New York State Department of Health
Division of Long Term Care

Name of Applicant_____ CIN #_____
Region_____

Initial Service Plan
HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Traumatic Brain Injury Program
Date of Plan:_____

Date: ____/____/_____ Referral. #: _____

1. Identification

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

Date of Birth: _____

CIN: _____ County of Fiscal Responsibility: _____ Verified: ____/___/____
***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

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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	Comments
Father:		☐ Living ☐ Died (date):	
Mother:		☐ Living ☐ Died (date):	
Step-Parent(s):		☐ Living ☐ Died (date):	
Sibling:	☐ Older ☐ Younger	☐ Living ☐ Died (date):	
Step-Sibling:	☐ Older ☐ Younger	☐ Living ☐ Died (date):	
Spouse: Current status: ☐ Married ☐ Separated ☐ Divorced	Date of Marriage:	☐ Living ☐ Died (date):	
Child:		☐ Living	

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		☐ Died (date):	
Step-Child:		☐ Living ☐ Died (date):	
Other significant family member:		☐ Living ☐ Died (date):	

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
☐ 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
☐ 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):

☐ Current substance abuse issues are managed by:
The applicant attends: ☐ Outpatient Treatment ☐ Daily ☐ Weekly ☐ Other (specify):
The applicant attends: ☐ Narcotics Anonymous (NA) ☐ Alcoholics Anonymous (AA)

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☐ Other:
If taking medication, the medication is prescribed by:
☐ Psychiatrist ☐ Primary Care Physician ☐ Other (specify):
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
☐ 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 that may impact services):

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:

- **Management of Medical Needs**

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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:

Injury Information:
Please describe the details regarding accident/illness/injury leading to or causing the traumatic brain injury (include dates, length of coma, unusual circumstances)

Please describe regarding rehabilitation process related to the accident or illness traumatic brain injury (include all inpatient and outpatient services with time frames)

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:

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

Attention/Concentration: ☐ able to stay on task independently ☐ easily distracted
☐ needs occasional verbal cues/prompts to stay on task ☐ requires constant cueing/prompting
Additional Comments:

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

Memory: ☐ memory is functional for day-to-day activities ☐ short term memory difficulties
☐ long term memory difficulties
Additional Comments:

Organization: ☐ good organizational skills ☐ ability varies based on task/activity
☐ needs prompting/cueing for organizational skills ☐ needs others to provide organization
Additional Comments:

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

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
Additional Comments:

Other Information Regarding Cognitive Status:

c. Physical Status and Ability

1. Visual Ability (check all that apply)

☐ Vision is adequate for daily activities

☐ Visually Impaired	☐ Blind	☐ Uses Braille	☐ Wears Glasses/contacts	☐ Needs Large Print

☐ Other:

2. Hearing Ability (check all that apply)

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☐ Hears adequately	☐ Hearing difficulty	☐ Uses Hearing Aid:	☐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	☐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

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

Instrumental Activities of Daily Living (ADL/IADL)

List dates of most recent assessments:

_____

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KEY
4 – Does independently without prompting – Can perform and takes responsibility on own
3 - Able to do on own, but needs prompting – Can perform but requires prompting and reminding
2 - Able to do with minimum assistance – Can perform but requires periodical checking/monitoring
1 - Able to do with maximum assistance – Can perform only with ongoing assistance
0 - Unable to do at all, even with assistance – Cannot perform at all
X – Under participation – This means they could be doing these things but are not

TBA – To be assessed

Shopping for food ___	Keeping track of finances ___	Preparing meals ___
Paying own bills ___	Feeding self ___	Balancing checkbook ___
Cleaning up after meals ___	Making necessary purchases ___	Choosing own clothes ___
Cleaning own room ___	Dressing self ___	Helping with household chores ___
Washing own clothes ___	Yard work and repairs ___	Showering/bathing ___
Brushing teeth ___	Washing hair ___	Community Orientation/mobility ___
Going to bathroom ___	Safety/Self Preservation ___	

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

Current behavioral style:

Past behavioral difficulties (include antecedents, duration, frequency, interventions and outcomes)

Present behavioral difficulties,(include antecedents, duration, frequency, interventions and outcomes)

- **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 emotional response (coping) to their current life situation(s):

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Describe how the applicant feels he/she is managing his/her known weaknesses:

Describe family and informal supports and how they impact the participant:

- **Before Injury and Present** (Complete the following areas indicating the participants status prior to sustaining the injury ***and*** how this has impacted their life)

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 new activities and other interests in which the applicant would like to be involved:**

5. **Culture and/or Religion** (Describe the applicants cultural and religious preferences and activities and how they can be addressed in this service plan):

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, 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:

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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. 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:

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Community – Identify the present level of support and services provided through community resources (e.g. neighbors, religious, fraternal, hobby groups, etc.).

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.).

Income and Resources Income Source	Amount	Denied	N/A	Pending	Change from Last plan
Social Security					
Social Security Disability Ins.					
Supplemental Security Income					
Public Assistance					
Supplemental Needs Trust (Please attach a copy)					
Worker's Compensation					
Wages from employment					
Alimony/Child Support					
Other:					
Federal, State and Private Resources Source					
HUD/Section 8					
HEAP					
Telephone Life Line					
Food Stamps					
Crimes Victims Funding					
Worker's Compensation					
TBI Waiver Housing:					
Rent					
Utilities					
Household Goods					

Insurance (check all that apply) □ Medicare- #: □ A □ B □ D – Rx. plan name: □ Private Insurance – company:

□ Other:

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Services paid for by non-Medicaid source (i.e. Medicare, private pay, etc.)

Include doctor, pharmacy, dentist and/or other services paid for by non-Medicaid sources. **Service**	**Vendor** (include name and address)	**Payer source**	**Change from last plan**

Medicaid Information

_ No spend down
□ Individual has a spend down and in the process of securing a Supplemental Needs Trust.
□ Individual does not have a Supplemental Needs Trust, but this option has been discussed w/ the individual and/or legal guardian.
□ Individual has a Special Needs Trust.
□ Individual has a spend down and has chosen not to pursue a Supplemental Needs Trust
□ Spend down - Amount per month: $
Who is responsible for ensuring the spend down is paid?
□ individual □ Representative Payee
□ family □ other:_____

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

Does the applicant need someone to accompany them to doctor's appointments and other essential outpatient services? __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)

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Medications are primarily funded through:
☐ Private Health Insurance ☐ Medicare ☐ Part D ☐ VA Medical ☐ Medicaid
☐ Other (specify):_____

Describe applicant's ability to self-administer medications**:**

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, PCA, CHAA, durable medical equipment, assistive technology, etc.). Indicate whether such efficiencies have been considered and are explained elsewhere in this Service Plan and how they support the goals of this:

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:

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8. Requested Waiver Services (indicate "N/A" for any service(s) not requested)
<u>Service Coordination</u> (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 twelve (12) months:
<u>Assistive Technology</u> (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):
Describe specific activities targeted for the next twelve (12) months: ***Attach Assistive Technology Description and Cost Projection form and copy of bid(s)**
<u>Community Integration Counseling</u> (CIC) Explain the need for this service:

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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 twelve (12) months:
Describe specific activities targeted for the next twelve (12) 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 twelve (12) months: ***Attach the Community Transition Service Description and Cost Projection form and copy of bid(s)**
Environmental Modification Services (E-Mods) including vehicle modifications Explain the need for this service:
Identify the applicant's desired goals for this service:
Describe specific activities targeted for the next twelve (12) months:

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***Attach Environmental Modification Description and Cost Projection form and copy of bid(s)**
<u>Home and Community Support Services</u> (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 twelve (12) months:
NOTE: Please attach the necessary documentation supporting the recommended frequency and duration of service(s).
<u>Independent Living Skills Training Services</u> (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 twelve (12) months:

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Substance Abuse Program
Explain the need for this service:

.

Identify the applicant's desired goals for this service:

Describe specific activities targeted for the next twelve (12) months:

Positive Behavioral Interventions and Supports (PBIS)
Explain the need for this service. Review any psychotropic medications utilized to address behaviors. Indicate timeframes for routine medications reviews. Include recommendations on physicians and clinicians.

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

Describe specific activities targeted for the next twelve (12) months:

NOTE: Please attach the necessary documentation supporting the recommended frequency and duration of service(s).

Respite Services
Explain the need for this service:

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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:
<u>Structured Day Program Services</u> (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 twelve (12) months:
<u>Social Transportation Services</u> 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 twelve (12) months:

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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
= $_____ (C)
(Total Projected Medicaid Monthly Cost x 12) (transfer total to page 20)**

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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
					Total:_____(D)

Total Medication, Supplies and Durable Medical Equipment from Page 19_____ (C)

Total Projected Medicaid Annual Costs for All Medicaid State Plan Services $ _____ (C+D)

Medicaid Spend down per month $_____

***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.

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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			**1**		

Total Projected Medicaid Annual Cost for All Waiver Services $ _____ (*transfer total to page 22)

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12. Projected Total Annual Costs for Initial Service Plan

1.

Total Projected Medicaid Annual Cost of Medicaid State Plan Services (from page 19 C + D) _____

2. Total Projected Medicaid Annual Cost of Waiver Services (from page 20 **+** _____

Total of # 1 and #2 = **=** _____

3. Total Projected Medicaid Annual Cost of Medicaid Spend-down incurred (page 19
(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)

_____

Note: *The DOH HCBS/TBI waiver program made an agreement with the Centers for Medicaid and Medicare Services (CMS) to guarantee the health and welfare of the participants on this program). Since its inception, the waiver has remained flexible and responsive to the needs of participants and providers. As a waiver provider, we are obligated to remain flexible and responsive to the needs of our participants as well as ensuring the health and safety of each participant we serve in the community.*

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13. Projected Weekly Schedule of All Services (Include informal supports, waiver and non-waiver services)

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							

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14. 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 have determined that without the provision of the TBI waiver services indicated in this service plan, this individual may not be successfully maintained in the community and will be at risk for placement in a Residential Health Care Facility.

*( ) **Yes** ( ) **No** ( ) n/a*

I approve this Initial Service Plan and authorize all services for the frequency and duration indicated within the Plan.

RRDS Comments: _____

This Service Plan is in effect from: _____ to: _____

Name of RRDS (print) Signature Date