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

INITIAL SERVICE PLAN

I. Identification

Name_____

Date of Birth_____
Date of Onset_____

Age of Onset_____

Diagnosis_____

SS#_____

Medicaid #_____

Medicare #_____

Other Insurance _____

Current Location _____
_____
_____
Phone _____

Proposed Residence (include County)_____

_____

_____
County of Fiscal Responsibility_____

Emergency Contact _____
_____
_____
Phone _____

Individuals who Participated in Developing the Service Plan

Name	Relationship	Phone

Service Coordinator_____ Agency_____

Address_____ Phone_____

DO NOT WRITE BELOW LINE

Date of Submission_____
Date of Decision _____

☐ Conversion
☐ In-State Facility
☐ Out-of-State Facility
☐ Diversion

II. Profile of Individual

A. Description of individual in person centered terms (include age, unique strengths and weaknesses).

B. Pre-injury Information.

- General developmental history

- Family composition (parents, siblings etc)

- Social history (friends, relationships, marriage, children, interests)

- Educational history (highest level achieved, degrees, special education, LD etc)

- Vocational history (jobs, time frames, volunteers positions, etc)

- Psychiatric history – if applicable

- Substance Abuse history – if applicable

- Criminal Justice history – if applicable

C. Injury Information.

- Details regarding accident/illness/injury (include dates, length of coma, unusual circumstances).

- Details regarding rehabilitation process (include all inpatient and outpatient services with time frames).

D. Current Post-Injury Information.

- Behavioral Status

  Current behavioral style –

  Past behavioral difficulties (include precipitating events, duration, frequency, interventions and results of these interventions) –

  Present behavioral difficulties (include precipitating events, duration, frequency, interventions and results of these interventions) –

- Cognitive Status

  Description of communication style (include any required adaptive devices)-

  Description of cognitive strengths and difficulties (include information on memory, organization, judgement, orientation, problem-solving, attention, learning etc.)-

  Description of most effective compensatory strategies and tools utilized by individual -

- Physical/Medical/Dietary Status

- Social/Natural Supports Overview (changes in social interactions and interests)

- Educational and Vocational Overview

- Psychiatric Status – if applicable

- Substance Abuse Involvement – if applicable

- Criminal Justice Involvement – if applicable

E. Post-Injury Information Continued

- Activities of Daily Living/Instrumental Activities of Daily Living (ADL/IADL)

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 - Underparticipation – 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	___	Yardwork and repairs	___
Showering/bathing	___	Could be trusted to take care	
Brushing teeth	___	of self living in own dwelling	___
Washing hair	___	Community Orientation/mobility	___
Going to bathroom	___	Safety/Self Preservation	___
Medication Management	___		

**This modification of the Activities of Daily Living Scale from The NYU Head Injury Family Interview JHTR, Kay, Cavallo, and Ezrachi (1995). Used by permission of authors.

F. Current Living Situation and Reason for Requesting HCBS/TBI Waiver Services
(Include why current arrangement is not meeting the individual's needs and why the applicant requires HCBS/TBI Waiver Services to avoid RHCF (nursing home) placement.

III. Individual's Preference and Plans for Community Living

A. Short-term Goals:

B. Long-term Goals:

C. Proposed Living Situation:

- General Location/Type of setting (rural,urban, etc):
- House or Apartment size/ description:
- Identify all individuals sharing this proposed household and their relationship to waiver participant:
- Accessibility requirements/E-mod requirements:
- Other Comments:

D. Expected Daily Activities (include social, recreational, leisure, vocational, and educational activities)

IV. Expected Sources of Support

A. Natural Supports

- Family (identify the level of support and the activities which they are providing. If applicable, please identify legal guardian, power of attorney, representative payee, and health care proxy - if the court has established legal guardian please attach copies of documents)

- Friends (identify the level of support and the activities which they are providing)

- Community

B. Income and Resources

Income Source	Amount	Denied	Pending	Will Apply Upon Enrollment
SSDI (after buy-in)				
SSI (after buy-in)				
VA				
PA				
Food Stamps				
Other				

C. Federal or State Agency Funded Resources

1. Non-Medicaid Resources

Funding Sources	Yes	No	Denied	Pending	Will Apply Upon Enrollment
HUD/Section-8					
DOH/TBI Housing Subsidy					
Telephone Lifeline Services					
HEAP					
Crime Victims Funding					
VESID					
OMRDD					
Worker's Comp.					
Other Insurance					
Other					

Medicare (check all that apply) Part A ☐ Part B ☐ Managed Care ☐

Medicare # _____ Primary Medical Payor____Secondary Medical Payor___

Services paid for by sources listed in Section B above (i.e. Medicare, Private Insurance, VESID, OMRDD, family member's etc)

Services	Payor	Percentage Paid

2. Medicaid Services

Medicaid Payor Status (check one) Primary ☐ Secondary ☐ Tertiary ☐ Managed Care ☐

Medicaid Spend Down Amount $ _____ per month toward_____
(service/county)

List Medicaid Services expected for next 12 months. Include information on provider and purpose.

Please list all Medications if any:

Medication Name	Dosage	Purpose	Pharmacy

What is the current plan to assist the individual with medication administration?

3. HCBS/TBI Waiver Services

Service Coordination:
Cost of Initial Plan Development (1X cost) _____
Annual Cost of SC Requested_____
Provider Agency_____

Identify participant's desired outcomes for this service:

Describe specific activities targeted for next 6 months:

Independent Living Skills Training and Development:
Frequency and Duration Requested _____
Annual Cost of ILST Requested _____
Provider Agency_____

Identify participant's desired outcomes for this service:

Describe specific activities targeted for the next 6 months:

Structured Day Program:
Frequency and Duration Requested _____
Annual Cost of SDP Requested _____
Provider Agency_____

Identify participant's desired outcomes for this service:

Describe specific activities targeted for the next 6 months:

Substance Abuse Program:
Frequency and Duration Requested _____
Annual Cost of SAP Requested _____
Provider Agency_____

Identify participant's desired outcomes for this service:

Describe specific activities targeted for the next 6 months:

Intensive Behavioral Program:
Frequency and Duration Requested _____
Annual Cost of IBP Requested _____
Provider Agency_____

Identify participant's desired outcomes for this service:

Describe specific activities targeted for the next 6 months:

Community Integration Counseling:
Frequency and Duration Requested _____
Annual Cost of CIC Requested _____
Provider Agency_____

Identify participant's desired outcomes for this service:

Describe specific activities targeted for the next 6 months:

Home and Community Support Services:
Frequency and Duration Requested _____
Annual Cost of HCSS Requested _____
Provider Agency_____

Total HCSS hour per week _____ _____ one on one hrs/week
_____ shared hrs/week
(please attached schedule reflecting shared hours and staff ratios)

Identify participant's desired outcomes for this service:

Describe specific activities targeted for the next 6 months:

Environmental Modifications:
Provider Agency_____
Projected Cost _____

Please attach E-mod forms and a single copy of each bid (3 bids required if projected cost is over $1,000.00).

Identify participant's desired outcomes for this service:

Describe specific activities targeted for the next 6 months:

Special Medical Equipment and Supplies:
Provider Agency_____
Projected Cost _____

Please attach SMES application forms and a single copy of each bid (3 bids required if projected cost over $2,500).

Identify participant's desired outcomes for this service:

Respite:
Frequency and Duration Requested _____
Annual Cost of Respite Requested _____
Provider Agency_____

Identify participant's desired outcomes for this service:

Describe specific activities targeted for the next 6 months:

Transportation:
Frequency and Duration Requested _____
Annual Cost of Transportation Requested _____
Approved Reimbursement Rate for Transportation_____
Provider Agency_____

Identify participant's desired outcomes for this service:

Describe specific activities targeted for the next 6 months:

MEDICAID STATE PLAN SERVICES

Type	Provider	Effective Date	Frequency & Duration (e.g. 1 time per month)	Annual Amou of Units

****NOTE: Total Cost should represent Projected Annual Total Cost of the Medicaid State Plan Service**

HCBS/TBI WAIVER SERVICES

Type	Provider	Effective Date	Frequency & Duration (2 hrs., 3X per week)	Annual Amou of Units
Service Coordination				
Independent Living Skills Training & Development				
Structured Day Program				

****NOTE: Total Cost should represent Projected Annual Total Cost of the HCBS/TBI Waiver Services**

HCBS/TBI WAIVER SERVICES

Type	Provider	Effective Date	Frequency & Duration (e.g. 2 hrs., 3X per week)	Annual Amount o Units
Substance Abuse Program				
Intensive Behavioral Program				
Community Integration Counseling				

****NOTE: Total Cost should represent Projected Annual Total Cost of the HCBS/TBI Waiver Services**

HCBS/TBI WAIVER SERVICES

Type	Provider	Effective Date	Frequency & Duration (e.g. 2 hrs., 3X per week)	Annual Amount o Units
Therapeutic Foster Care*				
Transitional Living*				
Home and Community Support Services				

***Not available at this time**

****NOTE: Total Cost should represent Projected Annual Total Cost of the HCBS/TBI Waiver Services**

HCBS/TBI WAIVER SERVICES

Type	Provider	Effective Date	Frequency & Duration (e.g. 2 hrs., 3X per week)	Annual Amount o Units
Environmental Modifications				
Respite Care				
Special Medical Equipment and Supplies				
Transportation				

****NOTE: Total Cost should represent Projected Annual Total Cost of the HCBS/TBI Waiver Services**

PROJECTED TOTAL ANNUAL COST OF MEDICAID STATE PLAN SERVICES: _____

PROJECTED TOTAL ANNUAL COST OF HCBS/TBI WAIVER SERVCIES: _____

PROJECTED TOTAL ANNUAL COST OF MEDICAID SPENDDOWN: _____ FOR:_____

PROJECTED TOTAL ANNUAL COST OF ALL MEDICAID SERVICES:_____ DAILY RATE:_____

Signatures of Individuals Participating in the Development of the Service Plan

Waiver Participant _____ Date _____

Advocate/Representative
(when applicable) _____ Date _____

Service Coordinator _____ Date _____

Service Coordinator Supervisor _____ Date _____

Regional Resource Development Specialist

[ ] has approved this Service Plan

[ ] The Service Coordinator has been presented with a list of specific areas of concern which must be addressed before this Service Plan can be approved.

Signature _____

Print Name _____

Title _____

Date _____