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 all 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

3. Profile of Applicant

A. Personal History

- **Developmental History** (Include any significant events)

☐ Within Normal Limits

☐ Developmental concerns (describe):

☐ Significant illnesses (describe):

☐ Significant injuries (describe):

☐ Significant hospitalizations (describe):

Other developmental information:

- **Family History**

	Full Name/Location	Status	Current Contact
Father:		☐ Living ☐ Died (date):	☐ None ☐ Occasional ☐ Daily ☐ Weekly ☐ Monthly ☐ Holidays
Mother:		☐ Living ☐ Died (date):	☐ None ☐ Occasional ☐ Daily ☐ Weekly ☐ Monthly ☐ Holidays
Step-Parent(s):		☐ Living ☐ Died (date):	☐ None ☐ Occasional ☐ Daily ☐ Weekly ☐ Monthly ☐ Holidays
Sibling:	☐ Older ☐ Younger	☐ Living ☐ Died (date):	☐ None ☐ Occasional ☐ Daily ☐ Weekly ☐ Monthly ☐ Holidays
Step-Sibling:	☐ Older ☐ Younger	☐ Living ☐ Died (date):	☐ None ☐ Occasional ☐ Daily ☐ Weekly ☐ Monthly ☐ Holidays
Spouse: Current status: ☐ Married ☐ Separated ☐ Divorced	Date of Marriage:	☐ Living ☐ Died (date):	☐ None ☐ Occasional ☐ Daily ☐ Weekly ☐ Monthly ☐ Holidays
Child:		☐ Living ☐ Died (date):	☐ None ☐ Occasional ☐ Daily ☐ Weekly ☐ Monthly ☐ Holidays

3. **Profile of Applicant (continued)**			
Step-Child:		☐ Living ☐ Died (date):	☐ None ☐ Occasional ☐ Daily ☐ Weekly ☐ Monthly ☐ Holidays
Other significant family member:		☐ Living ☐ Died (date):	☐ None ☐ Occasional ☐ Daily ☐ Weekly ☐ Monthly ☐ Holidays

Other family information:

- **Educational History** (Include the highest level of education achieved, degrees, special education, etc.):

- **Work History** (Describe the most significant employment experience(s); volunteer positions):

- **Mental Health History**:

☐ No history of mental health issues or concerns
☐ Declined to answer
☐ Indicated history of mental health issue/concerns but declined to provide any further information

☐ History of psychiatric diagnosis (list all past and current diagnoses with date of diagnosis, if known):

☐ History of psychiatric intervention (list all treatments and hospitalizations in order):

☐ Current psychiatric concerns (specify):

☐ Current psychiatric concerns are managed by: ☐ Counseling ☐ Medication
Receives counseling: ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other (specify):
If taking medication, the medication is prescribed by:
☐ Psychiatrist ☐ Primary Care Physician ☐ Other (specify):

☐ Psychiatric intervention has been recommended, but individual has deferred this option.

Other Mental Health information:

- **Substance Abuse History**

☐ No history of substance abuse issues or concerns
☐ Declined to answer
☐ Indicated history of substance abuse issue/concerns but declined to provide any further information

☐ History of substance abuse
With: ☐ alcohol ☐ prescription drugs ☐ over-the-counter legal drugs
☐ illegal drugs (specify): ☐ Other (specify):

☐ History of substance abuse treatment (list all treatments and hospitalizations in order):

3. Profile of Applicant (continued)

☐ Current substance abuse issues are managed by: ☐ Counseling ☐ Medication
The applicant attends: ☐ Outpatient Treatment ☐ Daily ☐ Weekly ☐ Other (specify):
The applicant attends: ☐ Narcotics Anonymous (NA) ☐ Alcoholics Anonymous (AA)
☐ Other:
The applicant has an AA/NA mentor: ☐ Yes ☐ No
Length of sobriety/abstinence:

Other Substance Abuse information:

- **Criminal Justice History** (Describe any history that impacts the applicant's life including current involvement in the criminal justice system, if applicable)

☐ No history of involvement in the criminal justice system
☐ Declined to answer
☐ Indicated history of involvement in the criminal justice system but declined to provide any further information

☐ History of criminal justice involvement (list all arrests and incarcerations in order):

The applicant is currently on ☐ probation ☐ parole for the following charge:
List any specific conditions of parole/probation:

Probation/parole is expected to end on:

Other Criminal Justice information:

B. Medical/Functional Information

- **Diagnoses and Medical Status**

Primary Diagnosis:	
Other Diagnoses:	
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:

3. Profile of Applicant (continued)

- **Management of Medical Needs**

List any current diagnoses, disease state or condition that needs ongoing management, monitoring and/or treatments. (Include injections, oxygen, dressing changes, dialysis, sleep apnea machines, nebulizers, lab work, etc.) Indicate if the applicant needs any assistance, the type of assistance, and who will provide:

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 if and how the applicant's disability or illness/injury has impacted his/her cognitive, physical and behavioral status** (include the applicant's strengths in each area)

a. Communication Ability

Primary Language is:	☐ English ☐ Other (specify):
Primary Mode of Communication:	
Other languages spoken/understood:	

Communication: ☐ effectively communicates wants/needs
☐ can carry on a conversation
☐ utilizes alternative communication (specify):_____
☐ needs a translator (specify person/agency):_____
☐ needs prompting/cueing to initiate communication
☐ has difficulties with articulation/speech
☐ needs prompting/cueing to engage in conversation

Other Information Regarding Communication Ability:

b. Cognitive Status (check all that apply for each)

Orientation: Oriented to ☐ time ☐ place ☐ person ☐ activities ☐ day/week
☐ needs prompting/cueing for orientation ☐ easily confused ☐ not oriented
Attention/Concentration: ☐ able to stay on task independently ☐ easily distracted
☐ needs occasional verbal cues/prompts to stay on task ☐ requires constant cueing/prompting

Initiation: ☐ initiates activities ☐ requests assistance when needed ☐ ability varies for ADLs
☐ needs cues/prompts to initiate tasks/activities ☐ cannot initiate tasks/activities

Memory: ☐ memory is functional for day-to-day activities ☐ short term memory difficulties
☐ long term memory difficulties
Organization: ☐ good organizational skills ☐ ability varies based on task/activity
☐ needs prompting/cueing for organizational skills ☐ needs others to provide organization

3. Profile of Applicant (continued)

Problem-Solving/Judgment: ☐ aware of current skills/limitations ☐ makes reasonable decisions
☐ needs cues/prompts for problem-solving ☐ unable to engage in problem-solving activities

Learning abilities: ☐ able to follow one-step directions ☐ able to follow multi-step directions
☐ interested in and willing to learn new strategies/tools ☐ not able to follow directions

Other Information Regarding Cognitive Status:

Overall Cognitive Status: ☐ self-directing ☐ needs periodic oversight/supervision
☐ needs constant oversight/supervision

c. Physical Status and Ability

1. Visual Ability (check all that apply)

☐ Vision is adequate for daily activities

☐ Visually Impaired	☐ Right Eye	☐ Left Eye	☐ Wears Glasses	☐ Needs Large Print
☐ Cataracts	☐ Right Eye	☐ Left Eye		
☐ Blind	☐ Right Eye	☐ Left Eye	☐ Uses Braille	
☐ Eye Prosthesis	☐ Right Eye	☐ Left Eye		

☐ Guide Dog

☐ Other:

Describe any specific information that pertains to the applicant's vision:

2. Hearing Ability (check all that apply)

☐ Hears adequately	☐ Hearing difficulty	☐ Uses Hearing Aid:	☐ Right Ear	☐ Left Ear
☐ Sign Language	☐ Other devices used:			

Other method(s) used:

Describe any specific information that pertains to the applicant's ability to hear:

3. Dietary Needs (check all that apply)

☐ Regular	☐ Low Sodium	☐ Low Fat	☐ Low Cholesterol
☐ Diabetic Diet	☐ Renal Diet	☐ Cardiac Diet	☐ Nutritional Supplement
☐ Swallowing Difficulties	☐ Pureed Foods	☐ Ground Consistency	☐ Chopped Consistency
☐ Aspiration Precautions	☐ Thickened Liquids	☐ Tube Feeding	☐ Adaptive equipment

☐ Dentures: ☐ Upper ☐ Lower ☐ Partial

☐ Special Dietary Considerations (e.g. vegetarian, kosher, etc.) specify:

Describe any specific information that pertains to the applicant's ability to eat and drink:

4. ADL/IADL Ability (check all that apply)

Mode of Ambulation: ☐ independent ☐ cane ☐ walker ☐ wheelchair ☐ scooter ☐ unable

Ability to Ambulate: ☐ independent ☐ needs periodic supervision/oversight
☐ needs ongoing supervision/oversight ☐ one person assist ☐ two-person assist ☐ unable

3. Profile of Applicant (continued)

Ability to Transfer: ☐ independent ☐ needs periodic supervision/oversight
☐ needs ongoing supervision/oversight
☐ one person assist ☐ two-person assist ☐ unable
☐ mechanical lift ☐ other _____

Basic ADLs (Eating, Dressing, Toileting, etc.): ☐ independent ☐ needs verbal cues/prompts
☐ needs physical cues/prompts ☐ needs hands-on assistance ☐ needs total support

Household Activities (Meal Prep, Laundry, etc.): ☐ independent ☐ needs verbal cues/prompts
☐ needs physical cues/prompts ☐ needs hands-on assistance ☐ must be completed by others

IADLs (Shopping, Banking, etc.): ☐ independent ☐ needs verbal cues/prompts
☐ needs physical cues/prompts ☐ needs hands-on assistance ☐ must be completed by others

Endurance/Strength: ☐ able to engage in routine activities
☐ experiences periodic fatigue ☐ fatigues easily ☐ requires frequent rest periods
☐ needs physical assistance to engage in routine activities

Other Information Regarding Physical Ability:

5. Behavioral Status (check all that apply)

☐ Takes most things in stride with positive outlook
☐ Communicates appropriately
☐ Shows appropriate affect and behavior in social situations
☐ Becomes anxious with changes in staff or environment
☐ Responds to redirection
☐ Exhibits behavior(s) that may not be accepted in community (Provide a full description and include frequency and duration, effective interventions, etc.):

- **Applicant's response to the disability, illness or injury:**

Describe how the applicant views himself/herself using his/her own words:

Describe the applicant's interest in and willingness to use available strategies/tools:

Describe the applicant's emotional response (coping) to current physical status:

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:

3. Profile of Applicant (continued)

- **Present** (Complete the following areas indicating what impact the disability or illness/injury is having on the applicant at this time)

1. **Unique Characteristics and Strengths** (Describe how the applicant sees him/herself in this capacity):

2. **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):

3. **Hobbies and Interests** (Describe how the disability or injury/illness has impacted what the applicant enjoys doing):

4. **Describe what activities the applicant would like to be involved in again or would like to initiate:**

5. **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:

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:

4. Applicant's Plans for Community Living (continued)

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)

Name	Age	Relationship	Support/Activities Provided	Support is
				☐ intermittent/periodic ☐ consistent/ongoing ☐ emergency only
				☐ intermittent/periodic ☐ consistent/ongoing ☐ emergency only
				☐ intermittent/periodic ☐ consistent/ongoing ☐ emergency only
				☐ intermittent/periodic ☐ consistent/ongoing ☐ emergency only

Additional Information:

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).

Name	Age	Relationship	Support/Activities Provided	Support is
				☐ intermittent/periodic ☐ consistent/ongoing ☐ emergency only
				☐ intermittent/periodic ☐ consistent/ongoing ☐ emergency only
				☐ intermittent/periodic ☐ consistent/ongoing ☐ emergency only

Additional Information:

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.

Name/Organization	Type of Service	Contact Person	Support/Activities Provided	Support is
				☐ intermittent/periodic ☐ consistent/ongoing ☐ emergency only
				☐ intermittent/periodic ☐ consistent/ongoing ☐ emergency only
				☐ intermittent/periodic ☐ consistent/ongoing ☐ emergency only

Additional Information:

B. Formal Supports

Federal/State Agency 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). **Note:** Transfer this information to the Insurance, Resources and Funding Information Sheet.

☐ SSI : ☐ SSDI ☐ SSA
☐ Medicare : ☐ Part A ☐ Part B ☐ Managed Care ☐ Part D
☐ QMBY ☐ SLMBY
☐ VA Pension: ☐ VA Medical ☐ VA Aide and Attendant Services ☐ VA Equipment
☐ HUD: ☐ Section-8 ☐ Other subsidized housing (specify): _____
☐ EPIC ☐ Other Pharmacy Program (specify):_____
☐ Food Stamps
☐ Office for the Aging ☐ Meals-on-Wheels ☐ EISEP (specify):_____
☐ Other OFA (specify):_____
☐ Other (specify):_____

Physician(s)/Specialist(s)/Dentist(s):
Primary Payor: ☐ Private Health Insurance ☐ Medicare ☐ VA Medical ☐ Medicaid
☐ Other (specify):_____
Secondary Payor: ☐ Private Health Insurance ☐ Medicare ☐ VA Medical ☐ Medicaid
☐ Other (specify): _____
Tertiary Payor: ☐ Private Health Insurance ☐ Medicare ☐ VA Medical ☐ Medicaid
☐ Other (specify):_____

List all medical providers currently treating the individual:

Primary Physician name:		Telephone:	
Physician name/Specialty:		Telephone:	
Physician name/Specialty:		Telephone:	
Physician name/Specialty:		Telephone:	
Dentist name:		Telephone:	

Are referrals to any other doctors 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 physicians? ☐ Yes ☐ No

5. Current Supports and Services (continued)

Does the 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 the applicant to medical appointments?	

Who sets up transportation? ___Applicant ___Other Specify: _____

C. Medications: (**Note**: Use the chart on page 20 to list all medications)
Medications are primarily funded through:
☐ Private Health Insurance ☐ Medicare ☐ VA Medical ☐ Medicaid
☐ Other (specify):_____

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 who will be contacted if there are concerns about the applicant's use of medication(s):

6. 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:

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?				

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:

8. Requested Waiver Services (indicate "N/A" for any service(s) not requested)

Service Coordination (SC)
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 (AT)
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):

8. Requested Waiver Services (continued)

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**

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. Include proposed number of Team Meetings for the next six (6) months:

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

8. Requested Waiver Services (continued)

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:

Environmental Modification 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. If informal supports are not sufficient to meet all of the applicant's oversight/supervision needs and a referral was made for HCSS assessment, indicate the extent to which HCSS will be used to meet those needs. **Note:** Attach a copy of the completed Home Assessment Abstract (LDSS-3139) with recommendations. Describe the time frame during which oversight/supervision will be required and clearly explain why oversight/supervision is needed during the time (e.g. unsafe wandering due to dementia). **Note:** Attach a copy of any related supportive documentation to this Service Plan (e.g. notes from the physician, hospital and/or nursing home):

Identify the applicant's desired goals for this service including the frequency/amount of the service. 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:

8. Requested Waiver Services (continued)
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).
Home Visits by Medical Personnel (HVMP) Explain the need for this service:
Identify the applicant's desired goals for this service including the frequency/amount of the service. Include proposed number of Team Meetings for the next six (6) months:
Describe specific activities targeted for the next six (6) months:
Independent Living Skills Training Services (ILST) 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:

8. Requested Waiver Services (continued)

Moving Assistance

Explain the need for this service:

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Identify the applicant's desired goals for this service:

Describe specific activities targeted for the next six (6) months:

***Attach the Moving Assistance Description and Cost Projection form and copy of bid(s), if applicable.**

Nutritional Counseling/Educational 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:

Peer Mentoring

Explain the need for this service:

Identify the applicant's desired goals for this service including the frequency/amount of the service:

8. Requested Waiver Services (continued)

Describe specific activities targeted for the next six (6) months:

Positive Behavioral Interventions and Supports (PBIS)
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:

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:

8. Requested Waiver Services (continued)
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 (SDP) 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:
Transportation 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:

8. Requested Waiver Services (continued)
Wellness Counseling 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:

9. Medication/Medical Supply/DME Information

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 23)**

10. Medicaid State Plan Services* and Cost Projection

Type of Service	Provider (Name and Telephone)	Effective Date	Annual Amount of Units	Rate	Total Projected Medicaid Annual Cost
Medications, Medical Supplies and DME from page 6					

Total Projected Medicaid Annual Costs for All Medicaid State Plan Services **$ _____**
(transfer total to page 23)**

***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.

11. Waiver Services and Cost Projection

Waiver Service	Provider (Name, Address, Telephone)	Effective Date	Annual Amount of Units	Rate	Total Projected Medicaid Annual Cost
Service Coordination		**Upon NOD - Authorization**	**1**		

Total Projected Medicaid Annual Cost for All Waiver Services $ _____
(transfer total to page 23)**

11. Projected Total Annual Costs for Initial Service Plan

1. Total Projected Medicaid Annual Cost of Medicaid State Plan Services (from page 21) _____

2. Total Projected Medicaid Annual Cost of Waiver Services (from page 22) **+** _____

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) _____

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 at any time a Notice of Decision is issued to me concerning my services under the HCBS Waiver and I disagree with the decision.

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