a tracking system to assure timely LOC reevaluations.
- c. At a minimum of every six months, with the waiver participant present, the SC conducts a Team Meeting to review the SP for revision. If the team has concerns about the LOC, a new LOC evaluation must be completed.
- d. During review of an RSP, the RRDS informs the Service Coordinator if an updated PRI and SCREEN is needed or if the PRI and SCREEN indicate an inappropriate LOC. The RRDS maintains

a system to track all LOC reevaluations to assure timeliness of submission.

- e. The NE who must be a certified assessor completes an updated PRI and SCREEN for LOC determination if the validity of the PRI and SCREEN is in question.
- f. The RRDS tracks data regarding all LOC reevaluations to monitor this assurance is being met.
- g. The QMS monitors for regional trends and suggest any additional training to the RRDS regarding the LOC process and waiver eligibility.
- h. The QMS and DOH WMS conducts an annual random retrospective record review of at least five-percent (5%) of all LOC reevaluations in Year One of the waiver, two-percent (2%) in Year Two, and one-percent (1%) in Year Three. Findings are evaluated for trends warranting any individual, regional or systemic changes or improvements.
- i. DOH conducts record reviews during surveys of Service Coordination agencies to assure LOC determinations were timely and appropriate.
- j. The data gathered regarding this assurance must be included in the RRDS and/or QMS Quarterly Reports for review by DOH WMS. That staff, in consultation with the QMS and RRDS will evaluate the need to change and/or improve policies/procedures.

3. The processes and instruments described in the approved waiver are applied to determine LOC

Activities:

- a. The NYS PRI and SCREEN are designated tools for documenting LOC and can only be completed by individuals properly trained and certified by the NYS DOH. The completed PRI and SCREEN must be signed by the assessor, attesting to the validity of the assessment. If necessary, DOH WMS has the ability to verify the credentials of the qualified assessor completing the PRI and SCREEN.
- b. The RRDS reviews 100% of all initial and subsequent PRI and SCREENS for timeliness and to be sure the instrument indicates the waiver participant meets the LOC requirement.
- c. Each RRDC maintains a system to track the timeliness and appropriateness of all LOC evaluations/reevaluations.
- d. The data gathered regarding this assurance must be included in the RRDS and/or QMS Quarterly Reports for review by DOH WMS.
- e. That staff, in consultation with the QMS and RRDS evaluates the need to change and/or improve policies/procedures.

4. The state monitors LOC decisions and takes action to address inappropriate LOC determinations

Activities:

- a. The RRDS reviews 100% of all initial and subsequent PRI and SCREENS to be sure the instruments indicate the waiver participant does meet the LOC requirement.
- b. When the accuracy of LOC data is questioned by the waiver participant, RRDS or SC, the NE reviews the data and, if necessary, completes a new PRI and SCREEN.
- c. The RRDS asks the NE to review all LOC denials when the denial is based on PRI and SCREEN results that do not meet the nursing home level of care requirement. The NE will evaluate the circumstances of the denial, the appropriateness and will assist the RRDS in monitoring regional trends.
- d. RRDC staff and DOH WMS takes action when inappropriate denials have been made e.g. reinforce RRDS training on the policies and protocols for LOC determinations.
- e. The RRDS may request technical assistance from DOH WMS when a problem or trend regarding LOC evaluations and decisions is noted.
- f. If a re-evaluation for LOC determines the waiver participant is no longer eligible for the waiver because he/she no longer meets the nursing home level of care requirement, and the participant disagrees with this decision, the NE may be asked to review the LOC evaluation. If the NE review confirms ineligibility, the RRDS, through a Notice of Decision informs the waiver participant of his/her right to a Conference and/or a Fair Hearing and Aid to Continue if he/she disagrees with the determination. The SC works with the waiver participant to ensure he/she understands his/her rights. If the NE review determines the original LOC decision to be incorrect, the NE will complete a new LOC assessment providing the assessment and determination to the RRDS and the SC.
- g. Before a participant is discontinued from the waiver, the SC assists the participant with referrals for other services, if needed.
- h. The RRDS notifies DOH WMS of any Fair Hearings initiated due to LOC denials.
- i. The RRDS tracks all LOC denials.
- j. The QMS analyzes data received from the RRDS for regional trends and addresses issues with the RRDS accordingly.
- k. The data gathered regarding this assurance must be included in the RRDS and/or QMS Quarterly Reports for review by DOH WMS. That staff, in consultation with the QMS and RRDS evaluates the need to change and/or improve in policies/procedures.

B. Individual Service Plan (ISP)

- 1. Service Plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the**

provision of waiver services or through other means.

Activities:

- a. The RRDS meets every potential waiver participant prior to the development of the ISP. This provides the RRDS with information regarding the potential waiver participant's unique strengths and needs. This information is used when the reviews the Initial SP. The information acquired by the RRDS during this interview is documented on a standardized Intake Form which is shared with the selected SC and used to develop the ISP.
- b. The SC works with the waiver participant to establish the ISP, RSP and any Addenda (refer to Appendix C – form C.15). The SP includes the range of services needed by the waiver participant including waiver and non-waiver services. It combines all services needed to address the waiver participant's health and welfare, personal goals, preferences and cultural traditions.
- c. The waiver participant's signature on the SP signifies that he/she has read it or it has been read to him/her and they understand its contents and purpose.
- d. A Plan of Protective Oversight (PPO) (refer to Appendix C – form C.4) is completed with the waiver participant by the SC during the development of the ISP and at each RSP.
- e. The PPO is reviewed with the participant by the SC during the development of an Addendum. Any changes in the PPO will result in the completion of a new PPO for submission to the RRDS with the Addendum. If no changes are indicated, the PPO is signed indicating the contents remain the same and attached to the Addendum.
- f. All SPs are forwarded to the RRDS for final review and approval. The RRDS conducts a comprehensive review of 100% of all SPs assuring the waiver participant's goals and preferences are recognized and the plan meets his/her health and welfare needs.
- g. If the RRDS finds the SP does not reflect the waiver participant's needs and goals, support health and welfare or follow the program's policies, immediate corrective action must be requested from the SC and completed before the SP can be resubmitted to the RRDS for re-review.
- h. If a SP exceeds \$300/day, the RRDS sends it to the QMS for review before approval.
- i. Waiver Service providers assess waiver participant satisfaction by conducting annual Participant Satisfaction Surveys and by investigating all complaints/grievances received. These surveys and complaints/grievances investigations will be viewed by DOH during the survey process.
- j. Any calls received regarding the SP by DOH WMS, directly or through the NHTD Complaint Line, or issues raised to DOH WMS

during the annual Regional Forums regarding waiver participant SPs, will be directed by DOH WMS to the RRDS. If the issues are of significant concerns and constitutes ad SRI, it must be referred to the QMS for follow up. As a result of the investigation, changes may be required to the SP.

- k. The QMS assures Participant Satisfaction Surveys are conducted annually, analyzing data for waiver provider performance, SP implementation and regional trends. The outcomes of these surveys must be provided to DOH WMS. When individual issues arise as a result of these interviews, the QMS informs the RRDS to assure action is taken to remedy the situation.
- l. During annual random retrospective record review conducted by the QMS and DOH WMS, all approved SPs will be reviewed at a rate of at least five-percent (5%) in Year One of the waiver, two-percent (2%) in Year Two, and one-percent (1%) in Year Three.
- m. The data gathered regarding this assurance must be included in the RRDS and/or QMS Quarterly Reports for review by DOH Waiver Management staff. That staff, in consultation with the QMS and RRDS will evaluate the need to change and/or improve policies/procedures.

2. The state monitors Service Plan development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in Service Plan development.

Activities:

- a. The RRDS is responsible to review 100% of all SPs to assure the plans are developed in accordance with waiver participant needs and goals, meet health and welfare, and reflect the policies and procedures of the waiver program. Any discrepancies in the SP must be referred back to the SC by the RRDS for further assessment and/or modification before re-review by the RRDS for approval.
- b. Each SP submitted to the RRDS for review and approval must be signed by the waiver participant to assure the waiver participant has read it or it has been read to him/her and that he/she understand its contents and purpose.
- c. The RRDS assures all SPs over \$300/day are reviewed by QMS prior to final approval.
- d. The RRDS examines all SRIs in relationship to the SP to understand if a change in the type or amount of service is needed and works with the SC to assure any immediate needed changes in the SP are made at the waiver provider level.
- e. The SC is responsible to assure that a safe and effective SP is established with the waiver participant's involvement and support. Plans are formulated initially and revised at least every six months

- or with more frequent Addenda, as needed. The SC must have a tracking system in place to guarantee the timeliness of SPs.
- f. The SC is responsible for facilitating Team Meetings with the waiver participant and all key parties to review the SP for revisions, to ensure the waiver participant is involved and the waiver participant's preferences are reflected in the SP.
 - g. The SC submits the SP to the RRDS for review as specified in this Program Manual (refer to Section V- The Service Plan) to assure the SP is appropriate and to avoid any lapse in service coverage.
 - h. DOH WMS monitor NHTD Complaint Line calls, data from the Regional Forums, complaints and annual Participant Satisfaction Surveys for trends or issues related to the SP. They will initiate an investigation to obtain further information regarding any identified issues.
 - i. DOH WMS may place restrictions on waiver providers for late submission of RSPs and/or Individual Service Reports (ISR) (refer to Appendix C – form C.16). Restrictions may include the discontinuance of the waiver provider agreement or a vendor hold, which prevents the waiver provider from accepting new waiver participants until the RSP and/or ISR is submitted and approved by the RRDS. In addition, the waiver provider may have to submit a plan of action if the submission of late SPs is an ongoing problem.
 - j. Where inadequacies in the SP development process are identified, DOH WMS request a review by the RRDS or QMS and/or a DOH survey of any waiver provider.
 - k. DOH WMS and QMS conduct annual random retrospective reviews of five-percent (5%) of all SPs in Year One of the waiver, two-percent (2%) in Year Two, and one-percent (1%) in Year Three. DOH WMS reserve the right to review SPs at any time.
 - l. The data gathered regarding this assurance must be included in the RRDS and/or QMS Quarterly Reports for review by DOH WMS. That staff, in consultation with the QMS and RRDS evaluates the need to change and/or improve policies/procedures.

3. Service Plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs. In the NHTD waiver, Service Plans are update/revised at least every six (6) months.

Activities:

- a. The SC must assure Team Meetings are held at least every six months with the waiver participant, key parties and anyone the waiver participant requests for the purpose of reviewing the SP for needed revisions and development of an RSP.
- b. An Addendum is used when there is a need for minor adjustments in the SP. The Addendum is a short form the RRDS can review

and approve quickly. An RSP is used when there are major changes in the types and amounts of waiver services needed to assure health and welfare.

- c. All RSPs and Addenda must be reviewed and approved by the RRDS assuring waiver participant needs, goals, and health and welfare are met.
- d. A waiver participant may request a review of his/her SP at any time and the SC must comply with this request. If needed, a Team Meeting will be held with all appropriate persons in attendance.
- e. In the event the outcome of an investigation of an SRI, Recordable Incident or complaint leads to an Addenda or revisions in the SP, the RRDS assures changes are implemented in a timely manner by waiver providers.
- f. The SC and RRDS track the submission and review of all SPs according to policy and procedure.
- g. In the event SPs are delinquent, RRDS notifies DOH WMS. (refer to Section V – The Service Plan).
- h. The data gathered regarding this assurance must be included in the RRDS and/or QMS Quarterly Reports for review by DOH Waiver Management staff. That staff in consultation with the QMS and RRDS evaluates the need to change and/or improve policies/procedures.

4. Services are delivered in accordance with the Service Plan, including in the type, scope, amount, duration, and frequency specified in the Service Plan.

Activities:

- a. The SC maintains regular contact with the waiver participant to discuss the delivery of services as approved in his/her SP.
- b. Discrepancies between SPs and actual service utilization may be discovered through a range of methods including a random retrospective review by DOH WMS of SPs against claims data acquired through eMedNY, OMIG audits of waiver providers, DOH surveys and audits of waiver providers, Line calls, waiver provider Participant Satisfaction Surveys, QMS Participant Satisfaction Surveys and Regional Forums regarding waiver participant experiences with provision of services. If problems are discovered, further investigation will be pursued. If it is found services are not being delivered in accordance with the SP, DOH WMS will take appropriate action which may include a Vendor Hold or termination of the Provider Agreement.
- c. The data gathered regarding this assurance must be included in the RRDS and/or QMS Quarterly Reports for review by DOH WMS. That staff, in consultation with the QMS and RRDS will evaluate the need to change and/or improve policies/procedures.

5. Participants are afforded choice between waiver services and institutional care.

Activities:

- a. The RRDC staff is responsible for outreach and community education regarding the NHTD Waiver.
- b. The RRDS interviews all potential waiver participants and offers them informed choice between community-based services versus institutional care. The RRDS tracks the number of potential waiver participants interviewed and the number of potential waiver participants who chose waiver services instead of institutionalization.
- c. The RRDS documents that potential waiver participants are offered choice by having the potential waiver participant sign the Freedom of Choice form (refer to Appendix B – form B.4) during the initial phase of the application process.
- d. The QMS and DOH WMS conducts an annual random retrospective review of five-percent (5%) of waiver participant records in Year One of the waiver, two-percent (2%) in Year Two, and one-percent (1%) in Year Three to assure that the Freedom of Choice form was completed and included in the Application Packet.
- e. DOH WMS conducts annual visits to the RRDC. These visits include review of Freedom of Choice forms.
- f. Potential waiver participants may contact the NHTD Complaint Line to express concerns about Freedom of Choice. DOH WMS will monitor the NHTD Complaint Line and take appropriate action to assure all potential waiver participants are offered the choice between community based services, including waiver services and institutional care.
- g. The QMS conducts an annual Participant Satisfaction Survey to assure waiver participants continue to be afforded choice between community services and institutional care. DOH WMS monitors these Surveys for trends related to freedom of choice and issues corrective action as necessary for remediation and improvement.
- h. The data gathered regarding this assurance must be included in the RRDS and/or QMS Quarterly Reports for review by DOH WMS. That staff, in consultation with the QMS and RRDS will evaluate the need to change and/or improve policies/procedures.

6. Participants are afforded choice between/among waiver services and providers.

Activities:

- a. In the intake interview with the potential waiver participant, the RRDS explains the use of waiver services.
- b. During the intake interview, the RRDS assures individuals are

offered choice in selection of SC by providing a list of available SC agencies. The potential waiver participant is encouraged to interview SCs prior to making a selection. Upon selection of a SC by the waiver participant, the RRDS assures the Service Coordination Selection form (refer to Appendix B – form B.4) is completed and signed by the waiver participant and maintained in his/her record.

- c. The waiver participant is informed during the initial interview with the RRDS and again by the SC that at any time he/she may request a change in waiver providers, including SCs and complete a Change of Provider Request form (refer to Appendix C – form C.18). The SC assures each waiver participant is given a list of available qualified waiver service providers for selection which is attached to the Change of Provider Request form. Upon selection of waiver service provider(s), the SC will assure the agency can accept the waiver participant. The SC maintains the completed and signed Change of Provider Request form in the participant's record.
- d. The SC assures the waiver participant signs the SP indicating his/her acceptance of waiver providers and waiver services.
- e. On an annual basis, the SC assures the waiver participant reviews and signs a Waiver Participant Rights and Responsibilities form (refer to Appendix C – form C.5) which includes information regarding a waiver participant's right to choose between/among waiver services/providers. A copy is kept in the waiver participant's record and is given to the waiver participant.
- f. During data collection from annual QMS Participant Satisfaction Surveys, DOH WMS and QMS will note any negative responses regarding a waiver participant's right to choose waiver services and waiver providers. QMS initiates action to further investigate any response and report findings to DOH WMS. DOH WMS imposes penalties on waiver providers as necessary.
- g. All waiver providers are responsible for conducting annual Participant Satisfaction Surveys containing questions about "choice". These surveys can be reviewed during DOH surveys and upon request by the RRDS, QMS and DOH WMS.
- h. DOH WMS and the QMS will conduct annual random retrospective review of at least five-percent (5%) of waiver participant records in Year One of the waiver, two-percent (2%) in Year Two, and one-percent (1%) in Year Three to assure Provider Selection forms have been appropriately completed and to monitor trends that warrant changes in protocol.
- i. During annual Regional Forums DOH WMS collects feedback from waiver participants regarding their choice of waiver services. That staff analyzes the information to determine if agency specific or system-wide improvements are needed.
- j. The data gathered regarding this assurance must be included in the

RRDS and/or QMS Quarterly Reports for review by DOH WMS. That staff, in consultation with the QMS and RRDS will evaluate the need to change and/or improve policies/procedures.

C. Qualified Providers

1. **The state verifies that providers meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services; and the state verifies on a periodic basis that providers continue to meet required licensure and/or certification standards and/or adhere to other state standards; and the state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.**

Activities:

- a. NYS will only enter into Provider Agreements with agencies that meet the requirements for qualified staff.
- b. Prior to approval of waiver service providers, the RRDS conducts interviews of potential waiver service providers which include evaluation of employee resumes to ensure employees meet the required qualifications. During implementation of the waiver, DOH WMS and QMS may also participate in the interview process of potential providers using a standard interview form (refer to Section III - Becoming a Waiver Provider).
- c. Waiver providers are responsible for assuring their staff meets all qualification requirements set by the waiver.
- d. The RRDS submits recommendations to DOH WMS regarding qualified providers.
- f. Character and competency verification will be obtained by DOH WMS through direct contact with other State agencies where applicable.
- g. Certain waiver providers are mandated to obtain Criminal History Record reports from the U.S. Attorney General's Office for all prospective direct care and supervisory staff prior to employment other than those persons licensed under Title 8 of the Education law or Article 28-D of the Public Health Law.
- h. If licensure or certification is a requirement for a waiver provider, DOH WMS verifies waiver provider agency qualifications before approving the agency as an NHTD waiver provider.
- i. The waiver provider must report any subsequent change in status to DOH WMS and/or RRDS/QMS (i.e. the provider is unable to maintain qualified staff and therefore, is unable to provide the waiver service(s), or if license or certification status changes).
- j. DOH will survey all licensed and/or certified and non-licensed/non-certified waiver provider agencies within the first three-years of the waiver including a component on staff qualifications.
- k. DOH conducts surveys of waiver providers to assure they adhere to

policies and procedures including Incident Reporting, Detailed Plans and Individual Service Reports, concerns/grievances and SPs.

- l. During surveys of waiver providers, DOH will also evaluate whether waiver provider employees meets job qualifications.
- m. The RRDS communicates specific concerns regarding waiver provider practices to DOH WMS, possibly leading to DOH survey, audit by OMIG or other further action.
- n. If a waiver provider is found not to have met licensure/certification requirements (including the mandatory statutes for Employee Criminal History Record checks), DOH WMS reserves the right to place a Vendor Hold against the waiver provider and/or terminate the Provider Agreement.
- o. A number of processes allow the RRDS, QMS and DOH WMS to develop an understanding of waiver provider capabilities and competencies. These are: review of SPs, SRI reports, annual waiver provider Incident Reports, training materials and staff interactions.
- p. The data gathered regarding this assurance must be included in the RRDS and/or QMS Quarterly Reports for review by DOH WMS. That staff, in consultation with the QMS and RRDS will evaluate the need to change and/or improve policies/procedures.

2. The state implements its policies and procedures for verifying that provider training has been conducted in accordance with state requirements and the approved waiver.

Activities:

- a. DOH WMS provides ongoing training and educational programs for QMS, RRDS and NE.
- b. DOH provides training modules for “Overview of NHTD and TBI Waiver Programs”, HCSS, Service Coordination, and ILST. These are to be used by waiver providers unless they have their own DOH approved training.
- c. The Program Manual sets forth areas of training and competencies required for all staff of each waiver provider.
- d. Waiver providers are responsible for maintaining ongoing training for their staff to assure waiver standards are met.
- e. The RRDS provides training that includes Basic Orientation Training, Participant Rights, and service specific training programs to all approved waiver providers utilizing the training course “Overview of NHTD and TBI Waiver Programs.” The RRDS will maintain a list of all those trained and include this information in quarterly reports.
- f. The RRDS conducts 8-10 training programs per year to waiver providers in their region.

- g. Documentation of training includes training curriculum, qualifications and name of trainer, attendance records, date and place of training, goals, and evaluation tools by waiver providers.
- h. During DOH surveys and audits of waiver providers, documentation is reviewed to assure compliance with training standards. If compliance is not met, a plan of correction will be required and, if unsatisfactory, may lead to termination of the Provider Agreement.
- i. DOH WMS, QMS or RRDS may examine waiver provider's training curriculum or training records at any time.
- j. The data gathered regarding this assurance must be included in the RRDS and/or QMS Quarterly Reports for review by DOH WMS. That staff, in consultation with the QMS and RRDS will evaluate the need to change and/or improve policies/procedures.

D. Health and Welfare

1. There is continuous monitoring of the health and welfare of waiver participant and remediation actions are initiated when appropriate

Activities:

- a. The SC serves as a liaison between waiver providers facilitating communication regarding issues pertinent to the waiver participant's health and welfare.
- b. The SC will provide all waiver participants with a Waiver Contact Sheet (refer to Appendix C – form C.6) listing SC, other waiver service providers, RRDS, QMS and DOH WMS. This information will be updated and provided to the waiver participant if any entity should change. These contacts allow for easier accessibility for waiver participants to communicate concerns regarding health and welfare.
- c. At least every six (6) months, the SC will facilitate Team Meetings with the waiver participant, anyone he/she chooses to attend, service providers and other key parties to review and revise the SP.
- d. Every SP and PPO will be reviewed by the RRDS to assure the waiver participant's health and welfare needs are being met.
- e. The SC will conduct face-to-face visits with the waiver participant based on the participant's health and welfare needs.
- f. All waiver provider staff will be trained to observe and report changes in the waiver participant's behavioral, physical and cognitive functioning and the process to follow if concerns arise.
- g. Waiver providers conduct a random sample of Participant Satisfaction Surveys annually including health and welfare issues.
- h. DOH WMS monitors calls received from the NHTD Complaint Line for trends.
- i. All SRI reports received will be investigated according to policy and procedure. (refer to Section X – Incident Reporting Policy and

- Complaint Procedure).
- j. On an ongoing basis, the QMS reviews the SRIs for trends and, as needed, the QMS or the DOH WMS may provide technical assistance to waiver providers.
 - k. Waiver providers submit annual reports to the QMS who reviews and analyzes the information in their region and sends the report to the DOH WMS.
 - l. DOH WMS initiates the development of a Quality Advisory Board to review statewide trends with a focus on health and welfare.
 - m. The data gathered regarding this assurance must be included in the RRDS and/or QMS Quarterly Reports for review by DOH WMS. That staff, in consultation with the QMS and RRDS will evaluate the need to change and/or improve policies/procedures.
 - n. If warranted, DOH WMS initiates additional remediation actions including restriction of a provider's opportunity level (vendor hold) for providing services to participants or termination of a provider agreement.
 - o. DOH WMS manages system performance ongoing based on the outcome of trend analysis, including SRI, complaints/grievances and Participant Satisfaction Surveys.

2. The state, on an on-going basis, identifies and addresses and seeks to prevent the occurrence of abuse, neglect and exploitation (SRI policy).

Activities:

- a. This Program Manual provides each waiver provider with the policies and procedures for SRI including abuse, neglect and exploitation reporting, investigation and monitoring of outcomes.
- b. The Program Manual describes the waiver provider's need to have a SIRC which has the responsibility for investigating reports of SRI and Recordable incidents, assuring appropriate and immediate corrective or disciplinary action has been taken and preventive measures are in place. Waiver providers must submit an annual report for review to the QMS. The QMS analyzes the data for trends and makes recommendations for changes/improvements on a provider and regional level. This data is compiled and sent by the QMS to DOH WMS with a copy forwarded to the RRDS.
- c. The QMS is the primary party to provide training regarding the SRI policy. The RRDS is available for any assistance that may be needed.
- d. During surveys, DOH will review a waiver provider's policies and procedures for managing complaints and grievances. The Provider's complaint/grievance log is reviewed to assure appropriate documentation, investigation and resolution has occurred within timeframes specified in the NHTD Program Manual.

Results of these provider surveys are forwarded to DOH WMS, QMS and RRDS for review, discussion and development/implementation of Remediation and/or Improvement initiatives. DOH WMS maintain survey results in a database for regional and statewide trend analysis.

- e. The QMS is the entity responsible for the management of the NHTD SRIs Policy and is responsible for alerting the DOH WMS of the most serious reports of allegations.
- f. To measure system performance and to identify active or potential instances of abuse, neglect and/or exploitation, the QMS annually conducts a random sample of face-to-face Participant Satisfaction Surveys.
- g. DOH WMS reviews Participant Satisfaction Surveys conducted by the QMS, analyzes these for trends and identifies any warranted programmatic changes.
- h. To meet this assurance, the DOH Waiver Management unit serves as a centralized collection site to receive data compiled from NHTD Complaint Line calls, SRI, Provider survey outcomes as well as quarterly and annual reports. Data is analyzed by staff for regional and statewide trends. Outcomes are reviewed with the QMS and RRDS for needed interventions which may include additional training programs, changes and/or improvements in policy/procedure, restriction of provider opportunity level (Vendor Hold) and/or termination of provider agreement.

E. Administrative Authority

- 1. The Medicaid (NYS Department of Health) agency retains ultimate authority and responsibility for the operation of the waiver by exercising oversight over the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.**

Activities:

- a. DOH WMS maintains overall authority and responsibility for the operation of the waiver by exercising oversight of the performance of waiver functions by contractors, such as the QMS and RRDC staff.
- b. DOH WMS manages and oversees the performance of the contractors (QMS and RRDC) through annual random retrospective reviews of the SPs, NHTD Complaint Line calls, quarterly and annual reports, complaints/grievances, and annual on-site visits with the QMS, RRDC staff. If DOH WMS determines a decision by the QMS or the RRDC staff does not reflect established policy, corrective actions must be initiated.
- c. DOH WMS has the final authority regarding acceptance/denial of an applicant and discontinuance of a waiver participant from the.

- d. DOH WMS has the final authority regarding approval and termination of waiver providers.
- e. DOH WMS maintains open discussion with waiver participants, QMS, RRDC's staff, waiver providers, Local Department of Social Services (LDSS), advocates and other community based organizations serving people with disabilities and seniors to understand and evaluate the functioning of contractor's staff.
- f. DOH WMS will maintain a database to gather, evaluate and monitor data collected from reports and survey results including Plan of Correction information for trend analysis and identification of the need for program changes or improvements.
- g. DOH WMS attends annual Regional Forums with waiver participants, families, advocates and waiver providers to gather information pertinent to contract or performance.
- h. DOH WMS maintains a NHTD Complaint Line for use by waiver participants and others.
- i. DOH WMS chairs RRDS and QMS Quarterly Meetings to review policies, network, present new policies/procedures, discuss regional trends and address waiver issues.
- j. Any data gathered regarding this assurance must be included in the RRDS and/or QMS quarterly reports for review by DOH WMS. That staff, in consultation with QMS and RRDS evaluates the need to change policies/procedures.

F. Financial Accountability

- 1. Claims for federal financial participation in the costs of waiver services are based on state payments for waiver services that have been rendered to waiver participants, authorized in the service plan, and properly billed by qualified waiver providers in accordance with the approved waiver.**

Activities:

- a. The claims for federal financial participation for these waiver services are subject to the same policies and procedures that the DOH - Office of Health Insurance Programs (OHIP) through the eMedNY system uses to claim federal financial participation for all other Medicaid services.
- b. Each waiver provider is assigned a separate waiver provider identification number in eMedNY to assure only qualified waiver providers are billing for services. Each waiver service is assigned a unique rate code.
- c. Upon approval of the waiver participant's ISP, a waiver participant Exception Code 60, which is unique to the NHTD waiver, is assigned by the LDSS to assure that claims are paid only for individuals enrolled in the waiver on the date of service.
- d. All Medicaid claims submitted to eMedNY are subject to a series of

edits to ensure validation of data. These edits include: whether the waiver participant is Medicaid eligible; whether the individual was enrolled in the waiver on the date of service; and whether the Service Providers are enrolled waiver providers.

- e. The QMS and DOH WMS performs a random retrospective review of at least five-percent (5%) of SPs in Year One of the waiver; two-percent (2%) in Year Two; and one-percent (1%) in Year Three. DOH WMS compares the SPs reviewed with the claims for each waiver participant in this review to verify the waiver services provided are authorized in the SP. DOH WMS runs queries to review participant SPs against claims data from the eMedNY system. Discrepancies may be referred to the OMIG.
- f. The responsibilities of the OMIG include, among other responsibilities, the Medicaid audit function. At least five-percent (5%) of NHTD waiver providers will be audited annually by the OMIG. The DOH WMS, QMS, and/or the RRDS may also recommend waiver providers to be audited.
- g. Upon completion of each audit, final audit reports will be written disclosing deficiencies pertaining to claiming, record keeping and provision of service. These final audit reports will be sent to the waiver provider with a copy provided to DOH WMS.
- h. The QMS conducts Participant Satisfaction Surveys to ask waiver participants about their experiences with the services they have received and whether they have received the services authorized in their SP. Responses will be shared with the RRDS and DOH WMS who may request a financial audit of the waiver providers if there are areas of concern.
- i. Based on DOH surveys, a financial audit may be triggered if areas of concern are identified.
- j. To ensure providers of Environmental Modifications (E-mods), Assistive Technology (AT), Community Transitional Services (CTS) and Moving Assistance are billing properly, they are required to submit projected cost estimates and actual costs to the SC. Upon financial audit of these providers, DOH WMS will ensure the claim amount is the same as the amount that was approved.
- k. As with any Medicaid service, the costs of waiver services that are the responsibility of a third party must be paid by that third party. If a waiver participant has third-party insurance coverage, he/she is required to inform the LDSS of that coverage.
- l. Waiver service billing is the same as all Medicaid billing. Claims will be subject to the same adjudication process, which involves prepayment edits for third party billing. If a waiver participant has third party coverage in the system and a waiver provider tries to submit a bill to Medicaid prior to billing the third party, an edit will prevent the waiver provider from receiving payment.
- m. If it was found that a claim was paid prior to the input of third party

insurance information, the State will pursue retroactive recovery of funds from the potentially liable third party insurance.

- n. The Explanation of Medical Benefits (EOMB) process is designed to inform waiver participants of services provided to them according to Medicaid records and to verify that services billed by waiver providers were actually delivered. eMedNY provides waiver participants with EOMBs including instructions to communicate any discrepancies. The forms are returned directly to the Department of Health EOMB unit.
- o. EOMBs can be produced for all, or for a random sample of waiver participants who received services. They can also be produced for specific waiver participants, waiver participants who received services from a specified waiver provider, or waiver participants receiving services related to a specified procedure or formulary code. The population of waiver participants who receive EOMBs is dictated by a set of user specified criteria.
- p. To meet this assurance, DOH WMS compiles data received from internal queries, audits of claim detail reports, retrospective record reviews, QMS quarterly reports, OMIG audits, DOH surveys and participant complaints (EOMBs). Data will be analyzed for regional and statewide trends.
- q. Remediation efforts may include additional provider audits by OMIG, DOH provider surveys, audits by DOH WMS, restriction of provider opportunity level (Vendor Hold), and/or termination of Provider Agreements.

NHTD Quality Management Program Tools and Processes

There are many tools and processes associated with the NHTD waiver's QMP. These are described elsewhere in this Program Manual and include, but are not limited to:

- 1. NHTD Waiver Program Manual
- 2. RRDS Interview with Potential Participants
- 3. Participants' Choice of Waiver Services and Providers
- 4. Provider Self-Monitoring Tools
- 5. Provider Participant Satisfaction Survey
- 6. Fair Hearing Procedures
- 7. Participants' Rights and Responsibilities Form
- 8. Waiver Contact List
- 9. RRDS Interview with Potential Waiver Service Providers
- 10. DOH Surveillance of Providers
- 11. Vendor Hold and Disenrollment of Providers
- 12. Review of Service Plans by RRDS/QMS
- 13. Retrospective Record Review
- 14. Participant Satisfaction Survey
- 15. Participants' Signature On Service Plans

16. Plan for Protective Oversight
17. Assurances for Timely Submission of Service Plans and Individual Service Reports
18. Addendum to Service Plan
19. Complaint/Grievance Reporting and Investigation
20. Incident Reporting Policy
21. Examination of Claim Detail Reports
22. DOH Coordination with Other State Agencies
23. DOH Technical Assistance to RRDC and to QMS Contracts
24. DOH/RRDS Quarterly Meetings with DOH
25. RRDS Technical Assistance to Providers, Waiver Participants and Family Members
26. DOH/QMS Quarterly Meetings with DOH
27. QMS Technical Assistance to Providers
28. Accessibility of DOH WMS
29. Policy Clarification Letters
30. Coordination with LDSSs
31. Technical Amendment Requests to CMS
32. DOH Annual Report to CMS
33. Standardized Reporting by Contractors
34. Waiver Complaint Line
35. Regional Forums
36. Quality Advisory Board

Section X

INCIDENT REPORTING POLICY and COMPLAINT PROCEDURE

Introduction

As part of its obligation to promote the well-being of every participant being served, the Nursing Home Transition and Diversion (NHTD) waiver must assure safeguards are in place to prevent, to the extent possible, circumstances/situations that can result in harm to the participant. The following process serves to identify, investigate and remedy potentially harmful situations and minimize the possibility of recurrence.

Incident Reporting Policy

This Incident Reporting Policy defines the type of incidents that must be reported and the process all waiver service providers must follow for reporting, investigating, reviewing and tracking the two categories of incidents involving waiver participants:

1. Serious Reportable Incidents (SRI); and
2. Recordable Incidents

The Quality Management Specialist (QMS) is the administrator of the Serious Reportable Incident process assuring the process is initiated, investigated and completed in a timely manner, outcomes are appropriate and waiver service provider follow-up is conducted. This section also defines the responsibilities of the Regional Resource Development Specialist (RRDS), Service Coordinator and other waiver service providers, and DOH Waiver Management staff (WMS) in the investigation process.

The waiver service provider will be responsible for the management of Recordable Incident reports and related investigation processes.

Background and Intent

The DOH WMS must be informed of Serious Reportable Incidents and the providers' response to these incidents in order to:

1. Assist the DOH WMS in their role as a single state Medicaid agency responsible for ensuring the quality of care provided to participants and to maintain the participant's health and welfare as set forth in the NHTD Waiver application approved by CMS;
2. Assist the DOH WMS to identify specific areas of concern or trends related to incidents. This information assists the DOH WMS in identifying and developing training and policies aimed at increasing provider skills in the prevention, identification, and investigation of incidents; and
3. Assist providers to identify trends in incidents within their agencies; take corrective measures to minimize the probability of a recurrence; and to develop and implement appropriate provider level interventions (e.g. staff training programs).

Serious Reportable Incidents (SRI)

Serious Reportable Incidents (SRI) are defined as any situation in which the participant experiences a perceived or actual threat to his/her health and welfare or to his/her ability to remain in the community. These incidents must be reported to DOH WMS through the QMS assigned to that region using the process outlined in this section of the Program Manual. Some of these incidents must also be reported to Adult Protective Services and/or the police.

Classifications of SRI include:

1. Allegations of Abuse and Neglect are defined as the maltreatment or mishandling of a participant which would endanger his/her physical or emotional well-being through the action or inaction of anyone, including but not limited to, any employee, intern, volunteer, consultant or contractor of any waiver service provider, or another waiver participant, family member, friend, or others, whether or not the participant is or appears to be injured or harmed.

The types of allegation(s) of abuse and neglect must be classified in the SRI report as one of the following:

- a. Physical Abuse is defined as physical actions such as hitting, slapping, pinching, kicking, hurling, strangling, shoving, unauthorized or unnecessary use of physical interventions, or other mishandling of a participant. Physical contact that is not necessary for the safety of the person and causes discomfort to the participant or the use of more force than is reasonably necessary is also considered to be physical abuse.

Emergency situations where physical intervention is used to assure the health and welfare of the participant or others must also be reported as a Serious Reportable Incident.

- b. Sexual Abuse is defined as any sexual contact between a participant and any employee, intern, volunteer, consultant or contractor of the waiver service provider providing services to the participant. Sexual abuse may also occur with any other person living in the community if it is non-consensual or if, according to New York State law, the participant is not competent to consent. Sexual contact is defined as the touching or fondling of the sexual or other body parts of a person for the purpose of gratifying the sexual desire of either party, whether directly or through clothing. Sexual contact also includes causing a person to touch someone else for the purpose of arousing or gratifying personal sexual desires. Forcing or coercing a participant to watch, listen to, or read material of a sexual nature is also considered sexual abuse. A situation in which one participant has a sexual contact with another participant, who is either not capable of consent to or did not agree to participate in the relationship, is considered to be a Serious Reportable Incident.
- c. Psychological Abuse is defined as the infliction of anguish, emotional pain or distress. Emotional or psychological abuse includes but is not limited to verbal assaults, insults, threats, intimidation, ridicule, humiliation, scorn, contempt, dehumanization or harassment, or are otherwise denigrating or socially stigmatizing. Manipulation, treating an adult like an infant, isolating an individual from family, friends or regular activities, and enforcing social isolation are further examples. The use of language and/or gestures and a tone of voice, such as screaming or shouting at or in the presence of a participant, may in certain circumstances, constitute psychological abuse.
- d. Seclusion is defined as the placement of the waiver participant alone in a locked room or area from which he/she cannot leave at will, or from which his/her normal egress is prevented by someone's direct and continuous

physical action.

The act of seclusion should not be confused with a limited quiet time procedure. Quiet time is a procedure in which a waiver participant is accompanied by staff away from an activity for a brief period of time to help the participant recompose him/herself. In addition, the participant may request time alone for this same purpose. In removing the participant from ongoing activity, the objective is to offer a changed environment in which the individual may calm down. The use of quiet time is not considered to be an incident unless it is excessive or used as a punishment.

- e. Use of Aversive Conditioning is defined as the use of unpleasant or uncomfortable procedures when trying to change the behaviors of a participant.
 - f. Violation of Civil Rights is defined as action or inaction that deprives a participant of the ability to exercise his or her legal rights, as articulated in State or federal law (e.g., the Americans with Disabilities Act).
 - g. Mistreatment is defined as a deliberate decision to act toward the participant in a manner that goes against that person's individual human rights, the Service Plan, or in a manner that is not generally considered acceptable professional practice.
 - h. Neglect is defined as a condition of deprivation in which a participant's health and welfare is jeopardized because of inconsistent or inappropriate services, treatment or care which does not meet their needs, or failure to provide an appropriate and/or safe environment. Failure to provide appropriate services, treatment or medical care through gross error in judgment and inattention is considered to be a form of neglect. For example, neglect occurs if a Service Coordinator is aware that an agency listed in a Service Plan cannot provide the requested services, but does not seek an alternate waiver service provider to meet the participant's needs.
 - i. Exploitation (financial or material) is defined as the illegal or improper use of an individual's funds, property, or assets. Examples include, but are not limited to, cashing an individual's checks without authorization or permission; forging an individual's signature; misusing or stealing an individuals' money or possessions; coercing or deceiving an individual into signing any document (e.g., contracts or will); and the improper use of guardianship, conservatorship or power of attorney.
2. Missing Person is defined as unexpected absence of a participant from his/her home or scheduled waiver service. When the absence of a participant constitutes a recognized danger to the well being of that individual or others, a formal search must be initiated immediately. This includes contacting informal supports, the Service Coordinator (if not the one discovering the participant's absence), and the police.

For those not considered in immediate danger to self or others, consideration should be given to the missing person's habits, deficits, capabilities, health problems, etc. in making the decision of when to begin a formal search, but this must be initiated no more than 24-hours after discovery that the participant is

missing.

3. Restraint is defined as the act of limiting or controlling a person's actions or behavior through the use of any device which prevents the free movement of any limb; any device or medication which immobilizes a person; any device which is ordered by a physician for the expressed purpose of controlling behavior in an emergency; or any medication as ordered by a physician which renders the participant unable to satisfactorily participate in services, community inclusion time or other activities.

Note: This does not preclude the use of mechanical supports to provide stability necessary for therapeutic measures such as immobilization of fractures, administration of intravenous fluids or other medically necessary procedures.

4. Death of a Waiver Participant is defined as any cessation of life, regardless of cause. The follow-up report of the investigation submitted to the QMS must include information concerning the death, and if obtainable medical records, death certificate, police reports, autopsy reports, EMS records, emergency room records and any other information deemed relevant.

5. Hospitalization is defined as any unplanned admission to a hospital as a result of an accident/injury or non-accident (e.g. medical condition) to the participant.

Note: The planned overnight use of a hospital for any procedure is not considered a Serious Reportable Incident, but should be noted in the subsequent Revised Service Plan, and is considered to be a Recordable Incident.

Note: Select either "Hospitalization" (#5) OR "Medical Treatment Due to Accident or Injury" (#9), but not both.

6. Possible Criminal Action is defined as any action by a participant that is or appears to be a crime under New York State or federal law.

7. Medication Error/Refusal is defined as any situation in which a participant experiences marked adverse reactions which threaten his/her health and welfare due to: refusing to take prescribed medication; taking medication in an incorrect dosage, form, or route of administration; taking medication on an incorrect schedule; taking medication which was not prescribed; or, the failure on the part of the staff of a provider of waiver services to properly follow the plan for assisting the participant in self-medication.

8. Medical Treatment is defined as any medical intervention(s) provided as a direct result of an accident/injury or non-accident (e.g. related to a medical condition) to the participant, regardless of whether hospitalization is required or not. This includes the use of an Emergency Room.

Note: Select either "Medical Treatment Due to Accident or Injury" (#9) OR "Hospitalization" (#5) but not both.

9. Sensitive Situation is defined as any situation which needs to be brought to the attention of DOH WMS through the QMS, as expeditiously as possible, and does not fit within the categories described above. This includes any situation that would threaten the participant's ability to remain in the community or the health and welfare of the participant, such as the admission to a psychiatric facility/unit or

substance abuse facility/unit.

Serious Reportable Incident Reporting Procedure

Reporting Responsibilities

Just as a variety of individuals associated with a waiver service provider may be involved in an alleged SRI they may also be a witness of such actions. The requirements for reporting this event also takes into account that the actual witness is obligated to inform his/her supervisor. In such cases the supervisor may be the one to report the alleged Serious Reportable Incident to the QMS.

In situations where only a family member or other informal support has witnessed the SRI or when there were no witnesses to the incident, the waiver service provider employee, who was made aware of the incident or his/her supervisor is responsible for filling out the reporting form and is considered to be the discoverer of the incident.

Regardless of who reports the incident, the QMS will assign the responsibility for the investigation to the waiver service provider agency whose employee was allegedly involved. If the incident does not involve a waiver service provider's employee, the QMS has the discretion to assign the responsibility of the investigation to any of the participant's waiver service providers or to undertake the investigation themselves.

If the QMS is concerned that the waiver service provider responsible for investigating the SRI is not in a position to conduct an objective, thorough investigation, the QMS has the discretion to assign the responsibility of the investigation to another provider or to undertake the investigation themselves. QMS must notify DOH WMS for technical assistance when there are any concerns regarding the investigation of a SRI.

Note: In the event an employee of an Assistive Technology, Community Transitional Services (CTS), Congregate Home and Delivered Meals, Environmental Modification or Moving Assistance provider witnesses an incident or has any concerns involving the participant, that employee must notify his/her agency's supervisor. The supervisor is responsible to contact the Service Coordinator (SC) to report the alleged incident.

All providers of Assistive Technology (AT), Community Transitional Services (CTS), Congregate Home and Delivered Meals, Environmental Modification (E-mods) and Moving Assistance must inform all subcontractors used of their responsibility to report any witnessed or suspected incident involving a waiver participant to the waiver service provider supervisor. Upon notification by any subcontractor, these waiver service provider supervisors must proceed with the same SRI reporting protocol as in the paragraph immediately above.

In the event an incident is witnessed by an employee of a Home Visits by Medical Personnel provider, that employee must notify the SC directly.

Upon notification by any of these providers, the SC becomes the 'discoverer' of the incident and is responsible to initiate the reporting process with QMS.

Note: Providers of AT, E-mods, Congregate and Home Delivered Meals and Home Visits by Medical Personnel will not be assigned the responsibility of investigating any allegations of a SRI unless they provide other services for which they are responsible for investigating incidents.

Procedure

Note: All forms used in the Serious Reportable Incident (SRI) procedure can be found in Appendix E - forms SRI.1 to SRI.6 of this Program Manual.

1. Within two (2) hours of discovering a SRI has occurred, the discovering waiver service provider, SC, RRDS or DOH must notify the QMS via telephone or email, then complete and forward the “**Initial Report**” form. A copy of this form must be sent to the RRDS and SC by the discoverer.

If the incident involves any type of abuse listed or the death of a participant, the QMS must notify DOH WMS by the next business day via phone, also providing a copy of the “**Initial Report**” form. Upon request of DOH WMS, QMS will provide copies of any other forms related to the incident to DOH WMS.

When appropriate, any waiver service provider or waiver entity may contact Adult Protective Services (APS) related to an alleged incident involving a waiver participant at any time during the Serious Incident Reporting process. In addition, a waiver service provider, SC, RRDS or QMS must assure the participant is reminded of his/her right to notify the police as appropriate. The QMS will assure that any known contact made by the provider with APS or with the police has been appropriately documented on the “Initial Report”, “24-Hour Provider Report”, “Provider Follow-Up Report”, or subsequent “Provider Follow-Up Reports”.

2. Within twenty-four (24) hours of discovery, the reporting waiver service provider must complete and send the “**24-Hour Provider Report**” to QMS. The QMS will forward a copy of the report to the RRDS and SC.

Note: If the SC is alleged to be involved in the incident, the “**24-Hour Provider Report**” is sent to the Service Coordination Supervisor.

Note: If the ‘discoverer’ of the incident is DOH WMS or RRDS, the QMS will assign completion of the “**24-Hour Provider Report**” to a waiver service provider.

3. Upon receipt of the “**24-Hour Provider Report**” form, the SC must contact the participant and/or legal guardian and informs him/her that an investigation is under way. In addition, the SC must notify any other waiver or non-waiver provider currently involved in the Service Plan (SP) when there is visible evidence of injury to the waiver participant or when the incident or response to the incident may impact services or activities. Consideration of the individual’s privacy should be balanced against the need to notify only service providers who need to know for the purpose of service delivery. Contact with the waiver participant and/or legal guardian and/or other waiver service providers must be documented using the “**Service Coordinator 24-Hour Notification Report**”. The SC sends this report to the QMS.

Note: If the SC is alleged to be involved in the incident, the Service Coordination Supervisor is responsible for contacting the participant and following Step #3 above.

Note: All waiver providers must assure that during the investigation, if the person alleged to be involved in the incident directly serves the participant (e.g. the SC), he/she must not continue to serve the participant. The agency’s supervisor must work with the participant to assure selection of an alternate individual to work with the participant. In addition, the participant must be offered the choice to select a

different provider if one is available.

4. Within twenty-four (24) hours of receiving the “**24-Hour Provider Report**” form, the QMS will review the form and then complete the QMS “**Initial Response**” form. The QMS assigns an incident number to the incident and enters it onto the form. This number must be included in all future reports and correspondence relating to the incident.

a. Assigning a number to an incident:

Each incident number consists of four sets of numbers, each series being separated by a dash (-):

- A two digit number indicating the Recipient/Exception code (e.g. code 60 for NHTD waiver participant);
- a four digit number indicating the year of the incident (e.g. 2008);
- a two digit number indicating the RRDC region (e.g. 09); and
- a three digit number assigned to the specific incident.

Numbers start at 001 for each RRDC region and continue in consecutive order from January to December.

Each RRDC Region is assigned a two-digit code number as follows:

- 01 Long Island
- 02 New York City
- 03 Unused
- 04 Lower Hudson Valley
- 05 Capital Region
- 06 Adirondack
- 07 Syracuse
- 08 Southern Tier
- 09 Rochester
- 10 Buffalo

Example: An incident in the NHTD waiver occurred in the Hudson Valley region in 2008 and is the 7th incident reported to that region. The QMS for that region creates an incident number as follow: 60-2008-04-007.

b. Classification and Category Verification

The QMS will document on the QMS “**Initial Response**” form acceptance of the original classification or, if indicated, the re-classification of the incident.

Note: In the event the QMS determines that the incident does not meet the definition of a SRI and re-categorizes the incident as a Recordable Incident, this must be noted on the QMS “**Initial Response**” form. In this instance, the case is considered CLOSED. The QMS also completes the QMS “**Status Report**” form.

The QMS will notify the participant via telephone that the incident has been closed and the reason why. This contact must be documented by the QMS “**Status Report**” form.

QMS provides a copy of the QMS “**Initial Response**” and the QMS “**Status Report**” forms to the reporting agency, RRDS and Service Coordinator.

c. Assigning Investigation

QMS will determine which waiver service provider will be responsible for conducting the investigation and will contact the provider agency to discuss the provider's plan for investigating the incident. The QMS will provide technical support to the waiver service provider and may request assistance from DOH in the process, if necessary. The QMS will document contact on the QMS "**Initial Response**" form and provide the dates of the expected seven (7) calendar day and thirty (30) calendar day Follow-Up Reports. A copy of the QMS "**Initial Response**" form is provided to the waiver service provider assigned to the investigation, the reporting provider, RRDS and SC by QMS.

Note: Providers of Assistive Technology, Environmental Modifications, Congregate and Home Delivered Meals and Home Visits by Medical Personnel will not be assigned the responsibility of investigating any allegations of a Serious Reportable Incident unless they provide other services for which they are responsible for investigating incidents.

5. QMS will forward the QMS "**Initial Response**" form and the "**24-Hour Provider Report**" form to the investigating waiver service provider, sending a copy to the discovering provider (if different from the investigating waiver service provider), RRDS and Service Coordinator.
6. The investigating provider must assign an appropriate individual from the waiver service provider agency or may choose to contract with another agency to conduct the investigation. At the same time, the investigating provider must notify its Serious Incident Review Committee (SIRC) (refer to the section below - Provider's Serious Incident Review Committee) that there has been an allegation and the investigation has been assigned (refer to "Investigation of Serious Reportable Incidents" in the section to follow).
7. Within seven (7) calendar days of receiving the QMS "**Initial Response**" form and the "**24-Hour Provider Report**" form, the investigating waiver service provider must complete and submit the "**Provider Follow-Up Report**" to the QMS including all formal investigating agency reports, interview statements, and any contact made with the SIRC. The QMS must forward a copy of the "**Provider Follow-Up Report**" to the RRDS and the SC.
8. Within seven (7) calendar days of receiving the "**Provider Follow-Up Report**", the QMS will make the decision whether to close the case or leave it open for further investigation, using the RRDS for consultation as needed. The QMS will complete the QMS "**Status Report**" indicating whether the case:
 - 1) is re-classified (with explanation);
 - 2) remains open (and the reason why); and/or
 - 3) is closed.

If left open for further investigation, the investigating waiver service provider must continue the investigation process and prepare information for submission of the completed "**Provider Follow-Up Report**" (30-day).

The QMS must send a copy of the report to the RRDS, the SC and the investigating provider.

9. Within thirty (30) calendar days of receiving the original QMS” **Initial Response**” and the “**24-Hour Provider Report**” forms, the investigating waiver service provider must submit the next “**Provider Follow-Up Report**” to QMS for review, with copies of all reports, statements, and supporting documentation attached. The QMS will forward the report to the RRDS and the SC.
10. Within seven (7) calendar days of receipt of the “**Provider Follow-Up Report**” form, the QMS will make the decision whether to close the case or leave the case open for further investigation, using the RRDS for consultation as needed. The QMS will complete the QMS “**Status Report**” indicating whether the case:
 - 1) is re-classified (with explanation);
 - 2) remains open (and the reason why); and/or
 - 3) is closed.

The QMS must send a copy of the report to the RRDS, the SC and the investigating provider.

11. If further investigation is deemed appropriate by the QMS, the “**Provider Follow-Up Report**” must continue to be submitted by the investigating waiver service provider monthly by the anniversary date of the discovery of the incident until the QMS determines the case to be ‘closed’. A copy of each report is forwarded to the RRDS and SC by QMS. When the case is deemed closed, QMS must complete the QMS “**Status Report**”, sending a copy to the RRDS, the Service Coordinator and the investigating provider.

If the case is re-classified, the investigation must continue under the same protocol as if open, until the QMS can determine that the investigation has been completed and the case can be closed.

12. Once the investigation is closed, the QMS must notify the participant via telephone that the investigation has been completed. Although details of the investigation are not disclosed, the final outcome is provided to the Participant/Legal Guardian. This contact is documented by the QMS on the QMS “**Post-Investigation Follow-Up Contact With Participant**” form.
13. Any further contact with the participant will be made at the discretion of the QMS depending on the type and outcome of the investigation. When indicated, QMS will consult with the RRDS and/or DOH WMS to determine what, if any additional contact needs to be made. The QMS will document all contacts on the QMS “**Post-Investigation Follow-Up With the Participant**” form.
14. The QMS must maintain an Incident database, tracking all incidents reported. The QMS must also maintain all documentation related to the SRI in a separate file.
15. The RRDS must also maintain copies of all documentation related to SRI in a file separate from the participant’s record and easily available to DOH WMS upon request.
16. If at any time during the procedure for SRI a waiver service provider does not comply with time frames outlined for reporting and/or has failed to comply with necessary documentation requirements, the QMS will notify DOH WMS. This may include, but is not limited to, the waiver service provider’s failure to submit any of

the required documents to the QMS (e.g. the seven (7) or thirty (30) day “Provider Follow-Up Report”, etc). DOH WMS will determine what actions must to be taken including the need to place the waiver service provider on Vendor Hold and if so, will a send the Notice of Vendor Hold to the provider agency’s Executive Director. The Notice of Vendor Hold will outline the need for immediate attention to the incident and a plan of action by the waiver service provider which will include information to correct the situation and ensure such delays do not occur in the future.

17. If there are extenuating circumstances as to why the SRI procedures were not followed, a representative from the waiver service provider agency’s administration is required to contact the QMS prior to the procedural deadlines to discuss the situation. The QMS will make the determination whether the situation warrants an extension of the policy and will notify DOH WMS of all such decisions.
18. When the waiver provider agency submits all necessary SRI documentation and a plan of action approved by DOH WMS and the QMS, the Vendor Hold process will be stopped via a letter from DOH WMS.
19. Should the waiver provider agency fail to submit the necessary SRI documentation and an acceptable plan of action within seven (7) calendar days of the Notice of Vendor Hold, the QMS will notify DOH WMS. DOH WMS will issue a Notice of Disenrollment to the waiver provider agency Executive Director indicating that due to continued non-compliance with the SRI Policy and Procedure, the waiver service provider will be disenrolled from the NHTD waiver sixty (60) calendar days from the Notice date.
20. If at any time during this process, the provider agency complies with all policy and procedures, as related to SRI, and submits an acceptable plan of action approved by DOH WMS and the QMS, DOH WMS will determine whether the disenrollment process may be stopped and will send written notification to the waiver service provider’s Executive Director.

Investigation of Serious Reportable Incidents

The waiver service provider assigned by the QMS must designate at least one individual to be responsible for conducting a thorough and objective investigation. The investigator is required to have experience and/or training in conducting investigations.

A waiver service provider may choose to contract with another agency to perform the investigation. However, the contracted agency must not have any involvement or stake in the outcome of the investigation. The decision of the contracted agency is binding on the investigating agency. The results of the investigation are presented to the SIRC, which will determine if the investigation is complete, the appropriate action to take and the necessary follow-up.

People conducting the investigation must not include:

- Individuals directly involved in the incident.
- Individuals whose testimony is incorporated in the investigation.
- Individuals who are supervised by the person alleged in the investigation, spouse, significant other or immediate family member of anyone involved in the investigation.

The investigative report of a SRI must contain the following information:

1. A clear and objective description of the event under investigation. This must include a description of the alleged victim, all people involved in the alleged incident, the names of all witnesses and the time and place the incident occurred;
2. Details of structured interviews with all individuals involved in the events and all witnesses;
3. Identification of whether this was a unique occurrence or if there is a pattern of such incidents believed to be related to previous activities or reported incidents;
4. The investigator's conclusions if the allegation is substantiated, unsubstantiated or whether no definitive conclusions can be reached. The reasoning behind this decision must be included; and
5. The investigator's recommendations for action(s). The action(s) may be directed towards individual employees or the participant, and/or may address larger program concerns such as training, supervision or agency policy.

If a participant is alleged to have abused another participant or member of the community (including staff), it is necessary for the investigation to take into consideration the aggressor's cognitive abilities to make a judgment about these actions when the interventions are established following investigation of the incident.

Investigations by DOH

As described in the NHTD Waiver Provider Agreement, DOH and its representative(s) (i.e., the QMS, RRDS or others identified as such by the DOH WMS) have the authority to investigate the conduct, performance and/or alleged neglect of duties of administrators or employees of any agency serving as a NHTD waiver service provider. This level of intervention will occur when there are concerns that the provider has not followed the procedures described in this policy. If the provider is found to have failed to comply with the SRI procedures described in this Program Manual, DOH will take appropriate action.

DOH will work cooperatively with other State agencies that provide services to individuals with disabilities, informing them when mutual providers experience significant or numerous SRI.

Any employee under investigation for Serious Reportable Incidents by DOH or another State agency is not permitted to provide service to any NHTD waiver participant.

Provider's Serious Incident Review Committee

Note: Providers of AT, E-mods, Congregate and Home Delivered Meals and Home Visits by Medical Personnel will not be assigned the responsibility of investigating any allegations of a SRI unless they provide other services for which they are responsible for investigating incidents.

1. Organization and Membership of the Serious Incident Review Committee

- The Committee may be organized on an agency-wide, multi-program or program-specific basis.

- The Committee must contain at least five individuals. Participation of a cross section of staff, including professional staff, direct care staff and at least one member of the administrative staff is strongly recommended.
- The Executive Director of the agency shall not serve as a member of the Committee but may be consulted by the Committee in its deliberations.
- The Program Administrator for NHTD Waiver services may be designated as a member only if the Committee is an agency-wide or multi-program committee.
- The individual assigned to conduct investigations for the agency can be part of the Committee, but may not serve on the Committee at the same time he/she is involved in an active investigation for the agency.
- The Committee must meet at least quarterly, and always within one (1) month of a report of a SRI involving a NHTD waiver participant.

2. **Responsibilities of the Serious Incident Review Committee**

This Committee is responsible for reviewing the investigation of every SRI. The SIRC will evaluate whether the investigation has been thorough and objective. It will determine if the conclusions and recommendations of the investigator are in line with generally accepted professional standards and are in compliance with the guidelines of the NHTD waiver.

In addition, the Committee will:

- a. Assure that the providers' Incident Reporting Policies and Procedures comply with DOH NHTD Incident Reporting Policy as detailed in this Program Manual.
- b. Review all SRI and Recordable Incidents to assure that incidents are appropriately reported, investigated and documented.
- c. Ascertain that necessary and appropriate corrective, preventive, and/or disciplinary action has been taken in accordance with the Committee's recommendations. If other actions are taken, the Committee must document the original recommendations and explain why these recommendations were revised.
- d. Develop recommendations, if warranted for changes in provider policy and procedure to prevent or minimize the occurrence of similar situations. These recommendations must be presented to the appropriate administrative staff.
- e. Identify trends in SRI (by type, client, site, employee, involvement, time, date, circumstance, etc.), and recommend appropriate corrective and preventive policies and procedures to the agency administration.
- f. Report annually to QMS regarding SRI, Recordable Incidents and all corrective, preventive and/or disciplinary actions taken pertaining to identified trends. This report must include the name and position of each of the members of the committee and documentation of any changes in the membership during the reporting period). This report will be submitted to the QMS in each agency's region where the provider is authorized to provide

waiver services by January 31 of each year for the prior year. A copy is also provided to the appropriate RRDS by the agency for further review, regional trend analysis and recommendations for interventions. QMS forwards the report with analysis to DOH WMS for further review. DOH may request reports at any time.

3. Documentation of Serious Incident Review Committee Activity

- The chairperson shall ensure that minutes are kept for all meetings and maintained in one location.
- Minutes are to be maintained in a manner that ensures confidentiality.
- Minutes addressing the review of SRI shall state the identification number of the incident (provided by QMS and the participant's CIN, a brief summary of the situation that caused the report to be generated (including date and type of incident), Committee findings and recommendations, and actions taken on the part of the agency/program as a result of such recommendations.
- DOH may request to review minutes at any time.

All information regarding SRI reports, including but not limited to the information collected to complete the investigation and the investigation report and minutes of the standing SIRC, must be maintained separately from the participant's records.

Recordable Incidents

Note: Providers of AT, E-mods, Congregate and Home Delivered Meals and Home Visits by Medical Personnel will not be assigned the responsibility of investigating any allegations of a SRI unless they provide other services for which they are responsible for investigating incidents.

Recordable Incidents are defined as incidents that do not meet the level of severity described as SRI, but which adversely affects the participant's life in the community. An example of these incidents is a fall that does not require medical attention. These Recordable Incidents do not need to be reported to DOH. However, Recordable Incidents must be investigated by the provider and included in the annual report prepared by the Serious Incident Review Committee provided to QMS. DOH WMS reserves the right to review Recordable Incidents at any time.

Provider policies and procedures regarding Recordable Incidents must include an explanation or identification of the:

1. Title or position of the individual(s) responsible for implementing these policies;
2. Process for reporting, investigating and resolving Recordable Incidents within the agency;
3. Process for identifying patterns of incidents which involve a specific participant or staff within the agency that threaten the health and welfare of participants in general;
4. System for tracking the reporting, investigation and the outcome of all Recordable Incidents which includes:
 - Name of the waiver Participant involved
 - Date(s) of the incident

- Time incident occurred
 - Type or description of Incident
 - Action(s) taken by the provider including making recommendations for changes in policies and procedures
 - Provider staff or others involved
5. Criteria used to determine when a Recordable Incident should be upgraded to a Serious Reportable Incident to be reported to DOH WMS.

Waiver Service Provider's Internal Complaint Procedure

Each waiver service provider must develop and implement a process for responding to complaints made by participants or other(s) on his/her behalf (e.g. guardian, family members or advocates). This process must be clearly written, easy to navigate and provided to the participant.

The complaint policy must include:

1. A description of how to register a verbal or written complaint, that registering a complaint in no way jeopardizes his/her right to receive services, who is responsible to receive and respond to the complaint, and a time frame for making initial contact with the participant (within seventy-two (72) hours) upon receipt of complaint;
2. A time frame for completing a complaint investigation and providing a written response to the complainant (maximum of thirty (30) calendar days from receipt of initial complaint);
3. An appeals process, including timeframes, if the person who registered the complaint is not satisfied with the response (to be completed in no more than fifteen (15) calendar days from notice from the complaint);
4. Additional appeals process, in which the complaint is forwarded to the provider agency's governing authority for review and recommendations (to be completed in no more than fifteen (15) calendar days from receipt of the information); and
5. Notification to the participant of his/her right to contact the RRDS if not satisfied with the outcome of the agency's response.

The RRDS may utilize the QMS for technical assistance as needed. If the RRDS is not able to resolve the difficulties, the RRDS forwards the matter to the DOH WMS for review and final resolution.

Note: At any time, the participant has the right to notify his/her SC regarding registering of a complaint with a provider agency. The participant may request that the SC act as advocate for the participant assisting him/her through the complaint process with the provider agency. The SC and/or participant may contact the RRDS for assistance when the appeals process does not lead to a satisfactory resolution.

There may be times when a complaint must be converted to a Serious Reportable or Recordable Incident report. A provider must inform the individual filing the complaint that this has occurred, the reason for converting the complaint, and documents the incident

review process.

Information regarding complaints must be made available to DOH WMS upon request and to DOH during survey of the agency.

Section XI

APPENDIX
and
FORMS

Appendix

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- A.2 Provider Agreement

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Appendix

Appendix C - Service Plan forms (continued)

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- *NYD Health Department Numerical Standards Master Sheet

Appendix G – Contact List for Regional Resource Development Centers, Quality Management Specialists and DOH Waiver Management Staff

RRDC: _____

EMPLOYEE VERIFICATION OF QUALIFICATIONS

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

Employee to provide the Waiver Service

Service Provider Name

Waiver Service you are applying for

Address

Waiver Service Position, if applicable

Telephone

I have submitted my resume and supporting documents which accurately reflects my education and work experience.

Employee Signature

Date

This individual has met the eligibility criteria for this position in the following manner:

Education: A copy of this individual's _____ diploma or official sealed transcript
_____ license is attached to this form.

Experience: _____ This individual's experience, relevant to this position, is highlighted on his/her attached resume. (****Please circle this person's relevant experience on the attached resume for quick reference for the interviewers****).

I have interviewed this individual and reviewed his/her resume. I verified his/her education, required licensures and work experience. Per waiver eligibility criteria, this individual is qualified to provide waiver services in the above named position and has been hired as an employee of our agency.

Service Provider Representative

Title

Signature

Date

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER NURSING HOME TRANSITION AND DIVERSION (NHTD)

AGREEMENT BETWEEN THE NEW YORK STATE DEPARTMENT OF HEALTH AND A PROVIDER OF HOME AND COMMUNITY-BASED WAIVER SERVICES

This Agreement is between the New York State Department of Health (DOH) and _____ (Provider), who is approved to provide New York State Home and Community-Based Services (HCBS). The Provider will receive a letter from DOH indicating the approved waiver services.

For the purpose of establishing eligibility for payment under Title XIX of the Federal Social Security Act, the Provider agrees to comply with all provisions of the New York State Social Services Law and regulations adopted under the authority of such law; the terms of the addenda attached to this contract and 42 CFR 431.107; the standards of operation set forth in the DOH Program Manual for Home and Community Based Services (HCBS) waivers; and all revisions and updates to the Manual and this agreement.

The Provider also agrees to:

- I. Keep any records necessary to disclose the type and extent of services furnished to recipients and on request, furnish to DOH, its designees, the Secretary of the U.S. Department of Health and Human Services or the State Medicaid Fraud Control Unit, information regarding these services and payments claimed under Title XIX;
- II. Collect personal information concerning a waiver applicant or participant directly from the waiver applicant or participant, whenever applicable. The Provider must keep confidential all information contained in the applicant or participant's records, regardless of the form or storage methods, except when release is required to fulfill the contractual responsibilities set forth in this agreement. The use of information obtained by the Provider in the performance of its duties under this Agreement shall be limited to purposes directly connected with such duties;
- III. Treat all information collected and utilized by its officers, agents, employees and subcontractors, with particular emphasis on information relating to waiver applicants and participants, obtained by it through its performance under this Agreement, as confidential information to the extent required by the laws and regulations of the State of New York, including the Personal Privacy Protection Law as may be applicable when personal information is being collected on behalf of the New York State Department of Health;
- IV. Abide by all applicable federal and State laws, and regulations of DOH and the Department of Health and Human Services including all requirements of the Health Insurance Portability and Accountability Act (HIPAA);
- V. Report all revenues and expenses associated with the provision of waiver services using the forms and procedures established in the Program Manual;
- VI. Submit claims for waiver services in accordance with instructions issued, specifically ensuring that services billed as waiver services are not also billed to Medicaid under the existing State Plan services;
- VII. Submit claims for all waiver service(s), except Service Coordination and Environmental Modifications, only when the recipient is Medicaid eligible, an approved waiver participant, and residing in the community;
- VIII. Submit claims for Service Coordination only when the recipient is Medicaid eligible, and an approved waiver participant and residing in the community or, when a waiver participant is hospitalized, in accordance with the Program Manual;
- IX. Submit claims for prior approved Environmental Modifications only when the recipient is Medicaid eligible, an approved waiver participant, and residing in the community. In situations where the individual is not

discharged into the community as anticipated, billing must be prior approved by the RRDS in accordance with the Program Manual;

- X. Attend fair hearings and provide testimony regarding the recipient of waiver services when requested by DOH or its designee and comply with such fair hearing decisions in accordance with 18 NYCRR 358-6.4;
- XI. When a provider is contacted by an individual inquiring about the HCBS waivers, the provider must refer the individual to the appropriate Regional Resource Development Center (RRDC) for information and referral. This will ensure that the individual is informed of their right to select waiver services from a list of approved service providers.

This Agreement shall be effective upon approval by DOH and shall remain in effect no later than **August 31, 2010**. This Agreement may be terminated sooner by either party for any reason upon sixty (60) days written notice to the other party. In the event the Agreement expires or is terminated, the Provider will cooperate with and assist DOH or its designee in obtaining services determined to be necessary and appropriate for waiver participants.

Provider Agency	Address	
<hr/>		
Authorized by	Signature	Date
<hr/>		
Contact Person	Telephone	

SERVICE CERTIFICATION

Issuance of a Provider Agreement constitutes certification of the covered services. It does not constitute a blanket commitment to sponsor unlimited services.

**AGREEMENT BETWEEN THE NEW YORK STATE DEPARTMENT OF HEALTH
AND
A PROVIDER OF HOME AND COMMUNITY-BASED WAIVER SERVICES (cont'd)**

Addendum I

Rights of Waiver Participants

- (A) Providers of HCBS waiver services must protect and promote the exercise of basic rights for participants including their right to:
1. Select or change individual service provider(s) and/or choose to receive waiver services from different agencies or different providers within the same agency without affecting overall waiver eligibility;
 2. Participate in the planning of his or her services and supports. In addition to the Service Plan, plans for each waiver service must be developed, implemented and updated in accordance with the waiver participant's requests and with the requirements established in the Program Manual for the HCBS waiver;
 3. Be given a statement of the services available to the participant under the waiver;
 4. Be informed of when and how approved services described in the Service Plan will be provided, and the name and functions of any person and affiliated entity providing care and services;
 5. Refuse care, treatment and services after being fully informed and understanding of the consequences of such actions;
 6. Submit complaints about care and services provided or not provided and complaints concerning lack of respect for the individual's rights and property. Receive support and direction from the Service Coordinator, the Regional Resource Development Specialist (RRDS), Quality Management Specialist (QMS) for resolving waiver participant's concerns and complaints about services and service providers. Such complaints may be directed to the agency employing the service provider, any outside representative of the individual's choice or the Department of Health, and must be investigated as outlined in the Program Manual. The resolution of such investigation must be provided to the participant. The participant may not be subjected to restraint, interference, coercion, discrimination or reprisal as a result of filing such complaint;
 7. Be treated with consideration, respect and full recognition of his or her dignity, property rights and individuality;
 8. Be afforded privacy, including confidential treatment of waiver participant records, and refusal of their release to any individual not authorized to have such records, except in the case of the participant's transfer to a health care facility, or as required by law or Medicaid requirements;
 9. Be informed of the rights contained herein and the right to exercise such rights, in writing, prior to the initiation of care as evidenced by written documentation in the record maintained by each service provider who has ongoing contact with the participant; and
 10. Be advised in writing of the address and telephone number of the Service Coordinator, all service providers and their supervisors, the Regional Resource Development Specialist (RRDS), Quality Management Specialist (QMS) and the NHTD Complaint line;
- (B) Each provider agency must inform its personnel providing services to waiver participants of the rights of participants and the responsibility of all personnel to protect and promote the exercise of such rights.
- (C) If a participant lacks capacity to exercise these rights, the participant's legal guardian will exercise those rights.
- (D) If a participant has been adjudicated incompetent in accordance with State law, all rights and responsibilities specified in this addendum may be exercised by the appointed [committee or legal] guardian authorized to act on behalf of the participant.

Addendum II

Provision of HCBS Waiver Services

Each provider of waiver services MUST adhere to the following standards:

1. Services must be provided in accordance with the participant's assessed needs, accepted standards of quality and effectiveness and the provider's recognized scope of practice and competence.
2. Services must be provided in a manner that promotes, and does not jeopardize the participant's health and welfare.
3. A Service Plan for the participant must be developed, implemented and updated in accordance with the requirements established in the Program Manual for the HCBS waiver.
4. Services will be provided to participants without regard to race, religion, color, creed, gender, national origin, sexual orientation, marital status or disability.
5. Provider personnel shall be governed by the applicable federal and State labor laws and regulations.
6. Providers must refer the participant to the Service Coordinator for other health and social community resources which may benefit the participant.
7. The Provider must oversee the provision of services to ensure that quality services are delivered in a timely manner and in accordance with the Service Plan.
8. Providers must support the participant's right to choose services from approved providers.
9. Participant records must include documentation of changes in the participant's condition, adverse reactions, and problems. Any changes impacting the participant's environment, health and welfare must be noted and immediately reported to a supervisor and the participant's Service Coordinator. All records must be maintained in accordance with applicable law. DOH or its representatives reserve the right to review records at any time.
10. There must be effective communication between the Service Coordinator and all service providers to ensure that the participant's health and welfare are maintained in accordance with the Service Plan. The Provider will inform the waiver participant of information that will be shared among service providers.
11. The Provider will document all Serious Reportable and Recordable Incidents and manage in accordance with the Incident Policy in the Program Manual.

The Regional Resource Development Specialist (RRDS), Nurse Evaluator (NE), and Quality Management Specialist (QMS), as designees of the DOH, shall have full access to all provider records regarding a participant and the provision of HCBS waiver services.

I acknowledge the information presented in Addendum I and II of this Agreement.

Provider Agency	Contact Person	Title
Authorized by	Signature	Date
Contact Person		Telephone

REFERRAL FORM

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

Transferred from: _____
(RRDS Region)

Referral # _____
(Date YYYYMMDD + Region number + R + referral counter,
Ex. 20061015-02-R012)

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

Date of Initial Referral: _____ Region: _____

Applicant Information

Current Telephone: () _____ Medicaid Active: Yes No Unknown

Current Location:

- Private Residence Hospital Physical Rehabilitation Facility Psychiatric Facility
 Nursing Home Adult Home/Assisted Living Substance Abuse Rehab. Facility
 Jail/Prison Other: _____

Location Address: _____
Street

City

State

Zip

Comments: _____

Is Applicant: Diverting from: In-state Out of State Transitioning from: In-state Out of State

Is applicant proficient in English? Yes No

Does the applicant need a translator? Yes No If yes, what language? _____
Does applicant need a sign language interpreter? Yes No

If yes, translation/interpretation provided by: _____

Telephone: () _____ Telephone: () _____

Does applicant require written materials in alternative formats? Yes No

Specify: _____

Contact Information

Legal Guardian Yes No

Name (if applicable): _____ Telephone: () _____

Contact Person Name: _____ Relationship to Applicant: _____

Address: same as above _____
Street

City

State

Zip

Telephone: () _____

Referral Form (continued)

Applicant Name: _____	Referral # _____
------------------------------	-------------------------

Demographics

Applicant Age: _____ Applicant Sex: Female Male
Applicant Birth Date (if known): ___/___/___ Marital Status: Single Married
 Separated Divorced Widowed

Referral Information

Reported Primary Diagnosis: _____

Areas of Concern: _____

Currently Living With: Alone Spouse Adult Children Minor Children Parents
 Siblings Other Family Members Friends/Significant Others Other _____

Onset of Needs Occurred Within: the last 3 months last 3-6 months last 6-12 months
 last 1-2 years last 2-5 years more than 5 years

Does Applicant have help in the home now? Yes No
If yes, specify type of service(s): _____

Proposed Living Arrangements

Proposed Region: _____ Proposed County: _____

Proposed Address: same as Current Location above Unknown

Street	City	State	Zip
--------	------	-------	-----

Proposed Living Situation: _____

Referral Source

Self Referral Comments: _____

Informal Referral Same as Contact Person above

Name: _____ Relationship to Applicant: _____

Telephone: () _____ Informal referral comments: _____

Referral Form (continued)

Applicant Name: _____ **Referral #** _____

Formal Referral

Provider Name: _____ Telephone: (____) _____

Referral Source type:

- | | | |
|--|--|---|
| <input type="checkbox"/> Nursing Home | <input type="checkbox"/> Adult Home/Assisted Living | <input type="checkbox"/> Criminal Justice |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Medical Personnel | <input type="checkbox"/> Community Based Services |
| <input type="checkbox"/> MDS data | <input type="checkbox"/> Physical Rehab. Facility | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Independent Living Center | <input type="checkbox"/> Psychiatric Facility | |
| <input type="checkbox"/> Local Department of Social Services | <input type="checkbox"/> Substance Abuse Rehab. Facility | |

Provider Contact/Title: _____ Email: _____

Formal Referral Comments: _____

How did the referral source learn about the waiver?

- | | | |
|--|--|--|
| <input type="checkbox"/> RRDC | <input type="checkbox"/> Local Department of Social Services | <input type="checkbox"/> Psychiatric Facility |
| <input type="checkbox"/> Nursing Home | <input type="checkbox"/> Home Care Agency | <input type="checkbox"/> Substance Abuse Rehab. Facility |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Medical Personnel | <input type="checkbox"/> Media (TV, Radio, Newspaper) |
| <input type="checkbox"/> Point of Entry | <input type="checkbox"/> Staff from other waiver | <input type="checkbox"/> Pamphlets |
| <input type="checkbox"/> Independent Living Center | <input type="checkbox"/> Physical Rehab. Facility | <input type="checkbox"/> Other: _____ |

Outcomes – this section to be completed by RRDC

Referral Status: Proceed to Intake Date: __/__/____ Closed Date: __/__/____

Transferred to: _____ Date: __/__/____ Comments: _____

If closed, why? Age Medicaid status Medically unstable Choose to stay in Nursing Home
 Unable to contact Other: _____

Referral made to other resource(s): Point of Entry TBI Waiver NHTD Waiver LTHHCP
 OMH OMRDD Consumer Directed/PCS CHHA
 Office for the Aging None Other: _____

RRDS Name/Signature: _____ Date: _____

INTAKE FORM

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

Date of Referral: ___/___/___

Referral #: _____

Region: _____

(Date YYYYMMDD + Region number +R + referral counter,
Ex. 20061015-02-R012)

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

Date Contacted : ___/___/___ Date Intake Scheduled for: ___/___/___ Final Intake Date: ___/___/___

Applicant Information

Current Telephone: () _____

Current Location:

- Private Residence Hospital Physical Rehabilitation Facility Psychiatric Facility
 Nursing Home Adult Home/Assisted Living Substance Abuse Rehab. Facility
 Jail/Prison Other: _____

Location Address: _____
Street City State Zip

Comments: _____

Legal Residence: same as Current Location Address _____
Street

City County/Region State Zip

Comments: _____

Mailing Address (Please check which one applies): Current Legal

Is applicant proficient in English? Yes No

Does the applicant need a translator? Yes No

If yes, what language? _____

Translation provided by: _____ Telephone: () _____

Does applicant need a sign language interpreter? Yes No

If yes, interpretation provided by: _____ Telephone: () _____

Does applicant require written materials in alternative formats? Yes No

Specify: _____

Contact Information

Legal Guardianship Yes No If yes, obtain documentation.

Legal Guardian Name (if applicable): _____ Telephone: () _____

Contact Person Name: _____ Relationship to Applicant: _____

Address: same as above _____
Street

City State Zip

Telephone: () _____

Intake Form (continued)

Applicant Name: _____	Referral # _____
------------------------------	-------------------------

Demographics

Applicant Birth Date: ___/___/____ Applicant Sex: Female Male

Applicant Age: _____ Marital Status: Single Married
 Separated Divorced Widowed

Race/Ethnicity: Caucasian Black or African American Asian Native American/Alaskan Native
 Hispanic/Latino Other: _____

Insurance

Medicaid Status: Active Pending Spend down Needs to Apply Denied Unknown Managed CIN: _____
County of fiscal responsibility: _____

Medicare Status: Active A B D Managed Pending Denied Needs to Apply N/A Medicare #: _____

Veteran: Yes No

Other insurance plan: _____

Diagnosis/Needs

Reported Primary Diagnosis: _____

Reported Other Diagnosis: _____

Population category (check all that apply)
 Senior (65+) Physical Disability (18-64) MR/DD Mental Illness

Impact on the Individual:
 Describe Physical Disabilities: _____
 Describe Cognitive Disabilities: _____
 Describe Behavioral Concerns: _____

Intake Form (continued)

Applicant Name:	Referral #
------------------------	-------------------

Currently Living With: Alone Spouse Adult Children Minor Children Parents
 Siblings Other Family Members Friends/Significant Others Other _____

Onset of Needs Occurred Within: the last 3 months last 3-6 months last 6-12 months
 last 1-2 years last 2-5 years more than 5 years

Expected Needs: personal care housekeeping meals
 getting out of bed supervision for safety reasons bill paying
 home modification assistive medical equipment structured social activities
 other: _____

Is there help in the home now? Yes No

Informal: Spouse Adult Children Minor Children Parents
 Siblings Other Family Members Friends/Significant Others Other: _____

Type of help: _____

Formal: TBI Waiver NHTD Waiver LTHHCP OMRDD
 OMH State Plan, Please list: _____ Other: _____

Type of help: _____

Previous experience with NYS HCBS Waivers. Yes No If yes, which waiver:

NHTD TBI LTHHCP Care at Home OMRDD
 OMH Children with Serious Emotional Disturbance Other: _____

Is Applicant: Diverting from: Transitioning from:
 In-state Out of State In-state Out of State

*Was the applicant going to go to an Out of State facility? Yes No

If Transitioning, approximate length of stay in the nursing facility: under 3 months 3-6 months
 7-11 months 1-2 years
 over 2 years

Proposed Living Arrangements

Proposed County: _____ Proposed Region: _____

Proposed Address: same as Current Location above Unknown

Street City State Zip Code

Intake Form (continued)

Applicant Name:	Referral #
-----------------	------------

Proposed Living Situation: Alone Spouse Adult Children Minor Children
 Parent Siblings Other Family Members
 Friends/Significant Others Unknown Other: _____

Proposed type of community residence:
 Home (owned or leased by individual or family)
 Apartment (individual lease, lockable access, etc.)
 Group home or other residence in which 4 or fewer unrelated individuals live
 Other: _____
 Unknown at this time

Intake Status: Pending Date: ____/____/____ Completed Date: ____/____/____

Intake Status

Decision reached Date: ____/____/____

Pending
 Transfer: Region _____ Date _____

Comments: _____

Proceed to Application

Do not proceed to Application due to:

<input type="checkbox"/> Level of Care
<input type="checkbox"/> Age
<input type="checkbox"/> Not MA eligible
<input type="checkbox"/> Guardian refused participation
<input type="checkbox"/> Chose not to apply
<input type="checkbox"/> Unable to meet for Intake within 60 days of the scheduled date
<input type="checkbox"/> Other: _____

Notice of Decision – Denial of Waiver Program – Issued NOD Date: ____/____/____
Date DOH WMS notified: ____/____/____

Intake Form (continued)

Applicant Name:	Referral #
-----------------	------------

Referral made to other resource(s):

- | | | | |
|---|---|--|---------------------------------|
| <input type="checkbox"/> Point of Entry | <input type="checkbox"/> TBI Waiver | <input type="checkbox"/> NHTD Waiver | <input type="checkbox"/> LTHHCP |
| <input type="checkbox"/> OMH | <input type="checkbox"/> OMRDD | <input type="checkbox"/> Consumer Directed/PCS | |
| <input type="checkbox"/> CHHA | <input type="checkbox"/> Office for the Aging | | |
| <input type="checkbox"/> None | <input type="checkbox"/> Other _____ | | |

Forms Checklist

- | | |
|--|---|
| <input type="checkbox"/> Initial Applicant Interview Acknowledgement | Date: ____/____/____ |
| <input type="checkbox"/> Freedom of Choice | Date: ____/____/____ |
| <input type="checkbox"/> Application for Participation | Date: ____/____/____ |
| <input type="checkbox"/> Service Coordinator Selection | Sent Date: ____/____/____ Accepted date: ____/____/____ |

Service Coordination Agency Name: _____

Existing PRI/SCREEN: Yes No Completed: ____/____/____ Expires: ____/____/____
(90 days from PRI Date)

Location of PRI/SCREEN, comments: _____

Indicates nursing home level of care? Yes No

Areas of Concern: Diagnosis Housing Level of care determination
 Medicaid status Intensity of support/service needs

Comments: _____

Date sent to Service Coordinator Agency ____/____/____

Potential MFP Demonstration candidate Yes No

Intake completed by: _____
(Signature) (Title)

**INITIAL APPLICANT INTERVIEW
AND ACKNOWLEDGEMENT**

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

Referral #

Applicant Name

Date of Interview

CIN

Regional Resource Development Specialist (RRDS)

The following has been provided to me and/or my legal guardian:

1. The philosophy and mission of the Home and Community Based Medicaid Services(HCBS) provided by the Nursing Home Transition and Diversion Waiver and the Traumatic Brain Injury Waiver.
2. Information about HCBS waivers and other Medicaid services to support people in the community and my right to choose whether or not to apply at this time.
3. The steps necessary to complete the application process including the roles and responsibilities of the participant, the Regional Resource Development Specialist, the Quality Management Specialist or Clinical Consultant, Service Coordinator and Service Providers.
4. The process of interviewing and choosing an approved Service Coordination agency and Provider agencies of my choice.
5. The process of changing waiver service providers at any time once I am approved as a participant in this waiver.
6. The process for the development and implementation of the Service Plan, the Revised Service Plan and subsequent addendums, change of providers and revisions, that will provide services to support me in the community if I am approved as a participant.
7. The process of receiving Notices of Decision forms including requesting an Informal Conference and /or a Fair Hearing.

Applicant and/or Legal Guardian or Authorized Representative (as applicable) Signature

Date

Regional Resource Development Specialist (RRDS) Signature

Date

FREEDOM OF CHOICE

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

I, _____ have been informed that I may be eligible for services provided through either a nursing facility or a Home and Community Based Services Medicaid Waiver.

Check One:

I have chosen to apply for the Nursing Home Transition and Diversion Medicaid Waiver.

I have chosen to apply for Medicaid State Plan Services and/or another Home and Community Based Services Medicaid Waiver

I have chosen **NOT** to apply for services through a Home and Community Based Services Medicaid waiver at this time.

Applicant Signature

Date

Legal Guardian Name (as applicable)

Signature

Date

Authorized Representative (as applicable)

Signature

Date

Regional Resource Development Specialist

Signature

Date

SERVICE COORDINATOR SELECTION

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

NOTE: This form must be returned to the Regional Resource Development Specialist (RRDS) to continue the waiver application process.

I understand that as an applicant for the Nursing Home Transition and Diversion Medicaid Waiver or the Traumatic Brain Injury Medicaid Waiver, I must select a Service Coordinator from the attached list of approved Service Coordination Agencies. I have been encouraged to interview these providers prior to making my selection.

I understand that this Service Coordinator will assist me in developing, implementing and monitoring my Service Plan.

I also understand that at any time I may change my Service Coordinator or the Service Coordination Agency and still be eligible for the waiver.

From the approved Service Coordinator Agency list, I have selected the following provider of Service Coordination:

Service Coordination Provider Agency	Telephone	Service Coordinator selected (if known)
--------------------------------------	-----------	---

Agency Address

Applicant Name	Applicant Signature	Date
----------------	---------------------	------

Legal Guardian Signature (if applicable)	Date
--	------

Authorized Representative Signature (if applicable)	Date
---	------

To be completed by the Service Coordination Agency:

Service Coordination Agency

_____ will provide Service Coordination to the above named applicant

_____ will not provide Service Coordination to the above named applicant because:

Service Coordinator Signature	Date
-------------------------------	------

Service Coordination Supervisor Signature	Date
---	------

Regional Resource Development Specialist Signature	Date
--	------

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

Applicant Name CIN

Current Residence

Telephone Date of Birth

- Not enrolled in Medicaid
 Medicaid application is pending

I am requesting participation in a Home and Community Based Services Medicaid Waiver.
I understand that approval to participate in the waiver is based on documentation of the following:

- Nursing home level of care
- Eligibility and authorization for Medicaid coverage of Community Based Long Term Care Services
- Being able to live in the community with the needed assistance of available informal supports; or non Medicaid supports; or Medicaid State Plan Services; and at least one waiver service(s)
- Age of at least eighteen (18) years at the time of approval for the waiver

Applicant Signature Date

Legal Guardian Name (as applicable) Signature Date

Authorized Representative Name (as applicable) Signature Date

Regional Resource Development Specialist Name Signature Date

**Home and Community Based Services Waiver
Nursing Home Transition and Diversion (NHTD) Waiver**

Letter of Introduction to Social Services District

Date: _____
LDSS Name: _____
Address: _____

Dear Social Services District:

This is to notify you that _____ is an applicant for the Home and Community Based Services Waiver for Nursing Home Transition and Diversion (HCBS/NHTD Waiver).

Participation in the NHTD Waiver is contingent, in part, upon the applicant being eligible for Medical Assistance (MA) and certified as disabled. In order to participate in the HCBS/NHTD Waiver, Medicaid eligibility must be determined for coverage of community-based long-term care services (which includes coverage for waiver services).

A Waiver participant is only required to provide documentation of his/her current resources. These individuals are not subject to a transfer of assets "look-back" period nor to a transfer penalty period. This applicant has not yet been determined to be MA eligible and/or certified as disabled. Please (check all that apply):

- Determine MA eligibility for this applicant and send us a copy of your decision.
- Determine MA eligibility for this applicant and the applicant's family and send us a copy of your decision. Spousal budgeting rules may be used.
- Determine disability for this applicant and send us a copy of your decision.

A prompt response to this request would be appreciated. If you have any questions about the applicant, you may call _____ at _____.

Thank you for your cooperation.

Sincerely,

(Signature)

(Title)

(Telephone)

Waiver Service Provider Interview

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

Regional Resource Development Specialist

RRDS: _____ Region(s): _____ Date: _____

Service Provider Agency: _____ Contact Person: _____ Title: _____

Service Provider Address: _____ Telephone: _____

Regional Satellite Office(s)? Yes No If Yes, please complete attached page at the end of this interview form.

Interested region(s): _____

Interested county(ies): _____

Approved for other TBI/NHTD Waiver Services Yes No If Yes, what service(s)/waiver: _____

Approved in what region(s): _____

What counties served: _____

Name and title of designee for signing contracts: _____ Telephone: _____

Executive Director: _____ Telephone: _____

Representatives of Agency in Attendance:

Representative: _____ Title: _____

Representative: _____ Title: _____

Representative: _____ Title: _____

Provider has requested to provide the following services:

- | | |
|--|---|
| <input type="checkbox"/> Service Coordination | <input type="checkbox"/> Moving Assistance |
| <input type="checkbox"/> Assistive Technology | <input type="checkbox"/> Nutritional Counseling/Educational Services |
| <input type="checkbox"/> Community Integration Counseling | <input type="checkbox"/> Peer Mentoring |
| <input type="checkbox"/> Community Transitional Services | <input type="checkbox"/> Positive Behavioral Interventions and Supports |
| <input type="checkbox"/> Congregate and Home Delivered Meals | <input type="checkbox"/> Respiratory Therapy |
| <input type="checkbox"/> Environmental Modifications Services | <input type="checkbox"/> Respite Services |
| <input type="checkbox"/> Home and Community Support Services | <input type="checkbox"/> Structured Day Program Services |
| <input type="checkbox"/> Home Visits by Medical Personnel | <input type="checkbox"/> Wellness Counseling Service |
| <input type="checkbox"/> Independent Living Skills Training Services | |

Waiver Service Provider Interview Part I: Overall Questions

RRDS provides a comprehensive description of the program.

1. Does the provider representative indicate that he/she understands how the waiver program works? Yes () No ()

RRDS Comments:

2. In what capacity has the provider served as a provider of services to seniors and/or people with disabilities?

Explain in detail:

3. The following written Policies and Procedures have been reviewed and are consistent with the corresponding section of the Program Manual:

Providers applying for AT, CTS, Congregate and Home Delivered Meals, E-mods, Home Visits by Medical Personnel, Moving Assistance, and Respiratory Therapy must satisfy the following:

- | | |
|--|---|
| <input type="checkbox"/> HIPAA compliance | <input type="checkbox"/> Handling of complaints and grievances from participants, advocates and family members |
| <input type="checkbox"/> Safety & Emergency Procedures | <input type="checkbox"/> Recording/addressing concerns from Service Coordinator, RRDS/NE and QMS |
| <input type="checkbox"/> Human Resources Policies/Procedures | <input type="checkbox"/> Recordkeeping/documentation for each participant |
| <input type="checkbox"/> Knowledge of Incident Reporting Policy | <input type="checkbox"/> Cooperate with NYS DOH, OMIG & other government agencies with jurisdiction to conduct surveys & audits |
| <input type="checkbox"/> Service provision tracking & billing system | |
| <input type="checkbox"/> Participant satisfaction survey | |

Providers applying for all other services must satisfy the following:

- | | |
|---|---|
| <input type="checkbox"/> HIPAA compliance | <input type="checkbox"/> Recording/addressing concerns from SC, RRDS, QMS, and/or DOH waiver management staff |
| <input type="checkbox"/> Safety & Emergency Procedures | <input type="checkbox"/> Recordkeeping/documentation for each participant |
| <input type="checkbox"/> Human Resources Policies/Procedures | <input type="checkbox"/> Waiver service training |
| <input type="checkbox"/> Incident Reporting/SRI Committee | <input type="checkbox"/> Handling of complaints and grievances from participants, advocates and family members |
| <input type="checkbox"/> Service provision tracking system | <input type="checkbox"/> Additional training programs for staff |
| <input type="checkbox"/> Plan for self-appraisal of services provision including suggestions and methods for improvements | <input type="checkbox"/> Cooperate with NYS DOH, OMIG & other government agencies with jurisdiction to conduct surveys & audits |
| <input type="checkbox"/> Participant satisfaction survey | |

RRDS Comments:

**Waiver Service Provider Interview
Part I continued**

4. Is the provider currently enrolled as a provider in eMedNY? Yes () No ()
In what capacity?
RRDS Comments:

5. Did the provider representative read the Program Manual before applying to become a provider? Yes () No ()
RRDS Comments:

6. Does he/she understand the importance and timeliness issues associated with the Service Plan and Individual Service Reports as well as the policy related to late submission? Yes () No ()
RRDS Comments:

Waiver Service Provider Interview Part II Specific Services

A. _____ (if applying for more than one service,
Name of Service attach additional copies of this section)

*The RRDS explains the service, and the qualifications and responsibilities of the provider.
(Refer to Program Manual).*

Does the provider representative indicate that he/she understands:

1. The definition of the service? Yes () No ()
2. The qualification requirements for: (a) provider, and Yes () No ()
(b) staff? Yes () No ()
3. How this service relates to other services? Yes () No ()
4. The agency's record keeping responsibilities? Yes () No ()
5. The participant's Right of Choice? Yes () No ()
6. The role of the Service Coordinator? Yes () No ()
7. That this is a prior approval program? Yes () No ()
8. The survey/audit procedure? Yes () No ()
9. Does the provider understand the qualifications (including any requirements of licensure) and requirements of the entity providing the service and/or the qualifications for the individuals providing this service? Yes () No () *If licensure is required, the RRDS must review the entity's license.*
10. Did the provider submit a resume and an Employee Verification Qualification form for each individual who is projected to provide this service? Yes () No ()
11. The RRDS should list the names of the individuals who appear to be qualified to provide this service.

General comments:

**Waiver Service Provider Interview
Part II continued**

B. Structured Day Program

The RRDS explains the service and the qualifications and responsibilities of the Structured Day Program provider.

Does the provider representative indicate that he/she understands?

1. The definition of the service? Yes () No ()
2. The qualification requirements for: (a) provider, and Yes () No ()
(b) staff? Yes () No ()
3. How this service relates to other services? Yes () No ()
4. The agency's record keeping responsibilities? Yes () No ()
5. The participant's Right of Choice? Yes () No ()
6. The role of the Service Coordinator? Yes () No ()
7. That this is a prior approval program? Yes () No ()
8. The survey/audit procedure? Yes () No ()
9. The qualifications (including any requirements of licensure) and requirements of the entity providing the service and/or the qualifications for the individuals providing this service?
Yes () No () *If licensure is require, the RRDS must review the entity's license.*
10. Did the provider submit a resume and an Employee Verification Qualification form for each individual who is projected to provide this service? Yes () No ()
11. The RRDS should list the names of the individuals who appear to be qualified to provide this service.

11. Did the provider submit a copy of the Certificate of Occupancy? Yes () No ()
12. From the site visit, the RRDS should list any outstanding issues that need to be addressed in order to be considered as a provider of this service:

**Waiver Service Provider Interview
Part III**

1. Does the provider representative have any other questions?
If yes, what are they? Yes () No ()

2. Were you able to answer his/her questions? Yes () No ()

3. Did the provider understand your responses? Yes () No ()

4. Did you need to refer him/her to someone else to answer questions?
If yes, who? Yes () No ()

5. RRDS Evaluation of Agency (Strengths, weaknesses and/or concerns):

Waiver Service Provider Interview

Part III continued

6. RRDS recommends this agency to provide the following services: (please specify regions(s)):

<u>Applied To Provide</u>		<u>Service</u>	<u>Recommended</u>	<u>Not Recommended</u>	<u>Counties</u>
<u>Yes</u>	<u>No</u>				
<input type="checkbox"/>	<input type="checkbox"/>	Service Coordination	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Assistive Technology	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Community Transitional Services	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Community Integration Counseling	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Congregate and Home Delivered Meals	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Environmental Modifications Services	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Home and Community Support Services	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Home Visits by Medical Personnel	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Independent Living Skills Training	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Moving Assistance	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Nutritional Counseling/Educational Services	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Peer Mentoring	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Positive Behavioral Interventions and Supports	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Therapy	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Respite Care Services	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Structured Day Program	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Wellness Counseling Service	<input type="checkbox"/>	<input type="checkbox"/>	

7. RRDS Reasons for the Decision:

 RRDS Signature/Date

**Waiver Service Provider Interview
Part IV**

DOH Waiver Management Decision:

- Approves
- Disapproves

DOH Waiver Management Comments:

DOH Waiver Management Signature/Date

Waiver Service Provider Interview Part V

Regional Satellite Office: _____

County(ies) served: _____

Contact Person/Title: _____

Telephone: _____

Address: _____

City/Zip: _____

Note: Have you verified the LHCSA license for this satellite office? Yes () No ()

Regional Satellite Office: _____

County(ies) served: _____

Contact Person/Title: _____

Telephone: _____

Address: _____

City/Zip: _____

Note: Have you verified the LHCSA license for this satellite office? Yes () No ()

Regional Satellite Office: _____

County(ies) served: _____

Contact Person/Title: _____

Telephone: _____

Address: _____

City/Zip: _____

Note: Have you verified the LHCSA license for this satellite office? Yes () No ()

Regional Satellite Office: _____

County(ies) served: _____

Contact Person/Title: _____

Telephone: _____

Address: _____

City/Zip: _____

Note: Have you verified the LHCSA license for this satellite office? Yes () No ()

****If you need additional space, please make copies of this page.**

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: _____
*Review Completed by SC	Date: _____
*Received by RRDS from SC with corrections	Date: _____
Submission to QMS (if applicable) over \$300/day	Date: _____
Submission to QMS for consultation	Date: _____
Returned to RRDS from QMS	Date: _____
*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/SCREEN	Date	___/___/___	___Y___N	_____
LOC appropriate for eligibility?			___Y___N	_____
Application for Participation form	Date	___/___/___	___Y___N	_____
Participant Rights/Responsibilities	Date	___/___/___	___Y___N	_____
Provider Selection form(s)	Date	___/___/___	___Y___N	_____
Plan for Protective Oversight	Date	___/___/___	___Y___N	_____
Insurance, Resource and Funding Information form	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. Personal Identification Information

YES NO

All identification items are completed including Transition/Diversion		
Comments:		

II. Individuals Selected by the Applicant to Participate in ISP Development

YES NO

All individuals selected by applicant are listed		
Comments:		

III. Profile of Applicant

YES NO COMMENTS

A. Personal History includes the following description of:	YES	NO	COMMENTS
•Developmental History			
•Family History			
•Educational History			
•Work History			
•Unique Characteristics and Strengths			
•Hobbies and Interests			
•Criminal Justice History			

III. Profile of Applicant (cont)	Yes	No	Comments
B. Medical/Functional Information			
1. Diagnosis and Medical Status			
•Mental Health History			
•Substance Abuse History			
2. Impact of disability or illness/injury on applicant			
3. Applicants response to disability/illness, or injury			
4. Medications			
A• All prescriptions and/or over-the-counter medications			
B• Medical Supplies/Durable Medical Equipment (DME)			
•Total Projected Medicaid Monthly Cost (x12) provided			
5. Physicians/Dentist			
6. Management of Medical Needs			
7. Dietary Needs			
8. Visual Ability			
9. Hearing Ability			
10.Communication Skills			
11.Other Needs			
Comments:			
C. Present			
•Goals			
•Hobbies/Interests			
•Culture and/or Religion			
Comments:			

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

V. Current Supports and Services

YES NO

A. Informal Supports	YES	NO
•Family		
•Friends		
•Community		
B. Formal Supports		
•All State and Federal non-Medicaid services received or anticipated are listed		
•Information transferred to the Insurance, Resources and Funding Info. form		
•All Medicaid State Plan services received or anticipated described		
•Information transferred to Medicaid State Plan Services chart		
Comments:		

VI. Oversight/Supervision and/or Assistance with ADLs and/or IADLs

YES NO

A. Applicant needs Oversight/Supervision due to cognitive difficulties		
B. Applicants needing assistance with ADLs/IADLs tasks but no Oversight/Supervision		
C. Alternatives Considered		
Comments:		

VII. 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:		

Instructions: For section VIII, 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.

VIII. Requested Waiver Services

YES NO N/A

COMMENTS

•Service Coordination				
•Assistive Technology				

VIII. Requested Waiver Services (cont.)

YES NO N/A

COMMENTS

•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 Intervention and Supports (PBIS)				
•Respiratory Therapy				
•Respite Services				
•Structured Day Program Services				
•Wellness Counseling Services				

IX. Medicaid State Plan Services

YES NO N/A

•All Medicaid State Plan Services items listed in the chart			
Comments:			
•The Consumer Directed Personal Assistance Program (CDPAP) is included in the ISP			

X. Waiver Services and Projected Total Projected Annual Costs for ISP

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:			

XI. 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:			

XII. Projected Weekly Schedule of All Services

YES NO

•All Services are documented appropriately		
Comments:		

RRDS Recommendation:

- Corrections needed
- Submit to QMS

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: _____

Comments: _____

RRDS Reviewer Signature

Date

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

NOD Issue Date: _____

NOD Effective Date (if applicable): _____

NOD type: _____

Initial Service Plan (ISP) Effective Date: from ____ / ____ / ____ to ____ / ____ / ____

RRDS Reviewer Signature

Date

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

Nursing Home Transition and Diversion (NHTD)

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: _____
*Received by RRDS from SC with corrections	Date: _____
Submission to QMS (if applicable) over \$300/day	Date: _____
Submission to QMS for consultation	Date: _____
Returned to RRDS from QMS	Date: _____
*Final Decision by RRDS	Date: _____

Attachments

Signed and Completed

Comments

Medicaid eligibility verification Co. _____	Date	__ / __ / __	__ Y __ N	_____
PRI/SCREEN	Date	__ / __ / __	__ Y __ N	N/A _____
LOC appropriate for eligibility?			__ 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	_____
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

YES NO N/A COMMENTS

B. Medical/Functional Information (cont)				
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				

•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:				

VII. Service Coordination Overview of Waiver Services **YES** **NO** **N/A** **COMMENTS**

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 approve this Revised Service Plan (RSP).

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

RRDS ADDENDUM REVIEW FORM HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER

Nursing Home Transition and Diversion (NHTD)

Date: _____

Participant's Name: _____ CIN: _____ Region: _____

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	Date: _____
Submission to QMS for consultation	Date: _____
Returned to RRDS from QMS	Date: _____
*Final Decision by RRDS	Date: _____

Attachments

Signed and Completed

Comments

Functional Assessment, if needed	Date	___/___/___	___Y___N___N/A	_____
Revised Waiver Contact List	Date	___/___/___	___Y___N___N/A	_____
Insurance, Resource, Funding form	Date	___/___/___	___Y___N___N/A	_____
Provider Selection form(s)	Date	___/___/___	___Y___N___N/A	_____
Plan for Protective Oversight	Date	___/___/___	___Y___N___N/A	_____
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**

	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

(RRDS LETTERHEAD)

Late Individual Service Report (ISR) Notification

Date:

Name of Agency Supervisor:

Name of Agency:

Address of Agency:

Dear _____,

The Individual Service Report (ISR) for Nursing Home Transition and Diversion (NHTD) waiver Participant, _____ is now late.

We recognize that many factors can contribute to not submitting the ISR in a timely manner. However, as you know, timely submission of the ISR to the Service Coordinator is imperative to assure the Service Plan is developed comprehensively and to avoid any delay in the provision of services to the participant.

Approval of service provision can not be issued until the required Service Plan is received and approved by the RRDS. In addition, the waiver participant may not be able to access needed services which may result in his/her inability to be maintained safely in the community.

Please submit the required ISR to the Service Coordinator within seven (7) calendar days of the date of this letter. To avoid notification to DOH Waiver Management staff and issuance of a Vendor Hold on your agency, the ISR must be received within this timeframe.

If you have any questions, please contact me at (_____) _____.

Sincerely,

Regional Resource Development Specialist

(RRDS LETTERHEAD)

Late Revised Service Plan Notification

Date:

Name of Agency Supervisor:

Name of Agency:

Address of Agency:

Dear _____,

The Revised Service Plan for _____, who is a Participant of the NHTD waiver is now late.

We recognize that many factors can contribute to not completing the RSP in a timely manner. However, as you know, the approval of service provision can not be issued until the required RSP is received and approved by the RRDS. The lack of a current RSP may prohibit the waiver participant from accessing needed services, which may result in his/her inability to be maintained safely in the community.

Please submit the required RSP to me within seven (7) calendar days of the date of this letter, to avoid notification to DOH Waiver Management staff and the issuance of a Vendor Hold on your agency.

If you have any questions, please contact me at (_____) - _____.

Sincerely,

Regional Resource Development Specialist

cc: Service Coordinator

**CHANGE OF SERVICE COORDINATOR REQUEST
HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER**
Nursing Home Transition and Diversion (NHTD)

I, (Participant Name) _____ (CIN) _____ request to make the following change in Service Coordinator or Service Coordination agency currently providing this service to me.

I have been informed of my right to remain with this current Service Coordinator and/or Service Coordination agency or select a new Service Coordinator or Service Coordination agency from a list of all available waiver service providers for this service.

Current Service Coordinator Name and Telephone	Current Service Coordination Agency and Telephone	Requested Service Coordinator / Agency Name and Telephone

NOTE: THE REGIONAL RESOURCE DEVELOPMENT SPECIALIST (RRDS) MUST CONTACT CURRENT SERVICE COORDINATOR/AGENCY AND THE NEWLY REQUESTED SERVICE COORDINATOR/AGENCY.

Participant Signature _____ Date _____

Legal Guardian Signature (as applicable) _____ Date _____

Authorized Representative Signature (as applicable) _____ Date _____

Current Service Coordinator Signature _____ Date _____

Current SC Supervisor Signature _____ Date _____

Transition Meeting to be held on: _____ / _____ /20 at _____ am / pm

To be completed by the Requested Service Coordinator and/or Requested Service Coordination Agency:	
_____ will provide service(s) to the above named participant	_____ will not provide service(s) to the above named participant
Reason: _____	
_____	_____
Service Coordinator Signature	Date
Service Coordination Supervisor Signature	Date

To be completed by the Regional Resource Development Specialist:

This request for change in Service Coordinator and/or Service Coordination Agency has been reviewed and:

approved Services to begin effective: _____ / _____ / 20

denied (explanation) _____

Regional Resource Development Specialist Signature _____ Date _____

- cc: Participant
Guardian (if applicable)
Authorized Representative (If applicable)
Current Service Coordinator and/or Service Coordination Agency
New Service Coordinator and/or Service Coordination Agency
All current Provider Agencies

**HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER
FOR
NURSING HOME TRANSITION AND DIVERSION (NHTD)**

**NOTICE OF DECISION
AUTHORIZATION**

Name & Address of Waiver Participant:

Client Identification Number (CIN): _____

Notice Date: _____

This is to inform you that your participation in the Home and Community-Based Services Medicaid Waiver for Nursing Home Transition and Diversion (NHTD) has been:

AUTHORIZED effective on _____. The services you are authorized to receive are identified in your Service Plan and will be reassessed at least every six (6) months.

The laws that allow us to do this are:

Section 1915(c) of the Social Security Act and, Section 366 (6-a) of the NYS Social Services Law

Regional Resource Development Specialist (Signature)

Regional Resource Development Specialist (Print)

Name of Regional Resource Development Center (RRDC)

Address

Address

Telephone

**IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE,
A FAIR HEARING, OR BOTH. PLEASE READ THE BACK OF THIS NOTICE TO FIND
OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.**

cc: Legal Guardian
Authorized Representative
Service Coordinator
NYS DOH NHTD Waiver Program
Social Services District with fiscal responsibility
Social Services District of residence (If different from county of fiscal responsibility)

RIGHT TO CONFERENCE: You may have a conference with the Regional Resource Development Specialist (RRDS) to review these actions. If you want a conference you should ask for one as soon as possible. At the conference, if the RRDS discovers that the wrong decision has been made, or if, because of information you provide, the RRDS decides to change the decision, corrective action will be taken. You will receive a new Notice of Decision. You may ask for a conference by calling the RRDS at the telephone number listed on the first page of this notice or by sending a written request to the address listed on the first page of this notice. ***This is not the way to request a fair hearing.*** If you ask for a conference, you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A Fair Hearing: If you believe that the above action is wrong, you may request a State Fair Hearing by:

1. **Telephone:** You may call the statewide toll free number at 1-800-342-3334. (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL) **OR**
2. **Fax:** Complete and fax a copy of this notice to (518) 473-6735 **OR**
3. **On-Line:** Complete and send the online request form at: <https://www.otda.state.ny.us/oah/forms.asp> **OR**

If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, or on-line, please write to ask for a fair hearing before 60 days from the date of this notice.

4. **Mail:** Complete and send a copy of this notice to the Fair Hearing Section, New York State Office of Temporary Disability Assistance, P. O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.
5. **New York City ONLY:** You may also walk-in to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 14 Boerum Place, Brooklyn, New York **or** 330 West 34th Street, 3rd Floor, NY, NY. Bring a copy of this notice with you.

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend, or other person or represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have the right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

I want a fair hearing. The decision is wrong because: _____

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking the yellow pages of your telephone book under "lawyer."

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your file. If you call or write to the RRDS, they will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. Also, if you call or write to the RRDS, they will provide you with free copies of other documents from your file, which you think you may need for your fair hearing. To ask for documents or to find out how to look at your file, call or write to the RRDS at the telephone number and address listed on the front page of this Notice. If you want copies of documents from your file, you should ask for them within a reasonable time before the date of the fair hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your file, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, please call or write the RRDS at the telephone number and address listed on the front page of this Notice.

Print Name _____ Client Identification Number (CIN) _____
Address _____ Telephone _____
Signature _____ Date _____

**HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER
FOR
NURSING HOME TRANSITION AND DIVERSION (NHTD)**

**NOTICE OF DECISION
DENIAL OF WAIVER PROGRAM**

Name & Address of Waiver Applicant:

Client Identification Number (CIN): _____

Notice Date: _____

This is to inform you that your application for participation in the Home and Community-Based Services Medicaid Waiver for Nursing Home Transition and Diversion (NHTD) has been **DENIED**.

Your participation in the NHTD waiver has been **DENIED** for the following reason(s):

The laws that allows us to do this are:

Section 1915(c) of the Social Security Act and, Section 366 (6-a) of the Social Services Law.

Regional Resource Development Specialist (Signature)

Regional Resource Development Specialist (Print)

Name of Regional Resource Development Center (RRDC)

Address

Address

Telephone

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING, OR BOTH. PLEASE READ THE BACK OF THIS NOTICE TO FIND OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.

cc: Legal Guardian
Authorized Representative
NYS DOH NHTD Waiver Program
Service Coordinator
Social Services District with fiscal responsibility
Social Services District in county of residence (If different from county of fiscal responsibility)

RIGHT TO CONFERENCE: You may have a conference with the Regional Resource Development Specialist (RRDS) to review these actions. If you want a conference you should ask for one as soon as possible. At the conference, if the RRDS discovers that the wrong decision has been made, or if, because of information you provide, the RRDS decides to change the decision, corrective action will be taken. You will receive a new Notice of Decision. You may ask for a conference by calling the RRDS at the telephone number listed on the first page of this notice or by sending a written request to the address listed on the first page of this notice. ***This is not the way to request a fair hearing.*** If you ask for a conference, you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A Fair Hearing: If you believe that the above action is wrong, you may request a State Fair Hearing by:

1. **Telephone:** You may call the statewide toll free number at 1-800-342-3334. (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL) **OR**
2. **Fax:** Complete and fax a copy of this notice to (518) 473-6735 **OR**
3. **On-Line:** Complete and send the online request form at: <https://www.otda.state.ny.us/oah/forms.asp> **OR**

If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, or on-line, please write to ask for a fair hearing before 60 days from the date of this notice.

4. **Mail:** Complete and send a copy of this notice to the Fair Hearing Section, New York State Office of Temporary Disability Assistance, P. O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.
5. **New York City ONLY:** You may also walk-in to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 14 Boerum Place, Brooklyn, New York or 330 West 34th Street, 3rd. Floor, NY, NY. Bring a copy of this notice with you.

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend, or other person or represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have the right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

I want a fair hearing. The decision is wrong because: _____

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking the yellow pages of your telephone book under "lawyer."

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your file. If you call or write to the RRDS, they will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. Also, if you call or write to the RRDS, they will provide you with free copies of other documents from your file, which you think you may need for your fair hearing. To ask for documents or to find out how to look at your file, call or write to the RRDS at the telephone number and address listed on the front page of this Notice. If you want copies of documents from your file, you should ask for them within a reasonable time before the date of the fair hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your file, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, please call or write the RRDS at the telephone number and address listed on the front page of this Notice.

Print Name _____ Client Identification Number (CIN) _____

Address _____ Telephone _____

Signature _____ Date _____

**HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER
FOR
NURSING HOME TRANSITION AND DIVERSION (NHTD)**

**NOTICE OF INTENT TO
DISCONTINUE FROM THE WAIVER PROGRAM**

Name & Address of Waiver Participant:

Client Identification Number (CIN): _____

Notice Date: _____

Effective Date: _____

This is to inform you that your participation in the Home and Community-Based Services Medicaid Waiver for Nursing Home Transition and Diversion (NHTD) is being **DISCONTINUED** as of the Effective Date above.

Your participation in the waiver is being **DISCONTINUED** because you have chosen to no longer receive waiver services(s).

Explanation:

The laws that allows us to do this are:

Section 1915(c) of the Social Security Act and, Section 366 (6-a) of the Social Services Law.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING, OR BOTH. PLEASE READ THE BACK OF THIS NOTICE TO FIND OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.

Regional Resource Development Specialist (Signature)

Regional Resource Development Specialist (Print)

Name of Regional Resource Development Center (RRDC)

Address

Address

Telephone

cc: Legal Guardian
Authorized Representative
Service Coordinator
NYS DOH NHTD Waiver Program
Social NEW Services District with fiscal responsibility
Social Services District in county of residence (If different from county of fiscal responsibility)

RIGHT TO CONFERENCE: You may have a conference with the Regional Resource Development Specialist (RRDS) to review these actions. If you want a conference you should ask for one as soon as possible. At the conference, if the RRDS discovers that the wrong decision has been made, or if, because of information you provide, the RRDS decides to change the decision, corrective action will be taken. You will receive a new Notice of Decision. You may ask for a conference by calling the RRDS at the telephone number listed on the first page of this notice or by sending a written request to the address listed on the first page of this notice. ***This is not the way to request a fair hearing.*** If you ask for a conference, you are still entitled to a fair hearing. Read below for fair hearing information.

If you only ask for a Conference, we will not keep your benefits the same while you appeal. Your benefits will stay the same only if you ask for a fair hearing. (See Continuing Your Benefits)

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

1. **Telephone:** You may call the statewide toll free number at 1-800-342-3334. (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL) **OR**
2. **Fax:** Complete and fax a copy of this notice to (518) 473-6735 **OR**
3. **On-Line:** Complete and send the online request form at: <https://www.otda.state.ny.us/oah/forms.asp> **OR**

If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, or on-line, please write to ask for a fair hearing before 60 days from the date of this notice.

4. **Mail:** Complete and send a copy of this notice to the Fair Hearing Section, New York State Office of Temporary Disability Assistance, P. O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.
5. **New York City ONLY:** You may also walk-in to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 14 Boerum Place, Brooklyn, New York **or** 330 West 34th Street, 3rd Floor, NY, NY. Bring a copy of this notice with you.

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING.

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have the right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

I want a fair hearing. The decision is wrong because: _____

CONTINUING YOUR BENEFITS: If you request a Fair Hearing before the Effective Date stated on the front page of this Notice, you will continue to receive your benefits unchanged until the fair hearing decision is issued. However, if you lose the Fair Hearing, New York State may recover the cost of any Medical Assistance benefits that you should not have received.

I want to continue my Medical Assistance benefits until the Fair Hearing decision is issued.

If you do NOT want your Medical Assistance benefits to continue while waiting for the decision of the fair hearing, check the box below and send this page to the Fair Hearing Section, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York, 12201.

I do NOT want to continue my Medical Assistance benefits while waiting for the decision of the Fair Hearing. I understand if I lose the Fair Hearing I may be responsible for the cost of any Medical Assistance benefits that the Fair Hearing determines I should not have received.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking the yellow pages of your telephone book under “lawyers.”

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your file. If you call or write to the RRDS, they will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. Also, if you call or write to the RRDS, they will provide you with free copies of other documents from your file, which you think you may need for your fair hearing. To ask for documents or to find out how to look at your file, call or write to the RRDS at the telephone number and address listed on the front page of this Notice. If you want copies of documents from your file, you should ask for them within a reasonable time before the date of the fair hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your file, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, please call or write the RRDS at the telephone number and address listed on the front page of this Notice.

Print Name _____ Client Identification Number (CIN) _____

Address _____ Telephone _____

Signature _____ Date _____

**HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER
FOR
NURSING HOME TRANSITION AND DIVERSION (NHTD)**

**NOTICE OF INTENT TO
DISCONTINUE FROM THE WAIVER PROGRAM**

Name & Address of Waiver Participant:

Client Identification Number (CIN): _____

Notice Date: _____

Effective Date: _____

This is to inform you that your participation in the Home and Community-Based Services Medicaid Waiver for Nursing Home Transition and Diversion (NHTD) is being **DISCONTINUED** as of the Effective Date above.

Your participation in the waiver is being **DISCONTINUED** because:

- You are determined to no longer be eligible for nursing home level of care, per H/C Patient Review Instrument and SCREEN.
- Waiver services cannot safely maintain you in the community.
- You do not have a current Service Plan.
- Other: _____

Explanation:

The laws that allows us to do this are:

Section 1915(c) of the Social Security Act and, Section 366 (6-a) of the Social Services Law.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING, OR BOTH. PLEASE READ THE BACK OF THIS NOTICE TO FIND OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.

Regional Resource Development Specialist (Signature)

Regional Resource Development Specialist (Print)

Name of Regional Resource Development Center (RRDC)

Address

Address

Telephone

cc: Legal Guardian
Authorized Representative
Service Coordinator
NYS DOH NHTD Waiver Program
Social Services District with fiscal responsibility
Social Services District in county of residence (If different from county of fiscal responsibility)

RIGHT TO CONFERENCE: You may have a conference with the Regional Resource Development Specialist (RRDS) to review these actions. If you want a conference you should ask for one as soon as possible. At the conference, if the RRDS discovers that the wrong decision has been made, or if, because of information you provide, the RRDS decides to change the decision, corrective action will be taken. You will receive a new Notice of Decision. You may ask for a conference by calling the RRDS at the telephone number listed on the first page of this notice or by sending a written request to the address listed on the first page of this notice. ***This is not the way to request a fair hearing.*** If you ask for a conference, you are still entitled to a fair hearing. Read below for fair hearing information.

If you only ask for a Conference, we will not keep your benefits the same while you appeal. Your benefits will stay the same only if you ask for a fair hearing. (See Continuing Your Benefits)

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

1. **Telephone:** You may call the statewide toll free number at 1-800-342-3334. (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL) **OR**
2. **Fax:** Complete and fax a copy of this notice to (518) 473-6735 **OR**
3. **On-Line:** Complete and send the online request form at: <https://www.otda.state.ny.us/oah/forms.asp> **OR**
If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, or on-line, please write to ask for a fair hearing before 60 days from the date of this notice.
4. **Mail:** Complete and send a copy of this notice to the Fair Hearing Section, New York State Office of Temporary Disability Assistance, P. O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.
5. **New York City ONLY:** You may also walk-in to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 14 Boerum Place, Brooklyn, New York **or** 330 West 34th Street, 3rd. Floor, NY, NY. Bring a copy of this notice with you.

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING.

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have the right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

I want a fair hearing. The decision is wrong because: _____

CONTINUING YOUR BENEFITS: If you request a Fair Hearing before the Effective Date stated in this notice, you will continue to receive your Medical Assistance benefits unchanged until the Fair Hearing decision is issued. However, if you lose the Fair Hearing, you may have to pay back any Medical Assistance benefits you should not have received while waiting for the decision.

I want to continue my Medical Assistance benefits until the Fair Hearing decision is issued.

If you do not want your Medical Assistance benefits to continue until the Fair Hearing decision is issued, you must tell the State when you call for a Fair Hearing, **or** if you send back this notice, check the box below:

I do not want to continue my Medical Assistance benefits until the Fair Hearing decision is issued.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking the yellow pages of your telephone book under "lawyers."

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your file. If you call or write to the RRDS, they will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. Also, if you call or write to the RRDS, they will provide you with free copies of other documents from your file, which you think you may need for your fair hearing. To ask for documents or to find out how to look at your file, call or write to the RRDS at the telephone number and address listed on the front page of this Notice. If you want copies of documents from your file, you should ask for them within a reasonable time before the date of the fair hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your file, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, please call or write the RRDS at the telephone number and address listed on the front page of this Notice.

Print Name _____ Client Identification Number (CIN) _____

Address _____ Telephone _____

Signature _____ Date _____

**HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER
FOR
NURSING HOME TRANSITION AND DIVERSION PROGRAM (NHTD)**

**NOTICE OF DECISION
REDUCTION AND/OR DISCONTINUATION OF WAIVER SERVICE(S)**

Name & Address of Waiver Participant:

Client Identification Number (CIN): _____

Notice Date: _____

Effective Date: _____

This notice is for waiver services approved for _____ to _____ as established in your most recent service plan.

1a. No reduction in waiver services is indicated at this time.

1b. The following waiver service(s) will be **reduced** as of the Effective Date of this notice.

_____	from _____	to _____
waiver service	hours/frequency	hours/frequency
_____	from _____	to _____
waiver service	hours/frequency	hours/frequency
_____	from _____	to _____
waiver service	hours/frequency	hours/frequency

2a. No discontinuation of waiver services is indicated at this time.

2b. The following waiver service(s) will be **discontinued** as of the Effective Date on this notice.

_____	_____
waiver service	waiver service
_____	_____
waiver service	waiver service
_____	_____
waiver service	waiver service

3a. We intend to take the action(s) identified above because:

The laws that allows us to do this are:

Section 1915(c) of the Social Security Act and, Section 366 (6-a) of the Social Services Law.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING OR BOTH. PLEASE READ THE BACK OF THIS NOTICE TO FIND OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.

Regional Resource Development Specialist (Signature)

Regional Resource Development Specialist (Print)

Name of Regional Resource Development Center (RRDC)

Address

Telephone

Address

cc: Legal Guardian
Authorized Representative
Service Coordinator
NYS DOH NHTD Waiver Program

RIGHT TO CONFERENCE: You may have a conference with the Regional Resource Development Specialist (RRDS) to review these actions. If you want a conference you should ask for one as soon as possible. At the conference, if the RRDS discovers that the wrong decision has been made, or if, because of information you provide, the RRDS decides to change the decision, corrective action will be taken. You will receive a new Notice of Decision. You may ask for a conference by calling the RRDS at the telephone number listed on the first page of this notice or by sending a written request to the address listed on the first page of this notice. ***This is not the way to request a fair hearing.*** If you ask for a conference, you are still entitled to a fair hearing. Read below for fair hearing information.

If you only ask for a Conference, we will not keep your benefits the same while you appeal. Your benefits will stay the same only if you ask for a fair hearing. (See Continuing Your Benefits).

- RIGHT TO A FAIR HEARING:** If you believe that the above action is wrong, you may request a State fair hearing by:
1. **Telephone:** You may call the statewide toll free number at 1-800-342-3334. (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL) **OR**
 2. **Fax:** Complete and fax a copy of this notice to (518) 473-6735 **OR**
 3. **On-Line:** Complete and send the online request form at: <https://www.otda.state.ny.us/oah/forms.asp> **OR**

If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, or on-line, please write to ask for a fair hearing before 60 days from the date of this notice.

4. **Mail:** Complete and send a copy of this notice to the Fair Hearing Section, New York State Office of Temporary Disability Assistance, P. O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.
5. **New York City ONLY:** You may also walk-in to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 14 Boerum Place, Brooklyn, New York **or** 330 West 34th Street, 3rd. Floor, NY, NY. Bring a copy of this notice with you.

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING.

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have the right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

I want a fair hearing. The decision is wrong because: _____

CONTINUING YOUR BENEFITS: If you request a Fair Hearing before the Effective Date stated in this notice, you will continue to receive your Medical Assistance benefits unchanged until the Fair Hearing decision is issued. However, if you lose the Fair Hearing, you may have to pay back any Medical Assistance benefits you should not have received while waiting for the decision.

I want to continue my Medical Assistance benefits until the Fair Hearing decision is issued for (specify action(s) from changes on page 1 above):

If you do not want your Medical Assistance to continue until the Fair Hearing decision is issued, you must tell the State when you call for a Fair Hearing, **or** if you send back this notice, check the box below:

I do not want to continue my Medical Assistance benefits until the Fair Hearing decision is issued.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking the yellow pages of your telephone book under “lawyers.”

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your file. If you call or write to the RRDS, they will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. Also, if you call or write to the RRDS, they will provide you with free copies of other documents from your file, which you think you may need for your fair hearing. To ask for documents or to find out how to look at your file, call or write to the RRDS at the telephone number and address listed on the front page of this Notice. If you want copies of documents from your file, you should ask for them within a reasonable time before the date of the fair hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your file, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, please call or write the RRDS at the telephone number and address listed on the front page of this Notice.

Print Name _____ Client Identification Number (CIN) _____
Address _____ Telephone _____
Signature _____ Date _____

**HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER
FOR
NURSING HOME TRANSITION AND DIVERSION (NHTD)**

**NOTICE OF DECISION
INCREASE AND/OR ADDITION OF WAIVER SERVICE(S)**

Name & Address of Waiver Participant:

Client Identification Number (CIN): _____

Notice Date: _____

Effective Date: _____

This notice is for waiver services approved for _____ to _____ as set forth in your most recent service plan:

1a. No increase in waiver service(s) indicated at this time.

1b. The following waiver service(s) will be **increased** as of the Effective Date of this notice:

_____ from: _____ to: _____
waiver service hours/frequency hours/frequency

_____ from: _____ to: _____
waiver service hours/frequency hours/frequency

_____ from: _____ to: _____
waiver service hours/frequency hours/frequency

2a. No addition of waiver service(s) indicated at this time.

2b. The following waiver service(s) will be **added** as of the Effective Date of this notice:

_____ at: _____
waiver service hours/frequency

_____ at: _____
waiver service hours/frequency

_____ at: _____
waiver service hours/frequency

3. We intend to take the action(s) identified above because:

The laws that allows us to do this are:

Section 1915(c) of the Social Security Act and, Section 366 (6-a) of the Social Services Law.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING, OR BOTH. PLEASE READ THE REST OF THIS NOTICE TO FIND OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.

Regional Resource Development Specialist (Signature)

Regional Resource Development Specialist (Print)

Name of Regional Resource Development Center (RRDC)

Telephone

Address

cc: Legal Guardian
Authorized Representative
Service Coordinator

RIGHT TO CONFERENCE: You may have a conference to review these actions. If you want a conference you should ask for one as soon as possible. At the conference, if the Regional Resource Development Specialist (RRDS) discovers that the wrong decision has been made, or if, because of information you provide, the RRDS decides to change the decision, corrective action will be taken. You will receive a new Notice of Decision. You may ask for a conference by calling the RRDS at the telephone number listed on the first page of this notice or by sending a written request to the address listed on the first page of this notice. ***This is not the way to request a fair hearing.*** If you ask for a conference, you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

1. **Telephone:** You may call the statewide toll free number at 1-800-342-3334. (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL) **OR**
2. **Fax:** Complete and fax a copy of this notice to (518) 473-6735 **OR**
3. **On-Line:** Complete and send the online request form at: <https://www.otda.state.ny.us/oah/forms.asp> **OR**

If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, or on-line, please write to ask for a Fair Hearing before 60 days from the date of this notice.

4. **Mail:** Complete and send a copy of this notice to the Fair Hearing Section, New York State Office of Temporary Disability Assistance, P. O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.
5. **New York City ONLY:** You may also walk-in to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 14 Boerum Place, Brooklyn, New York **or** 330 West 34th Street, 3rd Floor, NY, NY. Bring a copy of this notice with you.

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING.

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have the right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, hearing bills, medical verification, letters, etc. that may be helpful in presenting your case.

I want a fair hearing. The decision is wrong because: _____

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking the yellow pages of your telephone book under "lawyers."

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your file. If you call or write to the RRDS, they will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. Also, if you call or write to the RRDS, they will provide you with free copies of other documents from your file, which you think you may need for your fair hearing. To ask for documents or to find out how to look at your file, call or write to the RRDS at the telephone number and address listed on the front page of this Notice. If you want copies of documents from your file, you should ask for them within a reasonable time before the date of the fair hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your file, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, please call or write the RRDS at the telephone number and address listed on the front page of this Notice.

Print Name _____ Client Identification Number (CIN) _____
Address _____ Telephone _____
Signature _____ Date _____

**HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER
FOR
NURSING HOME TRANSITION AND DIVERSION (NHTD)**

**NOTICE OF DECISION
SUSPENSION**

Client Identification Number (CIN): _____

Notice Date: _____

Effective Date: _____

Name and Address of Waiver Participant

This is to inform you that your participation in the Home and Community-Based Services Medicaid Waiver for Nursing Home Transition and Diversion (NHTD) is being **SUSPENDED** as of the Effective Date above.

Your participation in the waiver is being **SUSPENDED** because:

- You have been hospitalized;
- You have been admitted into a Nursing Home;
- You are incarcerated;
- You have been admitted into an inpatient psychiatric or substance abuse facility;
- You have been admitted into an Intermediate Care Facility for persons with developmental disabilities
- Other: _____

Explanation:

The laws that allows us to do this are:

Section 1915(c) of the Social Security Act and, Section 366 (6-a) of the Social Services Law.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING, OR BOTH. PLEASE READ THE BACK OF THIS NOTICE TO FIND OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.

Regional Resource Development Specialist (Signature)

Regional Resource Development Specialist (Print)

Name of Regional Resource Development Center (RRDC)

Address

Address

Telephone

cc: Legal Guardian
Authorized Representative
Service Coordinator
NYS DOH NHTD Waiver Program

RIGHT TO CONFERENCE: You may have a conference with the Regional Resource Development Specialist (RRDS) to review these actions. If you want a conference you should ask for one as soon as possible. At the conference, if the RRDS discovers that the wrong decision has been made, or if, because of information you provide, the RRDS decides to change the decision, corrective action will be taken. You will receive a new Notice of Decision. You may ask for a conference by calling the RRDS at the telephone number listed on the first page of this notice or by sending a written request to the address listed on the first page of this notice. ***This is not the way to request a fair hearing.*** If you ask for a conference, you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

1. **Telephone:** You may call the statewide toll free number at 1-800-342-3334. (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL) **OR**
2. **Fax:** Complete and fax a copy of this notice to (518) 473-6735 **OR**
3. **On-Line:** Complete and send the online request form at: <https://www.otda.state.ny.us/oah/forms.asp> **OR**

If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, or on-line, please write to ask for a fair hearing before 60 days from the date of this notice.

4. **Mail:** Complete and send a copy of this notice to the Fair Hearing Section, New York State Office of Temporary Disability Assistance, P. O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.
5. **New York City participants ONLY:** You may also walk-in to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 14 Boerum Place, Brooklyn, New York **or** 330 West 34th Street, 3rd Floor, NY, NY. Bring a copy of this notice with you.

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING.

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have the right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

I want a fair hearing. The decision is wrong because: _____

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking the yellow pages of your telephone book under "lawyers."

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your file. If you call or write to the RRDS, they will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. Also, if you call or write to the RRDS, they will provide you with free copies of other documents from your file, which you think you may need for your fair hearing. To ask for documents or to find out how to look at your file, call or write to the RRDS at the telephone number and address listed on the front page of this Notice. If you want copies of documents from your file, you should ask for them within a reasonable time before the date of the fair hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your file, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, please call or write the RRDS at the telephone number and address listed on the front page of this Notice.

Print Name _____ Client Identification Number (CIN) _____
Address _____ Telephone _____
Signature _____ Date _____

**HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER
FOR
NURSING HOME TRANSITION AND DIVERSION (NHTD)**

**NOTICE OF DECISION
DENIAL OF A WAIVER SERVICE and/or
DENIAL OF A WAIVER PROVIDER**

Name & Address of Waiver Participant:

Client Identification Number (CIN): _____

Notice Date: _____

Effective Date: _____

1. Your request for the following NHTD waiver service(s) has been denied:

Service(s) requested: _____

We intend to take this action because:

2. Your request for the following NHTD waiver provider has been denied:

Provider requested: _____

We intend to take this action because: _____

The laws that allows us to do this are:

Section 1915(c) of the Social Security Act and Section 366 (6-a) of the Social Services Law.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING, OR BOTH. PLEASE READ THE REST OF THIS NOTICE TO FIND OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.

Regional Resource Development Specialist (Signature)

Regional Resource Development Specialist (Print)

Name of Regional Resource Development Center (RRDC)

Address

Address

Telephone

cc: Legal Guardian
Authorized Representative
Service Coordinator
NYS DOH NHTD Waiver Program

RIGHT TO CONFERENCE: You may have a conference with the Regional Resource Development Specialist (RRDS) to review these actions. If you want a conference you should ask for one as soon as possible. At the conference, if the RRDS discovers that the wrong decision has been made, or if, because of information you provide, the RRDS decides to change the decision, corrective action will be taken. You will receive a new Notice of Decision. You may ask for a conference by calling the RRDS at the telephone number listed on the first page of this notice or by sending a written request to the address listed on the first page of this notice. ***This is not the way to request a fair hearing.*** If you ask for a conference, you are still entitled to a fair hearing. Read below for fair hearing information.

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If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, or on-line, please write to ask for a fair hearing before 60 days from the date of this notice.
4. **Mail:** Complete and send a copy of this notice to the Fair Hearing Section, New York State Office of Temporary Disability Assistance, P. O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.
5. **New York City ONLY:** You may also walk-in to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 14 Boerum Place, Brooklyn, New York **or** 330 West 34th Street, 3rd. Floor, NY, NY. Bring a copy of this notice with you.

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING.

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have the right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

I want a fair hearing. The decision is wrong because: _____

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking the yellow pages of your telephone book under "lawyers."

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your file. If you call or write to the RRDS, they will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. Also, if you call or write to the RRDS, they will provide you with free copies of other documents from your file, which you think you may need for your fair hearing. To ask for documents or to find out how to look at your file, call or write to the RRDS at the telephone number and address listed on the front page of this Notice. If you want copies of documents from your file, you should ask for them within a reasonable time before the date of the fair hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your file, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, please call or write the RRDS at the telephone number and address listed on the front page of this Notice.

Print Name _____ Client Identification Number (CIN) _____
Address _____ Telephone _____
Signature _____ Date _____

**HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER
FOR
NURSING HOME TRANSITION AND DIVERSION (NHTD)**

**NOTIFICATION OF DEATH OF A WAIVER PARTICIPANT
TO
LOCAL DEPARTMENT OF SOCIAL SERVICES**

Name & Address of Waiver Participant:

Client Identification Number (CIN): _____

Notice Date: _____

This is to inform you that the individual name above is discontinued from the Nursing Home Transition and Diversion waiver due to the death of the waiver participant on _____ (date).

Regional Resource Development Specialist (Signature)

Regional Resource Development Specialist (Print)

Name of Regional Resource Development Center (RRDC)

Address

Address

Telephone

cc: Service Coordinator
NYS DOH NHTD Waiver Program
Social Services District with fiscal responsibility
Social Services District in county of residence (If different from county of fiscal responsibility)

INITIAL SERVICE PLAN

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

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**

Address: _____
Street

_____ City County State Zip

Mailing Address (if different from above): _____

Phone: Home (_____) _____ Work (_____) _____ Cell (_____) _____

Check 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	Telephone

INITIAL SERVICE PLAN

3. Profile of Applicant (continued)

B. Medical/Functional Information

1. Diagnoses and Medical Status

Primary Diagnosis: _____

Other Diagnosis: _____

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.)

Summarize the applicant's health and medical status as it relates to functional ability prior to application to the waiver.

Mental Health History (If applicable.) (Include hospitalizations, treatment(s))

Substance Abuse History (If applicable) (Include alcohol, drugs and etc.)

INITIAL SERVICE PLAN

3. Profile of Applicant (continued)

2. Describe if and how the applicant's disability or illness/injury has impacted his/her cognitive, physical and behavioral status. Also, include the applicant's strengths in each area):

Cognitive Status (e.g. memory, organizational skills, judgment, orientation, problem solving, and attention and learning abilities)

Physical Ability (e.g. functional performance)

Behavioral Status (e.g. changes in expected response to situations and environment)

3. Applicant's response to the disability, illness or injury:

Describe how the applicant views himself/herself using his/her own words:

Since disability or illness/ injury began, describe strategies and tools applicant has used to manage these issues (e.g. assistive technology, environmental modifications, reminders, cues):

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

Describe the applicant's emotional response (coping) to current physical status:

INITIAL SERVICE PLAN

3. Profile of Applicant (continued)

B. Medical/Functional Information (continued)

Describe how the applicant feels he/she is managing his/her disability, illness or injury:

Describe family and informal supports response to the applicant living in the community, his/her disability and its impact on his/her life:

4. Medications (NOTE: Use the charts that follow to list all medications and complete additional columns as indicated.)

Describe applicant's ability to self-administer medications (including the ability to prepare medications and to follow prescribed schedule and dosage):

If unable, who will assist applicant, and how will this be carried out?

Describe any assistance needed getting prescription(s) filled in a timely manner:

Identify whom will be contacted if there are concerns about the applicant's use of medications(s):

INITIAL SERVICE PLAN

3. Profile of Applicant (continued)

B. Medical/Functional Information (continued)

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	Payer Source	Total Projected Medicaid Monthly Cost

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

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

Total "A" \$ _____
 Total "B" + \$ _____
 Total Projected Medicaid Annual Costs for All Medications, Medical Supplies and Durable Medical Equipment
 = \$ _____

(Total Projected Medicaid Monthly Cost x 12)

(transfer total to page 22)**

INITIAL SERVICE PLAN

3. Profile of Applicant (continued)

B. Medical/Functional Information (continued)

4. **Physician/Dentist(s)** applicant is currently being treated by (include all primary and specialty physicians and nurse practitioner, if applicable):

Primary Physician name: _____ Telephone: _____

Physician name/Specialty: _____ Telephone: _____

Physician name/Specialty: _____ Telephone: _____

Physician name/Specialty: _____ Telephone: _____

Dentist name: _____ Specialty: _____

Are referrals to any other doctor's 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 physician's? Yes No

Does 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 applicant to medical appointment? _____

Who sets up transportation? Applicant Other - Specify _____

6. Management of Medical Needs

List any diagnoses, disease state or condition that needs ongoing management, monitoring and/or treatments. (Include injections, oxygen, dressing changes, lab work, etc.) Indicate if the applicant needs any assistance, the type of assistance, and who will provide.

INITIAL SERVICE PLAN

3. Profile of Applicant (continued)

B. Medical/Functional Information (continued)

7. Dietary Needs

- | | | | |
|---|-------------------------------------|---|--|
| <input type="checkbox"/> Regular | <input type="checkbox"/> Low Sodium | <input type="checkbox"/> Low Fat | <input type="checkbox"/> Thickened liquids |
| <input type="checkbox"/> Pureed | <input type="checkbox"/> Renal | <input type="checkbox"/> Aspiration precautions | <input type="checkbox"/> Swallowing difficulties |
| <input type="checkbox"/> Tube feeding | <input type="checkbox"/> Cardiac | <input type="checkbox"/> Diabetic Diet | <input type="checkbox"/> Uses adaptive equipment |
| <input type="checkbox"/> Dentures: | <input type="checkbox"/> Upper | <input type="checkbox"/> Lower | <input type="checkbox"/> Partial |
| <input type="checkbox"/> Special Dietary Considerations (e.g. vegetarian, kosher, etc): (specify) _____ | | | |

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

8. Visual Ability (Check all that apply)

- Blind: Right eye Left Eye Wears Glasses Needs Large Print
- Visually Impaired Right eye Left Eye
- Uses Braille Cataracts Eye Prosthesis Guide Dog
- Other: _____

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

9. Hearing Ability (Check all that 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 applicant's ability to hear:

10. Communication Skills

Primary language is: _____

Other languages spoken/understood: _____

Describe any specific information that pertains to the applicant's ability to speak and understand:
(include if a translator is needed and who provides the service):

11. Other Needs

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? _____

INITIAL SERVICE PLAN

3. Profile of Applicant (continued)

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

- **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.)

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

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

- **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

A. 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.

INITIAL SERVICE PLAN

4. Applicant's Plans for Community Living (continued)

Select type of dwelling:

- 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 (including applicant)
- Adult Care Facility
- Other: _____

B. 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. Informal Supports

Family – Identify the present family supports applicant considers most significant to his/her life, the level of support and the activities the family is providing. Describe the family's willingness and/or ability to continue with their support. (List name and relationship of applicable supports)

Friend(s) – Identify the present friend(s) applicant considers most significant to his/her life, the level of support and the activities these friends are providing. Describe the friend(s) willingness and/or ability to continue with their support. List name(s) of applicable support(s).

INITIAL SERVICE PLAN

5. Current Supports and Services (continued)

Community – Identify the present level of support and services provided through community resources (e.g. neighbors, religious, fraternal, hobby groups, etc). Describe the willingness and ability of community supports and services to continue.

B. Formal 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.) Include frequency and duration.

Note: Transfer this information on to the Insurance, Resources and Funding Information Sheet.

Explain all Medicaid State Plan services the applicant 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 on page 22.

INITIAL SERVICE PLAN

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 applicants 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: Answer each question in this section. Use "N/A" where applicable.

A. For applicants 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 applicant 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 page 14)

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 Pan should also address the necessary tasks.

INITIAL SERVICE PLAN

6. Oversight/supervision and/or Assistance with Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) (continued)

B. For applicants needing assistance with ADL/IADL tasks but not oversight/supervision

Indicate the extent to which informal supports will be available to provide the applicant 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 applicant'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 11 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 11 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.

INITIAL SERVICE PLAN

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:

INITIAL SERVICE PLAN

8. Requested Waiver Services (Indicate "N/A" for any service(s) not requested)

Service Coordination

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.

Assistive Technology

Explain the need for this service.

Identify the type(s) of Assistive Technology desired by the applicant and his/her goals for using this service(s).

Describe specific activities targeted for the next six (6) months

***Attach Assistive Technology Description and Cost Projection form and copy of bid(s), if applicable.**

INITIAL SERVICE PLAN

8. Requested Waiver Services (continued)

Community Integration Counseling (CIC)

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.

Community Transitional Services (CTS)

Explain the need for this service

Identify the applicant's desired goals for this service.

Describe specific activities targeted for the next six (6) months.

***Attach the Community Transition Service Description and Cost Projection form and copy of bid(s), if applicable.**

Congregate and Home Delivered Meals

Explain the need for this service

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

INITIAL SERVICE PLAN

8. Requested Waiver Services (continued)

Congregate and Home Delivered Meals (continued)

Describe specific activities targeted for the next six (6) months.

Environmental Modifications Services (E-Mods)

Explain the need for this service

Identify the applicant's desired goals for this service.

Describe specific activities targeted for the next six (6) months.

***Attach Environmental Modification Description and Cost Projection form and copy of bid(s), if applicable.**

Home and Community Support Services (HCSS)

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.

NOTE: Please attach the necessary documentation supporting the recommended frequency and duration of service(s)

INITIAL SERVICE PLAN

8. Requested Waiver Services (continued)

Home Visits by Medical Personnel

Explain the need for this service

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

Describe specific activities targeted for the next six (6) months.

Independent Living Skills Training Services (ILST)

Explain the need for this service

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

Describe specific activities targeted for the next six (6) months.

Moving Assistance

Explain the need for this service

Identify applicant's desired goals for this service.

Describe specific activities projected for the next six (6) months.

***Attach the Moving Assistance Description and Cost Projection form and copy of bid (s), if applicable.**

INITIAL SERVICE PLAN

8. Requested Waiver Services (continued)

Nutritional Counseling/Educational Services

Explain the need for this service

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

Describe specific activities targeted for the next six (6) months.

Peer Mentoring

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.

Positive Behavioral Interventions and Supports (PBIS)

Explain the need for this service

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

Describe specific activities targeted for the next six (6) months.

INITIAL SERVICE PLAN

8. Requested Waiver Services (continued)

Respiratory Therapy

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.

Respite Services

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.

Structured Day Program Services

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.

INITIAL SERVICE PLAN

8. Requested Waiver Services (continued)

Wellness Counseling 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.

INITIAL SERVICE PLAN

9. Medicaid State Plan Services* and Cost Projection

Type of Service	Provider (Name and Telephone)	Effective Date	Frequency & Duration (e.g. 2 hrs., 3X per week)	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 \$ _____

*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.

INITIAL SERVICE PLAN

10. Waiver Services and Cost Projection

Waiver Service	Provider (Name, Address, Telephone)	Effective Date	Frequency & Duration (e.g. 2 hrs., 3X per week)	Annual Amount of Units	Rate	Total Projected Medicaid Annual Cost
Service Coordination						

Total Projected Medicaid Annual Cost for All Waiver Services \$ _____

INITIAL SERVICE PLAN

11. Projected Total Annual Costs for Initial Service Plan

- | | | |
|---|---|-------|
| 1. Total Projected Medicaid Annual Cost of Medicaid State Plan Services (from page 22) | | _____ |
| 2. Total Projected Medicaid Annual Cost of Waiver Services (from page 23) | + | _____ |
| 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) | = | _____ |

INITIAL SERVICE PLAN

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 applicant

Applicant Name:

Date of Initial 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							

INITIAL SERVICE PLAN

13. 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 concerning my participation in the NHTD waiver at any time.

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

Name of Applicant (First/MI/Last/Generational Suffix)	Signature	Date
---	-----------	------

Name of Legal Guardian (if applicable) (print)	Signature	Date
--	-----------	------

Name of Other/Relationship to Applicant (if applicable) (print)	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.

Name of Service Coordinator (print)	Signature	Date
-------------------------------------	-----------	------

Name of Service Coordinator Supervisor (print)	Signature	Date
--	-----------	------

Name and Address of Agency	Telephone
----------------------------	-----------

I approve this Initial Service Plan as it is written.

RRDS Comments: _____

This Service Plan is in effect from: _____ to: _____

Name of RRDS (print)	Signature	Date
----------------------	-----------	------

PROVIDER SELECTION

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

NOTE: This form must be returned to the Service Coordinator to complete Provider Selection process. Services may not begin until final notification by Service Coordinator is received.

I understand that as an applicant/participant for the above indicated waiver, I must select a Provider(s) from the attached list of approved Waiver Service Provider Agencies. I have been encouraged to interview the Provider(s) prior to making my selection. I understand that the Provider(s) will assist me with the development and implementation of a Detailed Plan which reflects my wishes and needs, maintains my health and welfare, and monitors the provision of services for quality and appropriateness.

I also understand that at any time I may change my Provider Agency and still be eligible for the waiver.

From the approved Provider Agency list, I have chosen:

Name of Provider Agency

Telephone

Provider Address

From this Provider agency, I am requesting the following services:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Applicant Signature

Date

Applicant's Address

Legal Guardian Signature (if applicable)

Date

Authorized Representative Signature (if applicable)

Date

To be completed by Provider Agency:

Provider Agency _____

_____ will provide all of the above listed services
_____ is unable to provide the following service(s):

because: _____

_____ will not provide any of the above listed services

because: _____

Provider Contact Signature/Title

Date

Service Coordinator Signature

Date

INITIAL SERVICE PLAN

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

Insurance, Resources and Funding Information Sheet

Date: _____

Applicant Name: _____ CIN: _____

Address: _____

Phone: (H): _____ (W): _____ (C): _____

1. Insurance Information

Other Health Insurance: Company Name: _____

Telephone: _____ Policy #: _____ Group #: _____

Medicare #: _____ Medicare A Effective Date: ____/____/____

Medicare B Effective Date: ____/____/____

Medicare D Effective Date: ____/____/____

Name of Medicare D Prescription Plan: _____

Medicare Managed Care Yes No

Company Name: _____

Telephone: _____ ID #: _____

Supplemental Insurance Company Name: _____

Telephone: _____ Policy #: _____ Group #: _____

Other Prescription Plan: Company Name: _____

Telephone: _____ Policy #: _____ Group #: _____

Medicaid Spend-down Per Month \$ _____

Spend-down to be applied to LDSS **or** Service: _____

Medicaid Managed Care Yes No

Company Name: _____

Telephone: _____ ID #: _____

Veteran Yes No Receives services? No Yes (List) _____

Insurance and Resource/Funding Information Sheet (continued)

2. Resources and Funding

A. Income

Income Source	Amount	Denied/ Date	Will Apply Upon Enrollment	Who Will Assist With Application?
Social Security				
Social Security Disability Insurance				
Supplemental Security Income				
Veteran's Administration				
Public Assistance				
Supplemental Needs Trust				
Other Trust				
Worker's Compensation				

B. Federal, State and Private Funded Resources/Services

Funding Source	Amount	Denied/ Date	Type and Frequency of Service	Will Apply Upon Enrollment?	Who Will Assist With Application?
HUD/Section 8					
HEAP					
Food Stamps					
Crime Victims Funding					
VESID					
OMRDD					
Worker's Compensation					
No Fault Insurance					
Veteran's Administration					
Medicare					
Other Insurance:					
NHTD Housing Subsidy					
Other:					

Insurance and Resource/Funding Information Sheet (continued)

2. Resources and Funding (continued)

C. 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:		

Applicant Signature Date

Service Coordinator Signature Date

PLAN FOR PROTECTIVE OVERSIGHT

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

The location where PPO is kept in the participant's home is: _____

Participant Name: _____ CIN _____

Address: _____

Phone: (H) _____ (W) _____ (C) _____

1. Contacts

Legal Guardian Name (if applicable): _____ **Relationship:** _____

Address: _____

Street City State Zip

Phone: Home () Work () Cell ()

Guardianship verified, if applicable

Primary Contact: _____ **Relationship:** _____

Address: _____

Street City State Zip

Phone: Home () Work () Cell ()

Other Contact: _____ **Relationship:** _____

Address: _____

Street City State Zip

Phone: Home () Work () Cell ()

Out-of-Area Emergency/Disaster Contact (not same as above), if available

Name: _____ **Relationship:** _____

Address: _____

Street City State Zip

Phone: Home () Work () Cell ()

2. Advance Directives

Health Care Agent Name (if applicable): _____

Address: _____

Street City State Zip

Phone: Home () Work () Cell ()

For RRDS use only:

Effective date _____ to _____

PLAN OF PROTECTIVE OVERSIGHT (continued)

Participant Name: _____

2. Advance Directives (continued)

Alternate Health Care Agent Name (if applicable): _____

Address: _____

Street City State Zip

Phone: Home () Work () Cell ()

Health Care Proxy verified, if applicable

Is there a current Non-Hospital Do Not Resuscitate Order? Yes No

Non-Hospital DNR verified, if applicable

3. Financial Contacts

Power of Attorney Name (if applicable): _____ Relationship: _____

Address: _____

Street City State Zip

Phone: Home () Work () Cell ()

Specify type of assistance provided: _____

Power of Attorney verified, if applicable

Rep. Payee Name (if applicable): _____ Relationship: _____

Address: _____

Street City State Zip

Phone: Home () Work () Cell ()

Person/Agency who will assist with Financial Matters (if appropriate):

Name: _____ Relationship: _____

Address: _____

Street City State Zip

Phone: Home () Work () Cell ()

4. Hospital Preference

Participant's choice of hospital: _____

5. Revisions made to page(s) 1 and/or 2

Change(s) made: _____

Name of Waiver Participant Signature Date

Name of Guardian (if applicable) Signature Date

Name of Service Coordinator Signature Date

PLAN OF PROTECTIVE OVERSIGHT (continued)

Participant Name: _____

6. Fire/Safety Disaster Plan

<u>Yes</u>	<u>No</u>		
<input type="checkbox"/>	<input type="checkbox"/>	Residence has Smoke Detector	Comments: _____
<input type="checkbox"/>	<input type="checkbox"/>	Residence has Carbon Monoxide Detector	Comments: _____
<input type="checkbox"/>	<input type="checkbox"/>	Participant able to access all available exits	Comments: _____
<input type="checkbox"/>	<input type="checkbox"/>	Participant is bed bound	If yes, plan of action: _____
<input type="checkbox"/>	<input type="checkbox"/>	Participant needs assistance in the case of evacuation	If yes, plan of action: _____
<input type="checkbox"/>	<input type="checkbox"/>	Participant needs help outside of informal supports if a disaster occurs	If yes, plan of action: _____
<input type="checkbox"/>	<input type="checkbox"/>	Evacuation Plan reviewed with participant/legal guardian and informal supports	Date reviewed: ____/____/____ Date the local authorities were notified of assistance needed: ____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Discussed the need for a Disaster Preparedness Plan	Comments: _____
<input type="checkbox"/>	<input type="checkbox"/>	Discussed the need for a disaster kit	Dated discussed: ____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Participant uses oxygen	If yes, plan of action, in case of emergency: _____ Vendor Name and Telephone: _____
<input type="checkbox"/>	<input type="checkbox"/>	Participant uses ventilator	If yes, plan of action: _____ Vendor Name and Telephone: _____
<input type="checkbox"/>	<input type="checkbox"/>	Participant requires suctioning	If yes, plan of action: _____ Vendor Name and Telephone: _____
<input type="checkbox"/>	<input type="checkbox"/>	Power Company notified of all power-dependent life support equipment	Date notified: ____/____/____ <input type="checkbox"/> No life support used

7. Medications

<u>Yes</u>	<u>No</u>		
<input type="checkbox"/>	<input type="checkbox"/>	Does the participant need assistance with taking medications?	If yes, type of assistance provided: _____ By Whom: _____
<input type="checkbox"/>	<input type="checkbox"/>	Does the participant need assistance getting meds prescriptions filled?	If yes, type of assistance provided: _____ By whom: _____
<input type="checkbox"/>	<input type="checkbox"/>	Does the participant have someone to notify if there are concerns about their use of medications?	If yes, person(s) to contact: _____

PLAN OF PROTECTIVE OVERSIGHT (continued)

Participant Name: _____

8. Dietary

a. Who will be contacted if the participant experiences any changes in eating habits?

9. Plan for Back-Up

a. Would the absence of waiver services or informal supports during scheduled/expected times jeopardize the participant's health and welfare?

YES NO

If yes, list the waiver service and/or informal support and describe the back-up plan to be utilized:

b. Would the absence of non-waiver services (e.g. nursing services) during scheduled times jeopardize the participant's health and safety:

YES NO

If yes, list the non-waiver service(s) and describe the back-up plan to be utilized?

c. Does participant have any pets? YES NO If yes, type(s): _____

Who needs to be contacted to care for pets if participant becomes unable? _____

10. Other – List all Assistive Technology, medical equipment, and emergency communication devices used by participant and contact/agency if repairs are needed:

Device Type and Description	Contact Name/Agency and Telephone Number/Ext.

PLAN OF PROTECTIVE OVERSIGHT (continued)

Participant Name: _____

11. Signatures of Individuals Participating in the Plan For Protective Oversight

_____	_____	____/____/____
Name of Waiver Participant	Signature	Date

_____	_____	____/____/____
Name of Legal Guardian (if applicable)	Signature	Date

_____	_____	____/____/____
Name of Informal Support	Signature	Date

_____	_____	____/____/____
Name of Informal Support	Signature	Date

_____	_____	_____	____/____/____
Name of Formal Support/Title	Agency	Signature	Date

_____	_____	_____	____/____/____
Name of Formal Support/Title	Agency	Signature	Date

_____	_____	____/____/____
Name of Service Coordinator	Signature	Date

_____	_____	____/____/____
Name of Service Coordinator Supervisor	Signature	Date

12. Regional Resource Development Specialist

The information provided in this Plan for Protective Oversight summarizes alternatives so that the participant's health and welfare can be maintained in the community and that he/she is not at risk for nursing home placement.

Comments: _____

_____	_____	_____
Name of RRDS	Signature	Date

WAIVER PARTICIPANT'S RIGHTS AND RESPONSIBILITIES
HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion Waiver (NHTD)

All individuals participating in a Home and Community Based Services (HCBS) Medicaid waiver are ensured specific rights regarding the delivery of waiver services.

Waiver Participant's Rights

As a Waiver Participant You Have the Right to:

1. Be informed of your rights prior to receiving waiver services;
2. Receive services without regard to race, religion, color, creed, gender, national origin, sexual orientation, marital status, or disability;
3. Be treated as an individual with consideration, dignity and respect including but not limited to person, residence and possessions;
4. Have services provided that support your health and welfare;
5. Assume reasonable risks and have the opportunity to learn from these experiences;
6. Be provided with an explanation of all services available in the Nursing Home Transition and Diversion Waiver (NHTD) waiver and other health and community resources that may benefit you;
7. Have the opportunity to participate in the development, review and approval of all Service Plans, including any changes to the Service Plan;
8. Select service providers and choose to receive additional waiver services from different agencies or different providers within the same agency without jeopardizing participation in the waiver;
9. Request a change in services (add, increase, decrease or discontinue) at any time;
10. Be fully informed of the process for requesting an Informal Conference and Fair Hearing upon receipt of a Notice of Decision or at any time while a participant of the NHTD waiver;
11. Be informed of the name and duties of any person providing services to you under the Service Plan;
12. Have input into when and how waiver services will be provided;
13. Receive services from approved, qualified individuals;
14. Receive from the Service Coordinator, in writing, a list of names, telephone numbers, and supervisors for all waiver service providers, the RRDS, QMS, and the NHTD Complaint Line;

WAIVER PARTICIPANT'S RIGHTS AND RESPONSIBILITIES (continued)

15. Refuse care, treatment and services after being fully informed of and understanding the potential risks and consequences of such actions;
16. Have your privacy respected, including the confidentiality of personal records, and have the right to refuse the release of the information to anyone not authorized to have such records, except in the case of your transfer to a health care facility or as required by law or Medicaid requirements;
17. Submit complaints about any violation of rights and any concerns regarding services provided, without jeopardizing your participation in the waiver and not being subject to restraint, interference, coercion, discrimination or reprisal as a result of submitting a complaint;
18. Receive support and direction from the Service Coordinator to resolve your concerns and complaints about services and service providers;
19. Receive additional support and direction from the RRDS, QMS and DOH Waiver Management Staff as desired or in the event that your Service Coordinator is not successful in resolving concerns and complaints about services and service providers;
20. Have your complaints responded to and be informed of the final resolution of the investigation;
21. Have your service providers protect and promote your ability to exercise all rights identified in this document;
22. Have all rights and responsibilities outlined in this document forwarded to your court appointed legal guardian or others authorized to act on your behalf; and
23. Participate in surveys inquiring about your experiences as an NHTD waiver participant. This includes the right to refuse to participate in experience surveys without jeopardizing your continued participation in the NHTD waiver program.

Waiver Participant's Responsibilities

As a Waiver Participant You Are Responsible to:

1. Work with your Service Coordinator to develop/revise your Service Plan to assure timely reauthorization of the Service Plan;
2. Work with your waiver providers as described in your current Service Plan;
3. Follow your Service Plan and notifying your Service Coordinator if problems occur;
4. Talk to your Service Coordinator and other waiver providers if you want to change your goals or services;

WAIVER PARTICIPANT'S RIGHTS AND RESPONSIBILITIES (continued)

5. Provide to the best of your knowledge, complete and accurate medical history including all prescribed and over-the-counter medications you are taking and understand the risk(s) associated with your decisions about care;
6. Inform the Service Coordinator about all treatments and interventions you are involved in;
7. Maintain your home in a manner which enables you to safely live in the community;
8. Ask questions when you do not understand your services;
9. Not participate in any criminal behavior. You understand that, if you do, your service provider(s) may leave, the police may be called and your continuation in the waiver program may be jeopardized;
10. Report any significant changes in your medical condition, circumstances, informal supports and formal supports to your Service Coordinator;
11. Provide accurate information related to your coverage under Medicaid (including recertification and spend-down), Medicare or other medically-related insurance programs to your Service Coordinator;
12. Notify all providers as soon as possible if the scheduled service visit needs to be rescheduled or changed;
13. Notify appropriate person(s) should any problems occur or if you are dissatisfied with services provided; and
14. Show respect and consideration for staff and their property.

I have read this Waiver Participant's Rights and Responsibilities form, or it has been read to me and I understand its contents and purpose as written. I understand that failure to adhere to the responsibilities described in this Waiver Participant Agreement and/or my signed current Service Plan may result in termination from the waiver.

Applicant/Participant Name	Signature	Date
Legal Guardian/Committee Name (if applicable)	Signature	Date
Authorized Representative Name (if applicable)	Signature	Date
Service Coordinator Name	Signature	Date

cc: All current waiver service providers

WAIVER CONTACT LIST
HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
NURSING HOME TRANSITION AND DIVERSION

Date: _____

Participant: _____

Service Coordinator

Name: _____ Telephone _____

Supervisor: _____ Telephone: _____

Provider Agency: _____

Regional Resource Development Specialist (RRDS)

Name: _____ Telephone: _____

Supervisor: _____ Telephone: _____

Quality Management Specialist (QMS)

Name _____ Telephone: _____

Supervisor: _____

Complaint Line: _____

WAIVER CONTACT LIST (cont'd)

Service: _____

Agency Name: _____ **Telephone:** _____

Staff Name: _____ **Supervisor:** _____

Service: _____

Agency Name: _____ **Telephone:** _____

Staff Name: _____ **Supervisor:** _____

Service: _____

Agency Name: _____ **Telephone:** _____

Staff Name: _____ **Supervisor:** _____

Service: _____

Agency Name: _____ **Telephone:** _____

Staff Name: _____ **Supervisor:** _____

Service: _____

Agency Name: _____ **Telephone:** _____

Staff Name: _____ **Supervisor:** _____

Service: _____

Agency Name: _____ **Telephone:** _____

Staff Name: _____ **Supervisor:** _____

Other: _____ **Telephone:** _____

Other: _____ **Telephone:** _____

MOVING ASSISTANCE DESCRIPTION AND COST PROJECTION
HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Applicant/Participant: _____ CIN: _____
Current Address: _____
New Address: _____

1. Explain why the move is necessary.
2. How many times has this service been requested before or provided before? (Please be specific).
3. Moving company: _____ Telephone: _____
Contact person: _____ NYSDOT License # (if applicable): _____
FMCSA License # (if applicable): _____
4. Total Moving Assistance funds requested, attach all estimates received. \$ _____

Participant Signature: _____ Date: _____
Service Coordinator: _____
Signature: _____ Date: _____
Moving Assistance Provider: _____ Provider ID#: _____
Contact Person: _____
Signature: _____
Regional Resource Development Specialist (RRDS): _____
Signature: _____ Date: _____

Approved Denied
Reason for denial: _____

DOH Waiver Management Staff (if over \$5,000): _____
Signature: _____ Date: _____

ASSISTIVE TECHNOLOGY DESCRIPTION AND COST PROJECTION
HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Applicant/Participant _____

CIN _____

1. Describe the Assistive Technology being requested.

2. Explain how the Assistive Technology will help contribute toward the applicant/participant's health and welfare.

3. Attach all assessments and bids. Identify the selected bid.
NOTE: If this is a rental property, a signed authorization from the landlord must be attached.

Participant Signature: _____ Date: _____

Assistive Technology Provider: _____ Provider ID#: _____

Contact Person: _____

Signature: _____

Service Coordinator: _____

Signature: _____ Date: _____

Regional Resource Development Specialist (RRDS): _____

Signature: _____ Date: _____

Approved

Denied

Reason for denial: _____

DOH Waiver Management Staff (if over \$15,000): _____

Signature: _____ Date: _____

COMMUNITY TRANSITIONAL SERVICES (CTS) DESCRIPTION AND COST PROJECTION
HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Referral #: _____

Applicant Name: _____ CIN: _____

1. Describe each component of the Community Transitional Services being requested and explain how the Community Transitional Services will contribute toward the applicant's re-entry into the community. (Apartments for which a security deposit is being requested must have a monthly rent within Fair Market Rate (FMR) if the applicant is seeking a housing subsidy from waiver.)
2. Describe the applicant's ability to make monthly rental payments and meet other costs for maintaining the dwelling (utility, heat, telephone).

3. Total CTS funds requested (from attached page 2) \$ _____

Applicant Signature: _____ Date: _____

Guardian Signature, if applicable: _____ Date: _____

CTS Provider: _____ Provider ID#: _____

Contact Person: _____

Signature: _____

Service Coordinator: _____

Signature: _____ Date: _____

Regional Resource Development Specialist (RRDS): _____

Signature: _____ Date: _____

Approved

Denied

Reason for denial: _____

**COMMUNITY TRANSITIONAL SERVICES (CTS)
DESCRIPTION AND COST PROJECTION (cont'd)**

1. Funds needed to secure an apartment:

Address: _____ Apartment #: _____

Landlord: _____ Telephone: _____

Landlord Address: _____

of people sharing cost of residence: _____ Total Security Deposit: \$ _____ Please describe living situation: _____

Total monthly rent: \$ _____ CTS portion of security deposit \$ _____

2. Utility Set-up

Utility Company (Heating): _____ Account #: _____

of people sharing residence: _____ Total Set-up Fee: \$ _____ CTS portion of Set-up Fee \$ _____

Utility Company (Electricity): _____ Account #: _____

of people sharing residence: _____ Total Set-up Fee: \$ _____ CTS portion of Set-up Fee \$ _____

Utility Company (Phone): _____ Account #: _____

of people sharing residence: _____ Total Set-up Fee: \$ _____ CTS portion of Set-up Fee \$ _____
Total \$ _____

3. Other Expenses

Cleaning/Pest Control Company: _____

Address: _____ Telephone: _____

Purpose: _____

of people sharing residence: _____ Total Set-up Fee: \$ _____ CTS portion of Fee \$ _____

Moving Company: _____ \$ _____
Fee

Address: _____ Telephone: _____

4. Total Cost

Essential Household Furnishings (from Page 3) \$ _____

Amount

Total Community Transitional Services Requested \$ + _____

(not to exceed \$4,500 for NHTD and \$2,700 for TBI)

Administrative Fee for Community Transitional Services Provider \$ + _____

(10% of Total CTS Requested)

TOTAL \$ _____

**COMMUNITY TRANSITIONAL SERVICES (CTS)
DESCRIPTION AND COST PROJECTION (cont'd)**

Essential Household Furnishings

Please list the requested items and the cost of each item. Applicants must explore all other available resources before applying for CTS funds. Only necessary household goods are covered by this service. Items **not** allowed include diversional or recreational items, such as televisions, VCR/DVDs or music systems.

ITEM:	AMOUNT:
Bathroom Set-Up	
Bed:	
Chair	
Chest of Drawers	
Cleaning Utensils	
Clock	
Coffee Table	
Couch	
Dishes, Bowls	
Fire Extinguisher	
First Aid Kit	
Kitchen Table and Chairs	
Lamps	
Light bulbs	
Linens	
Microwave	
Night Stand	
Pots, Pans and Kitchen Utensils	
Silverware	
Waste Baskets	
Window Blinds	
Other	

TOTAL \$ _____
(Transfer this amount to #4 Total Cost on Page 2)

ENVIRONMENTAL MODIFICATION (E-Mod) DESCRIPTION AND COST PROJECTION
HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Applicant/Participant

Address of Proposed E-Mod

1. Describe the E-Mod that is being requested.

2. Explain how the E-Mod will help contribute toward the applicant/participant's health and welfare.

3. Attach all assessments and bids. Identify the selected bid.

NOTE: If this is a rental property, a signed authorization from the landlord must be attached.

Participant Signature: _____ Date: _____

E-Mod Provider: _____ Provider ID#: _____

Contact Person: _____

Signature: _____

Service Coordinator: _____

Signature: _____ Date: _____

Regional Resource Development Specialist (RRDS): _____

Signature: _____ Date: _____

Approved

Denied

Reason for denial: _____

DOH Waiver Management Staff (if over \$15,000): _____

Signature: _____ Date: _____

WAIVER SERVICES FINAL COST

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

Applicant/Participant: _____ CIN: _____

Final cost for: (Check One)

Assistive Technology Community Transition Services Environmental Modifications
 Moving Assistance

1. Original Projected Cost \$ _____ Final Cost \$ _____
(if final cost is GREATER THAN 10% attach documentation of RRDS approval)

2. Describe the completed Service. (Attach itemized list and copies of receipts of all expenses incurred).

3. Justify any difference of less than 10% of the above original cost between the projected and final costs.

I certify that the above Service was provided in accordance with the above costs.

Waiver Service Provider Agency

Provider Medicaid #

Provider Address

Telephone

Provider Contact

Signature

Date

I acknowledge that the above Service was provided in accordance with the Service Plan.

Service Coordinator

Signature

Date

**REGIONAL RESOURCE DEVELOPMENT SPECIALIST (RRDS)
APPROVAL of FINAL COST**

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

Service Coordinator

Date

The final cost for: (Check one)

Environmental Modifications Assistive Technology Community Transition Services

Moving Assistance

submitted for

Applicant/Participant

CIN

has been reviewed and is:

Approved for the amount of \$ _____

Not approved because:

RRDS Signature

Date

Cc: Waiver Service Provider
Service Coordinator

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: _____ Verified 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

REVISED SERVICE PLAN

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:

REVISED SERVICE PLAN

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:

REVISED SERVICE PLAN

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

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

REVISED SERVICE PLAN

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: _____

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? _____

REVISED SERVICE PLAN

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:

REVISED SERVICE PLAN

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:

REVISED SERVICE PLAN

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.

REVISED SERVICE PLAN

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)

REVISED SERVICE PLAN

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.

REVISED SERVICE PLAN

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.

REVISED SERVICE PLAN

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.

REVISED SERVICE PLAN

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.

REVISED SERVICE PLAN

9. Medicaid State Plan Services* and Cost Projection

Type of Service	Provider (Name and Telephone)	Effective Date	Frequency & Duration (e.g. 2 hrs., 3X per week)	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.

REVISED SERVICE PLAN

10. Waiver Services and Cost Projection

Waiver Service	Provider (Name, Address, Telephone)	Effective Date	Frequency & Duration (e.g. 2 hrs., 3X per week)	Annual Amount of Units	Rate	Total Projected Medicaid Annual Cost
Service Coordination						

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

REVISED SERVICE PLAN

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 -) | | _____ |

REVISED SERVICE PLAN

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							

REVISED SERVICE PLAN

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			

**REVISED SERVICE PLAN
HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)**

Insurance, Resources and Funding Information Sheet

Date: _____

Participant's Name: _____ CIN: _____

Address: _____

Phone: (H): _____ (W): _____ (C): _____

1. Insurance Information

Other Health Insurance: Company Name: _____

Telephone: _____ Policy #: _____ Group #: _____

Medicare #: _____
 Medicare A Effective Date: ___/___/___
 Medicare B Effective Date: ___/___/___
 Medicare D Effective Date: ___/___/___

Name of Medicare D Prescription Plan: _____

Medicare Managed Care Yes No

Company Name: _____

Telephone: _____ ID #: _____

Supplemental Insurance Company Name: _____

Telephone: _____ Policy #: _____ Group #: _____

Other Prescription Plan: Company Name: _____

Telephone: _____ Policy #: _____ Group #: _____

Medicaid Spend-down Per Month \$ _____

Spend-down to be applied to LDSS or Service: _____

Medicaid Managed Care Yes No

Company Name: _____

Telephone: _____ ID #: _____

Veteran Yes No Receives services? No Yes (List) _____

Insurance and Resource/Funding Information Sheet (continued)

2. Resources and Funding

A. Income

Income Source	Amount	Denied/ Date	Will Apply Upon Enrollment	Who Will Assist With Application?
Social Security				
Social Security Disability Insurance				
Supplemental Security Income				
Veteran's Administration				
Public Assistance				
Supplemental Needs Trust				
Other Trust				
Worker's Compensation				

B. Federal, State and Private Funded Resources/Services

Funding Source	Amount	Denied/ Date	Type and Frequency of Service	Will Apply Upon Enrollment?	Who Will Assist With Application?
HUD/Section 8					
HEAP					
Food Stamps					
Crime Victims Funding					
VESID					
OMRDD					
Worker's Compensation					
No Fault Insurance					
Veteran's Administration					
Medicare					
Other Insurance:					
NHTD Housing Subsidy					
Other:					

Insurance and Resource/Funding Information Sheet (continued)

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:		

Participant Signature Date

Service Coordinator Signature Date

ADDENDUM TO EXISTING SERVICE PLAN

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

Date: ____ / ____ / ____

1. Identification

Participant Name: _____ Date of Birth: _____

Address: _____
Street City County State Zip

Mailing Address (if different from above): _____

Phone: Home (____) _____ Work (____) _____ Cell (____) _____

CIN: _____ County of Fiscal Responsibility: _____ Verified Yes No

***Attach documented proof of Medicaid eligibility**

Current Service Plan Period From _____ To _____

Individuals who participated in developing the Addendum to the Existing Service Plan

Name	Relationship to Participant	Telephone

DO NOT WRITE BELOW THIS LINE – RRDS will complete

Date of Submission to RRDS by SC: _____

Date of Submission to QMS by RRDS (if applicable): _____

Date returned to RRDS by QMS (if applicable): _____

Date of Final Decision by RRDS: _____

ADDENDUM TO EXISTING SERVICE PLAN

2. Summary of Request for Changes in Waiver Service(s)

- A.** Describe the changes that the waiver participant has experienced which resulted in the need for this Addendum.
- B.** Describe which service(s) will be added, discontinued, and/or changed. Indicate the need for the addition, discontinuation or other change in service(s), the frequency and duration, and the participant's goals:
NOTE: Attach an Individual Service Report (ISR), where applicable for each added and/or changed service.
- C.** Describe what, if any, impact the requested changes in the NHTD waiver service(s) have on the Plan for Protective Oversight (PPO).
NOTE: If this Addendum impacts the current PPO, a revised PPO must be attached.

ADDENDUM TO EXISTING SERVICE PLAN

3. Medicaid State Plan Services* and Cost Projection

Type of Service	Provider (Name & Telephone)	Effective Date	Frequency & Duration (2 hrs., 3X per week)	Annual Amount of Units	Rate	Total Projected Medicaid Annual Cost
Medications, Medical Supplies and DME						

Total Projected Medicaid Annual Costs for All Medicaid State Plan Services \$ _____

Current Service Plan Cost \$ _____

Change in Cost from last plan \$ _____

* 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 and DME.

ADDENDUM TO EXISTING SERVICE PLAN

4. Waiver Services and Cost Projection

Complete the chart to indicate requested changes in services. Indicate all waiver services the participant will be receiving.

Waiver Service	Provider (Name, Address, Telephone)	Effective Date	Frequency & Duration (2 hrs., 3X per week)	Annual Amount of Units	Rate	Total Projected Medicaid Annual Cost
Service Coordination						

Total Projected Medicaid Annual Cost for All NHTD Waiver Services \$ _____
Current Service Plan Cost \$ _____
Change in Cost from last plan \$ _____

ADDENDUM TO EXISTING SERVICE PLAN

5. Projected Total Annual Costs for Service Plan

- | | | |
|---|---|-------|
| 1. Total Projected Medicaid Annual Cost for all Medicaid State Plan Services (page 3) | | _____ |
| 2. Total Projected Medicaid Annual Cost for all Waiver Services (page 4) | + | _____ |
| 3. Total Projected Medicaid Annual Cost of Medicaid Spend-down
(From the most current Revised Service Plan) | = | _____ |
| 4. Total Projected Medicaid Annual Cost for the Addendum (#1 plus #2 minus #3) | - | _____ |
| 5. Total Projected Daily Rate of all Medicaid Services (#4 divided by 365) | = | _____ |
| 6. Total Projected Change in Annual Cost from Current Service Plan
(Compare #4 to the Projected Total Annual Cost of the current Service Plan) | = | _____ |

ADDENDUM TO EXISTING SERVICE PLAN

6. 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's Name:

Date of Addendum:

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							

ADDENDUM TO EXISTING SERVICE PLAN

7. Signatures

I have participated in the development of this Addendum. I have read this Addendum or it has been read to me and I understand its contents and purpose as written. 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 services in this Addendum. I will talk with my Service Coordinator if I want to make any changes to this Addendum.

As a 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

I understand that a copy of this Addendum will be provided to all waiver providers involved in this service plan.

Name of Participant	Signature	Date
---------------------	-----------	------

Name of Legal Guardian (if applicable)	Signature	Date
--	-----------	------

Name of Other/Relationship to Participant (if applicable)	Signature	Date
---	-----------	------

I have written this Addendum and support the request for the waiver services detailed in this Addendum. I verify that in my professional opinion, they are necessary to maintain the health and welfare of the participant.

The information in the current PPO has been reviewed with the above named participant and there are:

- changes to the current PPO. A copy of the new PPO is attached **or**
 no changes to the current PPO

Name of Service Coordinator	Signature	Date
-----------------------------	-----------	------

Name of Service Coordinator Supervisor	Signature	Date
--	-----------	------

Name and Address of Agency	Telephone
----------------------------	-----------

I approve this Addendum as it is written.
The Effective Date of this Addendum is: _____

Name of RRDS	Signature	Date
--------------	-----------	------

INDIVIDUAL SERVICE REPORT (ISR)
HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Participant Name	CIN
------------------	-----

Waiver Service	Provider Agency	Telephone
----------------	-----------------	-----------

Date of Current Approved Service Plan From: _____ To: _____

Date of Addendum (if applicable) _____

1. Identify each of the participant's goal(s) for this service which have been addressed during the current Service Plan.

2. Identify the interventions used to address each goal as described in your Detailed Plan.

3. Identify any progress made for each goal.

INDIVIDUAL SERVICE REPORT (ISR) (continued)

4. Identify any barriers to progress for each goal.

5. Identify the participant's goal(s), expected interventions and outcomes for this service in the next Service Plan.

6. Provide recommendations for frequency and duration of this service in the next Service Plan.

7. Explain why this service is necessary to assure health and welfare in the next Service Plan.

Provider Signature Date

Service Coordinator Signature Date ISR Received

**Nursing Home Transition and Diversion Waiver
TEAM MEETING SUMMARY**

Participant's Name: _____

Date/Time of Meeting: ___/___/___ at _____ am/pm

Location: _____

Facilitator: _____



Participant's Comments: _____

Recommendations for changes in the Service Plan: _____

Issues Addressed: _____

TEAM MEETING SUMMARY
continued

Participant's Name: _____ Date: _____

Outstanding Issues/Health and Welfare Concerns: _____

Next Steps: _____

Anticipated Time Frame for Next Team Meeting: _____

TEAM MEETING SUMMARY
continued

Participant's Name: _____

Date: _____

ATTENDANCE:

Service	Attendee Signature	Agency Name	ISR Submitted? (Y) (N) (N/A)
Service Coordinator			
Assistive Technology			
Community Integration Counseling			
Community Transitional Services			
Congregate and Home Delivered Meals			
Environmental Modifications Services			
Home and Community Support Services			
Home Visits By Medical Personnel			
Independent Living Skills Training			
Moving Assistance			
Nutritional Counseling/Educational Supports			
Peer Mentoring			
Positive Behavioral Interventions and Supports			
Respiratory Therapy			
Respite Services			
Structured Day Program Services			
Wellness Counseling Service			

 Participant (and/or Guardian, if applicable) Signature

 Date

 Signature of Service Coordinator / Agency

 Date

CHANGE OF PROVIDER REQUEST
HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVERS
Nursing Home Transition and Diversion (NHTD)

I, (Participant Name) _____ (CIN) _____ request to make the following change in waiver service provider agency and/or the agency staff currently providing this service to me.

I have been informed of my right to remain with this current waiver service provider agency or select a new agency from a list of all available Waiver Service Providers for this service.

Waiver Service	Current Provider Agency Name or Provider Agency Staff Name and Telephone	Requested Provider Agency Name or Provider Agency Staff Name and Telephone

Participant Signature _____ Date _____

Legal Guardian Signature (as applicable) _____ Date _____

Authorized Representative Signature (as applicable) _____ Date _____

NOTE: SERVICE COORDINATOR MUST CONTACT CURRENT AND REQUESTED PROVIDER OF THIS REQUEST.

Current Service Coordinator Signature _____ Agency Name _____ Date _____

Transition Meeting to be held on: ____ / ____ /20____ at ____ am / pm

To be completed by the Requested Provider:	
_____ will provide service(s) to the above named participant	_____ will not provide service(s) to the above named participant
Provider / Provider Agency Reason: _____	_____
_____	_____
Provider Contact Signature/Title _____	Date _____

To be completed by the Regional Resource Development Specialist:

This request for change in waiver Provider and/or waiver Provider Agency has been reviewed and:

approved Services to begin effective ____ / ____ / ____

denied (explanation): _____

Regional Resource Development Specialist Signature _____ Date _____

- cc: Participant
Legal Guardian (if applicable)
Authorized Representative (If applicable)
Current Waiver Service Provider
New Waiver Service Provider
All current Provider Agencies

**QUALITY MANAGEMENT SPECIALIST
 SERVICE PLAN REVIEW FORM**

Nursing Home Transition and Diversion (NHTD) Medicaid Waiver

Applicant/Participant Name: _____ CIN: _____

To be completed by RRDS:	
RRDC: _____	RRDC Region: _____
Date received by RRDS: _____	Date reviewed by RRDS: _____
Proposed Daily Rate: \$ _____	Service Plan Effective Date: _____
RRDS Comments/Considerations:	

RRDS Signature: _____	
Date: _____	

To be completed by QMS:			
Date received by QMS: _____		RRDS review form attached: ___ yes ___ no	
SC agency: _____			
Date reviewed by QMS: _____			
QA Targets	Yes	No	Comments
1. Are all necessary components of the Service Plan packet provided for this review?			
2. Does the SP meet the health and welfare needs of this applicant/participant in the community?			
3. Are the waiver services being requested justified in the Service Plan?			

4. Does the Service Plan reflect the means of increasing the applicant/participant's independence?			
5. Does this Service Plan reflect the philosophy of the NHTD waiver and person-centered planning?			
6. Is there evidence that other payer sources have been appropriately utilized prior to waiver services?			
7. Can this Service Plan be supported as written?			

QMS Concerns:

QMS Recommendations:

Quality Management Specialist : _____ QMS Region: _____

Date returned to RRDS: _____

SERIOUS REPORTABLE INCIDENT INITIAL REPORT

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

RRDC Region: _____

Participant Name: _____ CIN: _____

Address: _____

Phone: _____

Discovery Date and Time: ___ / ___ / ___ am/pm Name of person discovering alleged incident: _____

Relationship to Participant: _____:

Date and Time alleged incident occurred: ___ / ___ / ___ am/pm

Preliminary category of alleged incident:

- | | | |
|--|---|--|
| <input type="checkbox"/> 1. Abuse/Neglect | <input type="checkbox"/> 4. Death of Participant | <input type="checkbox"/> 7. Sensitive Situation |
| <input type="checkbox"/> 2. Missing Person | <input type="checkbox"/> 5. Hospitalization | <input type="checkbox"/> 8. Medication Error/Refusal |
| <input type="checkbox"/> 3. Restraint | <input type="checkbox"/> 6. Possible Criminal Act | <input type="checkbox"/> 9. Medical Treatment Due to
Accident or Injury |

Describe the alleged incident (include the location where it occurred, any person(s) present at the time, and the circumstances). Include only known facts.

Describe waiver participant's current condition/status and current location:

List any person(s) alleged to be involved in incident:

Describe any actions taken to assist the waiver participant:

Name of Waiver Staff first notified, if not discoverer: _____ Title: _____

Report completed by: _____ Title: _____

Reporting Agency: _____ Telephone: _____

Date and Time reported to QMS: ___ / ___ / ___ am/pm Name of QMS: _____

Date and Time Initial Provider Report faxed to QMS: ___ / ___ / ___ am/pm

Date and Time copy of report sent to RRDS: ___ / ___ / ___ am/pm Name of RRDS: _____

Date and Time copy of report sent to SC: ___ / ___ / ___ am/pm Name of SC: _____

FOR QMS USE ONLY:

Form Sent to DOH WMS

Date: ___ / ___ / ___

SERIOUS REPORTABLE INCIDENT 24-HOUR PROVIDER REPORT

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

Participant Name: _____ CIN: _____ RRDS Region: _____

Date alleged incident discovered: ___/___/___ Time alleged incident discovered: _____ am / pm

Date alleged incident occurred: ___/___/___ Time alleged incident occurred: _____ am / pm

Location and address of alleged incident: _____

Did discovering person directly observe the alleged incident? Yes No

Individual(s)/witness(s) present at the time of the alleged incident:

Name	Agency/Relationship to Participant	Telephone Number	Waiver Service Provided (If Applicable)

Classification of the alleged incident: Check all that apply according to the definitions in the Serious Reportable Incident Policy.

a. Allegation of Abuse: (category)

- | | | |
|---|---|--|
| <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Psychological Abuse |
| <input type="checkbox"/> Neglect | <input type="checkbox"/> Seclusion | <input type="checkbox"/> Violation of Civil Rights |
| <input type="checkbox"/> Mistreatment | <input type="checkbox"/> Exploitation (financial or material) | |
| <input type="checkbox"/> Unauthorized or Inappropriate Use of Restraint | <input type="checkbox"/> Use of Aversive Conditioning | |

b. Other Serious Reportable Incidents:

- | | | |
|--|---|---|
| <input type="checkbox"/> Missing Person | <input type="checkbox"/> Possible Criminal Act | <input type="checkbox"/> Restraint |
| <input type="checkbox"/> Sensitive Situation | <input type="checkbox"/> Death | <input type="checkbox"/> Medication Error/Refusal |
| <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Medical Treatment Due to Accident/Injury | |

**SERIOUS REPORTABLE INCIDENT
24-HOUR PROVIDER REPORT (cont.)**

Participant Name: _____ CIN #: _____

c. Was the Alleged Incident:

- | | |
|--|--|
| <input type="checkbox"/> Participant only | <input type="checkbox"/> Participant to Participant? |
| <input type="checkbox"/> Participant to Staff? | <input type="checkbox"/> Participant to Other? |
| <input type="checkbox"/> Staff to Participant? | <input type="checkbox"/> Other to Participant? |

d. If there was an injury, identify type of injury sustained, and any information regarding the possible cause:

e. Describe the alleged incident including anyone who may have been involved, the follow-up steps taken, and person(s) conducting the follow-up?

f. Include a statement from the participant regarding this alleged incident (use "quotes" when applicable):

g. NOTIFICATIONS:

- | | |
|--|----------------|
| <input type="checkbox"/> APS notified | By Whom: _____ |
| <input type="checkbox"/> Police notified | By Whom: _____ |
| <input type="checkbox"/> Other notified: (specify) _____ | By Whom: _____ |
| <input type="checkbox"/> Other notified: (specify) _____ | By Whom: _____ |

SERIOUS REPORTABLE INCIDENT 24-HOUR PROVIDER REPORT (cont)

Participant Name: _____ CIN: _____

g. NOTIFICATIONS (continued):

Reporter's Notification to Waiver Entities:

	Person Notified, Title and Agency	Date Notified
Quality Management Specialist (QMS)		
Regional Resource Development Specialist (RRDS)		
Service Coordinator/ Supervisor		

 Person completing this report/Title Signature

 Provider Agency Telephone Date

 Supervisor of person completing this report/Title Signature

 Provider Agency Telephone Date

FOR QMS USE ONLY:
Form Sent to DOH WMS Date: ___/___/____

SERIOUS REPORTABLE INCIDENT PROVIDER FOLLOW-UP REPORT

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

Participant Name: _____ Incident # _____ - _____ - _____ - _____

Check One:

_____ Seven Day Report	_____
	Date Completed
_____ Thirty Day Report	_____
	Date Completed
_____ Additional Follow-Up Report(s)	_____
	Date Completed

1. What actions (initial or newly conducted) have been taken to investigate this incident (e.g. person(s) interviewed, record review, consultations, etc)?
NOTE: Attach all supporting documentation

2. What have been the results of these actions?

3. What follow-up actions have been taken in response to these results (e.g., changes to the Service Plan, staff changed, police called, etc.)?

4. What has been the results of these follow-up actions (e.g., NHTD waiver participant's behavior has changed, NHTD waiver participant is more satisfied with staff, safety of NHTD waiver participant has been secured, etc)?

SERIOUS REPORTABLE INCIDENT QUALITY MANAGEMENT SPECIALIST STATUS REPORT

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

Participant Name: _____ CIN: _____

___ This incident has been re-categorized as a Recordable Incident as indicated on the QMS Initial Response form and is considered **CLOSED**.

QMS Comments: _____

QMS received a Follow-Up Report on: _____ for incident #: _____ - _____ - _____
Date

Investigating Provider Agency _____

Address _____

Provider Representative _____ Agency Investigator _____

___ The incident has been re-classified. (Please change your database to reflect this revised classification). The incident was re-classified as: _____

QMS Comments: _____

Check One:

___ The incident is considered **OPEN**. Further follow-up/intervention/clarification is required. A Serious Reportable Incident Follow-Up Report must be submitted by: _____

QMS Comments: _____

___ The incident is considered **CLOSED**. No further action is necessary. Final Classification: _____

QMS comments: _____

QMS _____ Signature _____ Date _____

Copy sent to: RRDS _____ Date: _____
Service Coordinator _____ Date: _____
Investigating Provider _____ Date: _____

FOR QMS USE ONLY:
Form Sent to DOH WMS
Date: ___/___/___

**SERIOUS REPORTABLE INCIDENT
QUALITY MANAGEMENT SPECIALIST
POST-INVESTIGATION FOLLOW-UP CONTACT WITH PARTICIPANT**

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

Participant Name

Incident Number

Person(s) Contacted:

___ Participant Date Notified: _____ Time Notified: ___ am/pm

___ Other Person _____ Relationship to Participant: _____
Date Notified: _____ Time Notified: ___ am/pm

___ Other Person _____ Relationship to Participant: _____
Date Notified: _____ Time Notified: ___ am/pm

Participant/Legal Guardian Comments: _____

QMS Comments: _____

QMS Name

Signature

Date

Copy of this form was sent to: RRDS _____ Date
Service Coordinator _____ Date
Investigating Agency _____ Date

FOR QMS USE ONLY:

Form Sent to DOH WMS
Date: ___/___/___

RUG II Group (print name)
RHCF Level of Care: <input type="checkbox"/> HRF <input type="checkbox"/> SNF

Use with separate Hospital and Community PRI Instructions

I. ADMINISTRATIVE DATA

- | | |
|---|--|
| <p>1. OPERATING CERTIFICATE NUMBER
(1-8)</p> <p>3. OFFICIAL NAME OF HOSPITAL OR OTHER AGENCY/FACILITY COMPLETING THIS REVIEW</p> <p>4A. PATIENT NAME (AND COMMUNITY ADDRESS IF REVIEWED IN COMMUNITY)</p> <p>4B. COUNTY OF RESIDENCE</p> <p>5. DATE OF PRI COMPLETION
(18-25) - -
 MO DAY YEAR</p> <p>6. MEDICAL RECORD NUMBER/CASE NUMBER
(26-34)</p> <p>7. HOSPITAL ROOM NUMBER
(35-39)</p> <p>8. NAME OF HOSPITAL UNIT/DIVISION/BUILDING</p> <p>9. DATE OF BIRTH
(40-47) - -
 MO DAY YEAR</p> <p>10. SEX (48) 1=Male
 2=Female</p> | <p>2. SOCIAL SECURITY NUMBER
(9-17) - -</p> <p>11A. DATE OF HOSPITAL ADMISSION OR INITIAL AGENCY VISIT
(49-56) - -
 MO DAY YEAR</p> <p>11B. DATE OF ALTERNATE LEVEL OF CARE STATUS IN HOSPITAL (IF APPLICABLE)
(57-64) - -
 MO DAY YEAR</p> <p>12. MEDICAID NUMBER
(65-75)</p> <p>13. MEDICARE NUMBER
(76-85)</p> <p>14. PRIMARY PAYOR (86)
1=Medicaid
2=Medicare
3= Other</p> <p>15. REASON FOR PRI COMPLETION (87)
1. RHCF Application from Hospital
2. RHCF Application from Community
3. Other (Specify:)</p> |
|---|--|

II. MEDICAL EVENTS

- | | |
|--|---|
| <p>16. DECUBITUS LEVEL: ENTER THE MOST SEVERE LEVEL (0-5) AS DEFINED IN THE INSTRUCTIONS. _____</p> <p>17. MEDICAL CONDITIONS: DURING THE PAST WEEK. READ THE INSTRUCTIONS FOR SPECIFIC DEFINITIONS
1=YES
2=NO</p> <p>A. Comatose _____</p> <p>B. Dehydration _____</p> <p>C. Internal Bleeding _____</p> <p>D. Stasis Ulcer _____</p> <p>E. Terminally Ill _____</p> <p>F. Contractures _____</p> <p>G. Diabetes Mellitus _____</p> <p>H. Urinary Tract Infection _____</p> <p>I. HIV Infection Symptomatic _____</p> <p>J. Accident _____</p> <p>K. Ventilator Dependent _____</p> | <p>18. MEDICAL TREATMENTS: READ THE INSTRUCTIONS FOR THE QUALIFIERS.
1=YES
2=NO</p> <p>A. Trachesotomy Care/Suctioning (Daily—Exclude self-care) _____</p> <p>B. Suctioning-General (Daily) _____</p> <p>C. Oxygen (Daily) _____</p> <p>D. Respiratory Care (Daily) _____</p> <p>E. Nasal Gastric Feeding _____</p> <p>F. Parenteral Feeding _____</p> <p>G. Wound Care _____</p> <p>H. Chemotherapy _____</p> <p>I. Transfusion _____</p> <p>J. Dialysis _____</p> <p>K. Bowel and Bladder Rehabilitation (SEE INSTRUCTIONS) _____</p> <p>L. Catheter (Indwelling or External) _____</p> <p>M. Physical Restraints (Daytime Only) _____</p> |
|--|---|

III. ACTIVITIES OF DAILY LIVING (ADLs)

Measure the capability of the patient to perform each ADL 60% or more of the time it is performed during the past week (7 days). Read the Instructions for the Changed Condition Rule and the definitions of the ADL terms.

19. EATING: PROCESS OF GETTING FOOD BY ANY MEANS FROM THE RECEPTACLE INTO THE BODY (FOR EXAMPLE: PLATE, CUP, TUBE) 19. (113)

1=Feeds self without supervision or physical assistance. May use adaptive equipment.
2=Requires *intermittent* supervision (that is, verbal encouragement/guidance) and/or minimal physical assistance with minor parts of eating, such as cutting food, buttering bread or opening milk carton.

3= Requires continual help (encouragement/teaching/physical assistance) with eating or meal will not be completed.
4=Totally fed by hand, patient does not manually participate

5=Tube or parenteral feeding for primary intake of food. (*Not* just for supplemental nourishments)

20. MOBILITY: HOW THE PATIENT MOVES ABOUT 20. (114)

1=Walks with no supervision or human assistance. May require mechanical device (for example, a walker), but not a wheelchair.
2=Walks with intermittent supervision (that is, verbal cueing and observation). May require human assistance for difficult parts of walking (for example, stairs, ramps).

3= Walks with *constant* one-to-one supervision and/or constant physical assistance.
4= Wheels with no supervision or assistance, except for difficult maneuvers (for example, elevators, ramps). May actually be able to walk, but generally does not move.

5= Is wheeled, chairfast or bedfast. Relies on someone else to move about, if at all.

21. TRANSFER: PROCESS OF MOVING BETWEEN POSITIONS, TO/FROM BED, CHAIR, STANDING, (EXCLUDE TRANSFERS TO/FROM BATH AND TOILET). 21. (115)

1=Requires no supervision or physical assistance to complete necessary transfers. May use equipment, such as railings, trapeze.
2=Requires *intermittent* supervision (that is, verbal cueing, guidance) and/or physical assistance for difficult maneuvers only.

3=Requires one person to provide constant guidance, steadiness and/or physical assistance. Patient may participate in transfer.
4=Requires two people to provide constant supervision and/or physically lift. May need lifting equipment.
5=Cannot and is not gotten out of bed.

22. TOILETING: PROCESS OF GETTING TO AND FROM A TOILET (OR USE OF OTHER TOILETING EQUIPMENT, SUCH AS BEDPAN). TRANSFERRING ON AND OFF TOILET, CLEANSING SELF AFTER ELIMINATION AND ADJUSTING CLOTHES. 22. (116)

1=Requires no supervision or physical assistance. May require special equipment, such as a raised toilet or grab bars.
2=Requires *intermittent* supervision for safety or encouragement, or *minor* physical assistance (for example, clothes adjustment or washing hands).

3=Continent of bowel *and* bladder. Requires constant supervision and/or physical assistance with major/all parts of the task, *including* appliances (i.e., colostomy, ileostomy, urinary catheter).
4=Incontinent of bowel *and/or* bladder and is not taken to a bathroom.
5=Incontinent of bowel *and/or* bladder, but is taken to a bathroom every two to four hours during the day and as needed at night.

IV. BEHAVIORS

23. VERBAL DISRUPTION: BY YELLING, BAITING, THREATENING, ETC. 23. (117)

1=No known history
2=Known history or occurrences, but not during the past week (7 days)
3=Short-lived or predictable disruption regardless of frequency (for example, during specific care routines, such as bathing.)

4=Unpredictable, recurring verbal disruption at least once during the past week (7 days) for no foretold reason

5=Patient is at level #4 above, but does not fulfill the active treatment and assessment qualifiers (in the instructions)

24. PHYSICAL AGGRESSION: ASSAULTIVE OR COMBATIVE TO SELF OR OTHERS WITH INTENT FOR INJURY. (FOR EXAMPLE, HITS SELF, THROWS OBJECTS, PUNCHES, DANGEROUS MANEUVERS WITH WHEELCHAIR) 24. (118)

1=No known history.
2=Known history or occurrences, but not during the past week (7 days).
3=Predictable aggression during specific care routines or as a reaction to normal stimuli (for example, bumped into), regardless of frequency. May strike or fight.

4=Unpredictable, recurring aggression at least once during the past week (7 days) for no apparent or foretold reason (that is, not just during specific care routines or as a reaction to normal stimuli).

5=Patient is at level #4 above, but does not fulfill the active treatment and assessment qualifiers (in the instructions).

25. DISRUPTIVE, INFANTILE OR SOCIALLY INAPPROPRIATE BEHAVIOR: CHILDISH, REPETITIVE OR ANTISOCIAL PHYSICAL BEHAVIOR WHICH CREATES *DISRUPTION WITH OTHERS*. (FOR EXAMPLE, CONSTANTLY UNDRRESSING SELF, STEALING, SMEARING FECES, SEXUALLY DISPLAYING ONESELF TO OTHERS). EXCLUDE VERBAL ACTIONS. READ THE INSTRUCTIONS FOR OTHER EXCLUSIONS. **25.**
(119)

- | | |
|---|--|
| <p>1=No known history</p> <p>2=Displays this behavior, but is not disruptive to others (for example, rocking in place).</p> <p>3=Known history or occurrences, but not during the past week (7 days).</p> | <p>4=Occurrences of this disruptive behavior at least once during the past week (7 days)</p> <p>5=Patient is at level #4 above, but does not fulfill the active treatment and psychiatric assessment qualifiers (in instructions).</p> |
|---|--|

26. HALLUCINATIONS: EXPERIENCED AT LEAST ONCE DURING THE PAST WEEK. VISUAL, AUDITORY OR TACTILE PERCEPTIONS THAT HAVE NO BASIS IN EXTERNAL REALITY. **26.**
(120)

- | | | |
|--------------|-------------|---|
| <p>1=Yes</p> | <p>2=No</p> | <p>3=Yes, but does not fulfill the active treatment and psychiatric assessment qualifiers (in the instructions)</p> |
|--------------|-------------|---|

V. SPECIALIZED SERVICES

27. PHYSICAL AND OCCUPATIONAL THERAPIES: READ INSTRUCTIONS AND QUALIFIERS. EXCLUDE REHABILITATIVE NURSES AND OTHER SPECIALIZED THERAPISTS (FOR EXAMPLE, SPEECH THERAPIST). ENTER THE LEVEL, DAYS AND TIME (HOURS AND MINUTES) DURING THE PAST WEEK (7 DAYS).

A. Physical Therapy (P.T.)

P.T. Level
(121)

P.T. Days
(122)

P.T. Time
(123-126) HOURS MIN/WEEK

B. Occupational Therapy (O.T.)

O.T. Level
(127)

O.T. Days
(128)

O.T. Time
(129-132) HOURS MIN/WEEK

LEVEL

- 1=Does not receive.
- 2= Maintenance program-Requires and is currently receiving physical and/or occupational therapy to help stabilize or slow functional deterioration.

3=Restorative Therapy-Requires and is currently receiving physical and/or occupational therapy for the past week.

4=Receives therapy, but does not fulfill the qualifiers stated in the instructions. (For example, therapy provided for only two days).

DAYS AND TIME PER WEEK: ENTER THE CURRENT NUMBER OF DAYS AND TIME (HOURS AND MINUTES) DURING THE PAST WEEK (7 DAYS) THAT EACH THERAPY WAS PROVIDED. ENTER ZERO IF AT #1 LEVEL ABOVE. READ INSTRUCTIONS AS TO QUALIFIERS IN COUNTING DAYS AND TIME.

28. NUMBER OF PHYSICIAN VISITS: DO NOT ANSWER THIS QUESTION FOR HOSPITALIZED PATIENTS, (ENTER ZERO), UNLESS ON ALTERENATE LEVEL OF CARE STATUS. ENTER ONLY THE NUMBER OF VISITS DURING THE PAST WEEK THAT ADHERED TO THE PATIENT NEED AND DOCUMENTATION QUALIFIERS IN THE INSTRUCTIONS. THE PATIENT MUST BE MEDICALLY UNSTABLE TO ENTER ANY PHYSICIAN VISITS, OTHERWISE ENTER A ZERO. **28.**
(133-134)

VI. DIAGNOSIS

29. PRIMARY PROBLEM: THE MEDICAL CONDITION REQUIRING THE LARGEST AMOUNT OF NURSING TIME IN THE HOSPITAL OR CARE TIME IF IN THE COMMUNITY. (FOR HOSPITALIZED PATIENTS THIS MAY OR MAY NOT BE THE ADMISSION DIAGNOSIS).

ICD-9 Code of medical problem

29. -
(135-139)

If code cannot be located, print medical name here:

VII. PLAN OF CARE SUMMARY

This section is to communicate to providers any additional clinical information, which may be needed for their preadmission review of the patient. It does not have to be completed if the information below is already provided by your own form, which is **attached** to this H/C-PRI.

30. DIAGNOSES AND PROGNOSIS: FOR EACH DIAGNOSIS, DESCRIBE THE PROGNOSIS AND CARE PLAN IMPLICATIONS.

Primary Prognosis

- 1.
- Secondary (Include Sensory Impairments)
- 1.

- 2.
- 3.
- 4.

31. REHABILITATION POTENTIAL (INFORMATION FROM THERAPISTS)

A. POTENTIAL DEGREE OF IMPROVEMENT WITH ADLs WITHIN SIX MONTHS (DESCRIBE IN TERMS OF ADL LEVELS ON THE HC-PRI):

B. CURRENT THERAPY CARE PLAN: DESCRIBE THE TREATMENTS (INCLUDING WHY) AND ANY SPECIAL EQUIPMENT REQUIRED.

32. MEDICATIONS

NAME	DOSE	FREQUENCY	ROUTE	DIAGNOSIS REQUIRING EACH MEDICATION
------	------	-----------	-------	-------------------------------------

33. TREATMENTS: INCLUDE ALL DRESSINGS, IRRIGATIONS, WOUND CARE, OXYGEN.

A. TREATMENTS	DESCRIBE WHY NEEDED	FREQUENCY
---------------	---------------------	-----------

B. NARRATIVE: DESCRIBE SPECIAL DIET, ALLERGIES, ABNORMAL LAB VALUES, PACEMAKER.

34. RACE/ETHNIC GROUP: ENTER THE CODE WHICH BEST DESCRIBES THE PATIENT'S RACE OR ETHNIC GROUP 34.

- 1=White 4=Black/Hispanic 7=American Indian or Alaskan Native
- 2=White/Hispanic 5=Asian or Pacific Islander 8=American Indian or Alaskan Native/Hispanic
- 3=Black 6=Asian or Pacific Islander/Hispanic 9=Other

35. QUALIFIED ASSESSOR: I HAVE PERSONALLY OBSERVED/INTERVIEWED THIS PATIENT AND COMPLETED THIS H/C PRI.

YES NO

I CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS A TRUE ABSTRACT OF THE PATIENT'S CONDITION AND MEDICAL RECORD.

SIGNATURE OF QUALIFIED ASSESSOR

IDENTIFICATION NO.

7. To be completed by S S W

OTHERS IN HOME/HOUSEHOLD: Indicate days/hours that these persons will provide care to patient.
If none will assist explain in narrative.

	NAME	Age	Relationship	Days/Hours at Home	Days/Hours will Assist
1.					
2.					
3.					
4.					

8. To be completed by S S W

SIGNIFICANT OTHERS OUTSIDE OF HOME: Indicate days/hours when persons below will provide care to patient.

	Name	Address	Age	Relationship	Days/Hours Assisting
1.					
2.					
3.					
4.					
5.					

9. To be completed by S S W

COMMUNITY SUPPORT: Indicate organization/persons serving patient at present or has provided a service in the past six (6) months.

	Organization	Type of Service	Presently Receiving	Contact Person	Tel No.
1.					
2.					
3.					
4.					

10. To be completed by S S W and R.N.

PATIENT TRAITS:

	Yes	No	?N/A	If you check No. ?N/A, describe
Appears self directed and/or independent				
Seems to make appropriate decisions				
Can recall med routine/recent events				
Participates in planning/treatment program				
Seems to handle crises well				
Accepts diagnosis				
Motivated to remain at home				

11. To be completed by S S W and R.N. as appropriate
 FAMILY TRAITS:

	Yes	No	?	
a. Is motivated to keep patient home				If no, because _____
b. Is capable of providing care (physically & emotionally)				If no, because _____
c. Will keep patient home if not involved with care				Because _____
d. Will give care if support service given				How much _____
e. Requires instruction to provide care				In what – who will give _____

12. To be completed by R.N.

Home/Place where care will be provided:	Yes	No	?	If problem, describe
Neighborhood secure/safe				
Housing adequate in terms of: Space				
Convenient toilet facilities				
Heating adequate and safe				
Cooking facilities & refrigerator				
Laundry facilities				
Tub/shower/hot water				
Elevator				
Telephone accessible & usable				
Is patient mobile in house				
Any discernible hazards (please circle)				Leaky gas, poor wiring, unsafe floors, steps, other (specify)
Construction adequate				
Excess use of alcohol/drugs by patient/ caretaker; smokes carelessly.				
Is patient's safety threatened if alone?				
Pets				

ADDITIONAL ASSESSMENT FACTORS: _____

13. To be completed by R.N.
 RECOVERY POTENTIAL ANTICIPATED

		COMMENTS
Full recovery	<input type="checkbox"/>	_____
Recovery with patient management residual	<input type="checkbox"/>	_____
Limited recovery managed by others	<input type="checkbox"/>	_____
Deterioration	<input type="checkbox"/>	_____

**14. To be completed by R.N. – S S W to complete “D” as appropriate
FOR THE PATIENT TO REMAIN AT HOME – SERVICES REQUIRED**

WHO WILL PROVIDE

SERVICES REQUIRED	YES	NO	TYPE/FREQ/DUR	AGENCY/FAMILY	AGENCY FREQUENCY
A. Bathing					
Dressing					
Toileting					
Admin. Med.					
Grooming					
Spoon feeding					
Exercise/activity/walking					
Shopping (food/supplies)					
Meal preparation					
Diet Counseling					
Light housekeeping					
Personal laundry/household linens					
Personal/financial errands					
Other					
B. Nursing					
Physical Therapy					
Home Health Aide					
Speech Pathology					
Occupational Therapy					
Personal Care					
Homemaking					
Housekeeping					
Clinic/Physician					
Other 1.					
2.					
C. Ramps outside/inside					
Grab bars/hallways/bathroom					
Commode/special bed/wheelchair					
Cane/walker/crutches					
Self-help device, specify					
Dressings/cath. equipment, etc.					
Bed protector/diapers					
Other					
D. Additional Services (Lab, O ² , medication)					
Telephone reassurance					
Diversion/friendly visitor					
Medical social service/counseling					
Legal/protective services					
Financial management/conservatorship					
Transportation arrangements					
Transportation attendant					
Home delivered meals					
Structural modification					
Other					

15. To be completed by S S W and R.N

DMS Predictor Score _____ Override necessary Yes No

Can patient's health/safety needs be met through home care now? Yes No

If no, give specific reason why not _____

Institutional care required now? Yes No If yes, give specific reason why.

Level of institutional care determined by your professional judgment: SNF HRF DCF

Can the patient be considered at a later time for home care? Yes No N/A

16. To be completed by S S W

SUMMARY OF SERVICE REQUIREMENTS

Indicate services required, schedule and charges (allowable charge in area)

Services	Provided by	Hrs./Days/Wk.	Date Effective	Est. Dur.	Unit Cost	Payment by			
						MC	MA	Self	Other
Physician									
Nursing									
Home Health Aide									
Physical Therapy									
Speech Pathology									
Resp. Therapy									
Med. Soc. Work									
Nutritional									
Personal Care									
Homemaking									
Housekeeping									
Other (Specify)									
Medical Supplies/Medication									
1.									
2.									
3.									
Medical Equipment									
1.									
2.									
3.									
Home Delivered Meals									
Transportation									
Additional Services									
1.									
2.									
SUBTOTAL									
Structural Modification									
Other (Specify)									
1.									
2.									

SUBTOTAL _____

TOTAL COST _____

17. To be completed by S S W and R.N.

Person who will relieve in case of emergency

Name	Address	Telephone	Relationship
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Narrative: Use this space to describe aspects of the patients care not adequately covered above.

Assessment completed by:	_____	_____
	R.N.	Agency
	_____	_____
	Date Completed	Telephone No.
	_____	_____
	Local DSS Staff	District
	_____	_____
	Date Completed	Telephone No.
	_____	_____
	Supervisor DSS	District
	_____	_____
	Date	Telephone No.

Authorization to provide services: _____ Date _____
Local DSS Commissioner or Designee

**HOME ASSESSMENT ABSTRACT
FOR THE PERSONAL CARE SERVICES PROGRAM
Instructions**

Purpose:

The purpose of the Home Assessment Abstract is to assist in the determination of whether a patient's home environment is the appropriate setting for the patient to receive health and related services. This form is designed to provide a standardized method for all certified home health agencies and social services districts to determine the following questions essential to the delivery of home care services:

1. Is the home the appropriate environment for this patient's needs?
2. What is the functional ability of this patient?
3. What services are necessary to maintain this patient within this home setting?

General Information:

The assessment form includes an outline for the planning for the development of a comprehensive listing of services which the patient requires.

It is required that a common assessment procedure be used for the Long Term Home Health Care Program (LTHHCP), Home Health Aide Services and Personal Care Services. This procedure will apply to both initial assessments and reassessments. The Home Assessment Abstract must be used in conjunction with the physician's orders and the DMS-1 or its successor.

The assessment procedure will differ only in the frequency with which assessments are required. Assessments must be completed at the initial onset of care. Reassessments are required every 120 days for the LTHHCP and Home Health Aide Services. Reassessments for Personal Care Services are required on an as-needed basis, but must be done at least every six (6) months. At any time that a change in the condition of the patient is noted either by staff of the certified home health agency or the local social services district, that agency should immediately inform the other agency so that the procedures for reassessment can be followed.

The form has been designed so that certified home health agencies and local social services districts may complete assessments jointly, a practice which is highly recommended. When it is not possible to undertake assessments jointly, an indication of the person responsible for completing each section has been included on the form. If, while completing the assessment, a nurse or a social services worker believes they have information in one of the other areas of the form, for which they are not responsible, they may include that information.

It is required that the local certified home health agency complete the assessment form within fifteen (15) working days of the request from the local social services district. Completed forms should be forwarded to the local social services district. Differences in opinion on the services required should be forwarded to the local Professional Director, for review and final determination by a physician.

Instructions:

Section 1 – Reasons for Preparation (RN and SSW)

Check appropriate box depending on whether patient is being considered for admission to a LTHHCP, home health aide service provided by a certified home health agency, or personal care services.

For reassessment, include the dates covered by the reassessment and check whether the reassessment is for a LTHHCP patient, certified home health agency patient, or personal care service patient. If none is appropriate, specific under “other” why form is being completed.

Section 2 – Patient Identification (RN and SSW)

Complete patient’s name and place of residence. If the patient is or will be residing at a place other than his home address, give the address where he will be receiving care. Include directions to address where the patient will be receiving care.

The item “Social Services District” requires the name of the Social Services District which is legally responsible for the cost of the care. In large Social Services districts the number or name of the field office should be indicated.

Section 3 – Current Location of patient (RN and SSW)

Check the current location/diagnosis of the patient. If the patient is in an institution, give name of facility. If he/she is at home and receiving home care, give name of organization providing the service. Complete the “Diagnosis” on all cases.

Section 4 – Next of Kin/Guardian (SSW)

Complete this section with the name of the person who is legally responsible for the patient. This may be a relative or a non-relative who has been designated as power of attorney, conservator or committee for the management of the patient’s financial affairs.

Section 5 – Notify in Emergency (SSW)

Complete section with requested information on whom to call in an emergency situation.

Section 6 – Patient Information (SSW)

Complete all information pertinent to the patient. Use N/A if an item is not applicable. Specify the language(s) that the patient speaks and understands.

Check the category of living arrangements that best describes the living arrangements of the patient.

Definitions of Living Arrangements:

One family house – nuclear and extended family

Multi-family house – tow or more distinct nuclear families

Furnished room – one room in a private dwelling, with or without cooking facilities

Senior citizen housing – apartments, either in clusters or high-rise

Hotel – a multi-dwelling providing lodging and with or without meals

Apartment – a room(s) with housekeeping facilities and used as a dwelling by a family group or an individual

Boarding House – a lodging house where meals are provided

If walk-up – when the living unit requires walking up stairs, specify number of flights

Lives with – specify with whom the patient lives. Members of household should be detailed in Section 7.

Other Patient Information:

Social Security Number	To obtain correct numbers, the interviewer should ask to see the patient's identification care for each item.
Medicare Numbers	
Medicaid Number	
Blue Cross Number	
Worker's Compensation	
Veterans Claim Number	

Veterans Spouse – patient may be eligible for benefits if a veteran's spouse.

Other – Identify insurance company and claim number if the patient has coverage in addition to those listed above.

Source of Income/other benefits – Include all sources of income and benefits. When the patient is receiving Medicaid or if Medicaid is pending, the local social services district will already have all necessary information.

Amount of available funds – Since many elderly people have little money left after payment of rent, taxes and utilities, an effort should be made to determine the amount available after payment of these expenses. This is especially important in evaluating whether or not the patient has adequate funds for food and clothing.

Section 7 – Others in Home/Household (SSW)

Indicate all persons residing in the house with the patient and indicate if and when they will assist in the care of the patient. Indicate in Section 14 what service this person(s) will provide. This information must be specific as it will be used to prepare a summary of service requirements for the individual patient.

Section 8 – Significant others Outside of Home – (SSW)

A “Significant Other” is an individual who has an interest in the welfare of the patient and may influence the patient. This may be a relative, friend, or neighbor who may be able to provide some assistance in rendering care. Indicate the days/hours that this person will provide assistance.

Section 9 – community Support – (SSW)

Indicate organizations, agencies or employed individuals, including local social services districts or certified home health agencies who have, or who are presently giving service to the patient; also indicate those services that have been provided in the past six months. Agencies providing home care, home delivered meals, or other services should be included if they have been significant to the care of the patient.

Section 10 – Patient traits – (SSW and RN)

Patient traits should help to determine the degree of independence a patient has and how this will affect care to this patient in the home environment. A patient’s safety may be jeopardized if he shows emotional or psychological disturbance or confusion. It is important to determine if the patient is motivated to remain at home, otherwise services provided may not be beneficial.

For all criteria check the “yes” column if the patient meets the standard of the criteria defined. If, in your judgment the patient does not meet the standard as defined, check “no”. If you have insufficient evidence to make a positive or negative statement about the patient, check the box marked “?/NA” – unknown or not applicable. If you check a no or ?/NA, please explain the reason in the space to the right. Also indicate source of information used as basis for your judgment.

Definitions:

Appears self directed and/or independent – the patient can manage his own business affairs, household needs, etc., either directly or through instruction to others.

Seems to make appropriate decisions –n the patient is capable of making choices consistent with his needs, etc.

Can recall med. Routine/recent events – the patient’s memory is intact, and patient remembers when to take medication without supervision or assistance. Patient knows medical regimen.

Participates in planning/treatment program – the patient takes an active role in decision-making.

Seems to handle crisis well – this means that the patient knows whom to call and what to do in the event of an emergency situation.

Accepts Diagnoses – the patient knows his diagnoses and has a realistic attitude toward his illness

Motivated to remain at home – the patient wants to remain in his home to receive needed care.

Section 11 – Family Traits (SSW and RN as appropriate)

This section should be used to indicate whether the family is willing and/or able to care for the patient at home. The family may be able to care for the patient if support services are provided, and if required instruction and supervision are given, as appropriate, to the patient and/or family.

Definitions:

- a. Is motivated to keep patient home – this means that the family member(s) is (are) willing to have the patient stay at home to receive the needed care and will provide continuity of care in those intervals when there is no agency person in the home by providing care themselves or arranging for other caretakers.
- b. Is capable of providing care – the family member(s) is (are) physically and emotionally capable of providing care to the patient in the absence of caretaker personnel, and can accept the responsibility for the patient’s care.
- c. Will keep patient home if not involved with care – the family member(s) will allow the patient space in the home but will not (or cannot) accept responsibility for providing the necessary services in the absence of Home Care Services.

- d. Will give care if support services given – this means that the family member(s) will accept responsibility for and provide care to the patient as long as some assistance from support personnel is given to the family member(s).
- e. Requires instruction to provide care – this item means that the family is willing and able to keep the patient at home and provide care but will need guidance and teaching in the skills to provide care safely and adequately.

Section 12 – Home/Place where care will be provided – (RN)

In order to care for a person in the home, it is necessary to have an environment which provides adequate supports for the health and safety of the patient. This section of the assessment is to determine if the home environment of the patient is adequate in relation to the patient's physical condition and diagnosis. Input from the patient and family should be considered where pertinent.

Specifically describe the problem if one exists.

Definitions:

Neighborhood secure/safe – refers to how the patient and/or family perceives the neighborhood, for example, in the assessor's perception, the neighborhood may not be safe or secure but the patient may feel comfortable and safe.

Housing adequate in terms of space – refers to the available space that the patient will be able to have in the home. The space should be in keeping with the patient's home health care needs, without encroaching on other members of the family.

Convenient toilet facilities – refers to the accessibility and availability of toilet facilities in relation to the patient's present infirmities.

Heating adequate and safe – refers to the type of heating that will produce a comfortable environment. Safety and accessibility factors should be considered.

Laundry facilities – refers to appliances that are available and accessible to the patient and/or family.

Cooking facilities and refrigerator – refers to those appliances that are available and accessible for use by the patient or family.

Tub/shower/hot water – refers to what bathing facilities are available and if the patient is able to use what is available. Modifications may have to be made to make the facilities accessible to the patient.

Elevator – refers to the availability of a working elevator and if the patient is able to use it.

Telephone accessible and usable – refers to whether or not there is a telephone in the home, or if one is available. Specify whether or not the patient is able to reach and use the telephone.

Is patient mobile in house – refers to the ability of the patient to move about in the home setting. Modifications may have to be made to allow mobility, for example, widening doorways and adding ramps for a patient in a wheelchair.

Any discernible hazards – refers to any hazard that could possibly have a negative impact on the patient's health and safety in the home.

Construction adequate – refers to whether or not the building is safe for habitation.

Excess use of alcohol/drugs by patient or caretaker – refers to whether or not the patient or caretaker uses those materials enough to endanger the patient's health and safety because of inadequate judgment, poor reaction time, etc.; smokes carelessly.

Is patient's safety threatened if alone – refers to situations that may cause injury to the patient. This includes situations such as physical incapacitation, impaired judgment to the point where the patient will allow anyone to enter the home, wandering away from home, and possibility of the patient causing harm to himself or others.

Pets – refers to if the patient has a pet(s) and if so, what problems does it present, for example, is the patient able to take care of the pet, is the pet likely to endanger the patient's caretaker, and what plans, if any, must be made for the care of the animal.

Additional Assessment factors – include items that would influence the patient's ability to receive care at home that are not considered previously.

Section 13 – Recovery Potential (RN)

The anticipated recovery potential is important for short and long range planning.

Full recovery – the patient is expected to regain his optimal state of health.

Recovery with patient managed residual – the patient is expected to recover to his fullest potential with residual problem managed by himself, e.g., a diabetic who self-administers insulin and controls his diet.

Limited recovery managed by others – the patient is expected to be left with a residual problem that necessitates the assistance of another in performing activities of daily living.

Deterioration – it is expected that the patient’s condition will decline with no likelihood of recovery.

Section 14 – Services Required (RN, SSW to complete “D” as appropriate)

This section will serve as the basis for the authorization for service delivery. Fill in all services required, describing type, frequency and duration as pertinent. Specify whether the family or an agency will be providing services and frequency that the agency will be involved. It is necessary to determine the amount of services required to enable the local Social Services district to develop the summary of service requirements and to arrive at a total cost necessary to the Long Term Home Health Care Program. The local Social Services district will make the final budgetary determinations.

- A. This section determines that activities the patient can/cannot do for himself, also the frequency which the patient needs help in performing these activities.
- B. The RN should determine what level of services are needed or anticipated.

Example:

	Yes	No	Type/Freq. Dur.	Agency/Family Agency Freq.
Registered Nurse	X		1 hr.2xWk/1 mo.	V.N.S.
Physical Therapy		X		
Home Health Aide	X		4 hr/3xWk/ 1mo.	V.N.S.
Speech Pathology		X		
Occupational Therapy		X		
Personal Care	X		4 hr./5xWk/1 mo.	Homemaker Upjohn
Clinic	X		1xWk-Mondays 1 pm	

C. Equipment/Supplies

The nurse should determine what medical supplies and equipment are necessary to assist the patient. Consideration should be for the rehabilitation and safety needs of the patient. Circle the specific equipment required and described in type/freq./dur. column, etc.

Example:

Dressing, cath equipment----#18 Foley/1xmo/6mo

D. Other Services

The RN should indicate any other health service needed for the total care of the patient. The SSW should complete the balance of the service needs.

Service needs will not be changed by the local social services district without consulting with the nurse. If there is disagreement, the case will be referred to the local professional director for review and final determination by a physician.

Section 15 – (SSW and RN)

DMS-1 Predictor Score

The predictor score must be completed. To be eligible for the LTHHCP, the patient's level of care needs must be determined and must be at the Skilled Nursing Facility (SNF) or Health Related Facility (HRF) level. The predictor score must be completed for home health aide and personal care services to assure adequate information for placement of personnel.

If the patient is institutionalized the predictor score should be obtained from the most recent DMS-1 completed by the discharge planner of that facility. If the patient is at home, it may be necessary for the nurse from the LTHHCP or certified home health agency to complete a DMS-1 form during the home assessment to ascertain the predictor score. Refer to the instructions for completing the DSM-1, if necessary.

Override necessary

An override is necessary when a patient's predictor score does not reflect the patient's true level of care. For example, a patient with a low predictor score may require institutional care due to emotional instability or safety factors. Either the institution's Utilization Review physician or physician representing the local professional director must give the override.

Can needs be met through home care?

Indicate if the patient can remain at home if appropriate services are provided. If the patient should not remain at home for health or safety reasons, be specific in your reply.

Institutional Care

Give specific reason why institutionalization is required. Check the level of institutional care the patient requires. Indicate if the patient can be considered for home care in the future.

Section 16 – Summary of Service Requirements – (SSW)

This information is to be used in correlation with services required for the patient to remain at home (Section 14). This section is to determine the cost of each individual service, source of payment, data services are effective and total monthly budget.

The SSW should complete this section including unit cost and source of payment. Subtotal and total costs will be determined by the local social services department.

Section 17 – Person who will relieve in an emergency – (SSW and RN)

This should be an individual who would be available to stay with the patient, if required, in a situation where the usual, planned services are not available. An example would be, when an aide did not appear on schedule, and the patient could not be left alone.

Narrative – (SSW and RN)

The narrative should be used to describe details of the patient's condition, not covered in previous sections, that will influence the decision regarding placement of the patient.

Assessment completed by

Each professional should sign and date this form. Include agency and telephone number.

Authorization to provide services for the LTHHCP, Home Health Aide or Personal Care Services will be provided by the Local District Social Services Commissioner or his designee.

**NEW YORK STATE HEALTH DEPARTMENT NUMERICAL STANDARDS MASTER SHEET
 NUMERICAL STANDARDS FOR APPLICATION FOR THE LONG TERM CARE PLACEMENT FORM
 MEDICAL ASSESSMENT ABSTRACT
 (DMS-1)**

3.a.

Nursing Care and Therapy (Specify details in 3d, 3e or attachment)	Frequency			Self Care		Can Be Trained	
	None	Day Shift	Night/Eve. Shift	Yes	No	Yes	No
Parenteral Meds	0	25	60	-15	0	0	0
Inhalation Treatment	0	38	37	-20	0	0	0
Oxygen	0	49	49	-4	0	0	0
Suctioning	0	50	50	-1	0	0	0
Aseptic Dressing	0	42	48	0	0	+1	0
Lesion Irrigation	0	49	49	-20	0	0	0
Cath/Tube Irrigation	0	35	60	-1	0	+4	0
Ostomy Care							
Parenteral Fluids	0	50	50				
Tube Feedings	0	50	50				
Bowel/Bladder Rehab.	0	48	48				
Bedsore Treatment	0	50	50				
Other (Describe)	0	0	0				

b.

Incontinent

Urine: Often* [] 20 Seldom** [] 10 Never [] 0 Foley [] 15
 Stool: Often* [] 40 Seldom** [] 20 Never [] 0

c.

Does patient need a special diet? No [] Yes []

If yes, describe _____

4.

Function Status	Self Care	Some Help	Total Help	Cannot
Walks with or w/o aids	0	35	70	105
Transferring	0	6	12	18
Wheeling	0	1	2	3
Eating/Feeding	0	25	50	
Toileting	0	7	14	
Bathing	0	17	24	
Dressing	0	40	80	

5.

Mental Status	Never	Sometimes	Always
Alert	40	20	0
Impaired Judgement	0	15	30
Agitated (nighttime)	0	10	20
Hallucinates	0	1	2
Severe Depression			*
Assaultive	0	40	80
Abusive	0	25	50
Restraint Order	0	40	80
Regressive Behavior	0	30	60
Wanders			
Other (Specify)			

6.

Impairments	None	Partial	Total
Sight	0	1	2
Hearing	0	1	2
Speech	0	10	20
Communications			
Other (Contractures, etc.)			

7.

Short Term Rehab. Therapy Plan (To be completed by Therapist)

a. Describe Condition (not Dx) Short Term Plan of Treatment & Achievement Date
 Needing Intervention Eval. and Progress in last 2 weeks

b. Circle Minimum number of days/week of skilled therapy from each of the following:

REQUIRES

RECEIVES

0 1 2 3 4 5 6 7	PT	0 1 2 3 4 5 6 7
0 1 2 3 4 5 6 7	OT	0 1 2 3 4 5 6 7
0 1 2 3 4 5 6 7	SPEECH	0 1 2 3 4 5 6 7

+ 37 for skilled rehab/therapy (received & required both>0)

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF LONG TERM CARE

Nursing Home Transition and Diversion Waiver Program

Regional Resource Development Center (RRDC) List

Region/County	Regional Resource Development Center	RRDS & Phone Number
Adirondack: Fulton, Montgomery, Saratoga, Washington, Warren, Hamilton, Essex, Franklin and Clinton	Glens Falls Independent Living Center d/b/a Southern Adirondack Independent Living (SAIL) 71 Glenwood Avenue Queensbury, NY 12804 www.sail-center.org	Karen Thayer, RRDS kannthayer@aol.com (518) 792-1584 (518) 792-0979 (FAX)
Binghamton/Southern Tier: Broome, Steuben, Schuyler, Tioga, Delaware, Tompkins, Cortland, Chenango, Cayuga, Chemung, Cattaraugus, Allegany and Otsego	Southern Tier Independence Center (STIC) 24 Prospect Avenue Binghamton, NY 13901 www.stic-cil.org	Al Jennings, RRDS alj@stic-cil.org nhtd@stic-cil.org (607) 724-2111 (607) 772-3671 (FAX)
Buffalo: Erie, Chautauqua, Wyoming, Orleans and Niagara	Headway of Western New York, Inc. 976 Delaware Avenue Buffalo, NY 14209 www.headwayofwny.org	Ronald Fernandez, RRDS nhtdwaiver@headwayofwny.org (716) 629-3636 (716) 629-3639 (FAX)
Capital: Albany, Schenectady, Greene, Rensselaer, Schoharie and Columbia	Sunnyview Hospital and Rehabilitation 1270 Belmont Avenue Schenectady, NY 12308 www.sunnyview.org	Barbara McCarthy, RRDS mccarthyb@nehealth.com (518) 386-3555 (518) 386-3664 (FAX)
Long Island: Nassau and Suffolk	Self Initiated Living Options, Inc. (Suffolk Independent Living Organization (SILO)) 3680 Route 112, Suite 4 Coram, NY 11727 www.suffolkilc.org	Bonnie Hope, RRDS bhope@suffolkilc.org (631) 880-7929 (631) 946-6377 (FAX)
Lower Hudson Valley: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester	Westchester Independent Living Center 200 Hamilton Avenue 2nd Floor White Plains, NY 10601 www.wilc.org	Margaret Nunziato, RRDS mnunziato@wilc.org (914) 682-3926 (914) 681-7105 (FAX)
New York City:	Center for Independence of the Disabled, NY (CIDNY) 841 Broadway, #301 New York, NY 10003 www.cidny.org	Stuart Kaufer, RRDS skaufer@cidny.org (212) 674-2300 (646) 442-4188 (212) 254-5953 (FAX)
Rochester: Monroe, Wayne, Ontario, Seneca, Genesee, Livingston and Yates	Unity Health System 89 Genesee Street Rochester, NY 14611 www.unityhealth.org	Terri Mercado, RRDS tmercado@unityhealth.org (585) 368-3562 (585) 368-3567 (FAX)
Syracuse: Onondaga, Madison, Herkimer, Oneida, Oswego, Lewis, Jefferson and St. Lawrence	Southern Tier Independence Center (STIC) 24 Prospect Avenue Binghamton, NY 13901 www.stic-cil.org	Al Jennings, RRDS alj@stic-cil.org Stanley Johns, RRDS nhtd@stic-cil.org (607) 724-2111 (607) 772-3671 (FAX)

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF LONG TERM CARE

Nursing Home Transition and Diversion Waiver Program

Quality Management Specialist (QMS) List

EASTERN

School and Community Support, Inc.
17 British American Blvd.
Latham, NY 12110

Christina Alvarez-Ross
Work Phone (518) 782-7100
Fax Number (518) 782-7101
calvarezross@scssconsulting.com

WESTERN

School and Community Support, Inc.
South Hill Business Campus
950 Danby Road
Ithaca, NY 14850

Rhonda Bennett
Work Phone 607-330-4816
Fax Number 607-330-4817
rbennett@scssconsulting.com

METRO

School and Community Support, Inc.
64 Division Ave. Suite 103
Levitton, NY 11756

Natalia Gonzalez
Work Phone (518) 372-2026
Fax Number (518) 372-2028
ngonzalez@scssconsulting.com

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF LONG TERM CARE

Nursing Home Transition and Diversion Waiver Program

Waiver Management Staff (WMS) List

NYS DOH Nursing Home Transition and Diversion (NHTD) Program Staff	For questions concerning participants, contact: Carol Hodecker Andrea Swire For questions concerning providers, contact: Cheryl Udell Leah Sauer Patricia Smith NHTD Director: Bruce Rosen	NYS Department of Health Office of Long Term Care Division of Home and Community Based Services One Commerce Plaza, Suite 826 Albany, NY 12260 Tel: 518-486-3154 Fax: 518-474-7067 Email: NHTDWaiver@health.state.ny.us
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Section XII

GLOSSARY OF TERMS

Glossary of Terms for NHTD Waiver Program

Abbreviation	Definition
ADL	Activities of Daily Living
ALP	Assisted Living Program
APS	Adult Protective Services
AT	Assistive Technology
CDBG	Community Development Block Grant
CDPAP	Consumer Directed Personal Assistance Program
CHHA	Certified Home Health Agency
CIC	Community Integration Counseling
CIN	Client Identification Number
CMS	Centers for Medicare and Medicaid Services
CMCM	Comprehensive Medicaid Case Management
CTS	Community Transitional Services
DME	Durable Medical Equipment
DOH	Department of Health
E-mods	Environmental Modifications Services
HCBS	Home and Community-Based Services
HCSS	Home and Community Support Services
HEAP	Home Energy Assistance Program
HHA	Home Health Aide
HIPAA	Health Insurance Portability and Accountability Act
HUD	U.S. Department of Housing and Urban Development
IADL	Instrumental Activities of Daily Living
ICF/MRDD	Intermediate Care Facility for Individuals with Mental Retardation or Developmental Disabilities
ILST	Independent Living Skills Training Services
ISP	Initial Service Plan
ISR	Individual Service Report
LDSS	Local Department of Social Services
LHCSA	Licensed Home Care Services Agency
LOC	Level of Care
LTC	Long Term Care
LTHHCP	Long Term Home Health Care Program
MLTC	Managed Long Term Care
MMIS	Medicaid Management Information System
NE	Nurse Evaluator
NHTD	Nursing Home Transition and Diversion Waiver
NOD	Notice of Decision
OMH	Office of Mental Health
OMIG	Office of Medicaid Inspector General
OMRDD	Office of Mental Retardation and Developmental Disabilities
OT	Occupational Therapy
PACE	Program of All-Inclusive Care for the Elderly

PBIS	Positive Behavioral Interventions and Supports
PCA	Personal Care Aide
PCS	Personal Care Services
PERS	Personal Emergency Response System
POE	Point of Entry
PPO	Plan for Protective Oversight
PRI/SCREEN	Patient Review Instrument and SCREEN
PT	Physical Therapy
QA	Quality Assurance
QI	Quality Improvement
QMP	Quality Management Program
QMS	Quality Management Specialist
RHCF	Residential Health Care Facility (nursing home)
RRDC	Regional Resource Development Center
RRDS	Regional Resource Development Specialist
RSP	Revised Service Plan
SC	Service Coordination
SDP	Structured Day Program Services
SIRC	Serious Incident Reporting Committee
SNF	Skilled Nursing Facility
SP	Service Plan
SRI	Serious Reportable Incident
SS	Social Security
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
TBI	Traumatic Brain Injury
TOT	Training-Of-Trainer
USDA	United States Department of Agriculture
VESID	Vocational and Educational Services for Individuals with Disabilities
WMS	Waiver Management Staff

Section XIII

RRDC AND QMS MAPS

New York State Department of Health Office of Long Term Care

Nursing Home Transition and Diversion Waiver Program

Regional Resource Development Center Regions



