TBI ISP CHECKLIST

1. __ **Initial Service Plan _____**

2. __ **PRI/Screen (within 90 days prior to the effective date of NOD) (For Nursing**
3. **Home applicants, only) _____)**

4. __ **UAS *(must be completed within 90 days of enrollment onto the waiver)* _____**

5. __ **Supporting Medical Documentation _____**

6. __ **Proof of Active Medicaid- Long term Care (EPACES) _____**

7. __ **Application for Participation _____**

8. __ **Freedom of Choice _____**

9. __ **Service Coordination Service Selection Agency form_____)**

10. __ **Provider Selection Form _____**

11. __ **Participants Rights and Responsibilities _____**

12. __ **Plan of Protective Oversight _____**

13. __ **Waiver Contact List _____**

14. __ **Application and Assessments for E-Mods, Assistive Technology, and**
15. **Community Transition services _____**

16. __ **Home Assessment Abstract LDSS 3139 _____**

17. __ **Housing Standards Checklist & other Housing forms (DOH Housing**
18. **recipients only) _____**

19. __ **Waiver Services Final Cost & AT Cost Description and Cost Projection**
20. (only applicable if participant is receiving a PERS unit through the TBI Waiver)

21. __ **NYS DOH Plan of Care/Service Plan Grid for Social and Non-Medical**
22. **Transportation for the TBI/NHTD Waiver Participants *(only applicable if***
23. participant is receiving Waiver transportation) _____

24. __ **Other**