

Initial/Recertification Service Plan Checklist

COVER LETTER

- Identifies the participant and the waiver program
- Identifies the case manager, contact person, and phone numbers
- Defines special actions needed and related deadlines
- Provides additional information (e.g. change in living arrangements)
- Makes notes of missing or incomplete information and provides date when information can be expected
- Indicates a No Active Treatment rating is requested
- May indicate a preferred start date
- If CRI or Diversion application, all necessary forms requesting this funding are complete

ASSESSMENT/SUPPLEMENT

- Is completed fully
- Is signed and dated by the care manager
- Is signed and dated by a Registered Nurse (If supplement is not signed/dated by RN, must complete Health Form)
- Identifies current needs and preferences
- Information coincides with the Long Term Care Functional Screen

LONG TERM CARE FUNCTIONAL SCREEN

- Completed and dated on or within 90 days prior to effective date of eligibility
- Completed by a certified screener
- Includes all applicable pages
- Is appropriately completed
- Identifies an eligible Nursing Home level of care

ISP

- Identifies the specific waiver program
- Identifies the participant (name, address, telephone)
- Cites an accurate service plan development date (date the plan was first discussed with the participant)
- Indicates the living arrangement
- Lists all long term care services (formal and informal) regardless of funding
- Services meet all needs identified in the assessment/supplement
- Is properly signed and dated by the participant and case manager (durable power of attorney, guardian, authorized representative, or witness signature's must be properly identified)
- Describes the type of services
- Identifies all service providers
- Identifies service delivery start dates
- Lists unit of service (e.g. hours/day, day/month)
- Lists cost per unit of service (e.g. dollars/hr)
- There is a breakdown of care and supervision/ room and board costs and no waiver funding is used for room and board
- Lists and estimates of the actual daily costs for each waiver or COP service (e.g. annual cost divided by 365 days)
- Identifies all funding sources (e.g. SS, SSI, COP, CIPII, COP-W, Medicaid, Medicare, cost share, DVR, VA, personal, pensions, private insurance, etc.)
- Lists the total cost share amount, if applicable and identifies waiver-allowable services toward which cost share will be applied (if cost share is being applied to vendor)
- All SPC's listed in ISP are correct
- Signature date is not earlier than the ISP development date
- All columns in ISP Outcomes are complete
- All waiver services listed on ISP have an identified outcome listed

HEALTH FORM

- Must be completed for participants if the Supplement is not signed /dated by an RN
- Must be signed by an MD, RN, or PA and dated

FINANCIAL ELIGIBILITY

- F20919 or the CWB for expanded GROUP A participants (Group A)
- CWB screens are included for Group B and Group C
- Cost share coincides with information listed on the ISP
- If M/R expenses exceed \$100, is there information that conveys what the expenses are?
- F20920 for persons who will be residing in a substitute care facility

VARIANCE REQUESTS FOR INSTITUTIONAL RESPITE

For a participant to receive services in a Medicaid certified nursing home, hospital or ICF-MR, a variance request addressing the following must be sent with the packet:

- Reason(s) for the request and identify the caregiver in need of respite
- Anticipated length of placement
- Description of other community-based services of a similar nature available and specific barriers to using them.
- Description of proposed services
- Description of specific plans to address the limitations associated with institutional settings

VARIANCE REQUESTS FOR CBRF (OF ANY SIZE) STRUCTURALLY CONNECTED TO A NH FOR ELDERLY

For an elderly participant to receive services in a CBRF that is structurally connected to a NH, a variance request addressing the following must be sent with the packet:

- Must be person specific
- Must be non-institutional & enhance dignity & independence
- Must be the preferred residence of the person

HOME MODIFICATIONS – over \$2,000

For a participant to receive a home modification, a request for prior approval addressing the following must be sent with the packet:

- Complete breakdown of all material and labor costs
- Picture or diagram for the home modification, if possible

HOME MODIFICATIONS – all ramps

For a participant to receive a home modification (a ramp), a request for prior approval addressing the following must be sent with the packet:

- Complete breakdown of all material and labor costs
- Picture or diagram for the home modification, if possible

VARIANCE REQUESTS FOR ADULT DAY CARE IN OR ON GROUNDS OF A NURSING HOME

For a participant to receive services in an ADC in or on grounds of a nursing home, a variance request addressing the following must be sent with the packet:

- Must be person and provider specific
- Must explain why a provider outside of an institution is not available
- Must explain why a provider outside of an institution cannot be utilized by the person

VARIANCE REQUESTS FOR CBRF OVER 21 BEDS for ELDERLY

For a participant to receive services in a CBRF over 21 beds connected or not connected to a nursing home, a variance request addressing the following must be sent with the packet:

- Must be person specific
- Must be non-institutional & enhance dignity & independence
- Must be the preferred residence of the person