Revised Service Plan

To: WILC / PILS

From: A1 Service Coordination
7 Skyline Drive, Suite 350, Hawthorne, NY 10532
Phone: 914-429-4574
Fax: 914-690-8172

Date:_____

Please find attached a complete Revised Service Plan packet for: _____.

Contained in this packet:
☒ Completed 6 Month Review form (including signature page)
☒ Current Plan of Protective Oversight (including signature page)
☒ All relevant Individual Service Reports (including signatures)
☒ Waiver Service Provider Contact List
☒ Medicaid Verification Form
☒ Waiver Rights and Responsibilities
☒ Team Meeting minutes outlining the review of previous service plan and development of current plan
☒ Weekly Schedule

As the Service Coordinator for the outlined participant, I attest that the above required documents have been included in this packet. I understand that if any outlined documents are missing, this 6 Month Review packet will be returned to my supervisor by the RRDC as unacceptable.

_____

Service Coordinator Date

_____

Service Coordinator Supervisor Date

HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER FOR INDIVIDUALS WITH TRAUMATIC BRAIN INJURY (HCBS/TBI)
Revised Service Plan

1. Identification

Name: **Current Address**:

Date of Birth:

Date of Onset: **Home Phone**:

Age of Onset: **County of Residence**:

Medicaid #: **County of Fiscal Responsibility**:

Veteran of the US Armed Forces: yes ☐ no ☐
Emergency Contact (name, address, phone number):
Name:
Address:

Phone #:

Individuals who participated in the development of the Service Plan:

Name	Relationship to Individual	Telephone Number
	Self	
	Service Coordinator	
	Service Coordinator Supervisor	914-429-4574 X
Amanda Truffi-Nash	Director of Enrollment	914-429-4574 X 1001
Jenn DiBenedetto	Executive Director	914-429-4574 X 1000

Service Coordinator: Agency: A1 Service Coordination
Agency Address: 7 Skyline Drive, Suite 350, Hawthorne, NY 10532 Phone: 914-429-4574
Email Address: @a1servicecoordination.com

Service Coordinator Supervisor:
Email address: @a1servicecoordination.com
Service Coordinator Supervisor: Amanda Truffi-Nash
Email address: Amanda@a1servicecoordination.com
Service Coordinator Supervisor: Jenn DiBenedetto
Email address: Jenn@a1servicecoordination.com

Date of Previous Notice of Decision (NOD) Period: _____
Date of most recent Patient Review Instrument (PRI): N/A
Date of most recent Screen: N/A
PRI/Screen continues to meet eligibility for TBI Waiver: N/A
Date of most recent UAS NY Assessment: _____
PRI/Screen continues to meet eligibility for TBI Waiver: Yes ☐ No ☐
Date of most recent Waiver Rights and Responsibilities: _____
Was there an Addendum: Yes ☐ No ☐
If yes, please give date(s) and explain:

Individual Profile:

I, Physical/Medical (check all that apply)

Mobility Needs:
☐ Wheelchair
☐ power ☐ manual
☐ Walker
Other: _____

Functional Needs:
☐ Assistance w/ transfers required
☐ one person ☐ two person ☐ mechanical
☐ Adaptive equipment utilized for functional needs:
_____

Dietary Needs
☐ Regular ☐ Diabetic Diet ☐ Low Fat ☐ Thickened Liquids
☐ Low Sodium ☐ Tube Feeding ☐ Aspiration precautions
☐ Other: _____

Visual Ability:
☐ Visually Impaired ☐ Guide Dog
☐ Uses Braille ☐ Eye Prosthetic
☐ Blind – Right Eye
☐ Blind – Left Eye
☐ Requires Large Print
☐ Wears Glasses/Contacts

Hearing Ability:
☐ Hearing Difficulty- Right Ear
☐ Hearing Difficulty – Left Ear
☐ Hearing Aid – Right Ear
☐ Hearing Aid – Left Ear
☐ Sign Language

Communication:
☐ Can make needs/wants known
☐ Primary language other than English _____
☐ Aphasia ☐ Use of simplified language
☐ Difficulty with word recall
☐ Utilizes email – individual's email address: _____
☐ Alternative communication:
☐ Letter board ☐ Other _____
☐ Speech generated device

Disease Processes:

☐ Seizure Disorder (frequency /duration during last 6 months): _____
☐ Diabetes
☐ Cardiac Disease
☐ Renal Failure
☐ Other:

Diagnosis	Assistance Needed	Who assists

☐ New medical diagnosis since last reporting period: _____

Hospitalizations during this reporting period (note date and reason for hospitalization):

Additional comments and/or changes from last reporting period on physical/medical issues:

II. Cognitive (check all that apply)

☐ Individual is oriented to date/time/place
☐ Short term memory challenges
☐ Long term memory challenges
☐ Judgment challenges
☐ Organizational challenges
☐ Impulse Control challenges
☐ Problem Solving challenges

Additional comments and/or changes from last reporting period on cognitive issues:

III. Community Living (check all that apply)

Individual resides:
☐ alone ☐ w/ family ☐ w/ friends ☐ other _____

Level of TBI waiver staff required to support the individual during community activities:
☐ None ☐ Minimum ☐Maximum

Informal Supports:
List all persons who the individual identifies as providing informal support:
(name, relationship)

_____
_____
_____

If the individual is responsible for children in the home, please note name and ages:

_____

_____

☐ Court appointed Legal Guardian - Name/address/phone number:

_____

☐ Social Security appointed Representative Payee: Name/address/phone number:

_____

☐ Appointed Power of Attorney (POA): Name/address/phone number:

_____

☐ Appointed Health Care Proxy: Name/address/phone number:

_____

Formal, non-Waiver in home supports (for the next six months):

☐ Consumer Directed Personal Assistance Program (CDPAP)- hrs approved/week - _____
☐ Home Health Aide (HHA) – hrs. approved/week - _____
☐ visiting nursing service – hrs. approved/week - _____
☐ private duty nursing – hrs. approved/week - _____
☐ Other: _____

Additional comments and/or changes in formal non- waiver, in-home/informal support this reporting period:

Substance Abuse (SA):

☐ no SA history or current concerns
☐ history of SA length of sobriety: _____
☐ SA during past reporting period – known frequency: _____
☐ currently attending community outpatient SA treatment
☐ support group attendance ☐ Narcotics Anonymous (NA) ☐ Alcoholics Anonymous (AA)
Drug of Choice: ☐ alcohol ☐ un-prescribed legal drugs ☐ illegal drugs ☐ Other: _____
☐ Individual has been informed that substance abuse jeopardizes his/her TBI Waiver involvement, which may include service interruption and/or termination from program.

Psychiatric:

☐ no psychiatric history or current concerns ☐ history of psychiatric intervention
☐ current psychiatric concerns (specify): _____

_____

☐ currently under Mental Health professional care Diagnosis: _____
☐ psychiatric concerns are managed by medication
☐ is prescribed a psychotropic medication but is monitored by Personal Care Physician or other medical professional
☐ psychiatric intervention has been recommended; individual has deferred this option.

Criminal Justice:

☐ no criminal justice history or current concerns
☐ history of criminal justice activity
☐ criminal justice involvement during the past reporting period:
specify: _____
☐ individual has been informed that criminal justice involvement may jeopardize his/her TBI Waiver involvement, which may include service interruption and/or termination from program.
☐ individual is currently on:
☐ probation
☐ parole
if checked, indicate any specific conditions which may effect individuals community living:
_____

Behavioral:

☐ individual exhibits no behavioral challenges that impact his/her ability to remain in the community
☐ history of behavioral challenges but none noted this past reporting period
☐ behavioral challenges noted this reporting period
include specific challenge, w/ frequency and duration of each:
_____
_____
☐ behavioral challenges are managed by formal behavioral services and/or treatment.
☐ behavioral intervention has been recommended; individual has deferred this option.

Vocational/Education/Volunteer

☐ individual has stated, during this review period, that he/she does not wish to pursue any vocational/education or volunteer endeavors at this time.
☐ individual is currently continuing and/or would like to continue his/her education:
☐ GED ☐ Specialized trade school ☐ College
☐ individual is currently working or wishes to pursue a vocational goal
☐ employment specifics:
where is the individual working:_____
what are the individual's work duties: _____
average number of hours worked per week: _____
individual is earning at least minimum wage/hr.:
☐ yes ☐ no ; explain: _____
☐ Has been referred to VESID - date of referral: _____
☐ Type of work he/she is interested in: _____
☐ individual wishes to or is currently volunteering in the community
☐ volunteer specifics:
where is the individual volunteering: _____
what are the individual's volunteer duties: _____
average number of volunteer hours/week: _____
volunteering supported through: ☐ local faith community or civic group
☐ informal supports
☐ Structured Day Program
☐ Other: _____
☐ Type of volunteer duties interested in: _____

IV. Successes/Barriers/Concerns

Quoting the individual, what does he/she identify as successes this reporting period:

Quoting the individual, what does he/she identify as barriers this reporting period:

Quoting the individual, note if he/she has any concerns this reporting period:

Were there any barriers to service provision, as written in the last service plan? If so, explain:

Note each service being requested from the TBI Waiver in this Service Plan and note why the individual requires these services to circumvent a Nursing Home or RHCF level of care:

Check each waiver service being requested in this plan:

☐ Service Coordination
☐ Structured Day Program
☐ Community Integration Counseling
☐ Waiver Transportation
☐ Home and Community Support Services
☐ Independent Living Skills Training
☐ Substance Abuse Program
☐ Respite
☐ Positive Behavioral Interventions and Supports Service

(Note: a separate Addendum is required for all requests for Environmental Modifications and Assistive Technology)

Describe why, without the above noted waiver services, the individual would be at risk of a nursing home or RHCF placement:

Other community based services have been researched and/or are being utilized:

☐ VESID ☐ OMRDD ☐ Veteran's Administration
☐ Commission for Blind and Visually Handicapped (CBVH)
☐ Independent Living Center (ILC)
☐ Other: _____

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					
Worker's Compensation					
Wages from employment					
Alimony/Child Support					
Other:					

If the individual has no income, note how daily living expenses will be paid:

Federal, State and Private Resources

Source	Amount	Denied	N/A	Pending	Change from last plan
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: _____

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 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: _____

Medication

Medication	Dosage	Route	Purpose	Change from last plan

Check all that apply:

☐ Individual is self-medicating and requires no assistance or cueing for any part of this task.
☐ Individual requires assistance to fill a medication bar/caddy.
Note who provides physical support: ☐ CDPAP
☐ visiting nurse
☐ Informal Supports
☐ Other: _____

Note who provides verbal support: ☐ TBI Waiver staff ☐ CDPAP ☐HHA
☐ Informal Supports

☐ Other: _____

☐ Individual requires verbal cues to administer his/her own medication
Note who provides this support: ☐ TBI Waiver staff ☐ CDPAP ☐ HHA
☐ Informal Supports
☐ Other: _____

☐ Individual requires physical support to administer his/her medications
Note who provides this support: ☐ CDPAP ☐ HHA
☐ Informal Supports
☐ visiting nurse
☐ Other: _____

Individual utilizes the following compensatory strategies to be as independent as possible w/ medication administration:
☐ auditory cues (i.e. watch that beeps, clock that rings)
explain: _____
☐ visual cues (i.e. poster outlining meds and times, pictures of meds)
explain: _____
☐ other: be specific: _____

If individual is on an injection medication, note who is responsible for this:
☐ individual ☐ informal supports ☐ private duty nursing
☐ doctor ☐ CDPAP ☐ Other: _____

☐ Individual requires routine blood testing and/or lab work due to medical concerns and/or medications.

If the individual requires routine blood testing (i.e. glucose), note who is responsible for this:
☐ individual ☐ informal supports ☐ private duty nursing
☐ doctor ☐ CDPAP ☐ Other: _____

If individual is on a specialized diet, note who is responsible for menu planning, meal preparation and grocery shopping.
☐ individual completes independently
☐ individual instructs Waiver staff on process
☐ individual receives non-waiver supports for these tasks (i.e. HHA, CDPAP)
☐ individual's informal supports assist him/her with these tasks

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:	

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.

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	A1 Service Coordination 7 Skyline Drive, Suite 350 Hawthorne, NY 10532 914-429-4574		**12**		

Total Projected Medicaid Annual Cost for All Waiver Services $ _____

Projected Total Annual Costs for Initial Service Plan

1. Total Projected Medicaid Annual Cost of Medicaid State Plan Services _____

2. Total Projected Medicaid Annual Cost of Waiver Services + _____

Total of # 1 and #2 = = _____

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

Signatures of Individuals Participating in the Development of the Revised Service Plan:

I have assisted my Service Coordinator in developing this Revised Service Plan and agree with all the information outlined. I understand my Service Coordinator will be providing copies of this plan to other TBI Waiver agencies that work with me.

Waiver Participant	Date
Legal Guardian/Advocate	Date
Service Coordinator	Date
Service Coordinator Supervisor	Date

Regional Resource Development Specialist

☐ has approved this Service Plan

☐ has denied this Service Plan for the following reason(s):Proposed Sample Weekly Schedule

Signature _____

Print Name _____

Title _____

Date _____

Individual Name**:** _____ Reporting period: _____

	Sunday	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Sunday**
7:00 am							
8:00 am							
9:00 am							
10:00 am							
11:00 am							
12 Noon							
1:00 pm							
2:00 pm							
3:00 pm							
4:00 pm							
5:00 pm							
6:00 pm							
7:00 pm							
8:00 pm							
9:00 pm							
10:00 pm							
11:00 pm							
12 Midnight							
1:00 am							
2:00 am							
3:00 am							
4:00 am							
5:00 am							
6:00 am							

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 (2006 DOH Manual, pg. 89). "Since its inception, the waiver has remained flexible and responsive to the needs of participants and providers (2006 DOH Manual, pg. 8). 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.*