



# TITLE XIX MR/DD WAIVER MANUAL

## - WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

### MR/DD WAIVER NURSING ACUITY GRID

8 HOURS PER DAY OR MORE NURSING SERVICES

Member \_\_\_\_\_

Agency \_\_\_\_\_

Medicaid Number \_\_\_\_\_

|   | Pt | Sc |   | Pt  | Sc |   | Pt  | Sc |
|---|----|----|---|-----|----|---|-----|----|
| Weight < 100 lbs                                  | 2  |    | Weight < 125 lbs  | 3.0 |    | Weight 125 lbs or greater   | 4.5 |    |
| Minimal on-going assessments<br>(less than daily) | 2  |    | Moderate on-going assessments<br>(Hands on every 4 - 6 hours) | 4.0 |    | Frequent visual monitoring<br>(both technical and patient assessment) | 9.0 |    |
|   |    |    | VS/GLU/NEURO/RESP assess < q4 hr*                             | 1.5 |    | Continual assessments   | 6.0 |    |
|   |    |    |   |     |    | VS/GLU/NEURO/RESP assessments > q 4 hr                                | 1.0 |    |
| Routine meds > q 4 hrs                            | 2  |    | Complicated med schedule > q 2 hrs                            | 5.0 |    | VS/GLU/NEURO/RESP assessments > q 2 hr                                | 3.0 |    |
|   |    |    | Central line  | 2.5 |    | Regular blood draws/IV Peripheral site **                             | 4.5 |    |
|   |    |    | Occasional transfusion/IV < month                             | 2.5 |    | Regular blood draws/IV central line **                                | 6.0 |    |
|   |    |    |   |     |    | IV Rx < q 4 hr  | 4.5 |    |
| Uncomplicated tube feeding                        | 2  |    | Tube feeding with minimal problem                             | 2.5 |    | IV Rx q 4 hr or more often  | 6.0 |    |
| Difficult/prolonged oral feeding                  | 2  |    | Occasional reflux   | 0.5 |    | Central line with TPN   | 6.0 |    |
|   |    |    | Gastrostomy tube  | 0.5 |    | Chemotherapy  | 6.0 |    |
| O2 via cannula low flow rate                      | 2  |    | Tracheostomy (routine care)                                   | 1.5 |    | IV pain control   | 6.0 |    |



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|  |   |  |     |  |      |
|--|---|--|-----|--|------|
| Suctioning < q 2 hrs                           | 2 | Suctioning > q 2 hrs   | 2.5 | Ventilator   | 9.0  |
| Aspiration precautions                         | 2 | Humidification   | 1.5 | No respiratory effort                                  | 12.0 |
|  |   |  |     | C PAP or IMV < 12 hours/day                            | 6.0  |
|  |   |  |     | C PAP or IMV > 12 hours/day                            | 9.0  |
|  |   | CPT or Neb Tx < q 4 hours  | 1.5 | Standby  | 3.0  |
| Requires all personal care/hygiene             | 2 |  |     | Rehab transition (from ventilator)                     | 9.0  |
|  |   | Mild-mod seizures (Req min intervention)                             | 2.5 | CPT or Neb Rx > q 4 hr * (enter # _____ )              | 3.0  |
|  |   | Frequency < 4 x day  | 1.5 | CPT or Neb Rx > q 2 hr * (enter # _____ )              | 3.0  |
|  |   | Frequency 4 - 6 x day  | 2.0 | Severe seizures ( reg IM or IV intervention )          | 4.5  |
| Uncontrolled incontinence                      | 2 | Intermittent straight catheter                                       | 3.5 | Frequency > 6 x day                                    | 1.5  |
| Awake no more than 3 hr a night                | 2 | Moderate sleep disturbance<br>(Awake/turned q > 2 hr a night)        | 3.5 | Uncontrolled incontinence (Frequent linen change)      | 6.0  |
| Communication deficit<br>(cognitive or verbal) | 2 | Disorientation/combativeness<br>(Strikes out, attempts to hurt self) | 5.0 | Severe sleep disturbance (Awake > q 2 hr)              | 6.0  |
| Developmental deficit                          | 2 | < 80 lbs   | 1.5 |  |      |
|  |   | < 110 lbs  | 2.0 | Disoriented/combativeness > 140 lbs                    | 6.0  |
|  |   | < 140 lbs  | 2.5 |  |      |
| Developmentally delayed mobility               | 2 |  |     | Requires isolation                                     | 6.0  |
| Basic ROM (No PT or OT program)                | 2 | Full OT (Set program q 4 hr)   | 5.5 | Acute mobility problems (Potential for skin breakdown) | 6.0  |



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|                         |   |  |                                     |     |  |                            |     |
|-------------------------|---|--|-------------------------------------|-----|--|----------------------------|-----|
| Play therapy            | 2 |  | Full PT (Set program q 4 hr)        | 5.0 |  |                            |     |
| Fracture or casted limb | 2 |  |                                     |     |  | Attends therapy with nurse | 6.0 |
| Body cast               | 2 |  | RN case management < 4 hrs week *** | 2.5 |  | Peritoneal dialysis        | 6.0 |
|                         |   |  | RN case management > 4 hrs week *** | 5.0 |  |                            |     |
| <b>TOTAL</b>            |   |  | <b>TOTAL</b>                        |     |  | <b>TOTAL</b>               |     |

Pt - Point Sc - Score \* Give points for each type of assessment and each Neb or CPT Rx \*\* Give points for each IV Rx or blood draw ordered to a maximum of 10 points

**\*\*\* Documentation must support item selected**

Nurse: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Total Points: \_\_\_\_\_

**MR/DD WAIVER**



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### MR/DD WAIVER NURSING PSYCHOSOCIAL GRID

8 HOURS PER DAY OR MORE NURSING SERVICES

Member \_\_\_\_\_

Agency \_\_\_\_\_

Medicaid Number \_\_\_\_\_

|  | Minimal   | Pt | Sc | Moderate  | Pt | Sc | Extensive   |
|--|---|----|----|---|----|----|---|
| <b>Medical Management</b>                            | Managed by primary care provider or one specialist.   | 1  |    | Requires periodic medical specialty consultation.   | 2  |    | Requires multidisciplinary  |
| <b>Primary Caregivers</b>                            | Other caregivers present in home to provide care.   | 1  |    | Other caregivers available outside of home by arrangement.  | 2  |    | No other caregivers   |
| <b>Wage Earner</b>                                   | At least 2 responsible adults in home. Primary caregiver is not primary wage earner.                          | 1  |    | At least 2 responsible adults in the home. Primary caregiver contributes to wage earnings or is primary wage earner.  | 2  |    | Primary caregiver must be<br>Only one responsible                     |
| <b>Family Constellation</b>                          | No other dependents/or dependents have minimal needs.   | 1  |    | 1 to 3 dependents with moderate medical or emotional needs.   | 2  |    | Greater than 3 dependents<br>or emotional needs.                      |
| <b>Problem Solving Skills</b>                        | Family exhibits problem identification and problem solving skills.  | 1  |    | Family requires assistance in identifying problems/problem solving.   | 2  |    | Family requires extensive support<br>and identify solutions           |
| <b>Coping</b>  | Family follows through with recommendations, keeps appointments.  | 1  |    | Family needs encouragement to follow through on recommendations. Inconsistent in keeping appointments.  | 2  |    | Family follows through with<br>extensive support and                  |
| <b>Support Systems</b>                               | Support systems present and utilized.   | 1  |    | Support system present but family needs encouragement to utilize.   | 2  |    | Support systems absent  |
| <b>Other Stressors</b>                               | No history of mental illness, and/or behavior problems.   | 1  |    | History of mental illness or behavior problems among family members.  | 2  |    | Current diagnosis of<br>problems among family                         |
| <b>Resource Utilization and/or Private Insurance</b> | Family's physical survival and security needs are met. Community resources and/or private insurance utilized. | 2  |    | Family resources are inadequate, barely meets its needs for security and physical survival. Able to buy only necessities. Requires assistance in identification/utilization of resources. | 4  |    | Family does not meet<br>survival. Unable to<br>assistance to identify |
| <b>Safety/Shelter</b>                                | No safety or health hazards identified in home environment.   | 1  |    | Needs assistance to correct safety and health hazards.  | 2  |    | Home inadequate standards.  |



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| ADL's (age appropriate) | ADL's met consistently. | 1 |  | Inconsistent in meeting ADL's. | 2 |  | ADL's not met. |
|-------------------------|-------------------------|---|--|--------------------------------|---|--|----------------|
|                         | <b>TOTAL</b>            |   |  | <b>TOTAL</b>                   |   |  |                |

**Pt - Point      Sc - Score**

**Nurse:** \_\_\_\_\_  
**Date** \_\_\_\_\_

**Signature:** \_\_\_\_\_  
**Points** \_\_\_\_\_

**Total**

**MR/DD WAIVER**



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**West Virginia Department of Health and Human Resources**  
**ICF/MR Level of Care Evaluation**

- Initial       Annual Renewal       Title XIX MR/DD Waiver

**Service Coordination Agency:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Service Coordinator:** \_\_\_\_\_

**Contact Person:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**I. DEMOGRAPHIC INFORMATION**

|  |                      |  |                                       |               |  |
|--|----------------------|--|---------------------------------------|---------------|--|
| 1. Individual's Full Name                            |                      | 2. Sex:<br><input type="checkbox"/> F <input type="checkbox"/> M |                                       | 3. Medicaid # |  |
| 4. Address (including Street/Box, City, State & Zip) |                      |  |                                       |               |  |
| 5. County  | 6. Social Security # | 7. Birthday (MM/DD/YY)   | 8. Age                                | 9. Phone      |  |
| 10. Spouse's Name                                    |                      |  | 11. Address (if different from above) |               |  |



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**12. Check if applicant has any of the following:**

- a.  Guardian
- b.  Committee
- c.  Medical Power of Attorney
- d.  Power of Attorney
- e.  Durable Power of Attorney
- f.  Living Will
- g.  Other \_\_\_\_\_

Name & Address of Representative: \_\_\_\_\_  
\_\_\_\_\_

Phone:(      )

**13. Living Arrangement**

- Natural/adoptive family       Specialized family care provider
- ISS – One person (Intensive support setting)       ISS – 2 person (Intensive support setting)
- ISS – Three person (Intensive support setting)       Group Home (4 or more persons)

**14. Description of current living arrangements, including formal and informal support(i.e. family, friends, other services)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**15. Significant Health History – (include recent hospitalization(s) and/or surgery(s) with dates, history of infectious disease)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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**II. MEDICAL ASSESSMENT**

**NAME:**

\_\_\_\_\_

**DATE:**

\_\_\_\_\_

| 16. Height | Weight | BP | P | R | T |
|------------|--------|----|---|---|---|
|------------|--------|----|---|---|---|

**17. Allergies:**

CODE:   √ = NORMAL       N = NOT DONE       NA = NOT APPLICABLE       X = ABNORMAL (PLEASE DESCRIBE)

|             |  |  |  |  |  |
|-------------|--|--|--|--|--|
| SKIN        |  |  |  |  |  |
| EYES/VISION |  |  |  |  |  |
| NOSE        |  |  |  |  |  |
| THROAT      |  |  |  |  |  |
| MOUTH       |  |  |  |  |  |
| SWALLOWING  |  |  |  |  |  |
| LYMPH NODES |  |  |  |  |  |
| THYROID     |  |  |  |  |  |
| HEART       |  |  |  |  |  |
| LUNGS       |  |  |  |  |  |
| BREAST      |  |  |  |  |  |



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|                                 |  |  |
|---------------------------------|--|--|
| ABDOMEN                         |  |  |
| EXTREMETIES                     |  |  |
| SPINE                           |  |  |
| GENITALIA                       |  |  |
| RECTAL (MALES INCLUDE PROSTATE) |  |  |
| BI-MANUAL VAGINAL               |  |  |
| <b>NEUROLOGICAL</b>             |  |  |
| ALERTNESS                       |  |  |
| COHERENCE                       |  |  |
| ATTENTION SPAN                  |  |  |
| SPEECH                          |  |  |
| SENSATION                       |  |  |
| COORDINATION                    |  |  |
| GAIT                            |  |  |
| MUSCLE TONE                     |  |  |
| REFLEXES                        |  |  |
|                                 |  |  |
| VISION                          |  |  |



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|         |  |  |
|---------|--|--|
| DENTAL  |  |  |
| HEARING |  |  |

NAME \_\_\_\_\_

DATE \_\_\_\_\_

### MEDICAL ASSESSMENT II, CONT.

Problems requiring Special Care (check all appropriate blanks)

| MOBILITY                        | CONTINENCE STATUS        | FEEDING               |
|---------------------------------|--------------------------|-----------------------|
| Ambulatory _____                | Continent _____          | Feeds self _____      |
| Ambulatory w/human help _____   | Incontinent _____        | Needs to be fed _____ |
| Ambul. w/mechanical help _____  | Not Toilet trained _____ | Gastric/J tube _____  |
| Wheelchair self propelled _____ | Catheter _____           | Special Diet _____    |
| Wheelchair w/assistance _____   | Ileostomy _____          |                       |
| Transfer w/assistance _____     | Colostomy _____          |                       |
| Bedfast _____                   |                          |                       |

| PERSONAL HYGIENE/SELF CARE | MENTAL AND BEHAVIORAL DIFFICULTIES |                               |
|----------------------------|------------------------------------|-------------------------------|
| Needs total care _____     | Alert _____                        | Self-injurious behavior _____ |
| Independent _____          | Confused/Disoriented _____         | EPS/TD _____                  |
| Needs Assistance _____     | Irrational behavior _____          | Unable to communicate _____   |
|                            | Needs close supervision _____      |                               |

### ADDITIONAL RECOMMENDATIONS

VISION THERAPY \_\_\_\_\_



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|                      |       |                     |       |           |
|----------------------|-------|---------------------|-------|-----------|
| SPEECH THERAPY       | _____ | OXYGEN THERAPY      | _____ | IV FLUIDS |
| _____                |       |                     |       |           |
| OCCUPATIONAL THERAPY | _____ | SUCTIONING          | _____ |           |
| PHYSICAL THERAPY     | _____ | TRACHEOSTOMY        | _____ |           |
| SOAKS, DRESSINGS     | _____ | VENTILATOR          | _____ |           |
| TRACTION, CASTS      | _____ | DIAGNOSTIC SERVICES | _____ |           |
| LABS ORDERED         | _____ |                     |       |           |
|                      | _____ |                     |       |           |

---

\_\_\_\_\_ Please Complete All Sections Below to Ensure Certification For The Program

\_\_\_\_\_

### DIAGNOSTIC SECTION

AXIS I: (List all Emotional and/or psychiatric conditions)

AXIS II: (List all Cognitive, Developmental conditions and personality disorders)

AXIS III: (List ALL medical conditions)

PROGNOSIS:

I certify that this patient's developmental disability, medical condition and related health needs are as documented above AND the

Patient requires the level of care and services provided in an "intermediate care facility" for individuals with mental retardation

and/or related conditions.



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YES \_\_\_\_\_ NO \_\_\_\_\_

(Note: ICF/MR level of care means the Individual needs a high level of habilitation training and supervision. This level of care does not have to occur in an institution and can be provided in a community setting.)

| DATE | PHYSICIANS SIGNATURE | LICENSE # |
|------|----------------------|-----------|
|------|----------------------|-----------|

FOR DEPARTMENT OF HEALTH AND HUMAN RESOURCES USE ONLY

Approved for ICF/MR Level of Care \_\_\_\_\_ Yes \_\_\_\_\_ No

Name of Reviewer: \_\_\_\_\_ Date \_\_\_\_\_

## WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES COMPREHENSIVE PSYCHOLOGICAL EVALUATION (TRIENNIAL)

NAME: \_\_\_\_\_ EVALUATION DATE: \_\_\_/\_\_\_/\_\_\_

BIRTHDATE: \_\_\_/\_\_\_/\_\_\_ AGENCY/FACILITY: \_\_\_\_\_

REASON FOR EVALUATION: \_\_\_\_\_

I. RELEVANT HISTORY:

- A. Prior Hospitalization/Institutionalization
- B. Prior Psychological Testing



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C. Behavioral History

## II. CURRENT STATUS:

A. Physical/Sensory Deficits

B. Medications (Type, frequency and dosage)

C. Current Behaviors

1. Psychomotor

2. Self Help

3. Language

4. Affective

5. Mental Status

6. Others (Social interaction, use of time, leisure activities)



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## III. CURRENT EVALUATION

### A. Intellectual/Cognitive:

1. Instruments used:
2. Results:
3. Discussion:

DD-3

Revised July 2004

### B. Adaptive Behavior:

1. Instruments used: ABS I & II Others (list)
2. Results:
3. Discussion:

### C. Other:

1. Instruments used:
2. Results:





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B.

IV. RECOMMENDATIONS:

A. Training

B. Activities

C. Therapy/Counseling/Behavioral Intervention

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V. DIAGNOSIS:

VI. PROGNOSIS:

VII. PLACEMENT RECOMMENDATIONS:

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Signature of Supervised Psychologist

Signature of Licensed Psychologist

---

Title

---

License #/Title

---

Date

---

Date

DD-3

Revised July 2004



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### WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

#### SOCIAL HISTORY

PARTICIPANT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

I. DEVELOPMENTAL HISTORY: Provide information summarizing personal growth from infancy through adolescence with attention to the development of his/her physical, social, and emotional competencies. As outlined below, if development is delayed, describe the circumstances or conditions associated with the delay and date of onset. If more space is needed, use back of this sheet and identify information by Roman numeral and Letter.

a) Physical

b) Social

c) Emotional

II. FAMILY: List parents, spouse, children, siblings, significant others, and type of relationships, i.e., are they an available source of support and/or resources. Include description of family's socio-economic circumstances, and family composition. Past and current living arrangements, special problems, such as alcohol, substance abuse, and mental illness should be included.



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- III. EDUCATION/TRAINING: Describe education and training experiences; identify schools and programs attended, relationships with peers and teachers, any adjustment problems, levels of accomplishment and any other pertinent information.
  
- IV. FUNCTIONAL STATUS: Describe levels of functioning relating to employment capabilities, work-related experiences, and assessment of skills relevant to the activities of daily living and self-care skills. Is applicant/participant now or ever been gainfully employed? Indicate level of care recommendation.
  
- V. RECREATION/LEISURE ACTIVITIES: Identify and describe recreational and leisure time activities, frequencies, accessibility, and degree of involvement.
  
- VI. HOSPITALIZATIONS: List medical and psychiatric hospital dates and reason for admissions.

DD-4 – Revised July 2004



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VII. FAMILY MEDICAL HISTORY (Identify relationship to the participant):

|                       |                       |                          |
|-----------------------|-----------------------|--------------------------|
| _____ MR/DD _____     | Heart Disease _____   | Cerebral Palsy _____     |
| _____ Autism _____    | Diabetes _____        | Tuberculosis _____       |
| _____ Hepatitis _____ | Mental Illness _____  | Kidney Disease _____     |
| _____ Cancer _____    | Hypertension _____    | Metabolic Disease _____  |
| _____ Allergies _____ | Thyroid Disease _____ | Muscular Dystrophy _____ |
| _____ Epilepsy _____  | Other _____           | Other _____              |

Deceased Siblings (Cause of Death) \_\_\_\_\_

VIII. LEGAL STATUS: (Guardianship, committee, custody).

IX. OTHER RELEVANT INFORMATION: (Family medical history; applicant/participant military service; religious preference; or significant events or circumstances not covered in other sections).

\_\_\_\_\_  
DATE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF TEMPORARY LSW

\_\_\_\_\_  
SIGNATURE/CO-SIGN OF DEGREED/LSW

\_\_\_\_\_  
LICENSE #/DEGREE

\_\_\_\_\_  
LICENSE #/DEGREE



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### MY PLAN

### A PERSON CENTERED PLAN FOR:

#### Demographics

|  |  |
|--|--|
| <b>Name:</b><br><b>Address:</b><br><b>Phone Number:</b><br><b>Emergency Phone #:</b><br><b>Date of Birth:</b>  | <b>Social Security Number:</b><br><b>Medicaid ID Number:</b><br><b>Additional Insurance:</b><br><b>Marital Status:</b>   |
| <b>Legal Guardian:</b><br>No <input type="checkbox"/> Yes <input type="checkbox"/> Full <input type="checkbox"/> Limited <input type="checkbox"/><br><b>Name:</b><br><b>Address:</b><br><b>Phone:</b>  | <b>Health Care Surrogate, Medical Power of Attorney:</b><br>No <input type="checkbox"/> Yes <input type="checkbox"/><br><b>Name:</b><br><b>Address:</b><br><b>Phone:</b>   |
| <b>Payee:</b> No <input type="checkbox"/> Yes <input type="checkbox"/> <b>Conservator:</b> No <input type="checkbox"/> Yes <input type="checkbox"/><br><b>Name:</b> <b>Name:</b><br><b>Address:</b> <b>Address:</b><br><b>Phone:</b> <b>Phone:</b> | <b>Provider Agencies by Service (except SC) :</b><br>Residential:<br>Day (or Prevocational/supported employment):<br>Respite:<br>Adult Companion:<br>QMRP:<br>Nursing:   |
| Interdisciplinary Team Meeting Date:   | IPP Review Date:   |
| Date Current Plan Begins:  | Date <b>Next</b> Plan Begins:  |
| <b>SC Name:</b><br><b>SC Provider Agency:</b><br><b>SC Telephone #, ext:</b><br><b>SC e-mail:</b>  | (N/A if non-applicable)<br><b>Date of Positive Behavior Support Plan:</b><br><b>Date of HRC Approval:</b><br><b>Date of Behavior Protocol:</b><br><b>Date of Behavior Guidelines:</b><br><b>Date of Crisis Plan:</b> |



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|  |        |
|--|--------|
| <b>Level of Care:</b><br>Date of DD-2A:<br>Date of DD-3:<br>Other Information: | Other: |
|--|--------|

## PROMPTS FOR “MY GOALS/DREAMS” AND “MY CIRCLE OF SUPPORT”

The following is a series of questions or prompts for the service coordinator to begin facilitation of the development of the overall goals/dreams of the participant and identification of the participant’s circle of support. This section (page 2 only) is for discussion at the annual IPP team meeting and may be prepared prior to the team meeting, then, reviewed with the remainder of the team members. No other section of the IPP may be completed prior to the team meeting. This series of prompts must be provided or billed as a service coordination activity and must not be provided or billed as an IPP team meeting activity.

**What I did last year:** *(Include achievements, special events, progress on goals, etc.)*

**I like to spend time with:** *(This could be a family, friends, church members, employers, providers, classmates, etc. Include how contact is made such as on the phone, visiting, or letters, and also how to assist the person in their contact with others – what supports are needed.)*

**During my leisure time I like to:** *(Include continuing and developing new leisure activities and any club affiliations, also include activities specific to an individual’s culture.)*

**The things that I am good at are:** *(My strengths and abilities are. List things I do well, that I can do, or enjoy doing, or that others feel I am good at doing.)*

**In order to be more independent, I would like to continue working on and/or learn how to:** *(This may include things taught through a variety of sources such as the school, community, enrichment programs; or include independent living skills such as hygiene, cooking, or skills for community access, or skills for achieving vocational interests. Include what assistance is needed – how can the team support such goals?)*

**Things that are extremely important to me are:** *(List possessions and activities specific to an individual’s culture and religious practices.)*

**The things I never want in my life are:** *(There may be things or situations that make me mad, sad, scared or confused. It might be people I don’t want to be around, fear of animals, foods that I don’t like, or anything that would cause me undue stress.)*



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**My core support team members are:** *(Include natural supports, friends, family members, or professionals providing evaluation or support.)*

**What I want to accomplish within the plan year and who will help me:**

*(Include things like taking a trip with my family and/or provider, earning money, learning to self-medicate; get a piece of special equipment.)*

**My long-term goals for the future are:**

*(What would make me happy? What do I want to work toward the most? What would make my life better? These are things I want to do in the future.)*

**Transitions in the future are:**

*(Include things like guardian changes, change in residence, and change in school.)*



# TITLE XIX MR/DD WAIVER MANUAL - WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

## MY DREAMS/GOALS

|   |   |
|---|---|
|  <p><b>COMMUNITY</b></p> |  <p><b>HOME AND SUPPORTS</b></p> |
|---|---|



# TITLE XIX MR/DD WAIVER MANUAL - WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS



FRIENDS



FAMILY

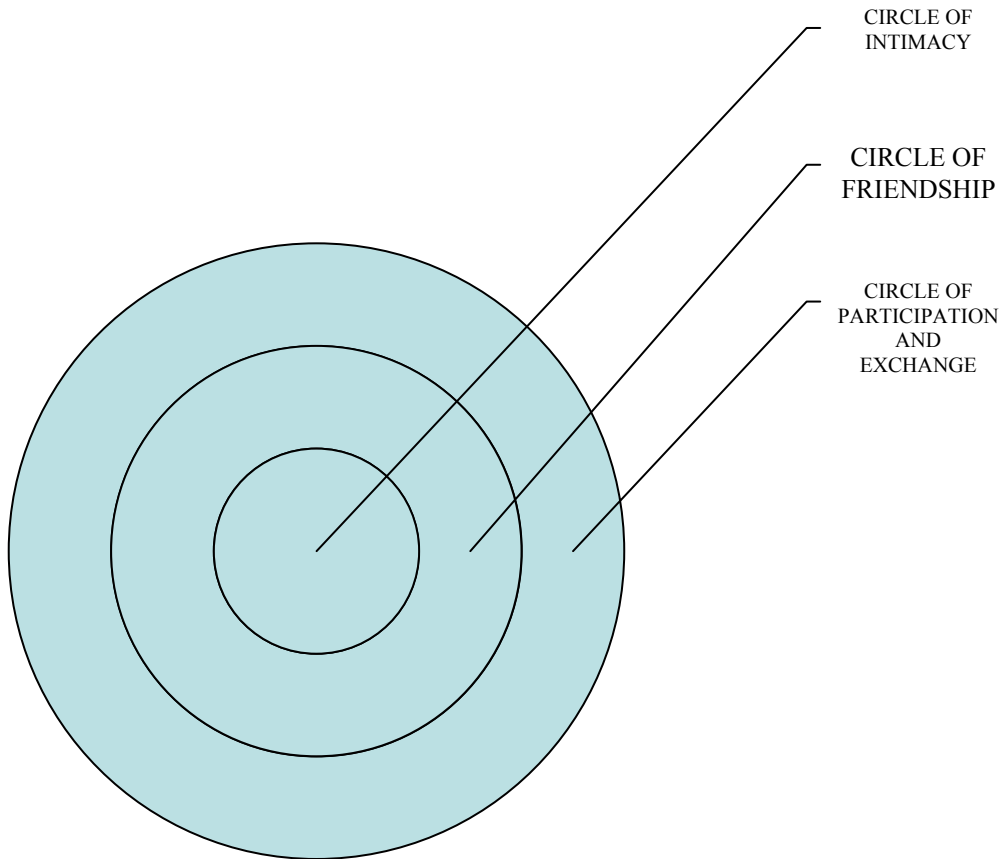


# TITLE XIX MR/DD WAIVER MANUAL - WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

## CIRCLE OF SUPPORT



CIRCLE OF INTIMACY

CIRCLE OF FRIENDSHIP

CIRCLE OF PARTICIPATION AND EXCHANGE

CIRCLE OF INTIMACY \_\_\_\_\_

CIRCLE OF FRIENDSHIP \_\_\_\_\_

CIRCLE OF PARTICIPATION/EXCHANGE \_\_\_\_\_



# TITLE XIX MR/DD WAIVER MANUAL

## WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

### Assessment and Evaluation Information

| Evaluation                                   | Date of Evaluation | Professional Recommendation |
|--|--------------------|-----------------------------|
| DD-2A  |                    |                             |
| DD-3, ABS                                    |                    |                             |
| DD-4   |                    |                             |
| <b>PT</b>                                    |                    |                             |
| <b>OT</b>                                    |                    |                             |
| <b>ST</b>                                    |                    |                             |
| ABS  |                    |                             |
| <b>Extraordinary<br/>Care<br/>Assessment</b> |                    |                             |
| <b>Nursing</b>                               |                    |                             |
| Other  |                    |                             |

### ICAP and/or SIS

| Adaptive Behaviors                                  | Score        | Maladaptive Behaviors                               | Score        |
|---|--------------|---|--------------|
| Motor Skills  |              | Internalized  |              |
| Social/Communication Skills                         |              | Asocial   |              |
| Personal Living Skills                              |              | Externalized  |              |
| Community Living Skills                             |              | General   |              |
| <b>Functional Limitations and Needed Assistance</b> | <b>Score</b> | <b>Functional Limitations and Needed Assistance</b> | <b>Score</b> |
|   |              |   |              |
| <b>Supports and Services</b>                        | <b>Score</b> | <b>Supports and Services</b>                        | <b>Score</b> |
|   |              |   |              |
|   |              |   |              |





# TITLE XIX MR/DD WAIVER MANUAL

## WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

### Individual Services Plan

May Utilize More Than One Page

| Service              | Availability/Accessibility |  | Provider            |
|----------------------|----------------------------|--|---------------------|
|                      | Yes                        |  |                     |
|                      | No                         |  |                     |
| Frequency of Service | Plan of Action             |  | Start Date/End Date |
|                      |                            |  |                     |
| Service              | Availability/Accessibility |  | Provider            |
|                      | Yes                        |  |                     |
|                      | No                         |  |                     |
| Frequency of Service | Plan of Action             |  | Start Date/End Date |
|                      |                            |  |                     |
| Service              | Availability/Accessibility |  | Provider            |
|                      | Yes                        |  |                     |
|                      | No                         |  |                     |
| Frequency of Service | Plan of Action             |  | Start Date/End Date |
|                      |                            |  |                     |
| Service              | Availability/Accessibility |  | Provider            |
|                      | Yes                        |  |                     |
|                      | No                         |  |                     |
| Frequency of Service | Plan of Action             |  | Start Date/End Date |
|                      |                            |  |                     |



**TITLE XIX MR/DD WAIVER MANUAL**  
**WORKING DRAFT ONLY**



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

**UNIVERSAL OBJECTIVE PAGE**  
**(HABILITATION SERVICES ONLY)**

Use as many of these sheets as necessary

|                    |  |                 |  |
|--------------------|--|-----------------|--|
| <b>Member Name</b> |  | <b>Provider</b> |  |
|--------------------|--|-----------------|--|

**My Goal is:**

**Start Date:**

**End Date:**

| <b>Goal Number</b> | <b>My Objective is</b> | <b>Method(s)</b> |
|--------------------|------------------------|------------------|
|                    |                        |                  |

**What are the barriers that slow my progress?**

**My Goal is:**

**Start Date:**

**End Date:**

| <b>Goal Number</b> | <b>My Objective is</b> | <b>Method(s)</b> |
|--------------------|------------------------|------------------|
|                    |                        |                  |

**What are the barriers that slow my progress?**

**NOTE: ATTACH TASK ANALYSIS/METHOD FORMS, CRISIS PLAN, BEHAVIORAL SUPPORT PLAN, BEHAVIORAL PROTOCOL, OR BEHAVIORAL GUIDELINES TO THE PLAN**

**WORKING DRAFT ONLY - TITLE XIX MR/DD WAIVER MANUAL**





**TITLE XIX MR/DD WAIVER MANUAL**  
**WORKING DRAFT ONLY**



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

**SIGNATURES**

| Relationship<br>(Print Name)   | Signature | Date Attended/Time | Agree | Disagree |
|--|-----------|--------------------|-------|----------|
| Participant  |           |                    |       |          |
| Parent/Guardian  |           |                    |       |          |
| Service Coordinator  |           |                    |       |          |
| Physician  |           |                    |       |          |
| Psychologist   |           |                    |       |          |
| RN   |           |                    |       |          |
| Others<br>(include members of my Circle of Support in this category, or PT, OT, ST, etc) |           |                    |       |          |
|  |           |                    |       |          |
|  |           |                    |       |          |

*\*IDT member has disagreed with My Plan; rationale attached*

**WORKING DRAFT ONLY - TITLE XIX MR/DD WAIVER MANUAL**



TITLE XIX MR/DD WAIVER MANUAL  
**WORKING DRAFT ONLY**



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

**Rationale for Disagreement with My Plan**

Date of IDT: \_\_\_\_\_

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# TITLE XIX MR/DD WAIVER MANUAL - WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

Signature

Date

## WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES INFORMED CONSENT TO A CHOICE OF ALTERNATIVES BETWEEN INSTITUTIONAL AND WAIVER HOME AND COMMUNITY-BASED SERVICES

**NAME:**

**AGENCY/FACILITY**

- \_\_\_\_\_ 1. The findings and results of the evaluations and needs have been discussed with the participant and/or family or legal representative.
- \_\_\_\_\_ 2. Alternative plans for providing services to meet the participant's needs have been discussed and a choice of services between ICF/MR and community-based MR/DD Waiver services has been presented to the participant and/or family or legal representative.
- \_\_\_\_\_ 3. The participant and/or family or legal representative have chosen \_\_\_ICF/MR \_\_\_Community-based MR/DD Waiver as described by the Service Coordinator.
- \_\_\_\_\_ 4. The participant and/ or family or legal representative have requested that an Individual Program Plan be developed for their approval.
- \_\_\_\_\_ 5. The right to a fair hearing and the agency and state appeal process have been discussed with the participant and/or family or legal representative.
- \_\_\_\_\_ 6. A copy of the MR/DD Waiver Manual has been offered to the participant and/or family or legal representative and he/she has \_ accepted \_ refused the copy of the handbook.

I, consent for the state DHHR to disclose Case Status Information and/or Eligibility Information to Behavioral Health Providers for Treatment, Payment, and Health Care Operations as is necessary to assist in the provision of Title XIX MR/DD Waiver Services.

\_\_\_\_\_ Participant  
Date    Parent or Legal Guardian Date    \_\_\_\_\_

\_\_\_\_\_ Service Coordinator    Date    SC Supervisor    Date

\_\_\_\_\_ Witness    Date

**DD-7**

Revised December 2005

**WORKING DRAFT ONLY - TITLE XIX MR/DD WAIVER MANUAL**



# TITLE XIX MR/DD WAIVER MANUAL - WORKING DRAFT ONLY



## PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES INFORMED CONSENT TO A CHOICE OF MR/DD WAIVER PROVIDERS AND MR/DD WAIVER SERVICES

**NAME:**

**AGENCY/FACILITY**

- \_\_\_\_\_ 1. The right to choose among all qualified providers has been discussed with the participant and/or family or legal representative.
- \_\_\_\_\_ 2. All enrolled service coordination agencies in the participant's catchment area have been discussed with the participant, family and/or legal representative.
- \_\_\_\_\_ 3. The participant and/or family or legal representative have chosen \_\_\_\_\_ as their service coordination agency.
- \_\_\_\_\_ 4. The right to choose among all available MR/DD Waiver services to meet the participant's needs have been discussed with the participant and/or family or legal representative.
- \_\_\_\_\_ 5. The participant, family and/or legal representative has been informed of their right to a fair hearing if denied service(s) and the provider(s) of their choice.
- \_\_\_\_\_ 6. A copy of the MR/DD Waiver Reference Guide to Providers has been offered to the participant, family and/or legal representative have \_\_\_\_\_ accepted \_\_\_\_\_ refused a copy of the Reference Guide.

\_\_\_\_\_ Participant      Date  
Parent or Legal Guardian Date \_\_\_\_\_

\_\_\_\_\_ Date      SC Supervisor      Date  
Service Coordinator

\_\_\_\_\_ Date  
Witness

DD 7-A

Revised December 2005



# TITLE XIX MR/DD WAIVER MANUAL

## WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

### MR/DD WAIVER PROGRAM

### RESIDENTIAL HABILITATION, ADULT COMPANION, AND RESPITE TRACKING FORM

Participant Name

Service Coordination Agency

Provider Name

Service Coordinator Name

Provider Address:

**TYPE OF RESIDENCE:**  Natural Family  Specialized Family Care Home  Group Home  ISS

In the spaces below, write in number of hours under the date that the participant received community residential habilitation, adult companion, respite and/or related transportation services.

THIS REPORT IS FOR THE MONTH OF \_\_\_\_\_, 2\_\_\_\_\_.

| Code | 1  | 2  | 3  | 4  | 5  | 6  | 7  | 8  | 9  | 10 | 11 | 12 | 13 | 14 | 15 |
|------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
|      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 16   | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |

**SERVICE CODES: Residential Habilitation**

T2017-UA= Community Residential Habilitation

**Adult Companion**

- S5135-UAU4= Adult Companion Level I, 1:1 ratio
- S5135-UAU3= Adult Companion Level I, 1:2 ratio
- S5135-UAU2= Adult Companion Level I, 1:3 ratio
- S5135-UBU4= Adult Companion Level II, 1:1 ratio
- S5135-UAU3= Adult Companion Level II, 1:2 ratio
- S5135-UBU2= Adult Companion Level II, 1:3 ratio

**ABSENCE CODES:** Hospitalization= H Home Visit= HV Respite Care=RC Illness= I Other= O

**Transportation**

A0160=Transportation I A0120=Transportation II

**Respite**

- T1005-UAU4= Respite Care Level I, 1:1 ratio
- T1005-UAU3= Respite Care Level I, 1:2 ratio
- T1005-UAU2= Respite Care Level I, 1:3 ratio
- T1005-UBU4= Respite Care Level II, 1:1 ratio
- T1005-UBU3= Respite Care Level II, 1:2 ratio
- T1005-UBU2= Respite Care Level II, 1:3 ratio

I certify that the above documented services were delivered for the participant in accordance with the Individual's Program Plan (DD-5) and the regulations governing the Title XIX MR/DD Waiver Program. No services are claimed that were not provided to the participant.



# TITLE XIX MR/DD WAIVER MANUAL - WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

Provider Signature \_\_\_\_\_ Date Completed \_\_\_\_\_  
DD-8 Revised January 2006

Service Coordinator Signature \_\_\_\_\_ Date Reviewed \_\_\_\_\_

### MR/DD Waiver

#### Monthly Service Coordination Visit

*Residential Habilitation for ISS/Group Home*

**Today's Visit Date:**      \_\_\_/\_\_\_/\_\_\_

**Next Planned Visit Date:**      \_\_\_/\_\_\_/\_\_\_

**Last IPP Team Review:**      \_\_\_/\_\_\_/\_\_\_

**Date of Next IPP Review:**      \_\_\_/\_\_\_/\_\_\_

**Service Code:** \_\_\_\_\_

### I. WAIVER PARTICIPANT INTERVIEW



# TITLE XIX MR/DD WAIVER MANUAL - WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

NAME OF WAIVER PARTICIPANT: \_\_\_\_\_ age \_\_\_\_\_

ADDRESS: \_\_\_\_\_

- 1) Is the participant safe, neat and clean?  YES  NO
  - 1a) If no, list intervention: \_\_\_\_\_
- 2) Do you have any concerns or recommendations about your services?  YES  NO
  - 2a) If yes, list: \_\_\_\_\_
  - \_\_\_\_\_
- 3) List next months community integration events or special plans you have: \_\_\_\_\_
- \_\_\_\_\_
- 4) What has improved over the last month for you? \_\_\_\_\_
- \_\_\_\_\_

## II. HABILITATION PROVIDER INTERVIEW

- 1) Describe the overall status report of the participant given by the provider: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- 1a) List any concerns with sleep patterns: \_\_\_\_\_
- 1b) List any concerns with appetite: \_\_\_\_\_
- 1c) List any concerns with behaviors: \_\_\_\_\_
- 2) List dates and outcomes of past months medical and/or other therapy appointments.  
*(Include any hospitalizations, diagnostic changes, needs for referral for prior authorization, side effect monitoring, illnesses....)*
  - 2a) \_\_\_\_\_
  - 2b) \_\_\_\_\_
  - 2c) \_\_\_\_\_
- 3) Were there any medication changes over the month?  YES  NO
  - 3a) List if yes: \_\_\_\_\_
  - 3b) If yes, was the Waiver RN and IDT team notified?  YES  NO
- 4) List Dates/Purposes of Upcoming Appointments: \_\_\_\_\_
- \_\_\_\_\_

- 5) Has the participant progressed in any areas?  YES  NO Specify: \_\_\_\_\_
- \_\_\_\_\_
- 6) Has the participant regressed in any areas?  YES  NO Specify: \_\_\_\_\_
- \_\_\_\_\_
- 7) Is there a current complete *and* signed copy of the IPP on site?  YES  NO



# TITLE XIX MR/DD WAIVER MANUAL - WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

## IV. STATUS OF LAST MONTHS REQUESTS FOR SC FOLLOW-UP

SC Task #1: \_\_\_\_\_  Completed  Ongoing  Pending  
Plans for resolution of any identified barriers: \_\_\_\_\_

SC Task #2: \_\_\_\_\_  Completed  Ongoing  Pending  
Plans for resolution of any identified barriers: \_\_\_\_\_

SC Task #3: \_\_\_\_\_  Completed  Ongoing  Pending  
Plans for resolution of any identified barriers: \_\_\_\_\_

SC Task # 4: \_\_\_\_\_  Completed  Ongoing  Pending  
Plans for resolution of any identified barriers: \_\_\_\_\_

## V. ADDITIONAL REQUESTS FOR SC FOLLOW UP





TITLE XIX MR/DD WAIVER MANUAL  
- **WORKING DRAFT ONLY**



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

**MR/DD Waiver**

**Monthly Service Coordination Visit**

*Residential Habilitation for Natural Family/SFCP*

**Today's Visit Date:**     \_\_\_/\_\_\_/\_\_\_

**Next Planned Visit Date:**     \_\_\_/\_\_\_/\_\_\_

**Last IPP Team Review:**     \_\_\_/\_\_\_/\_\_\_

**Date of Next IPP Review:**     \_\_\_/\_\_\_/\_\_\_

**Service Code:** \_\_\_\_\_

**I. WAIVER PARTICIPANT INTERVIEW**



# TITLE XIX MR/DD WAIVER MANUAL - WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

NAME OF WAIVER PARTICIPANT: \_\_\_\_\_ age \_\_\_\_\_

ADDRESS: \_\_\_\_\_

- 1) Is the participant safe, neat and clean?  YES  NO
  - 1a) If no, list intervention: \_\_\_\_\_
- 2) Do you have any concerns or recommendations about your services?  YES  NO
  - 2a) If yes, list: \_\_\_\_\_
- 3) List next months community integration events or special plans you have: \_\_\_\_\_
- 4) What has improved over the last month for you? \_\_\_\_\_

## II. HABILITATION PROVIDER OR PARENT/GUARDIAN INTERVIEW

- 1) Describe the overall status report of the participant given by the provider: \_\_\_\_\_
- 1a) List any concerns with sleep patterns: \_\_\_\_\_
- 1b) List any concerns with appetite: \_\_\_\_\_
- 1c) List any concerns with behaviors: \_\_\_\_\_
- 2) List dates and outcomes of past months medical and/or other therapy appointments.  
*(Include any hospitalizations, diagnostic changes, needs for referral for prior authorization, side effect monitoring, illnesses....)*
  - 2a) \_\_\_\_\_
  - 2b) \_\_\_\_\_
  - 2c) \_\_\_\_\_
- 3) Were there any medication changes over the month?  YES  NO
  - 3a) List if yes: \_\_\_\_\_
  - 3b) If yes, was the Waiver RN and IDT team notified?  YES  NO
- 4) List Dates/Purposes of Upcoming Appointments: \_\_\_\_\_

5) Has the participant progressed in any areas?  YES  NO Specify: \_\_\_\_\_

6) Has the participant regressed in any areas?  YES  NO Specify: \_\_\_\_\_

7) Is there a current complete and signed copy of the IPP on site?  YES  NO



# TITLE XIX MR/DD WAIVER MANUAL - WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

## IV. STATUS OF LAST MONTHS REQUESTS FOR SC FOLLOW-UP

SC Task #1: \_\_\_\_\_  Completed  Ongoing  Pending

Plans for resolution of any identified barriers: \_\_\_\_\_

SC Task #2: \_\_\_\_\_  Completed  Ongoing  Pending

Plans for resolution of any identified barriers: \_\_\_\_\_

SC Task #3: \_\_\_\_\_  Completed  Ongoing  Pending

Plans for resolution of any identified barriers: \_\_\_\_\_

SC Task # 4: \_\_\_\_\_  Completed  Ongoing  Pending

Plans for resolution of any identified barriers: \_\_\_\_\_

## V. ADDITIONAL REQUESTS FOR SC FOLLOW UP





# TITLE XIX MR/DD WAIVER MANUAL - WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

|   |   |
|---|---|
| <p><b>MR/DD Waiver Service Coordination Visit</b></p> <p><b>Day Habilitation</b> (Every Other Month)</p> <p>Check One</p> <p>Day Program <input type="checkbox"/> Community Day Habilitation</p> <p>Pre-Vocational Training <input type="checkbox"/> Supported Employment</p> | <p><b>Today's Visit Date:</b>      ___/___/___</p> <p><b>Next Planned Visit Date:</b>      ___/___/___</p> <p><b>Last IPP Team Review:</b>      ___/___/___</p> <p><b>Date of Next IPP Review:</b>      ___/___/___</p> <p><b>Service Code:</b> _____</p> |
| <b>I. WAIVER PARTICIPANT INTERVIEW</b>  |   |



# TITLE XIX MR/DD WAIVER MANUAL - WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

NAME OF WAIVER PARTICIPANT: \_\_\_\_\_ age \_\_\_\_\_

LOCATION: \_\_\_\_\_

- 1) Is the participant safe, neat and clean?  YES  NO
  - 1a) If no, list intervention: \_\_\_\_\_
- 2) Do you have any concerns or recommendations about your services?  YES  NO
  - 2a) If yes, list: \_\_\_\_\_
- 3) What has improved over the last month for you? \_\_\_\_\_

## II. HABILITATION PROVIDER INTERVIEW

- 1) Describe the overall status report of the participant given by the provider: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 1a) List any concerns with attendance: \_\_\_\_\_  
 1b) List any concerns with behaviors: \_\_\_\_\_
- 2) List dates and outcomes of past months medical and/or other therapy appointments.  
*(Include any hospitalizations, diagnostic changes, needs for referral for prior authorization, side effect monitoring, illnesses....)*  
 2a) \_\_\_\_\_  
 2b) \_\_\_\_\_
- 3) Were there any medication changes over the month?  YES  NO  
 3a) List if yes: \_\_\_\_\_  
 3b) If yes, was the Waiver RN and IDT team notified?  YES  NO
- 4) List Dates/Purposes of Upcoming Appointments: \_\_\_\_\_  
 \_\_\_\_\_

- 5) Has the participant progressed in any areas?  YES  NO Specify: \_\_\_\_\_  
 \_\_\_\_\_
- 6) Has the participant regressed in any areas?  YES  NO Specify: \_\_\_\_\_  
 \_\_\_\_\_
- 7) Is there a current, complete, and signed copy of the IPP on site?  YES  NO
- 8) Is liaison work requested between the day and residential habilitation settings?  YES  NO  
 7a) If yes, state purpose: **WORKING DRAFT ONLY** - TITLE XIX MR/DD WAIVER MANUAL \_\_\_\_\_
- 9) Do you have the necessary equipment/ materials to provide active treatment services?  YES  NO  
 9a) If no, list needed items: \_\_\_\_\_
- 10) Is all adaptive equipment in working condition?  YES  NO Specify: \_\_\_\_\_  
 10a) If no, targeted resolution date: \_\_\_\_\_



TITLE XIX MR/DD WAIVER MANUAL  
- WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

**IV. STATUS OF PAST MONTHS REQUESTS FOR SC FOLLOW-UP**

SC Task #1: \_\_\_\_\_  Completed  Ongoing  Pending

Plans for resolution of any identified barriers: \_\_\_\_\_

SC Task #2: \_\_\_\_\_  Completed  Ongoing  Pending

Plans for resolution of any identified barriers: \_\_\_\_\_

SC Task #3: \_\_\_\_\_  Completed  Ongoing  Pending

Plans for resolution of any identified barriers: \_\_\_\_\_

SC Task # 4: \_\_\_\_\_  Completed  Ongoing  Pending

Plans for resolution of any identified barriers: \_\_\_\_\_

**V. ADDITIONAL REQUESTS FOR SC FOLLOW UP**



# TITLE XIX MR/DD WAIVER MANUAL - WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

- 1) \_\_\_\_\_ 2) \_\_\_\_\_  
 3) \_\_\_\_\_ 4) \_\_\_\_\_

## VI. ENVIRONMENTAL ASSESSMENT

- 1) Is the site sanitary and safe?  YES  NO  
 1a) Specify any needed improvements: \_\_\_\_\_  
 1b) Targeted Resolution Date: \_\_\_\_\_ Other: \_\_\_\_\_
- 2) Is the site accessible for the participant?  YES  NO  
 2a) If yes, then specify: \_\_\_\_\_  
 2b) Targeted Resolution Date: \_\_\_\_\_ Other: \_\_\_\_\_
- 3) Does the person have adequate crisis prevention, intervention and response plans?  YES  NO  
 3a) If no, then specify plans for improvement: \_\_\_\_\_  
 3b) Targeted Resolution Date: \_\_\_\_\_ Other: \_\_\_\_\_
- 4) Are there effective evacuation and disaster response plans in place?  YES  NO  
 4a) If no, then specify plans for improvement: \_\_\_\_\_  
 4b) Targeted Resolution Date: \_\_\_\_\_ Other: \_\_\_\_\_

## VII. SERVICE TIME

|                                       |                                     |
|---------------------------------------|-------------------------------------|
| Travel TO Start Time: _____ : _____   | Travel TO End Time: _____ : _____   |
| Visit START Time: _____ : _____       | Visit END Time: _____ : _____       |
| Travel FROM Start Time: _____ : _____ | Travel FROM End Time: _____ : _____ |
| TOTAL Number of Miles: _____          | TOTAL Number of Minutes: _____      |

## VIII. SIGNATURE SECTION

|  |             |  |             |
|--|-------------|--|-------------|
| _____<br>Participant Signature         | Date: _____ | _____<br>Habilitation Provider Signature   | Date: _____ |
|  |             | (Check ONE): <input type="checkbox"/> WITNESS or <input type="checkbox"/> GUARDIAN |             |
| _____<br>Service Coordinator Signature | Date: _____ | _____<br>Signature   | Date: _____ |



TITLE XIX MR/DD WAIVER MANUAL  
- **WORKING DRAFT ONLY**



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

**MR/DD WAIVER PROGRAM  
ADULT COMPANION SERVICES TRACKING FORM**

\_\_\_\_\_

Participant Name

\_\_\_\_\_

Service Coordination Agency

\_\_\_\_\_

Provider Name

\_\_\_\_\_

Service Coordinator Name



**TITLE XIX MR/DD WAIVER MANUAL**  
**- WORKING DRAFT ONLY**



**PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS**

Provider Address

**TYPE OF RESIDENCE:**  Natural Family  Specialized Family Care Home  Group Home  ISS

In the spaces below, write in number of hours under the date that the participant received adult companion services and/or related transportation services.

**THIS REPORT IS FOR THE MONTH OF** \_\_\_\_\_, 2\_\_\_\_\_.

| Code | 1  | 2  | 3  | 4  | 5  | 6  | 7  | 8  | 9  | 10 | 11 | 12 | 13 | 14 | 15 |
|------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
|      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 16   | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |

DD-10

Revised July 2004

**ABSENCE CODES**

**COMMENTS:** \_\_\_\_\_

Hospitalization H \_\_\_\_\_  
 Home Visit HV \_\_\_\_\_  
 Respite Care RC \_\_\_\_\_  
 Illness I \_\_\_\_\_  
 Other (specify O \_\_\_\_\_  
 under comments)



# TITLE XIX MR/DD WAIVER MANUAL - WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

I certify that the above documented services were delivered for the participant in accordance with the Individual's Program Plan (DD-5) and the regulations governing the Title XIX MR/DD Waiver Program. No services are claimed that were not provided to the participant.

\_\_\_\_\_

Provider Signature

\_\_\_\_\_

Date Completed

\_\_\_\_\_

Service Coordinator Signature

\_\_\_\_\_

Date Reviewed

**DD-10**

**Revised July 2004**

## MR/DD WAIVER PROGRAM RESPITE TRACKING FORM

\_\_\_\_\_

Participant Name

\_\_\_\_\_

Service Coordination Agency

\_\_\_\_\_

Provider Name

\_\_\_\_\_

Service Coordinator Name

Provider Address

**TYPE OF RESPITE CARE:**

W0106

W0107

If respite care was provided during the month by more than one provider, a separate DD-11 for each provider is requested.

**WORKING DRAFT ONLY** - TITLE XIX MR/DD WAIVER MANUAL



**TITLE XIX MR/DD WAIVER MANUAL**  
**- WORKING DRAFT ONLY**



**PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS**

In the spaces below, write in number of hours under the date that the participant received respite care services and transportation related to respite if applicable.

**THIS REPORT IS FOR THE MONTH OF \_\_\_\_\_, 2\_\_\_\_\_.**

| Code | 1  | 2  | 3  | 4  | 5  | 6  | 7  | 8  | 9  | 10 | 11 | 12 | 13 | 14 | 15 |
|------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
|      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 16   | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |

**REASON FOR RESPITE CARE:** \_\_\_\_\_

I certify that the above documented services were delivered for the participant in accordance with the Individual's Program Plan (DD-5) and the regulations governing the Title XIX MR/DD Waiver Program. No services are claimed that were not provided to the participant.

\_\_\_\_\_  
 Provider Signature

\_\_\_\_\_  
 Date Completed

\_\_\_\_\_  
 Service Coordinator Signature

\_\_\_\_\_  
 Date Reviewed

DD-11  
 Revised July 2004



TITLE XIX MR/DD WAIVER MANUAL  
- **WORKING DRAFT ONLY**



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS



TITLE XIX MR/DD WAIVER MANUAL  
**- WORKING DRAFT ONLY**



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

**Community Residential Habilitation, Respite or Adult Companion  
 Documentation Form**

\_\_\_\_\_

Participant Name/Client Number

Service Coordinator

-

\_\_\_\_\_

Provider Name

Month/Year

**Check One:**  Community Residential Habilitation  Adult Companion I  Adult Companion II  Respite I  Respite II

|       |       |                            |                          |                            |                                  |   |
|-------|-------|----------------------------|--------------------------|----------------------------|----------------------------------|---|
| Date: | Code: | Start Time:<br>Start Time: | Stop Time:<br>Stop Time: | Total Time:<br>Total Time: | Training/Objectives<br>#<br>_N/A | Transportation: yes__ no __<br>Total Miles: |
|-------|-------|----------------------------|--------------------------|----------------------------|----------------------------------|---|

**WORKING DRAFT ONLY - TITLE XIX MR/DD WAIVER MANUAL**



# TITLE XIX MR/DD WAIVER MANUAL

## - WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

Summary: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Signature/Title of Provider: \_\_\_\_\_

|       |       |             |            |             |                       |                            |
|-------|-------|-------------|------------|-------------|-----------------------|----------------------------|
| Date: | Code: | Start Time: | Stop Time: | Total Time: | Training/Objectives # | Transportation: yes__ no__ |
|       |       | Start Time: | Stop Time: | Total Time: | __N/A (No Training)   | Total Miles:               |

Summary: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Signature/Title of Provider: \_\_\_\_\_

|       |       |             |            |             |                       |                            |
|-------|-------|-------------|------------|-------------|-----------------------|----------------------------|
| Date: | Code: | Start Time: | Stop Time: | Total Time: | Training/Objectives # | Transportation: yes__ no__ |
|       |       | Start Time: | Stop Time: | Total Time: | __N/A (No Training)   | Total Miles:               |

Summary: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Signature/Title of Provider: \_\_\_\_\_

|       |       |             |            |             |                       |                            |
|-------|-------|-------------|------------|-------------|-----------------------|----------------------------|
| Date: | Code: | Start Time: | Stop Time: | Total Time: | Training/Objectives # | Transportation: yes__ no__ |
|       |       | Start Time: | Stop Time: | Total Time: | __N/A (No Training)   | Total Miles:               |

Summary: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Signature/Title of Provider: \_\_\_\_\_

|       |       |             |            |             |                       |                            |
|-------|-------|-------------|------------|-------------|-----------------------|----------------------------|
| Date: | Code: | Start Time: | Stop Time: | Total Time: | Training/Objectives # | Transportation: yes__ no__ |
|       |       | Start Time: | Stop Time: | Total Time: | __N/A (No Training)   | Total Miles:               |

Summary: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Signature/Title of Provider: \_\_\_\_\_



**TITLE XIX MR/DD WAIVER MANUAL**  
**- WORKING DRAFT ONLY**



**PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS**

|       |       |             |            |             |                       |                            |
|-------|-------|-------------|------------|-------------|-----------------------|----------------------------|
| Date: | Code: | Start Time: | Stop Time: | Total Time: | Training/Objectives # | Transportation: yes__ no__ |
|       |       | Start Time: | Stop Time: | Total Time: | __N/A (No Training)   | Total Miles:               |

Summary: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Signature/Title of Provider: \_\_\_\_\_

|       |       |             |            |             |                       |                            |
|-------|-------|-------------|------------|-------------|-----------------------|----------------------------|
| Date: | Code: | Start Time: | Stop Time: | Total Time: | Training/Objectives # | Transportation: yes__ no__ |
|       |       | Start Time: | Stop Time: | Total Time: | __N/A (No Training)   | Total Miles:               |

Summary: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Signature/Title of Provider: \_\_\_\_\_

DD 12 REVISED 12/05

**Instructions for Completing Community Residential Habilitation, Respite or Adult Companion Documentation Form**

1. Complete top portion of the form.

|                                       |                            |
|---------------------------------------|----------------------------|
| _____                                 | _____                      |
| <b>Participant Name/Client Number</b> | <b>Service Coordinator</b> |
| _____                                 | _____                      |
| <b>Provider Name</b>                  | <b>Month/Year</b>          |

2. Check type of service being provided. *\*Only one type of service may be entered/recorded on a form.*

**Check One:**  Community Residential Habilitation  Adult Companion I  Adult Companion II  Respite I  Respite II



# TITLE XIX MR/DD WAIVER MANUAL

## - WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

3. Enter the date of the service.

|        |  |  |  |  |  |  |
|--------|--|--|--|--|--|--|
| Date:  |  |  |  |  |  |  |
| 1/1/06 |  |  |  |  |  |  |

4. Enter the code of the service.

|         |  |  |  |  |  |
|---------|--|--|--|--|--|
| Code:   |  |  |  |  |  |
| T2017UA |  |  |  |  |  |

**SERVICE CODES: Residential Habilitation**

T2017-UA= Community Residential Habilitation

**Adult Companion**

- S5135-UAU4= Adult Companion Level I, 1:1 ratio
- S5135-UAU3= Adult Companion Level I, 1:2 ratio
- S5135-UAU2= Adult Companion Level I, 1:3 ratio
- S5135-UBU4= Adult Companion Level II,1:1 ratio
- S5135-UAU3= Adult Companion Level II,1:2 ratio
- S5135-UBU2= Adult Companion Level II,1:3 ratio

**Transportation**

A0160=Transportation I A0120=Transportation II

**Respite**

- T1005-UAU4= Respite Care Level I, 1:1 ratio
- T1005-UAU3= Respite Care Level I, 1:2 ratio
- T1005-UAU2= Respite Care Level I, 1:3 ratio
- T1005-UBU4= Respite Care Level II, 1:1 ratio
- T1005-UBU3= Respite Care Level II, 1:2 ratio
- T1005-UBU2= Respite Care Level II, 1:3 ratio

5. Enter the time service session begins (Start Time). *\* If two (2) sessions are done in one day, there are to be two (2) Start Times.*

|  |  |                            |  |  |  |
|--|--|----------------------------|--|--|--|
|  |  | Start Time: <b>9:30 am</b> |  |  |  |
|  |  | Start Time:                |  |  |  |

6. Enter the time service session ends (Stop Time). *\*If two (2) sessions are done in one day, there are to be two (2) Stop Times.*

|  |  |                            |  |  |  |
|--|--|----------------------------|--|--|--|
|  |  | Stop Time: <b>11:00 am</b> |  |  |  |
|  |  | Stop Time:                 |  |  |  |

7. Enter the full time it takes to complete the session (Total Time). *\*If two (2) sessions are done in one day, there are to be two (2) Total Times.*

|  |  |                         |  |  |  |
|--|--|-------------------------|--|--|--|
|  |  | Total Time: <b>1:30</b> |  |  |  |
|  |  | Total Time:             |  |  |  |

8. Enter the number(s) of the training objective(s) worked on during the service session. If no training is done, mark "N/A".

|  |  |                                    |  |  |
|--|--|------------------------------------|--|--|
|  |  | Training/Objectives # <b>1,5,6</b> |  |  |
|  |  | __N/A (No Training)                |  |  |



TITLE XIX MR/DD WAIVER MANUAL  
**- WORKING DRAFT ONLY**



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

9. Mark “yes” if transportation was provided to the participant and the total miles used. Mark “no” if no transportation was provided.

|  |  |  |  |  |  |                                     |
|--|--|--|--|--|--|-------------------------------------|
|  |  |  |  |  |  | Transportation: yes <u>X</u> no ___ |
|  |  |  |  |  |  | Total Miles: <b>10</b>              |

10. Write a brief note describing the service session.

Summary: **Josh completed his shopping, purchasing, and choice training programs this morning at the local grocery. He was attentive and did well except with making change. Completed all programs.**Signature/Title of Provider: **Joe Staff, Res Hab**

DD 12 Revised 12/05

**MR/DD WAIVER PROGRAM**

**CERTIFICATION OF TRAINING FOR HABILITATION PROVIDERS**

**WORKING DRAFT ONLY - TITLE XIX MR/DD WAIVER MANUAL**



# TITLE XIX MR/DD WAIVER MANUAL - WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

Name of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Service Coordination Agency: \_\_\_\_\_

Name of Subcontracting Agency (If applicable): \_\_\_\_\_

Name of Location:  GH  ISS/Semi-I/Apt  Day Pro  SFCH  NF Home

Period for Which Training is Valid: From \_\_\_\_\_ To \_\_\_\_\_

Trained on the Following Program Objectives:

- |          |           |
|----------|-----------|
| 1. _____ | 9. _____  |
| 2. _____ | 10. _____ |
| 3. _____ | 11. _____ |
| 4. _____ | 12. _____ |
| 5. _____ | 13. _____ |
| 6. _____ | 14. _____ |
| 7. _____ | 15. _____ |
| 8. _____ | 16. _____ |

\* Note: Specific procedure/techniques/methods may be found attached to the program plan.  
Amount of time spent training is documented in the QMRP case notes.

DD-13

Revised July 2004



# TITLE XIX MR/DD WAIVER MANUAL - WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

I certify that I have received training on the program objectives listed above. I will contact the service coordinator or QMRP if additional training is needed.

\_\_\_\_\_  
Signature of Person Trained/Title

\_\_\_\_\_  
Signature of Person Trained/Title

\_\_\_\_\_  
Signature of Person Trained/Title

\_\_\_\_\_  
Signature of Person Trained/Title

\_\_\_\_\_  
Signature of Person Trained/Title

\_\_\_\_\_  
Signature of Person Trained/Title

\_\_\_\_\_  
Signature of Person Trained/Title

\_\_\_\_\_  
Signature of Person Trained/Title

\_\_\_\_\_  
Signature of Person Trained/Title

\_\_\_\_\_  
Signature of Person Trained/Title

\_\_\_\_\_  
Signature and Credentials of Trainer

\_\_\_\_\_  
Date

DD-13

Revised July 2004



# TITLE XIX MR/DD WAIVER MANUAL - WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

## MR/DD WAIVER PROGRAM PARTICIPANT EXIT/TRANSFER FORM

(This form should be completed and received at the MR/DD Waiver office **within seven days** of the participant's exit/transfer from the center)

NAME OF CENTER \_\_\_\_\_

DATE \_\_\_\_\_

NAME OF PARTICIPANT \_\_\_\_\_

DATE OF EXIT OR TRANSFER FROM THE PROGRAM \_\_\_\_\_

REASON FOR EXITING THE PROGRAM:

- OPTED OFF THE MR/DD WAIVER PROGRAM.

Reason \_\_\_\_\_

Date of Transitional IPP Meeting \_\_\_\_\_

Participant and/or Legal Representative \_\_\_\_\_ agreed or \_\_\_\_\_ refused to participant in the transitional IPP meeting.

**WORKING DRAFT ONLY** - TITLE XIX MR/DD WAIVER MANUAL



# TITLE XIX MR/DD WAIVER MANUAL - WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

- DECEASED
  
- PARTICIPANT IS NO LONGER MEDICALLY ELIGIBLE FOR AN ICF/MR LEVEL OF CARE
  
- PARTICIPANT IS NO LONGER FINANCIALLY ELIGIBLE FOR THE MR/DD WAIVER PROGRAM
  
- PARTICIPANT IS NO LONGER ELIGIBLE FOR AN ICF/MR LEVEL OF CARE
  
- STILL ON THE WAIVER PROGRAM; TRANSFERRED TO ANOTHER AGENCY

Transferred to: \_\_\_\_\_

OTHER \_\_\_\_\_

NAME OF PERSON COMPLETING THIS FORM: \_\_\_\_\_

DD-16

Revised July 2004



# TITLE XIX MR/DD WAIVER MANUAL - WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

Name of QMRP \_\_\_\_\_

Date \_\_\_\_\_

Service Coordination Agency \_\_\_\_\_

Name of Subcontracting Agency (If applicable) \_\_\_\_\_

\* Highest level of QMRP approved to bill:     QMRP I     QMRP II     QMRP III

\* QMRP is:     An employee of the service coordination agency  
                   Subcontracting with the service coordination agency through another licensed B  
                   Privately subcontracting with the service coordination agency (community provider)

\* Bachelor's degree obtained:     Yes     N/A    In what area? \_\_\_\_\_  
                  Is a copy on file:     Yes     N/A

\* Master's degree obtained:     Yes     N/A    In what area? \_\_\_\_\_  
                  Is a copy on file:     Yes     N/A

\* Doctoral degree obtained:     Yes     N/A    In what area? \_\_\_\_\_  
                  Is a copy on file:     Yes     N/A

\* Current license/certification verifying registration as a medical therapist:     Yes     N/A  
                  In what area? \_\_\_\_\_ Is a copy on file:     Yes     N/A

\* Outline the years/months of experience with MR/DD individuals (previous employment, training, paid internship etc.). Include dates, names of agencies/institutions and any other specific details of the experiences (***This section is not applicable for licensed QMRP III's***):





# TITLE XIX MR/DD WAIVER MANUAL - WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

## MR/DD WAIVER PROGRAM REQUEST FOR ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS

TO BE COMPLETED BY THE SERVICE COORDINATOR:

Date \_\_\_\_\_

Participant Name \_\_\_\_\_

Medicaid Recipient # \_\_\_\_\_

Living Situation:                     Natural Family    SFCP    ISS                     Group Home

Service Coordination Agency \_\_\_\_\_

Service Coordination Agency Address \_\_\_\_\_

Service Coordination Phone Number \_\_\_\_\_

Service Coordinator Name \_\_\_\_\_

Brief Description of the Environmental Accessibility Adaptation Needed: \_\_\_\_\_

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# TITLE XIX MR/DD WAIVER MANUAL - WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

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Total Cost of the Environmental Accessibility Adaptation: \$ \_\_\_\_\_

Has the Participant utilized this service in the current calendar year?  YES  NO

If yes, what is the total amount of funding utilized in the current calendar year? \$ \_\_\_\_\_

**ATTACH THE FOLLOWING DOCUMENTATION:**

- IPP recommendations
- Documentation of denials or exhaustion of non-Medical and non-family resources
- Purchase order detailing costs and description for the Environmental Accessibility Adaptations.

Service Coordinator Signature/Date \_\_\_\_\_

Agency Contact Person Signature/Date \_\_\_\_\_

**\*\*All Original Documentation (form and attachments) must be maintained in the participant's file. A copy of this form must be maintained in a single file by the Agency Contact Person.\*\***

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Revised July 2004



# TITLE XIX MR/DD WAIVER MANUAL - WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

## MR/DD WAIVER NOTIFICATION OF PARTICIPANT DEATH

(This form is only used to report deaths of participants who reside in a 24 hour staffed setting.)

**TO:** Office of Behavioral Health Services  
MR/DD Waiver Program  
350 Capitol Street, Room 350  
Charleston, West Virginia 25301-3702

**FROM:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### INFORMATION ON THE DECEASED:

Name \_\_\_\_\_ Gender \_\_\_\_\_ Age \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ Medicaid Number \_\_\_\_\_

### DIAGNOSIS AND MEDICAL CONDITION:

Axis  
I \_\_\_\_\_

\_\_\_\_\_

Axis  
II \_\_\_\_\_

\_\_\_\_\_

Axis  
III \_\_\_\_\_



# TITLE XIX MR/DD WAIVER MANUAL - WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

**Medications:** (Use additional paper if necessary)

List all current medications prescribed and non-prescribed.

| <u>Medication</u> | <u>Dosage/Frequency</u> | <u>Purpose of Medication</u> |
|-------------------|-------------------------|------------------------------|
|                   |                         |                              |
|                   |                         |                              |
|                   |                         |                              |
|                   |                         |                              |
|                   |                         |                              |
|                   |                         |                              |
|                   |                         |                              |
|                   |                         |                              |

Date of Death \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Time of Death \_\_\_\_\_ a.m. / p.m. (Circle One)

Location of Death \_\_\_\_\_







TITLE XIX MR/DD WAIVER MANUAL  
- WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

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**INFORMATION OF PERSON COMPLETING THIS FORM:**

Name and Position/Title \_\_\_\_\_

Agency \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



TITLE XIX MR/DD WAIVER MANUAL  
- **WORKING DRAFT ONLY**



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

New Application

**MR/DD WAIVER PROGRAM  
PARTICIPANT EXIT/TRANSFER FORM**

(This form should be completed and received at the MR/DD Waiver office **within seven (7) days** of the participant's exit/transfer from the agency)

NAME OF AGENCY: \_\_\_\_\_ DATE: \_\_\_\_\_

NAME OF PARTICIPANT: \_\_\_\_\_

DATE OF EXIT OR TRANSFER FROM THE PROGRAM: \_\_\_\_\_

