Map 109
(Rev 07/08)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

PLAN OF CARE/PRIOR AUTHORIZATION FOR WAIVER SERVICES

- ☐ **Initial**
- ☐ **30 Day**
- ☐ **Annual**
- ☐ **Modification**

Type of Waiver Program

- ☐ **SCL**
- ☐ **HCB**
- ☐ **MP**
- ☐ **ABI**
- ☐ **ABI/LTC**
- ☐ **Traditional**
- ☐ **CDO**
- ☐ **Blended (CDO/Traditional)**

Residential Status

- ☐ **In Home**
- ☐ **Family Home Provider**
- ☐ **Adult Foster Care Provider**
- ☐ **Staffed Residence**
- ☐ **Group Home**

1. MEMBER NAME: ______________________ Last ______________ First ___ MI   Sex: ☐ MALE ☐ FEMALE

2. MEDICAID MEMBER ID #: ____________________________ 3. DOB: ____________________

4. ADDRESS: ____ Street

______________ City ___ State _____ Zip ________ County   5. HOME PHONE:____________

6. CASE MANAGEMENT/SUPPORT BROKER AGENCY (CDO):________________ __________ Phone

7. GUARDIAN NAME: ______________________________ __________ Relationship: __________ Phone

8. POWER OF ATTORNEY: __________________________ __________ Relationship: __________ Phone

9. REPRESENTATIVE NAME (CDO ONLY): ______________________: __________ Relationship

10. ADDRESS: ____ Street

______________ City ___ State _____ Zip ________ County   11. PHONE:______________

12. LEVEL OF CARE (LOC) CERTIFICATION NUMBER: ______________

13. LOC CERTIFICATION DATES: FROM: ____________ TO: ______________

14. PRIMARY CAREGIVER: ______________________________ __________ Relationship

15. ADDRESS: ____ Street

______________ City ___ State _____ Zip ________ County   16. PHONE:______________

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

PLAN OF CARE/PRIOR AUTHORIZATION FOR WAIVER SERVICES

Member Name: ______________________________ **Medicaid Member ID#**:___________________________

Identification of Needs/Outcomes/Services/Providers

NEED(S)	OUTCOMES/GOAL(S)	OBJECTIVES/INTERVENTION(S)	SERVICE CODE	PROVIDER NAME/#

Map 109
(Rev 07/08)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
PLAN OF CARE/PRIOR AUTHORIZATION FOR WAIVER SERVICES

Member Name: ______________________ **Medicaid Member ID#:** ______________ **Date Services Start:** ________

Support Spending Plan

Traditional Waiver Services

Service Code A	Provider Name and Number B	Units per Week C	Units per Month D	Cost per Unit E	Cost per Week (Column CxE) F	Total Cost Monthly (4.6xColumn F) G
						Total Cost per Month $

Consumer Directed Services

Service Code A	Description of Service B	Employee Providing the Service C	Units per week D	Units per Month (Column D x 4.6) E	Hourly Wage F	Number of Hours per Month G	Sum of Wages Times Hours H	Administrative Costs I	Total Monthly Amount J
									Total Cost Per Month $

Map 109
(Rev 07/08)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
PLAN OF CARE/PRIOR AUTHORIZATION FOR WAIVER SERVICES

Member Name: ____ **Medicaid Member ID #:** _______________________

List each provider/employee name, address and telephone number:

Provider/Employee Name	Provider Number	Address	Phone Number

Clinical Summary:
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
PLAN OF CARE/PRIOR AUTHORIZATION FOR WAIVER SERVICES

Member Name: ______________________________ Medicaid Member ID #: ____________________

Emergency Back-up Plan (CDO only)

____

____

____

____

____

____

____

I certify the information contained above is accurate and that I have made an informed choice when selecting the providers/employees to provide each service.

______________________________ ____________________
Member/Guardian Signature Date

______________________________ ____________________
Case Manager/Support Broker Signature Date

______________________________ ____________________
Representative Signature (CDO) Date

Plan of Care/Support Spending Plan ☐ **Approved** ☐ **Denied**

______________________________ ____________________
QIO Signature/Title **Date**