FORMS

This appendix includes the following forms that are used in the New Opportunities Waiver Program:

- Environmental Accessibility Adaptation Job Completion Form
- Specialized Medical Equipment and Supplies Purchase and Repair Form
- Rights and Responsibilities for Individuals Requesting Home and Community-Based Waiver Services
- Transitional Expenses Planning and Approval (TEPA) Request Form
- NOW TEPA Invoice Form
- OCDD Verification of Actual TEPA Costs

Web Reference Information

Information for support planning can be obtained from the OCDD *Guidelines for Support Planning* at the following DHH website:

http://www.dhh.louisiana.gov/offices/page.asp?ID=77&Detail=9069

Information about reporting critical incidents can be obtained from the OCDD *Critical Incident Reporting for Waiver Services* at the following DHH website:

http://www.dhh.louisiana.gov/offices/page.asp?ID=77&Detail=8421

The *Quality Enhancement Provider Handbook* can be obtained from the DHH website at

http://www.dhh.louisiana.gov/offices/publications/pubs-191/QE_Provider_Handbook_08-01_08.pdf

A copy of the BHSF Form 90-L can be obtained from the following DHH website:

http://www.dhh.louisiana.gov/offices/publications/pubs-112/90-L%20Form%20rev%2012-08.pdf

Department of Health and Hospitals
Office for Citizens with Developmental Disabilities

ENVIRONMENTAL ACCESSIBILITY ADAPTATION JOB COMPLETION FORM

Instructions: This form is to be used for all requests for Environmental Accessibility Adaptations. The Support Coordinator will complete **Section 1** and submit with the Plan of Care or Revision Request to the OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District. **Section 2** will be completed by the OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District. **Section 3** will be completed by the enrolled service provider/contractor. **Section 4** will be completed by the Support Coordinator and signed by the recipient/family/guardian. All signatures are mandatory.

SECTION 1 – COMPLETED BY SUPPORT COORDINATOR		
Recipient's Name:	SSN #:	
Address:		
Support Coordination Agency:	Phone #: ( )	Fax #: ( )
Provider Agency:	Phone #: ( )	
Address:	Provider #:	
Description of Requested Services:	Requested Amount: $	
Anticipation Completion Date:	Date Modification Needs to be Completed by:	
Funds Available? ☐ Yes ☐ No		
Has this equipment been requested through the Medicaid DME Program or Medicaid State Plan? ☐ NO Why? _____ ☐ YES Was request denied? ☐ NO ☐ YES (Notice of denial must be attached)		
Provider Agency Agreement Signature: _____ Date: _____ ***Providers/contractors are NOT to complete the purchase without having received the Prior Authorization for the purchase***		
Support Coordination Agency Agreement Signature:	Date:	
Recipient/Family Agreement Signature:	Date:	
SECTION 2 - WAIVER OFFICE - AGREEMENT AND PRIOR APPROVAL DETAILS **(To be completed by OCDD Regional/Authority/District Waiver Staff and forwarded to SRI for PA)**		
Description of Approved Service:		
Procedure Code:	Approved Amount:$	
Waiver Office Prior Approval Signature:	Date of Prior Approval:	
SECTION 3 – ENROLLED SERVICE PROVIDER/CONTRACTOR - VERIFICATION OF JOB COMPLETION **(To be completed by the provider and contractor then forwarded to the Support Coordinator)**		
Description of Completed Job:	Does Job Meet All State and Local Requirements? ☐ Yes ☐ No	
Date Job Began:	Date Job Completed:	
Has Recipient Received A Certificate of Warranty For All Labor and Installation and All Manufacturers' Warranties? ☐ Yes ☐ No		
Provider Agency Signature: **Date:**	**Contactor's Signature:** **Date:**	
Recipient/Family Signature:	**Date:**	
SECTION 4 – FINAL VERIFICATION OF JOB COMPLETION **(To be completed by the support coordinator and forwarded to OCDD Regional/Authority/District Waiver Staff)**		
Date Completed Job Verified:	Job Acceptable? ☐ Yes ☐ No	
Comments:		
Support Coordinator's Signature:	Date:	
Recipient/Family Acceptance Signature:	Date:	
Waiver Staff Final Approval Signature:	Date of Final Approval:	

Issued October 25, 2010
All prior issues obsolete

OCDD-PF-03-009

Environmental Accessibility Adaptation Job Completion Form Instructions

This form is to be used for all requests for Environmental Accessibility Adaptations included in the OCDD approved Plan of Care (POC) or Revision Request. Support Coordinator (SC) completes **Section 1**, obtain proper signatures and a written itemized detailed bid, which includes the drawing with the dimensions of the existing and proposed plans related to the modification, from the service provider/contractor, and send along with the POC or Revision to OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District. **Section 2** will be completed by the OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District and if approved, forwarded to SRI with the POC budget pages if it is requested an initial or annual or revision request for PA and then send back to the SC who will forward it to the service provider/contractor. **Section 3** will be completed by the service provider/contractor and returned to SC as soon as the job is completed. **Section 4** will be completed by the SC, signed by the recipient/family/guardian and the support coordinator to indicate that they have accepted the job, and submitted to the OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District for their signature and final approval, who will forward the approval to SRI for issuance of the Post Authorization (payment). All signatures are mandatory. ***All work is to be performed and completed in the current approved POC year. Enough time should be allowed for completion of job before the end of the POC year.***

Section 1: After the POC or revision request is approved and the family has agreed upon a service provider/contractor for the job, this information shall be completed by the SC. The SC will then obtain signatures of service provider/contractors and recipient/family member to indicate agreement of all parties involved. The SC will ensure that the service provider/contractor is aware of any applicable vendor standards and/or requirement for delivery and installation of environmental accessibility adaptations. The service provider/contractor will bear the burden of liability with all applicable local and state building codes and licensing/certification requirements in effect for the area of the state in which the work is being performed.

Recipient's identifying information:	The recipient's full legal name, SSN, and address.
SC Agency's identifying information:	The SC agency's name, phone and fax #.
Provider Agency's identifying information:	The provider agency's name, address, phone # and the provider number.
Description of Requested Service:	SC will describe the requested environmental accessibility adaptation.
Anticipated Completion Date:	SC will enter the anticipated completion date of job as indicated by service provider/contractor.
Date Job Must be Completed By:	The job must be within the POC year.
Requested Amount:	SC will enter the amount requested for the environmental accessibility adaptation.
Funds Available:	Shows that the recipient does have available funds. SC will contact appropriate OCDD personnel to verify whether or not the recipient has funds available. The SC should also check their records to determine if anything has been previously requested, as not all services may have been billed/paid. It is the SC's responsibility to track this, and the family's responsibility to know if they have utilized their funding.
Procedure Code:	SC will indicate appropriate procedure code for the environmental accessibility adaptation.
Denial from Medicaid/State Plan:	Indicate whether this equipment has been requested through Medicaid DME or Medicaid State Plan and provide documentation of this.

Issued October 25, 2010
All prior issues obsolete

OCDD-PF-03-009

Agreement Signatures:	Signatures in this section validate that the environmental accessibility adaptation is a new need of the recipient and that the environmental accessibility adaptation has not already been completed or in the process of completion.
Provider Agreement Signature:	Presence of a signature of service provider/contractor indicates agreement to provide the service, cost, and anticipated completion date.
Support Coordination Agency Agreement Signature:	Presence of a signature of SC Agency representative indicates agreement with the need of the service, cost, and anticipated completion date.
Recipient/Family Agreement Signature:	Presence of a signature indicates approval of the service provider/contractor, and agreement with the cost and anticipated completion date.

After Section 1 has been completed by SC, the job completion form with the revision request or budget pages if at annual or initial certification, will be forwarded to OCDD Regional/Authority/District Waiver Office for review and completion of Section 2.

Section 2: OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District staff will enter the approved environmental accessibility adaptation, procedure code of the approved service, and the dollar amount approved. Presence of signature in section labeled "Waiver Office Agreement and Prior Approval" indicates authorization of the requested service and dollar amount payable to contractor for environmental accessibility adaptation job completion. OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District staff will enter the date of the approval for the environmental accessibility adaptation and then forwards approved Environmental Accessibility Adaptation form and Revision Request form to Statistical Resources, Inc., for issuance of Prior Authorization (PA). The approval of the OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District does not override any limits the participant has already met.

Description of Approved Service:	Waiver Office/Authority/District staff will describe the waiver service that has been approved.
Procedure Code:	Waiver Office/Authority/District staff will indicate appropriate procedure code for the environmental accessibility adaptation.
Approved Amount:	Waiver Office/Authority/District staff will enter the approve amount for the environmental accessibility adaptation.
Waiver Office/Authority/District Prior Approval Signature:	Signature of the waiver staff that authorized prior approval.
Date of Prior Approval:	Waiver Office/Authority/District staff will indicate the date that prior approval was given.

After Section 2 has been completed by the OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District, the form will be returned to the Support Coordinator. The SC notifies the service provider/contractor by forwarding the prior authorization form along with the revision request/budget pages if an annual or initial, to the service provider/contractor for completion of Section 3.

Section 3: The selected service provider/contractor will complete the following after the environmental accessibility adaptation is completed:

Description of Completed Job:	Description of environmental accessibility adaptation completed.

Does Job Meet all State and Local Requirements:	Check yes or no.
Date Job Began:	Actual date environmental accessibility adaptation job began.
Date Job Completed:	Actual date environmental accessibility adaptation job completed.
Provider Agency and Contractor's Signature:	Presence of signature(s) indicates the environmental accessibility adaptation has been completed by service provider agency and contractor as agreed upon.
Recipient/Family Signature:	Presence of a signature verifies that the environmental accessibility adaptation was completed.

After Section 3 has been completed by the service provider, the form will be forwarded to the SC Agency for final approval. This form can be faxed to the Support Coordinator to expedite the process, but the original needs to be mailed immediately to the S.C.

Section 4: Upon receipt of this form the Support Coordinator shall complete this section, with the SC's signature and obtain signature of recipient/family member indicating approval/agreement, and send a copy of the form to the OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District via fax or mail, who will sign this once final approval is given for payment. The completed form must be mailed or faxed to the OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District within ten (10) working days of the date of the actual environmental accessibility adaptation completion.

Date Completed Job Verified:	Enter the date the S.C viewed the completed job with the recipient/family.
Job Acceptable:	Indicate whether or not the completed job is acceptable to recipient/family. If not considered acceptable the SC shall negotiate with the provider/contactor in accordance with established policy.
Comments:	Enter any comments made by the recipient/family/SC.
Signatures: (SC and recipient/family)	Obtain signatures of the SC and the recipient/family.

The completed form must be mailed or faxed by the SC to the OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District within ten (10) working days of the date of the actual job completion.

Waiver Office/Authority/District Staff Signature:	Waiver Office/Authority/District staff must sign the job completion form indicating final approval of the job for issuance of post authorization (release of payment).

Once a final determination is made the OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District will submit the job completion form to the SC and data contractor (i.e. SRI).

Reimbursement for this service shall require prior and final approval by the OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District staff.

Reimbursement shall not be authorized until verification has been received that the job has been completed in accordance with the prior approved agreement and the family is satisfied with the adaptation.

After the completed form is received in the OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District, it is then forwarded to Statistical Resources, Inc., for issuance of Post Authorization allowing for release of payment.

Issued October 25, 2010
All prior issues obsolete

OCDD-PF-03-009

DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES
NEW OPPORTUNITIES WAIVER (NOW)

Specialized Medical Equipment and Supplies Purchase and Repair Form

Instructions: This form is to be used for all requests for purchases and repairs for Specialized Medical Equipment and Supplies. The Support Coordinator will complete Section 1 and submit with the Plan of Care and/or Revision Request to the OCDD Regional Office. Section 2 will be completed by the OCDD Regional Office. Section 3 will be completed by the enrolled service provider/contractor. Section 4 will be completed by the Support Coordinator and signed by the recipient/guardian. All signatures are mandatory.

SECTION 1	
Participant's Name:	Medicaid ID #:
Address:	
Support Coordination Agency:	Phone #/Fax: ( ) - /( ) -
Provider Agency:	Phone #: ( ) -
Address:	Provider #:
Purchase ☐ Repair ☐ Description:	Anticipated Completion Date:
Requested Amount: Funds Available? ☐ Yes ☐ No	Procedure Code:
Has this equipment been requested through the Medicaid DME Program? (Not applicable to requests for repairs) ☐ NO Why? _____ ☐ YES Was request denied? ☐ NO ☐ YES (Notice of denial must be attached)	
Provider Agreement Signature: _____ Date: _____ Providers are NOT to complete the purchase/repair without having received the Prior Authorization for the purchase/repair	
Support Coordination Agency Agreement Signature:	Date:
Participant/Family Agreement Signature:	Date:
SECTION 2 - OCDD AGREEMENT DETAILS	
Approved Purchase/Repair:	
Procedure Code:	Approved Amount:$
OCDD Signature:	Date of Approval:
OCDD REGIONAL OFFICE FORWARDS TO STATISTICAL RESOURCES, INC., FOR ISSUANCE OF PRIOR AUTHORIZATION APPROVAL OF THE OCDD OFFICE DOES NOT OVERRIDE ANY LIMITS THE INDIVIDUAL HAS ALREADY MET	
SECTION 3 - VERIFICATION OF COMPLETION	
Description of Completed Purchase/Repair:	
Date Purchase/Repair Began:	Date Purchase/Repair Completed:
Provider's Signature:	Date:
Recipient/Family Signature:	Date:
FORWARD COMPLETED FORM TO THE SUPPORT COORDINATOR	
SECTION 4 – SUPPORT COORDINATOR'S VERIFICATION OF COMPLETION	
Date Completed Purchase/Repair Verified:	Purchase/Repair Acceptable? ☐ NO ☐ YES
Comments:	
Support Coordinator's Signature:	Date:
Recipient/Family Acceptance Signature:	Date:
SUPPORT COORDINATION AGENCY SUBMITS TO OCDD REGIONAL OFFICE FOR POST AUTHORIZATION (PA) RELEASE	

Issued January 1, 2004
Revised/Re-issued December 20, 2007

OCDD-PF-03-009

Specialized Medical Equipment and Supplies Purchase and Repair Form Instructions
New Opportunities Waiver (NOW)

This form is to be used for all requests for Specialized Medical Equipment and Supplies Purchase and Repairs identified in the OCDD approved Plan of Care and/or Revision Request. Support Coordinator will complete Section 1, obtain proper signatures, and send along with the Plan of Care or Revision to OCDD Regional Office. Section 2 will be completed by the Regional OCDD Office and sent back to the Support Coordinator who will forward it to the provider. Section 3 will be completed by the service provider/contractor and returned to Support Coordinator as soon as purchase/repair is completed. Section 4 will be completed by the Support Coordinator, signed by the recipient/guardian to indicate that they have accepted the purchase/repair, and submitted to the OCDD Regional Office who will forward the approval to SRI for issuance of the Prior Authorization (PA). All signatures are mandatory. All work is to be performed in the current approved Plan of Care year, or a Plan of Care revision must be completed.

Section 1: After the Plan of Care is approved and the family has agreed upon a provider for the purchase/repair, this information shall be completed by the Support Coordinator. The Support Coordinator will then obtain signatures of service provider/contractors and recipient/family member to indicate agreement of all parties involved. The Support Coordinator will ensure that the service provider/contractor is aware of any applicable vendor standards and/or requirement for manufacturing, design and installation of technological equipments and supplies and the repair of same. The service provider/contractor will bear the burden of liability with all applicable vendor standards and/or requirements in effect for the area of the state in which the work is being performed.

Purchase/Repair Description:	Support Coordinator will check whether purchase or repair and include a description of the item to be purchased or a description of the repair and the item to be repaired.
Anticipated Completion Date:	Support Coordinator will enter the anticipated completion date of purchase/repair as indicated by service provider/contractor.
Requested Amount:	Support Coordinator will enter the amount requested for the purchase/repair.
Funds Available:	Shows that the recipient does have available funds. Support Coordinator will contact appropriate OCDD personnel to verify whether or not the recipient has funds available. The Support Coordinator should also check their records to determine if anything has been previously requested, as not all services may have been billed/paid. It is the Support Coordinator's responsibility to track this, and the family's responsibility to know if they have utilized their funding.
Procedure Code:	Support Coordinator will indicate appropriate procedure code for this purchase/repair.
Agreement Signatures:	Signatures in this section validate that this equipment is a new need, and has not been ordered or currently in the possession of the recipient or to validate the need for repair to equipment/supplies currently in possession of the recipient.
Provider Agreement Signature:	Presence of a signature of service provider/contractor indicates agreement to provide the service, cost, and anticipated completion date.
Support Coordination Agency Agreement Signature:	Presence of a signature of Support Coordination Agency representative indicates agreement with the need of the service, cost, and anticipated completion date.
Recipient/Family Agreement Signature:	Presence of a signature indicates approval of the provider, and agreement with the cost and anticipated completion date.

After Section 1 has been completed by Support Coordinator, the job completion form will be forwarded to OCDD Regional Office for review and completion of Section 2.

Section 2: OCDD Regional Office will enter the approved purchase/repair, procedure code of the approved purchase/repair and the dollar amount approved. Presence of signature in section labeled "OCDD Agreement" indicates authorization of the requested service and dollar amount payable to contractor for purchase/repair. OCDD Regional Office staff will enter the date of the approval for the purchase/repair. OCDD Regional Office forwards approval to Statistical Resources, Inc., for issuance of Prior Authorization (PA). The approval of the OCDD Office does not override any limits the individual has already met.

Section 3: The selected service provider/contractor will complete the following after the purchase/repair is finished:

Description of Completed Purchase/Repair:	Description of purchase/repair provided and completed.
Provider's Signature:	Presence of a signature indicates the purchase/repair has been completed by service provider/contractor as agreed upon.
Recipient/Family Signature:	Presence of a signature verifies that the purchase/repair was completed.
Date Purchase/Repair Completed:	Actual date purchase/repair completed

The service provider/contractor will then provide the form with their original signature to the Support Coordinator who will then view the purchase/repair with the family and complete Section 4. This form can be faxed to the Support Coordinator and the original form mailed to expedite the process.

Section 4: The Support Coordinator shall complete this section and obtain signature of recipient/family member indicating approval/agreement, and send a copy of the form to the OCDD Regional Office via fax or mail. The completed form must be mailed or faxed to the OCDD Regional Office within ten (10) working days of the date of the actual purchase/repair completion. After the completed form is received in the OCDD Regional Office, it is then forwarded to Statistical Resources, Inc., for issuance of Post Authorization (PA) allowing for release of payment.

Office for Citizens with Developmental Disabilities

Rights and Responsibilities for Individuals Requesting or Receiving Home and Community-Based Waiver Services

These are your **rights** as an individual requesting Home and Community-Based Waiver Services:

- To be treated with dignity and respect, free of any abuse or neglect on the part of the provider.
- To participate in and receive person-centered, individualized planning of supports and services.
- To receive accurate, complete, and timely information that includes a written explanation of the process of evaluation and participation in a Home and Community Based Waiver, including how you qualify for it and what to do if you are not satisfied.
- To work with competent, capable people in the system.
- To file a complaint or grievance with a support coordination agency, a service provider, or the Department of Health and Hospitals/Office for Citizens with Developmental Disabilities (DHH/OCDD) regarding services provided to you, please call Health Standards Section (HSS) toll free Complaint Line at 1-800-660-0488.
- To contact OCDD for general information about your waiver services, please call the OCDD toll free number 1-866-783-5553 or contact your OCDD regional waiver office, human services authority or district.
- To file an appeal after you have been denied a service or additional services through OCDD, call or write the Division of Administrative Law - Health and Hospitals Section
  P.O. Box 4189
  Baton Rouge, LA 70821-4189
  Oral Appeal Phone: (225) 342-5800
  Fax Appeal: (225) 219-9823
- You have the right to a fair hearing after you have been denied a service or additional services. You may contact your regional OCDD regional waiver office, human services authority or district or request assistance from your support coordinator.
- To have a choice of service/support providers when there is a choice available.
- To receive services in a person-centered way from trained competent caregivers.
- To have timely access to all approved services identified in your Plan of Care (POC).
- To receive in writing any rules, regulations, or other changes that affect your participation in a Home and Community Based Waiver.
- To receive information explaining support coordinator and direct service provider responsibilities and requirements in providing services to you.
- To have all available Medicaid services explained to you and how to access them **if you are a Medicaid recipient,** as well as non-Medicaid community services relevant to your identified needs.
- To change your Support Coordinator or Support Coordination Agency; may change Support Coordination Agency after every 6 months without "good cause" or at any time with "good cause."

Issued January 10, 2010 and revised February 15, 2011
Replaces OCDD-005

OCDDWSS-R-11-002
Page 1 of 3

These are your **responsibilities** as an individual requesting Home and Community-Based Waiver Services include the following:

- To actively participate in planning and making decisions on supports and services you need.
- To cooperate in planning for all the services and supports you will be receiving.
- To refuse to sign any paper that you do not understand or that is not complete.
- To provide all necessary information about yourself. This will help the support coordinator to develop a Plan of Care (POC) that will determine what services and supports you need.
- To not ask providers to do things in a way that are against the laws and procedures they are required to follow.
- To cooperate with the Office for Citizens with Developmental Disabilities (OCDD) waiver staff and your support coordinator by allowing them to contact you by phone and visit with you at least quarterly. Necessary visits include an initial visit in order to gather information and complete an assessment of needs, regular quarterly visits at the location of your choice to assure your plan of care is sufficient to meet your needs, and visits resulting from complaints to OCDD and visits needed to assure the services as reported by your provider are being received.
- To immediately notify the support coordinator and direct service provider who works with you if your health, medications, service needs, address, phone number, alternate contact number, or your financial situation changes.
- To help the support coordinator to identify any natural and community supports that would be of assistance to you in meeting your needs.
- To follow the requirements of the program, and if information is not clear, ask the support coordinator or direct service provider to explain it to you.
- To verify you have received the waiver and medical services the provider says you have received, including the number of hours your direct care provider works, and report any differences to your support coordinator and the HSS Complaint line at 1-800-660-0488.
- To obtain assessment information /documentation requested by your support coordinator or service provider that is required for accessing the services that you are requesting, i.e. BHSF Form 90-L "Request for Level of Care Determination", 1508 Evaluation/Update, IEP, etc.
- To understand that all waiver programs have an age requirement and that they will not be offered services in a program that they previously requested if they no longer meet the age requirement for that program.
- To understand as a recipient of the waiver program, if you fail to receive waiver services for thirty (30) calendar days or more your waiver case may be closed.
- To request different waiver services if you no longer meet any of the criteria as outlined on the waiver fact sheet that you received.

I have read and understand my rights and responsibilities in applying for / participating in Home and Community-Based Waiver services. I understand my responsibility to cooperate with OCDD in this process. I understand that Waiver Services may be discontinued for me or the person whom I am authorized to represent in this matter. Listed below are ***some*** of the reasons that waiver services ***may*** be discontinued:

- Loss of Medicaid eligibility, per Medicaid;
- Loss of eligibility for an ICF/DD level of care;
- Incarceration or placement under the jurisdiction of penal authorities, courts or state juvenile authorities;
- Change of residence to another state;
- Admission to an ICF/DD or nursing facility;
- Health and welfare of the waiver recipient cannot be assured in the community;
- Failure to cooperate in either the eligibility determination process, or the initial or annual implementation of the CPOC; or
- Continuity of service is interrupted.

Applicant/Recipient Name **(Please print name)**	
Signature of Applicant/Recipient/Authorized Representative **(Signature of parent or guardian if individual is a minor)**	Date:

If this form is sent to you at the time a waiver offer is submitted to you, please complete this page and return this page only to:

Statistical Resources, Inc
11505 Perkins Road, Suite H
Baton Rouge, LA 70810
Phone: 1-800-364-7828
Fax: 225-767-0502

NOTE: This form may also be given to you for your signature by your support coordinator or by the Regional OCDD Waiver Supports and Services Office or Human Services Authority or District.

Issued January 10, 2010 and revised February 15, 2011
Replaces OCDD-005

OCDDWSS-R-11-002
Page 3 of 3

Department of Health and Hospitals
Office for Citizens with Developmental Disabilities

TRANSITIONAL EXPENSES PLANNING AND APPROVAL (TEPA) REQUEST FORM

Instructions: Each item purchased must be indicated in the appropriate area with the actual cost of the item, based on the receipt, indicated in the "Actual Cost Based on Receipt" column. All sections of this form must be filled out completely and contain all appropriate signatures in order to process the request.

PARTICIPANT'S NAME:	SSN:
WAIVER POPULATION: ☐ NOW ☐ ROW	OCDD REGIONAL OFFICE:
CURRENT ICF/DD FACILITY:	
PROJECTED MOVE DATE:	ACTUAL MOVE DATE:
PRE-142 APPROVAL DATE:	FINAL APPROVED TEPA DATE:
TOTAL ESTIMATED TEPA COST:	TOTAL ACTUAL TEPA COST:
INITIAL PLAN OF CARE END DATE:	

ITEMIZED EXPENSE INFORMATION

AREA	ITEM	DESIGNATED PURCHASER'S INITIALS	NUMBER OF ITEMS REQUESTED	ESTIMATED COST RANGE	ESTIMATED COST	ACTUAL COST BASED ON RECEIPT
LIVING ROOM	SOFA			$250-$440		
	LOVE SEAT			$150-$300		
	CHAIR			$75-$150		
	COFFEE TABLE			$50-$70		
	END TABLE			$50-80		
	WALL HANGINGS			$10-$45		
	RECLINER			$140-$210		
DINING ROOM	DINING TABLE/CHAIRS			$140-$210		
KITCHEN	DISHES/PLATES			$15-$30		
	GLASSWARE			$5-$15		
	CUTLERY/FLATWARE			$15-$30		
	MICROWAVE			$30-$70		
	COFFEE MAKER			$10-$20		
	POTS/PANS			$35-$70		
	MISCELLANEOUS (DRAIN BOARD, DISH CLOTHS/TOWELS, POT HOLDERS, STORAGE CONTAINERS, BROOM, MOP/BUCKET)			$50-$300		
	MISCELLANEOUS (IRON, SMALL KITCHEN APPLIANCES)			$25-$75		
BATHROOM	MISCELLANEOUS (TOWELS, HAMPER, SHOWER CURTAIN, PERSONAL CARE ITEMS, BATH MATS)			$50-$150		

Issued November 18, 2009
(Obsoletes BCSS-RF-03-004)

OCDDWSS-R-09-008

AREA	ITEM	DESIGNATED PURCHASER'S INITIALS	NUMBER OF ITEMS REQUESTED	ESTIMATED COST RANGE	ESTIMATED COST	ACTUAL COST BASED ON RECEIPT
BEDROOM	BEDROOM SET INCLUDING MATTRESS/BOXSPRINGS			$250-$500		
	NIGHT STAND			$75-$100		
	MISCELLANEOUS (COMFORTER, SHEETS, PILLOWS, LAMPS, CURTAINS)			$100-$300		
MOVING EXPENSES	MOVING COMPANY			$100-$200		
HEALTH AND SAFETY	ONE-TIME CLEANING FEE			$25-$100		
	PEST ERADICATION			$50-$150		
	ALLERGEN CONTROL			$25-$30		
	FIRE EXTINGUISHER			$30-$40		
	SMOKE DETECTOR			$10-$20		
	FIRST AID KIT / SUPPLIES			$15-$40		
NON-REFUNDABLE SETUP FEES	TELEPHONE					
	ELECTRICITY					
	HEATING BY GAS					
				TOTALS:		

SUPPORT COORDINATION INFORMATION

SUPPORT COORDINATION AGENCY: TELEPHONE NUMBER(S):

ADDRESS: E-MAIL ADDRESS:

SUPPORT COORDINATOR'S NAME:

SUPPORT COORDINATOR'S SIGNATURE: DATE:

DESIGNATED PURCHASER INFORMATION

DESIGNATED PURCHASER'S NAME: AGENCY:

ADDRESS: E-MAIL ADDRESS:

DESIGNATED PURCHASER'S SIGNATURE: DATE:

DESIGNATED PURCHASER'S NAME: AGENCY:

ADDRESS: TELEPHONE NUMBER:

DESIGNATED PURCHASER'S SIGNATURE: DATE:

OCDD PRE-APPROVED SERVICE AUTHORIZATION AMOUNT: $

OCDD REGIONAL OFFICE SIGNATURE:

Issued November 18, 2009
(Obsoletes BCSS-RF-03-004)

OCDDWSS-R-09-008

NOW TEPA INVOICE FORM
DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES

Name and Address of Purchaser:

PURCHASER (VENDOR) ID #: _____ DHH REGION: _____

RECIPIENT OF ITEMS/SERVICES: _____

DATE INVOICE COMPLETED: _____

DATE OF PURCHASE	DESCRIPTION OF ITEMS/SERVICES	AMOUNT
TOTAL		$

PURCHASER'S CERTIFICATION:
"This is to certify that the information contained on this form is true, accurate and complete and that expenditures shown above were made for the recipient named above."

_____ _____
Signature of Purchaser Date

_____ _____ _____
Support Coordinator's ***Signature*** Date Contact Phone#

AGENCY **340** EFFECTIVE DATE: ____ / ____ (MO/YR)

ORG#	OBJECT	REPORTING#	AMOUNT	REMARKS

OCDDWSS-I-10-001

Issued November 3, 2010
Replaces All Prior Issuances

Department of Health and Hospitals
Office for Citizens with Developmental Disabilities

OCDD VERIFICATION OF ACTUAL TEPA COSTS

This form is used to verify that OCDD has reviewed the "Transitional Expenses Planning and Approval (TEPA) Request" form for completeness and compliance and has verified receipts for actual expenditures. This form is required for final approval of all TEPA requests.

Section 1 – OCDD Verification of Actual TEPA Costs	
PARTICIPANT'S NAME:	
TOTAL DOLLAR AMOUNT VERIFIED BY OCDD: $	
OCDD STATE OFFICE SIGNATURE:	DATE:
Section 2 – Approval	
TOTAL ACTUAL COST: $	❒ APPROVED ❒DISAPPROVED
OCDD REGIONAL OFFICE SIGNATURE:	DATE:

Issued November 18, 2009 OCDDWSS-I-09-002

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
OCDD WAIVER SUPPORTS AND SERVICES
NEW OPPORTUNITIES WAIVER (NOW) - COMPREHENSIVE PLAN OF CARE
CONFIDENTIAL

TYPE: ☐ INITIAL ☐ ANNUAL WAIVER: ■ NOW LEVEL OF CARE: ■ ICFMR ☐ LEVEL ____ ☐ SHARED SUPPORT

INDIVIDUAL'S NAME (LAST NAME, FIRST NAME)		LEGAL GUARDIAN/AUTHORIZED REPRESENTATIVE	
SOCIAL SECURITY NUMBER	DOB / /	RELATIONSHIP	
MEDICAID #	MEDICARE #	LEGAL STATUS: ☐ MINOR ☐ INTERDICTED ☐ POWER OF ATTORNEY ☐ COMPETENT MAJOR ☐ OTHER _____	
ADDRESS (PHYSICAL)	MAILING (IF DIFFERENT)	ADDRESS (PHYSICAL)	MAILING (IF DIFFERENT)
CITY/STATE/ZIP CODE	PARISH	CITY/STATE/ZIP CODE	PARISH
DAY PHONE	NIGHT PHONE	DAY PHONE	NIGHT PHONE
CASE MANAGEMENT AGENCY (NO ABBREVIATIONS)		PROVIDER NUMBER	
CASE MANAGEMENT AGENCY ADDRESS		SUPPORT COORDINATOR (TYPE/PRINT)	SC SUPERVISOR (TYPE/PRINT)
CITY/STATE/ZIP CODE		TELEPHONE NUMBER	

SEX: ☐ MALE ☐ FEMALE **ETHNICITY:** ☐ AFRICAN-AMERICAN ☐ CAUCASIAN ☐ HISPANIC ☐ ASIAN ☐ OTHER

EDUCATION: ☐ ATTENDS SCHOOL ☐ HOMEBOUND ☐ N/A **90L:** PHYSICIAN DATE: _____ CM REC'D: _____

PRIMARY DISABILITY/DIAGNOSIS: _____ **DATE OF ONSET:** / /

SECONDARY DISABILITY/DIAGNOSIS: _____ **DATE OF ONSET:** / /

MR: ☐ MILD ☐ MODERATE ☐ SEVERE ☐ PROFOUND ☐ OTHER:

ADAPTIVE FUNCTIONING: ☐ MILD ☐ MODERATE ☐ SEVERE ☐ PROFOUND

AMBULATION: ☐ INDEPENDENT ☐ WITH PERSONAL ASSISTANCE ☐ WITH ASSISTIVE DEVICE(S) ☐ DOES NOT AMBULATE

SIL: ☐ YES ☐ NO **24-HOUR SERVICE:** ☐ YES ☐ NO

PRIMARY MODE OF LOCOMOTION: ☐ AMBULATION ☐ WHEELCHAIR WITHOUT ASSISTANCE ☐ WHEELCHAIR WITH ASSISTANCE ☐ OTHER

EMERGENCY SELF-EVACUATE: ☐ YES ☐ NO **Attach Individualized Emergency Evacuation/Response Plan**

EMERGENCY RESPONSE: ☐ **LEVEL 1** TOTAL ASSISTANCE WITH LIFE SUSTAINING EQUIPMENT ☐ **LEVEL 2** TOTAL ASSISTANCE
☐ **LEVEL 3** CAN RESPOND/NEEDS TRANSPORTATION ☐ **LEVEL 4** CAN RESPOND INDEPENDENTLY

WILL RESIDENCE CHANGE WITH WAIVER PARTICIPATION? ☐ YES ☐ NO IF YES, WHEN & PROPOSED ADDRESS?

IS THIS A TRANSITION FROM A DEVELOPMENTAL CENTER OR NURSING FACILITY? ☐ YES ☐ NO DEPOSIT REQUIRED? ☐ YES ☐ NO

ARE THERE MULTIPLE WAIVER RECIPIENTS IN THE HOME? ☐ YES ☐ NO IF SO, HOW MANY? _____

ARE THERE MULTIPLE INDIVIDUALS WITH DISABILITIES (NON-RECIPIENT) IN THE HOME? ☐ YES ☐ NO IF SO, HOW MANY? _____

ARE PAID CARE GIVERS RELATED TO INDIVIDUAL? ☐ YES ☐ NO IF YES, RELATIONSHIP & SERVICE PROVIDED

DO PAID CARE GIVERS LIVE WITH RECIPIENT? ☐ YES ☐ NO IF YES, NAME & SERVICE(S) _____

DOES INDIVIDUAL RECEIVE HOME HEALTH SERVICE? ☐ NO ☐ YES IF YES, ATTACH A HOME HEALTH PLAN.

Present Housing
☐ Own Home (Alone)
☐ Own Home (With Partner)
☐ Own Home (With Others)
☐ Other's Home

ANTICIPATED HOUSING: ☐ ICF/MR ☐ NURSING FACILITY

RENT HOME: ☐ WITH SUBSIDY ☐ WITHOUT SUBSIDY

RENT APARTMENT: ☐ WITH SUBSIDY ☐ WITHOUT SUBSIDY

FOR WSS USE ONLY: HIGH RISK RECIPIENT? ☐ YES ☐ NO (IF YES, WSS WILL ADD TO HIGH RISK TRACKING)

CPOC BEGIN DATE: _____ **CPOC END DATE:** _____

Revised August 16, 2010
Replaces November 14, 2008 Issuance

Page 1 of 20

OCDDWSS-CPOC-NOW2025

Section I: Emergency Information **Confidential**

Attach Individualized Emergency Evacuation/Response Plan

INDIVIDUAL'S NAME: _____ **AGE:** _____

ADDRESS: _____

DIRECTIONS TO MY HOME: _____

PERSON RESPONSIBLE FOR EVACUATING/BRINGING SUPPLIES TO INDIVIDUAL'S HOME:

NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____

ADDRESS: _____

FAMILY MEMBERS/OTHER TO CONTACT IN CASE OF EMERGENCY (INCLUDING PROVIDERS):

1. NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____

ADDRESS _____

2. NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____

ADDRESS: _____

3. NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____

ADDRESS _____

EMERGENCY EQUIPMENT IN HOME:

☐ FIRE EXTINGUISHER: LOCATION _____ ☐ FIRST AID SUPPLIES: LOCATION _____

☐ HOME EVACUATION PLAN: LOCATION: _____ ☐ SPECIALIZED MEDICAL EQUIPMENT: (E.G., VENTILATOR, SUCTION MACHINE, ETC.)

☐ SMOKE DETECTOR(S): LOCATION: _____ LOCATION: _____

☐ OTHER _____

SPECIAL CONSIDERATIONS/NECESSITIES (DETAILED INFORMATION REQUIRED): UTILIZES ASSISTIVE TECHNOLOGY, DEPENDENT ON VENTILATOR, MEDICATIONS, ETC. (SEE INDIVIDUAL EMERGENCY EVACUATION/RESPONSE PLAN)

DOCTOR'S NAME: _____ PRIMARY: _____ PHONE: _____

DOCTOR'S NAME: _____ SPECIALTY: _____ PHONE: _____

DOCTOR'S NAME: _____ SPECIALTY: _____ PHONE: _____

DOCTOR'S NAME: _____ SPECIALTY: _____ PHONE: _____

DOCTOR'S NAME _____ SPECIALTY _____ PHONE: _____

NAME: _____

Revised August 16, 2010
Replaces November 14, 2008 Issuance

Page 2 of 20

OCDDWSS-CPOC-NOW2025

SECTION II: Health Profile **Confidential**

A. Health Status

1. PHYSICAL (e.g., GENERAL HEALTH, MOBILITY, ASSISTIVE DEVICES):

2. ALLERGIES (e.g., MEDICATION, FOOD, ENVIRONMENTAL):

   DESCRIBE WHAT HAPPENS WHEN THERE IS AN ALLERGIC REACTION

3. MEDICAL DIAGNOSES/SIGNIFICANT MEDICAL HISTORY/CONCERNS:

4. DOCTOR VISITS (PAST YEAR AND SCHEDULED VISITS):

5. PSYCHIATRIC/BEHAVIOR CONCERNS:

6. BEHAVIOR SUPPORT PLAN ATTACHED (IF NEEDED): ☐ YES ☐ NO

7. INCIDENT REPORTS (FOR PAST 6 MONTHS):

A. CRITICAL INCIDENTS	
1. UNPLANNED HOSPITAL	#
2. ER VISITS	#
3. PSYCHIATRIC ADMITS	#
4. ABUSE/NEGLECT	#
5. OTHER	#
B. NON-CRITICAL INCIDENTS	#
C. HOSPITAL ADMISSIONS	#
D. EMERGENCY DOCTOR VISITS	#
E. PSYCHIATRIC HOSPITAL ADMISSIONS	#

ADDITIONAL INFORMATION/SUMMARY:

NAME: _____

Revised August 16, 2010
Replaces November 14, 2008 Issuance

Page 3 of 20

OCDDWSS-CPOC-NOW2025

Confidential

B. LIST OF MEDICATIONS: (INCLUDING OVER THE COUNTER MEDICATIONS)

MEDICATIONS	WHAT IS IT FOR?	DOSAGE/FREQUENCY	HOW IS IT TAKEN?	PRESCRIBING PHYSICIAN *(CHECK BOX IF PHYSICIAN DELEGATION IS NEEDED)	To Be Given by: (SELF, FAMILY, STAFF, CMA, CNA, ETC.)
1.				☐	
2.				☐	
3.				☐	
4.				☐	
5.				☐	
6.				☐	
7.				☐	
8.				☐	
9.				☐	
10.				☐	

C. LIST OF TREATMENTS (e.g. CATHERIZATIONS, TUBE FEEDING, DRESSING CHANGES, SUCTIONING, OXYGEN, SPLINTS, BRACES, ETC.)

TREATMENTS	WHAT IS IT FOR?	FREQUENCY	HOW IS IT PERFORMED?	PRESCRIBING PHYSICIAN *(CHECK BOX IF PHYSICIAN DELEGATION IS NEEDED)	To Be Given by: (SELF, FAMILY, STAFF, CMA, CNA, ETC.)
1.				☐	
2.				☐	
3.				☐	
4.				☐	
5.				☐	

NAME: _____

Revised August 16, 2010
Replaces November 14, 2008 Issuance

Page 4 of 20

OCDDWSS-CPOC-NOW2025

Section III. All About Me **Confidential**

Information included in this section is relevant to my life today and is my way of sharing social/family history with you. I hope that this information will be helpful in assisting you to help me achieve my personal outcomes. My personal outcomes worksheet (see attached Personal Outcomes Worksheets) will assist you in helping me tell you about myself. If I need assistance telling my story, please ask those who know me best.

A. HISTORICAL INFORMATION: INFORMATION in this section includes historical issues, for example, nature and cause of person's disability, person's age at onset of disability (if not known, please indicate by writing "unknown" in this section), education, work history; recurring situations that impact support needs; summary of events leading to request for support at this time.

B. CURRENT LIVING SITUATION: INFORMATION in this section includes family's involvement and understanding of individual's strengths, skills and abilities, current issues/situations that may present barriers to individual obtaining supports and services they desire, individual's/family/circle of support knowledge of disability and how individual wants to be supported; economic issues, including current employment; connections to community and natural supports, relationships/friends/family/other, where and with whom individual lives, rural/urban area, accessibility to resources, own home/rents/lives with relative/extended family/alone, does physical home environment meet accessibility/safety needs, health and age of family care-givers (if supported by family), feelings of safety and continuity of supports/care, etc.

C. CURRENT COMMUNITY SUPPORTS OR OTHER AGENCY INVOLVEMENT: Information in this section includes significant life events, including family issues, social/law enforcement issues, social services caseworker or Probation Officer involvement which may require interaction with legal/social agencies, current community supports and resources being utilized, etc.

NAME: _____

SECTION IV: Things You Need to Know to Support Me — Confidential

A. My gifts and talents:

B. I communicate best by (speaking, gesturing, communication board, sign language, behaving in certain ways, etc.):

List of non-verbal ways I communicate in this communication log

When I do this	It means this

C. I understand best when (shown and told how, shown, use hand-over hand techniques, etc.):

D. I need help with:

E. When I am scared I need someone to:

F. When I am angry I need you to:

G. Things that work/things I like (favorite things such as…food hobbies, past time):

H. Things that don't work/things I dislike:

I. Other things I'd like you to know about me:

NAME: _____

Revised August 16, 2010
Replaces November 14, 2008 Issuance

Page 6 of 20

OCDDWSS-CPOC-NOW2025

SECTION V: PERSONAL OUTCOMES **Confidential**

Vision:

NOTE: Planning must include and reflect emergency backup plans where the health and welfare of the recipient may be adversely affected.

MY PERSONAL OUTCOMES	SUPPORT STRATEGY NEEDED	HOW OFTEN FOR SUPPORTS AND SERVICES	REVIEW/ACCOMPLISHED DATE
What I want for myself. What is important to me right now? What do I want /expect as a result of supports and services?	What I need to achieve my personal outcomes. How will services and supports be provided to me? Who will deliver the services and supports (Paid/unpaid)? Where will services and supports be provided? What (if any) assistive devices will be required? **Be Specific**	How and when (how often) do I want services and supports provided? **Be Specific**	When/how often will the supports and services be reviewed. When was the personal outcome accomplished/achieved? Is this still an outcome I want in my life now? Has anything changed in my life that needs to be addressed at this time? **Be Specific** **Date** **Review** **Accomplished**
1.	1.	1.	1.
2.	2.	2.	2.
3.	3.	3.	3.

NAME: _____

Revised August 16, 2010
Replaces November 14, 2008 Issuance

Page 7 of 20

OCDDWSS-CPOC-NOW2025

SECTION V: PERSONAL OUTCOMES (CONTINUED) **Confidential**

NOTE: Planning must include and reflect emergency backup plans where the health and welfare of the recipient may be adversely affected.

MY PERSONAL OUTCOMES	SUPPORT STRATEGY NEEDED	HOW OFTEN FOR SUPPORTS AND SERVICES	REVIEW/ACCOMPLISHED DATE
What I want for myself. What is important to me right now? What do I want /expect as a result of supports and services?	What I need to achieve my personal outcomes. How will services and supports be provided to me? Who will deliver the services and supports (Paid/unpaid)? Where will services and supports be provided? What (if any) assistive devices will be required? **Be Specific**	How and when (how often) do I want services and supports provided? **Be Specific**	When/how often will the supports and services be reviewed. When was the personal outcome accomplished/achieved? Is this still an outcome I want in my life now? Has anything changed in my life that needs to be addressed at this time? **Be Specific** **Review Date** **Accomplished**
4.	**4.**	**4.**	**4.**

NAME: _____

Revised August 16, 2010
Replaces November 14, 2008 Issuance

Page 8 of 20

OCDDWSS-CPOC-NOW2025

CONFIDENTIAL

SECTION VI: IDENTIFIED SERVICES, NEEDS, AND SUPPORTS

IDENTIFIED SERVICES AND SUPPORTS THAT WILL HELP ME MAINTAIN AND/OR ACHIEVE MY PERSONAL OUTCOMES.

NOW Waiver	NOW WAIVER	MEDICAID FUNDED SERVICES	NON-WAIVER SUPPORT
☐ Individual/Family Support (IFS) ☐ Day (D) ☐ Night (N) ☐ SHARED SUPPORTS ☐ IFS – D ☐ IFS – N ☐ SKILLED NURSING ☐ CID ☐ SUBSTITUTE FAMILY CARE ☐ CENTER-BASED RESPITE ☐ PROFESSIONAL CONSULTATION ☐ PROFESSIONAL SERVICES ☐ TRANSITION PROFESSIONAL SUPPORT ☐ SKILLED NURSING SERVICES ☐ ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS ☐ Specialized Medical Equipment and Supplies ☐ Personal Emergency Response SYSTEM (PERS) ☐ Community Integration Development (CID)	☐ Supported Employment ☐ Transportation – REG ☐ TRANSPORTATION – W/C ☐ EMPLOYMENT-RELATED TRAINING ☐ DAY HABILITATION ☐ DAY HAB/EMPLOYMENT-RELATED TRAINING SERVICES TRANSPORTATION ☐ TRANSPORTATION – REG ☐ TRANSPORTATION – W/C	☐ Dental ☐ Eye Glasses ☐ Home Health Extended ☐ Hospice ☐ Medical Transportation ☐ Mental Health ☐ Podiatry Services ☐ Substance Abuse ☐ Prescriptions/Medication ☐ Others	☐ OCDD ☐ LRS ☐ DSS
☐ Supported Independent Living (SIL)			☐ Natural Supports
☐ One-Time Transitional Expenses			☐ Community Supports

NOTE: Informed individual of all state plan services. Case Manager Initials: _____

NAME: _____

Revised August 16, 2010
Replaces November 14, 2008 Issuance

Page 9 of 20

OCDDWSS-CPOC-NOW2025

Section VII: Typical Weekly Schedule **Confidential**

FOR PLANNING PURPOSES ONLY. IF NEEDS CHANGE, I WILL CONTACT MY CASE MANAGER AS SOON AS POSSIBLE.

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
12:00 AM							
1:00 AM							
2:00 AM							
3:00 AM							
4:00 AM							
5:00 AM							
6:00 AM							
7:00 AM							
8:00 AM							
9:00 AM							
10:00 AM							
11:00 AM							
12:00 PM							
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							

CODE	HOURS
F = FAMILY	
FR = FRIENDS	
S = SELF	
SC = SCHOOL	
W = WORK	
PW = PAID WAIVER	
P = PAID SUPPORT	
Total	

COMMENTS:

* FOR ALL PW SERVICES IDENTIFY – EXAMPLE = PW-IFS

NAME: _____

Revised August 16, 2010
Replaces November 14, 2008 Issuance

Page 10 of 20

OCDDWSS-CPOC-NOW2025

Section VIII – Typical Alternate Schedule Confidential

FOR PLANNING PURPOSES ONLY. IF NEEDS CHANGE, I WILL CONTACT MY CASE MANAGER AS SOON AS POSSIBLE.

JANUARY 20__

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				

FEBRUARY 20__

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						

MARCH 20__

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				

COMMENTS:

APRIL 20__

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					

MAY 20__

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				

JUNE 20__

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					

COMMENTS:

JULY 20__

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				

AUGUST 20__

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				

SEPTEMBER 20__

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					

COMMENTS:

OCTOBER 20__

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				

NOVEMBER 20__

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					

DECEMBER 20__

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				

COMMENTS:

NAME: _____

Revised August 16, 2010
Replaces November 14, 2008 Issuance

Page 11 of 20

OCDDWSS-CPOC-NOW2025

SECTION IX (A): CPOC Requested Waiver Services (Budget Sheet) – Typical Weekly & Alternate Schedule **Confidential**

List The Individual's Requested Services As Described In The CPOC. SSN# _____

TYPICAL WEEKLY SCHEDULE – DAILY SERVICE TOTALS

PROVIDER NAME (FULL NAME)	SERVICE PROCEDURE CODE(S)	SERVICE TYPE	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY	TOTAL WEEKLY # OF UNITS OF SERVICE

TYPICAL ALTERNATE SCHEDULE – TOTAL ADDITIONAL UNITS OF SERVICE PER QUARTER

			MTH/ DAY/ YR _____ MTH/DAY/YR- ---------- 1ST PARTIAL QUARTER		MTH/YR---------- MTH/YR. ---------- 1ST FULL QUARTER		MTH/YR._____ MTH/ YR._____ 2ND QUARTER		MTH/YR._____ MTH/ YR._____ 3RD QUARTER		MTH/ YR_____ MTH/DAY/ / YR._____ 4TH PARTIAL QUARTER			TOTAL ALT. COST FOR ALL QUARTERS
PROVIDER NAME (FULL NAME)	SERVICE PROCEDURE CODE(S)	SERVICE TYPE	TOTAL # OF UNITS	DATE/ PURPOSE	TOTAL # OF UNITS	DATE/ PURPOSE	TOTAL # OF UNITS	DATE/ PURPOSE	TOTAL # OF UNITS	DATE/ PURPOSE	TOTAL UNITS (+ OR -)	DATE/ PURPOSE		

*I HAVE REVIEWED THE BUDGET SHEET AND AGREE TO PROVIDE THE ABOVE STATED SERVICES. TOTAL TYPICAL ALTERNATE SCHEDULE COST

*Provider Name/Provider Representative Signature: _____ Date: _____

*Provider Name/Provider Representative Signature: _____ Date: _____

Case Manager Signature: _____ Initials: _____ Date: _____

I HAVE REVIEWED THE BUDGET SHEET AND AM IN AGREEMENT WITH SERVICES AS OUTLINED ABOVE: RECEIPIENT/GUARDIAN SIGNATURE _____ Date_____

WSS Approval Signature: _____ Date: _____

NAME: _____
Revised August 16, 2010
Replaces November 14, 2008 Issuance

Page 12 of 20

OCDDWSS-CPOC-NOW2025

SECTION IX (B): CPOC Requested Waiver Services (Budget Sheet)

1. Provider Name (Full Name)	2. Provider #	3. Service Type	4. Procedure Code(s)	5. Typical Weekly # Of Units	X	6. Cost/ Rate Per Unit	=	7. TOTAL TYPICAL Weekly Costs	X	8. # of Weeks in CPOC Year (52 weeks in a Yr.)	=	9. Total Typical Annual Costs
					X		=		X		=	
					X		=		X		=	
					X		=		X		=	
					X		=		X		=	
					X		=		X		=	
								10. Total Typical Schedule Annual Cost				
								11. Total Typical Alternate Schedule Annual Cost				
								12. Total Combined Typical & Alt. Schedule Annual Cost				

*I HAVE REVIEWED THE BUDGET SHEET AND AGREE TO PROVIDE THE ABOVE STATE SERVICES.

*Provider Name/Provider Representative Signature: _____ Date: _____

*Provider Name/Provider Representative Signature: _____ Date: _____

Case Manager Signature: _____ Initials: _____ Date: _____

I HAVE REVIEWED THE BUDGET SHEET AND AM IN AGREEMENT WITH SERVICES AS OUTLINED ABOVE: RECEIPIENT/GUARDIAN SIGNATURE _____ Date _____

FOR WSS USE ONLY:

APPROVED: _____ DENIED: _____ APPROVED CPOC BEGIN DATE: _____ APPROVED CPOC END DATE: _____

WSS AUTHORIZED REPRESENTATIVE: _____ INITIALS _____ DATE: _____

NAME: _____

Revised August 16, 2010
Replaces November 14, 2008 Issuance

Page 13 of 20

OCDDWSS-CPOC-NOW2025

Section X: CPOC Participants **Confidential**

SIGNATURES OF ALL PLANNING MEETING PARTICIPANTS	
Planning Participant/Relationship	**Planning Participant/Relationship**

SUPPORT COORDINATOR SIGNATURE **Date**

	Participant/Authorized Representative Initials
I have been offered a choice between waiver and institutional services and I have chosen (check one): ___ waiver ___ institutional	
I have been informed of the available support coordination agencies and I have chosen: (Name of Agency Chosen)_____	
I have been offered the choice of available direct service providers from the OCDD Provider Freedom of Choice Listing and I have chosen: (List all Chosen Providers)_____	
I have been informed of all state plan services.	
I have been informed of my rights and responsibilities regarding home and community based waiver services and have been given the WSS Rights and Responsibilities Form which includes information on how to report abuse, neglect, exploitation, or extortion.	
My support coordinator has provided me with the toll-free number to contact the Health Standards Section if I want to report a complaint about my support coordinator or waiver service provider(s). That number is 1-800-660-0488.	

I have reviewed the services contained in this plan. I choose to accept this plan and the services described instead of the alternatives explained or offered to me. I understand it is my responsibility to notify my support coordinator of any change in my status, which might affect the effectiveness of this program. I further agree to notify my support coordinator of any changes in my income, which might affect my financial eligibility. I understand that I have the right to accept or refuse all or part of the services identified in this support plan.

I understand that if I disagree with any decision rendered regarding the approval of this plan, I have the right to an informal discussion with WSS and/or a fair hearing by the DHH Appeals Bureau within 30 days of the approved/denied decision. Contact your WSS Regional Office for an informal discussion. I understand that a DHH Appeals Bureau Fair Hearing may be requested by contacting the DHH Bureau of Appeals, P.O. Box 4183, Baton Rouge, LA 70821-4183.

Participant/Guardian Signature **Date**

Witness **Date**

Reviewed by Support Coordinator Supervisor - Signature/Title:_____ Date:_____

FOR WSS USE ONLY:

PARTICIPANT NAME: **PROGRAM TYPE: NEW OPPORTUNITIES WAIVER**

DATE COMPLETE CPOC RECEIVED IN WSS RO: **WSS PRE-CERT HOME VISIT DATE:**

THIS CPOC MEETS THE IDENTIFIED NEEDS OF THE INDIVIDUAL: ☐ **APPROVED** ☐ **DENIED**

WITHOUT THE SERVICES AVAILABLE THROUGH THIS WAIVER, THE RECIPIENT WOULD QUALIFY FOR INSTITUTIONAL CARE: ☐ YES ☐ NO

APPROVED CPOC BEGIN DATE: **Approved CPOC End Date:**

SERVICES APPROVED:

SIGNATURE/TITLE OF WSS REPRESENTATIVE:

DATE:

NAME:

PERSONAL OUTCOMES WORKSHEETS
(Required as part of CPOC)

"MY PERSONAL OUTCOMES" WORKSHEET **Confidential**

	CURRENT LIFE SITUATION	CURRENT SUPPORT SITUATION – NATURAL AND PAID (WHAT'S GOING ON THAT SUPPORTS MY DESIRED OUTCOME?)	CURRENT LEVEL OF SATISFACTION (1 TO 5 SCALE)
Identity – "Who Am I?"			
1. What Goals have I set for myself? 2. Where and with whom do I want to live? 3. What do I want to do for my work? 4. Who is closest to me? 5. How satisfied am I with the services and supports I receive? 6. How satisfied am I with my personal life situation?			
Autonomy – "My Space"			
7. What are my preferred daily routines? 8. Do I have the time, space, and opportunity for the privacy I need? 9. Am I in control of who knows personal information about me? 10. Do my home, work, and other environments support what I want and need to be?			
Affiliation – "My Community"			
11. Do I have access to the place I want to be? 12. Do I participate in what happens in my community? 13. Am I pleased with the type and extent of my interaction with other people in my community? 14. Am I known for the different social roles I play? 15. Do I have enough friends? 16. Am I respected by others?			
Attainment – "My Success"			
17. Are the supports and services I receive the ones I want? 18. Have I realized any of my personal goals?			
Safe Guards – "My Safe Guards"			
19. Am I connected to the people who support me the most? 20. Am I safe?			
Rights – "My Rights"			
21. Do I exercise the rights that are important to me? 22. Do I feel that I am treated fairly?			
Health and Wellness – "My Health"			
23. Is my health as good as I can make it? 24. Am I free from Abuse and Neglect? 25. Do I have a sense of continuity and security?			

CURRENT LEVEL OF SATISFACTION:

1 – NOT AT ALL SATISFIED: AREA DISCUSSED BUT NO PLANS TO ADDRESS – NOT AT ALL SATISFIED/NO PROGRESS
2 – NOT VERY SATISFIED: AREA DISCUSSED BUT NO ADEQUATELY ADDRESSED/PLANNED FOR – LITTLE OR NO SATISFACTION/PROGRESS
3 – SOMEWHAT SATISFIED: AREA DISCUSSED AND ADDRESSED/PLANNED FOR – SOME SATISFACTION/PROGRESS
4 –SATISFIED: AREA DISCUSSED/PLANNED FOR – MOSTLY SATISFIED WITH NOTICEABLE PROGRESS
5 –VERY SATISFIED : AREA DISCUSSED AND ADEQUATELY PLANNED FOR (I.E., TO MAINTAIN CURRENT STATUS, CONTINUE WITH CURRENT OR ADJUSTED PLAN, ETC.) – VERY SATISFIED AT THIS TIME

NAME: _____

Top/Most Important Personal Outcomes/Goals

Look at the Personal Outcomes Worksheet, Personal Outcomes Importance and Satisfaction Worksheet, as well as other information that will help you in choosing the top/most important things you would like to see change, improve or maintain in your life right now. What matters to you the most? The number of Personal Outcome/Goals will be based on what is most important to you. (Copy this form as needed.)

Use the space below to help you with identifying what matters the most to you in your life right now, and then decide what help/support you need to get what you want.

Outcome/Goal # _____

I want (my desired outcome/goal):

What is currently in place to support/help me get what I want?

What are some barriers that may keep me from getting what I want? (Things/actions that move me further away from what I want):

What do I need to help me get what I want (reach my desired outcome/goal)?

NAME: _____

Top/Most Important Personal Outcomes/Goals

Look at the Personal Outcomes Worksheet, Personal Outcomes Importance and Satisfaction Worksheet, as well as other information that will help you in choosing the top/most important things you would like to see change, improve or maintain in your life right now. What matters to you the most? The number of Personal Outcome/Goals will be based on what is most important to you. (Copy this form as needed.)

Use the space below to help you with identifying what matters the most to you in your life right now, and then decide what help/support you need to get what you want.

Outcome/Goal # _____

I want (my desired outcome/goal):

What is currently in place to support/help me get what I want?

What are some barriers that may keep me from getting what I want? (Things/actions that move me further away from what I want):

What do I need to help me get what I want (reach my desired outcome/goal)?

NAME: _____

Top/Most Important Personal Outcomes/Goals

Look at the Personal Outcomes Worksheet, Personal Outcomes Importance and Satisfaction Worksheet, as well as other information that will help you in choosing the top/most important things you would like to see change, improve or maintain in your life right now. What matters to you the most? The number of Personal Outcome/Goals will be based on what is most important to you. (Copy this form as needed.)

Use the space below to help you with identifying what matters the most to you in your life right now, and then decide what help/support you need to get what you want.

Outcome/Goal # _____

I want (my desired outcome/goal):

What is currently in place to support/help me get what I want?

What are some barriers that may keep me from getting what I want? (Things/actions that move me further away from what I want):

What do I need to help me get what I want (reach my desired outcome/goal)?

NAME: _____

Top/Most Important Personal Outcomes/Goals

Look at the Personal Outcomes Worksheet, Personal Outcomes Importance and Satisfaction Worksheet, as well as other information that will help you in choosing the top/most important things you would like to see change, improve or maintain in your life right now. What matters to you the most? The number of Personal Outcome/Goals will be based on what is most important to you. (Copy this form as needed.)

Use the space below to help you with identifying what matters the most to you in your life right now, and then decide what help/support you need to get what you want.

Outcome/Goal # _____

I want (my desired outcome/goal):

What is currently in place to support/help me get what I want?

What are some barriers that may keep me from getting what I want?
(Things/actions that move me further away from what I want):

What do I need to help me get what I want (reach my desired outcome/goal)?

NAME: _____