907 KAR 3:090 and E
MATERIAL INCORPORATED BY REFERENCE

MAP-011
Acquired Brain Injury (ABI) Assessment of Needs and Plan of Care

MAP-24B
Acquired Brain Injury (ABI) Recipient's Admission or Discharge
Department for Community Based Services (DCBS) Notification

MAP-26
Acquired Brain Injury (ABI) Waiver Services Program Application

MAP-95
Request for Equipment Form

MAP-350
Long Term Care Facilities and
Home and Community Based Program Certification Form

MAP-552K
Department for Community Based Services Notice of Availability for
Long Term Care/Waiver Agency/Hospice

MAP-4096
Acquired Brain Injury (ABI) Waiver Services Program Memorandum of Understanding

MAP-4097
The Acquired Brain Injury (ABI) Plan of Care

MAP-4098
Acquired Brain Injury (ABI) Plan of Care Modification

MAP-4099
Acquired Brain Injury (ABI) Waiver Services Program Physician Certification

MAP-4102
Freedom of Choice of Home and Community Based Waiver Service Providers

Incident Report

Rancho Los Amigos Level of Cognitive Function Scale

Acquired Brain Injury (ABI) Services and Reimbursement Program Manual
September 2001 (Dirty)

The Request for Kentucky State Police (KSP) Conviction Data Only Employment form is being deleted from the material incorporated by reference. (Dirty)

Filed: _____

MAP-011
Rev. 5/03

DEPARTMENT FOR MEDICAID SERVICES
ABI ASSESSMENT OF NEEDS AND PLAN OF CARE

CERTIFICATION DATE:
RECIPIENT NAME: _____ FROM: _____ THROUGH: _____

RECIPIENT MAID #: _____ CASE MANAGER: _____

AGENCY NAME: _____ PROVIDER #: _____

_____ _____ KY _____ _____
(Provider Address) (City) (Zip code) (County)

_____
(Provider Telephone)

ADMITTED FROM:	BIRTHDATE:	ASSESSMENT/REASSESSMENT:
☐ Home ☐ Staffed Res. ☐ Hospital ☐ Group Home ☐ Long Term Care	_____ Month Day Year	☐ Initial Assessment ☐ Reassessment
DIAGNOSIS: AXIS I: _____ AXIS II: _____ AXIS III: _____ AXIS IV: _____ AXIS V: _____	SEX: ☐ Male ☐ Female	☐ Adjudicated ☐ Non-adjudicated
	CAUSE OF BRAIN INJURY:	DATE OF BRAIN INJURY:

ALLERGIES: _____ HEIGHT: _____ WEIGHT: _____

INDIVIDUAL DEPENDENCIES

DRESSING:
- ☐ Independent
- ☐ Independent with minimal supervision
- ☐ Aid of others
- ☐ Totally dressed
- ☐ Bed attire

GROOMING:
- ☐ Independent
- ☐ Grooms self with supervision
- ☐ Aid of others
- ☐ Totally dressed

BED MOBILITY:
- ☐ Independent
- ☐ Occasional help to turn & sit up
- ☐ Always helped to turn & sit up
- ☐ Turned & repositioned by others

TOILETING:
- ☐ Independent
- ☐ Help to toilet
- ☐ Occasional incontinence
- ☐ Nocturnal incontinence only
- ☐ Incontinent bladder
- ☐ Incontinent bowel

BATHING:
- ☐ Independent
- ☐ Minimal supervision in bathing
- ☐ Supervision only
- ☐ Aid in and out of tub
- ☐ Moderate assistance with bathing
- ☐ Totally bathed

EATING:
- ☐ Independent
- ☐ Independent with minimal supervision
- ☐ Receives help to cut meat/arrange
- ☐ Receives partial help/occasional gagging and choking
- ☐ Totally fed

AMBULATION:
- ☐ Independent
- ☐ Independent with device
- ☐ Aid of one person
- ☐ Aid of two persons
- ☐ Does not walk

TRANSFERRING:
- ☐ Independent
- ☐ Receives guidance only
- ☐ Aid of one person
- ☐ Aid of two persons/ mechanical device
- ☐ Remains bedfast

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CLIENT NAME: _____

VISION: (with glasses if used)

- ☐ Adequate
- ☐ Difficult seeing print
- ☐ Difficult seeing objects
- ☐ No useful vision
- ☐ Not determined

COMMENTS

_____
_____
_____
_____
_____

HEARING: (with hearing aid if used)

- ☐ Adequate
- ☐ Hearing difficulty at level
- ☐ Hears loud sounds only
- ☐ No useful hearing
- ☐ Not determined

COMMENTS

_____
_____
_____
_____
_____

COMMUNICATION:

- ☐ Communicates needs/can be understood
- ☐ Communicates needs with difficulty/can be understood
- ☐ Communicates needs with sign language/gestures
- ☐ Inappropriate content
- ☐ Unable/does not communicate

COMMENTS

_____
_____
_____
_____
_____

BEHAVIOR PROBLEMS:

- ☐ No intervention required
- ☐ Requires verbal cues
- ☐ Exhibits disruptive behavior
- ☐ Exhibits assaultive/self injurious behavior

COMMENTS

_____
_____
_____
_____

SPECIAL TREATMENT:

- ☐ No special procedure
- ☐ Tube feeding
- ☐ Oxygen/Respiratory Therapy (nursing only)
- ☐ Ostomy/Catheter
- ☐ Wound/decubiti care
- ☐ Skin care
- ☐ Rehabilitation procedures
- ☐ Toileting (bladder)
- ☐ Toileting (bowel)
- ☐ Hyper alimentation
- ☐ Intravenous fluids
- ☐ Intravenous medications
- ☐ Blood transfusions
- ☐ Drainage tubes
- ☐ Symptom Control
- ☐ Isolation precautions

MENTAL / EMOTIONAL STATUS:

- ☐ Oriented
- ☐ Minor forgetfulness
- ☐ Partial/intermittent disorientation
- ☐ Total disorientation
- ☐ Comatose
- ☐ Impaired judgment

SELF-PRESERVATION:

- ☐ Independent
- ☐ Minimal supervision
- ☐ Mentally unable
- ☐ Physically unable
- ☐ Both mentally and physically unable

MAP-011
Rev. 5/03
CLIENT NAME: _____

MENTAL/EMOTIONAL STATUS CONTINUED:

CHECK THOSE DIFFICULTIES YOU THINK CLIENT IS EXPERIENCING:

	SOMETIMES	OFTEN	COMMENTS
Recognizing people	☐	☐	
Feeling lonely	☐	☐	
Sleeping problems	☐	☐	
Worried anxious	☐	☐	
Irritable, easily upset	☐	☐	
Loss of interest in things	☐	☐	
Suicidal talk/behavior	☐	☐	
Medication abuse	☐	☐	
Drinking problem	☐	☐	
Memory loss	☐	☐	

Recent major changes or crisis:

_____
_____
_____
_____
_____
_____

NUTRITION

- ☐ Adequate food/fluids
- ☐ Inadequate food/fluids
- ☐ Malnourished
- ☐ Obese
- ☐ Therapeutic diet
- ☐ NG/G tube feeding

ADLS:

	CAN DO			HAS HELP		
	No	With Help	Independent	Adequate	Inadequate	No
Cook Meal	☐	☐	☐	☐	☐	☐
Light Housekeeping	☐	☐	☐	☐	☐	☐
Heavy Housework	☐	☐	☐	☐	☐	☐
Laundry	☐	☐	☐	☐	☐	☐
Shop	☐	☐	☐	☐	☐	☐
Take Medicine	☐	☐	☐	☐	☐	☐
Travel	☐	☐	☐	☐	☐	☐
Handle Money	☐	☐	☐	☐	☐	☐
Use Telephone	☐	☐	☐	☐	☐	☐

COMMENTS:

_____
_____
_____

MAP-011
Rev. 5/03
CLIENT NAME: _____

PHYSICAL ENVIRONMENT:

	YES	NO	COMMENTS
Sound Building	☐	☐	
Sound Furnishings	☐	☐	
Indoor Plumbing	☐	☐	
Running Water	☐	☐	
Hot Water	☐	☐	
Adequate Heating/Cooling	☐	☐	
Tub/Shower	☐	☐	
Stove	☐	☐	
Refrigerator	☐	☐	
Microwave	☐	☐	
Telephone	☐	☐	
TV/Radio	☐	☐	
Washer/Dryer	☐	☐	
Adequate Lighting	☐	☐	
Adequate Locks	☐	☐	
Adequate Fire Escape	☐	☐	
Smoke Alarms	☐	☐	
Insect/Rodent Problem	☐	☐	
Accessibility Problems	☐	☐	

ADAPTIVE EQUIPMENT:

	NEEDS	HAS	USES	COMMENTS
Dentures	☐	☐	☐	
Hearing Aid	☐	☐	☐	
Glasses/Lenses	☐	☐	☐	
Hospital Bed	☐	☐	☐	
Commode	☐	☐	☐	
Prosthesis	☐	☐	☐	
Ambulation Aid	☐	☐	☐	
Hoyer Lift	☐	☐	☐	
Bathroom Aids	☐	☐	☐	
Hearing Impaired Devices	☐	☐	☐	
Wheel Chair Ramp	☐	☐	☐	

Guardian Name: _____ Address: _____

_____ Guardian Telephone Number: _____

Primary Caretaker

Name/Relationship Address/Phone #	Age	Functional Ability	Care Provided/ Frequency

RESPITE: Are respite services needed? ☐ Yes ☐ No

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CLIENT NAME: _____

MEDICATIONS:

Medication	Dosage	Frequency	Route	Purpose

HOSPITAL/NURSING HOME ADMISSIONS (PAST 6 MONTHS):

_____
_____
_____

FORMAL SUPPORT SYSTEM (Assistance provided by an agency/organization):

Agency/Worker	Address/Phone #	Frequency

TRADITIONAL HOME HEALTH SERVICES (Cost Factors):
(Please list services covered by Medicare/Medicaid/Third Party Insurance)

Service	Units per week	Coverage	(Medicare, Medicaid Private Insurance, Private Pay)

MAP-011
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DEPARTMENT FOR MEDICAID SERVICES

RECIPIENT NAME: _____

SUMMARY OF RECIPIENT'S SITUATION & PERSONAL PROFILE (likes, dislikes, non-negotiable):

Neuro/Emotional Behavioral Status:

1. **Cognitive functioning (Participant's current level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands)**
   - ☐ Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
   - ☐ Requires prompting (cueing, repetition, reminders) only under stressful or unfamiliar conditions.
   - ☐ Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.
   - ☐ Required considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
   - ☐ Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

2. **When Confused (Reported or Observed):**
   - ☐ Never
   - ☐ In new or complex situations only
   - ☐ On awakening or at night only
   - ☐ During the day and evening, but not constantly
   - ☐ Constantly
   - ☐ NA (non-responsive)

3. **When Anxious (Reported or Observed):**
   - ☐ None of the time
   - ☐ Less often than daily
   - ☐ Daily, but not constantly
   - ☐ All of the time
   - ☐ NA (non-responsive)

4. **Depressive Feelings (Reported or Observed):**
   - ☐ Depressed mood (e.g., feeling sad, tearful)
   - ☐ Sense of failure or self-reproach
   - ☐ Hopelessness
   - ☐ Recurrent thoughts of death
   - ☐ Thoughts of suicide
   - ☐ None of the above feelings reported or observed

5. **Patient Behaviors (Reported or Observed):**
   - ☐ Indecisiveness, lack of concentration
   - ☐ Diminished interest in most activities
   - ☐ Sleep disturbances
   - ☐ Recent changes in appetite or weight
   - ☐ Agitation
   - ☐ Suicide attempt
   - ☐ None of the above behaviors observed or reported

6. **Behaviors Demonstrated at Least Once a Week:**
   - ☐ Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24-hours, significant memory loss so that supervision is required.
   - ☐ Impaired decision-making: failure to perform usual ADL's, inability to inappropriately stop activities, jeopardizes safety through actions.
   - ☐ Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
   - ☐ Physical aggression: aggressive or combative to self and others (e.g. hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects).
   - ☐ Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions).
   - ☐ Delusional, hallucinatory, or paranoid behavior.
   - ☐ None of the above behaviors demonstrated.

7. Frequency of Behavior Problems (Reported or Observed) such as wandering episodes, self abuse, verbal disruption, physical aggression, etc.:

- ☐ Never
- ☐ Less than once a month
- ☐ Once a month
- ☐ Several times each month
- ☐ Several times a week
- ☐ At least daily

8. Is this patient receiving Psychiatric Nursing Services at home provided by a qualified psychiatric nurse?

- ☐ No
- ☐ Yes

9. Mental Status:

- ☐ Oriented
- ☐ Forgetful
- ☐ Depressed
- ☐ Disoriented
- ☐ Lethargic
- ☐ Agitated
- ☐ Other _____

COMMENTS:

IDENTIFICATION OF NEEDS/GOALS/SERVICES/PROVIDER

Recipient Name: _____ **MAID #:** _____

Certification Period: _____

Date	Identified Need	Goal	Objective	Service	Provider

MAP-011
Revised 5/0_

Recipient Name: _____ **MAID #:** _____

Provider Name & Number	Service	Units Duration/Frequency	Monthly Cost

Total Monthly Cost: _____

Interdisciplinary Team:

_____ Date: _____ _____ Date: _____

_____ Date: _____ _____ Date: _____

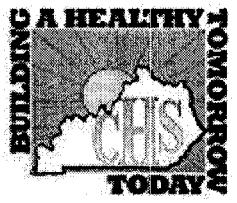
_____ Date: _____ _____ Date: _____

The services prescribed above have been explained to me and I agree to receive these services.

_____ _____
Recipient/Legal Representative Date

_____ _____
Case Manager Date

CABINET FOR HEALTH SERVICES
COMMONWEALTH OF KENTUCKY
FRANKFORT, 40621-0001



DEPARTMENT FOR MEDICAID SERVICES
"An Equal Opportunity Employer M/F/D"

ACQUIRED BRAIN INJURY SERVICES RECIPIENT'S ADMISSION DISCHARGE DEPARTMENT FOR COMMUNITY BASED SERVICES NOTIFICATION FORM

INSTRUCTIONS MAP-24B

Upon discharge of an individual from the Acquired Brain Injury (ABI) Waiver Program, the case manager shall forward a MAP-24B form to the local office, Department for Community Based Services (DCBS) and the Department for Mental Health/Mental Retardation (DMH/MR) Services. The case manager shall complete the form through line seven (7).

This form is also to be used by the DMH/MR Services to notify the DCBS when a Medicaid applicant/recipient is admitted to or discharged from the ABI Waiver Program. These forms should be mailed to the local DCBS office where the family or interested party of the applicant or recipient resides. A copy of the MAP-24B form should be mailed to the case manager.

Use the following instructions to fill in the blanks on the MAP-24B:

Line One (1): Address form to the local county Department for Community Based Services.

Line Two (2): List name of Department for MH/MR staff person who completed the MAP-24B form.

Line Three (3): List the date the form was prepared.

Line Four (4): List the last name, first name, middle initial and social security number of the recipient/applicant.

Line Five (5): List the current address, city, zip code and telephone number of the recipient/applicant.

Line Six (6): List date applicant/recipient was admitted/discharged to the brain injury program.

Line Seven (7): List name, provider number and monthly cost of the case manager.

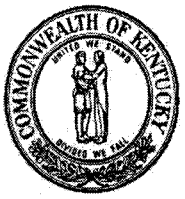
Line Eight (8): List complete address, and telephone number of case manager.

Line Nine (9): List the name, provider number and monthly cost of the primary provider.

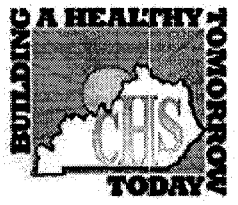
Line Ten (10): List complete address and telephone number of primary provider.

Line Eleven (11), Twelve (12), Thirteen (13) and Fourteen (14): List the name, telephone number, provider number and monthly costs for each additional provider.

MAP-24B
Revised 5/03



CABINET FOR HEALTH SERVICES
COMMONWEALTH OF KENTUCKY
FRANKFORT, 40621-0001



DEPARTMENT FOR MEDICAID SERVICES
"An Equal Opportunity Employer M/F/D"

To: _____ County Office
Department for Community Based Services

From: _____
Department for Mental Health/Mental Retardation

Date: _____

Subject: Brain Injury Waiver Admission/Discharge

_____ (last name) _____ (first name) _____ (mi) _____-_____-_____ (social security number)

_____ (address) _____ (city) KY _____ (zip code) _____ (telephone number)

was admitted/discharged to the Brain Injury Waiver Program on

_____ (date).

The case manager is _____ (name) _____ (provider number) _____ (cost)

_____ (address) _____ (city) KY _____ (zip code) _____ (telephone number)

Primary Provider: _____ (name) _____ (provider number) _____ (cost)

_____ (address) _____ (city) KY _____ (zip code) _____ (telephone number)

_____ (name) _____ (telephone number) _____ (provider number) _____ (monthly cost)

_____ (name) _____ (telephone number) _____ (provider number) _____ (monthly cost)

_____ (name) _____ (telephone number) _____ (provider number) _____ (monthly cost)

MAP-26
Edition 5/03

Cabinet for Health Services
Department for Medicaid Services

For BISU Use Only:

Date received:	Time received:
Received by:	Date notice sent:

PROGRAM APPLICATION
KENTUCKY MEDICAID PROGRAM
ACQUIRED BRAIN INJURY (ABI) WAIVER SERVICES PROGRAM

Please provide the following personal information for the individual seeking services through the Medicaid waiver.

Name: _____ Medical Assistance #: _____

Mailing Address: _____

Date of Birth: _____ Telephone #: _____

Name of guardian (if applicable): _____

Address of guardian: _____

Guardian Telephone #: _____

Name of individual's caregiver (if applicable): _____

Address of caregiver: _____

Caregiver Telephone #: _____

Please answer the following questions.

1. Has the individual identified a case management provider to assist in securing and coordinating services once you are admitted to the ABI waiver program? ☐ Yes ☐ No

2. If yes, what is the name of the organization that will provide case management?

3. Does the individual currently demonstrate behavior that places himself/herself or a caregiver at risk of significant harm? ☐ Yes ☐ No

4. If yes, please attach a statement from a physician or other qualified mental health professional describing the nature and extent of the risk of harm involved.

Cabinet for Health Services
Department for Medicaid Services

PROGRAM APPLICATION
KENTUCKY MEDICAID PROGRAM
ACQUIRED BRAIN INJURY (ABI) WAIVER SERVICES PROGRAM

5. Has the individual been arrested? ☐ Yes ☐ No

6. If yes, please attach a statement from law enforcement or the court indicating when the type of offense(s) for which the individual has been arrested.

_____
Signature of guardian

_____
Signature of applicant

_____
Name of person completing application

_____
Relationship to applicant

_____
Telephone # of person completing application

Questions about individual referrals or the Medicaid Acquired Brain Injury Waiver program may be directed to the brain Injury Services Unit by calling, toll free, (800) 374-9146. Thank you.

Cabinet for Health Services
Department for Medicaid Services

PROGRAM APPLICATION
KENTUCKY MEDICAID PROGRAM
ACQUIRED BRAIN INJURY (ABI) WAIVER SERVICES PROGRAM

To be placed on the Acquired Brain Injury Medicaid Waiver waiting list, an individual must first submit this application and a signed physician certification form. A copy of the physician certification form is enclosed for your use. Please mail the completed application and the signed physician's certification form to:

Brain Injury Services Unit
100 Fair Oaks Lane, 4W-C
Frankfort, Kentucky 40621

An individual will be placed in the waiting list in the order in which the application and the physician certification form are received in the office of the Brain Injury Services Unit. If the individual meets one of the following emergency criteria, he/she will be determined to have emergency status. Funding available will be allocated to individuals having emergency status prior to allocating funding to individuals having non-emergency status. The emergency status criteria are:

1. The individual is demonstrating behavior that places himself/herself, the caregiver, or others at risk of significant harm; OR

2. The recipient is demonstrating behavior which has resulted in arrest

If the individual is applying for emergency status, please provide detailed written information explaining his/her current circumstances. Additional sheets of paper may be used.

MAP-95
Revised 09/02

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

REQUEST FOR EQUIPMENT FORM

RECIPIENT'S NAME _____ MAID # _____ BIRTHDATE _____
Mo Day Yr

List Other Insurance Coverage _____

Estimated Time Needed # Months_____ Indefinitely _____ Permanently _____

Specific Equipment Item Requested: Please include Medicare codes for parts to items such as Braces, Prostheses, and Wheelchairs (if applicable). Otherwise, group parts together under Code E1399 or appropriate miscellaneous code for braces/prostheses.

PURCHASES:

ITEM	CODE	MANUFACTURER'S SUGGESTED LIST PRICE (IC ITEMS ONLY)	AGENCY'S ACQUISITION COST (ALL ITEMS)

Trade Name/Model Number of Equipment item (if applicable) _____

_____

Manufacturer's Name _____

RENTAL:

If Rental is Requested, Please Specify Amount $_____

Supplier of Equipment _____

Address _____

Date of Delivery if Equipment Item is Already Place in Home – Date _____

Agency Name _____ Provider # _____

Authorized Signature _____ Date _____

LONG TERM CARE FACILITIES AND HOME AND COMMUNITY BASED PROGRAM CERTIFICATION FORM

I. ESTATE RECOVERY

Pursuant to the Omnibus Budget Reconciliation Act (OBRA) of 1993, states are required to recover from an individual's estate the amount of Medicaid benefits paid on the individual's behalf during a period of institutionalization or during a period when an individual is receiving community based services as an alternative to institutionalization.

In compliance with Section 1917 (b) of the Social Security Act, estate recovery will apply to nursing facility long term care services (NF, NF/BI, ICF/MR/DD), home and community based services that are an alternative to long term care facility services and related hospital and prescription drug services.

Recovery will only be made from an estate if there is no surviving spouse, or children under age 21, or children of any age who are blind or disabled.

I certify that I have read and understand the above information.

_____ _____
Signature Date

II. HOME AND COMMUNITY BASED WAIVER SERVICES FOR THE AGED AND DISABLED, PEOPLE WITH MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES, MODEL WAIVER II, BRAIN INJURY WAIVER

A. HCBS - This is to certify that I/ legal representative have been informed of the HCBS waiver for the aged and disabled. Consideration for the HCBS program as an alternative to NF placement is requested _____; is not requested _____.

_____ _____
Signature Date

B. This is to certify that I/legal representative have been informed of the home and community based waiver program for people with mental retardation/ developmental disabilities. Consideration for the waiver program as an alternative to ICF/MR/DD is requested _____; is not requested _____.

_____ _____
Signature Date

C. MODEL WAIVER II - This is to certify that I/legal representative have been informed of the Model Waiver II program. Consideration for the Model Waiver II program as an alternative to NF placement is requested _____; is not requested _____.

_____ _____
Signature Date

D. BRAIN INJURY (BI) WAIVER - This is to certify that I/legal representative have been informed of the BI Waiver Program. Consideration for the BI Waiver Program as an alternative to NF or NF/BI placement is requested _____; is not requested _____.

_____ _____
Signature Date

III. FREEDOM OF CHOICE OF PROVIDER

I understand that under the waiver programs, I may request services from any Medicaid provider qualified to provide the service and that a listing of currently enrolled Medicaid providers may be obtained from Medicaid Services.

_____ _____
Signature Date

IV. RESOURCE ASSESSMENT CERTIFICATION

This is to certify that I/legal representative have been informed of the availability, without cost, of resource assessments to assist with financial planning provided by the Department for Community Based Services.

_____ _____
Signature Date

V. RECIPIENT INFORMATION

Medicaid Recipient's Name: _____

Address of Recipient: _____

_____

Phone: _____

Medicaid Number: _____

Responsible Party/Legal Representative: _____

Address: _____

_____

Phone: _____

Signature and Title of Person Assisting with Completion of Form:

_____

Agency/Facility: _____

Address: _____

MAP-552K
(01/01)

DEPARTMENT FOR COMMUNITY BASED SERVICES
NOTICE OF AVAILABILITY OF INCOME FOR LONGTERM CARE/WAIVER AGENCY/HOSPICE

MAID NUMBER:
PROGRAM: COUNTY:

( ) INITIAL ( ) CORRECTION
( ) CHANGE ( ) SPECIAL CIRCUMSTANCE
( ) SSN CHANGE ( ) DISCHARGE

CLIENT'S NAME: BIRTH DATE:

PROVIDER NUMBER:
ADMISSION DATE: DISCHARGE DATE: DEATH DATE:
LEVEL OF CARE: LTC INELIGIBLE DATE:

FAMILY STATUS: SPOUSE STATUS:

INCOME COMPUTATION

UNEARNED INCOME SOURCE	AMOUNT
RSDI	$.00
SSI	$.00
RR	$.00
VA	$.00
STATE SUPPLEMENTATION	$.00
OTHER	$.00
SUB-TOTAL UNEARNED INC.	$.00

EARNED INCOME	AMOUNT
WAGES	$.00
EARNED INCOME DEDUCTION	$.00
SUB-TOTAL EARNED INC.	$.00

TOTAL INCOME $.00

DEDUCTIONS	AMOUNT
PERSONAL NEEDS ALLOWANCE	$.00
INCREASED PNA	$.00
SPOUSE/FAMILY MAINT.	$.00
SMI	$.00
HEALTH INSURANCE	$.00
INCURRED MEDICAL EXPENSES	$.00
TOTAL DEDUCTIONS	$.00

THIRD PARTY PAYMENTS $.00

AVAILABLE INCOME $.00
AVAILABLE INCOME (ROUNDED) $.00

CASE STATUS
ACTIVE CASE:
IF ACTIVE, EFF. MA DATE:
IF DISC, EFF. MA DISC:

NOTIF. FORM: DMS LETTER OF APPROVAL
DATE PATIENT STATUS MET:

EFF. DATE OF CORR:
ENDING DATE OF CORR:

PRIVATE PAY PATIENT
FROM: THRU:

AVAILABLE MONTHLY INCOME: $.00 EFFECTIVE DATE:

WORKER CODE: CASELOAD CODE: UPDATE DATE:

MAP-4096
Revised 5/03

COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES
AQUIRED BRAIN INJURY WAIVER SERVICES PROGRAM
APPLICANT/RECIPIENT MEMORANDUM OF UNDERSTANDING

I, _____ and/or _____ my legal representative or family
Applicant name
member have been informed on _____ and understand the following:
Date

1. The Medicaid Acquired Brain Injury Waiver Services Program provides temporary part-time assistance to me, _____ and others who are involved in my care;
Applicant name

2. The acquired brain injury services are available only so long as my care needs meet the Kentucky Medicaid Program nursing facility level of care requirements which allow Medicaid payment;

3. The provision of services under the Program do not replace services provided by family members and other community resources at no cost to the Medicaid Program;

4. To be Medicaid-reimbursed, acquired brain injury waiver services shall be provided in accordance with the written plan of care developed by health care professionals who are assisting me with my rehabilitation and retaining (the plan of care is developed with my knowledge and input);

5. I and my caregivers are obligated to actively participate and cooperate in all rehabilitation and retraining provided to me by the Acquired Brain Injury Waiver Program as we work toward the common goal of my discharge from the Program; and,

6. I and my caregivers are obligated to actively work together toward a common goal of discharge from the Program.

I and/or my legal representative also acknowledge and accept that I shall be discharged from the Acquired Brain Injury Waiver Services Program:

1. At such time the Department for Medicaid Services, or its designated agent, determines that I no longer meet the nursing facility level of care criteria;

2. When it is determined by the Department for Medicaid services, or its designed agent, that the provision of waiver and other Medicaid-covered services in the community are more expensive than they would be if provided in a nursing facility; and/ or,

3. When it is determined by the Department for Medicaid Services, or its designed agent, that I am able to function in the community without acquired brain injury waiver services with the assistance of family, other informal supports and community services that are usually available.

We further understand that my Medicaid financial eligibility could end upon discharge from the Waiver Program, if my eligibility is based on the special income provision of the Acquired Brain Injury Waiver Services Program or spend-down.

I have been informed of my appeal rights under the Acquired Brain Injury Waiver Services Program.

Recipient/ Applicant	Legal Counsel (If Applicable)	Date
Family Member	Relationship	Date
Legal Representative	Title	Date
Case Manager/Witness	Employer Agency	Date

MAP-4098
Revised 5/03

ACQUIRED BRAIN INJURY
PLAN OF CARE MODIFICATION

Effective Date of Requested Change:

____/____/____

Case Manager: _____
Name **Phone**

Individual's Name: _____ **MAID #:** _____

What has happened to the individual, which necessitates a plan of care change?

_____

_____

_____

_____

_____

Changes Requested:

	Service/Code	Provider Number	Frequency/Duration
A. Addition			
B. Deletion			
C. Change			

Who participated in the decision-making that determined the need for a plan of care change?

_____

_____

_____

_____

_____

_____ _____
Case Manager's Signature **Date**

MAP-4099
Revised 5/03

KENTUCKY MEDICAID PROGRAM
ACQUIRED BRAIN INJURY WAIVER
SERVICES PROGRAM
PHYSICIAN CERTIFICATION FORM

TO: _____

AGENCY: _____

ADDRESS: _____

_____ PHONE: _____

PHYSICIAN'S RECOMMENDATION

I recommend the Acquired Brain Injury Waiver Services Program for:

CLIENT: _____

ADDRESS: _____

_____ PHONE: _____

SOCIAL SECURITY #: _____ MAID #: _____

DIAGNOSIS (ES): _____

_____

I certify that if acquired brain injury waiver services were not available, nursing facility placement shall be appropriate for this individual in the near future.

PHYSICIAN'S NAME: _____ UPIN #: _____

ADDRESS: _____

_____

_____ _____
SIGNATURE DATE

MAP – 4102
Revised 5/03

FREEDOM OF CHOICE OF HOME AND COMMUNITY BASED WAIVER SERVICE PROVIDERS

The Home and Community Based Waiver for persons in the Support of Community Living or Acquired of Brain Injury Program offers people freedom to choose from any and all service providers available. Attached is a listing of all providers enrolled with the State Medicaid Agency who can provide waiver services. Please indicate below the providers of your choice and sign and date the form.

SERVICES REQUESTED	PROVIDER REQUESTED
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____
Signature

_____
Date

ABI	☐
SCL	☐
SGF	☐

INCIDENT REPORT

Incident Class	
Class I	☐
Class II	☐
Class III	☐

IDENTIFYING INFORMATION:

MAID/SS#:_____ Name:_____

DOB:___/___/___ Reporting Agency:_____ Provider #_____

Reporting Person:_____ Title:_____ Phone:_____

Support Coordination Provider:_____ Support Coordinator:_____

INCIDENT INFORMATION:

Date of Incident:___/___/___ Time:___:___AM PM

Location (where occurred):

CH ☐ Group Home ☐ FHP ☐ Respite ☐ Staffed Residence ☐ In-Home ☐ Community ☐ Community Job ☐ Other_____☐

DESCRIPTION OF INCIDENT: (To be completed by staff witnessing or discovering the incident)

Who was involved? What happened? Where did it happen? Action Taken?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ / / ___

Signature of Person Reporting **Title** **Date**

	NOTIFICATIONS			FINAL REPORT		
Reported to:	Class I 24 hours	Class II 24 hours	Class III 8 hours	Class I 10 days	Class II 10 days	Class III 7 days
Support Coordinator	Date:___/___/___ Time:_____am pm By whom:	Date:___/___/___ Time:_____am pm By whom:	Date:___/___/___ Time:_____am pm By whom:	Date:___/___/___ Time:_____am pm By whom:	Date:___/___/___ Time:_____am pm By whom:	Date:___/___/___ Time:_____am pm By whom:
DMR	N/A	N/A	Date:___/___/___ Time:_____am pm By whom:	N/A	Date:___/___/___ Time:_____am pm By whom:	Date:___/___/___ Time:_____am pm By whom:
Guardian/ Individual	Date:___/___/___ Time:_____am pm By whom:	Date:___/___/___ Time:_____am pm By whom:	Date:___/___/___ Time:_____am pm By whom:	Date:___/___/___ Time:_____am pm By whom:	Date:___/___/___ Time:_____am pm By whom:	Date:___/___/___ Time:_____am pm By whom:
DCBS	N/A	N/A	**IMMEDIATE** Date:___/___/___ Time:_____am pm By whom:	N/A	N/A	Date:___/___/___ Time:_____am pm By whom:
Other	Date:___/___/___ Time:_____am pm By whom:	Date:___/___/___ Time:_____am pm By whom:	Date:___/___/___ Time:_____am pm By whom:	Date:___/___/___ Time:_____am pm By whom:	Date:___/___/___ Time:_____am pm By whom:	Date:___/___/___ Time:_____am pm By whom:

MAID/SS# _____ Name: _____ Date of Incident:_____

Revision 2/03

SUPERVISOR/SUPPORT COORDINATOR REVIEW

INCIDENT FOLLOW-UP:

Analysis of incident, staff action taken and incident follow-up:_____

_____

_____

_____

_____

How could this incident have been prevented and how can this incident be avoided in the future? (who made this decision)_____

_____

_____

_____

_____

Staff training needs identified (include training plan and who's responsible):_____

_____

_____

_____

_____

Individual support needs identified:_____

_____

_____

_____

_____

Current Status:_____

_____

_____

_____

Submitted by:_____ Title:_____ Date:___/___/___

Additional Signatures:

_____ Title: Support Coordinator Date:___/___/____

_____ Title:_____ Date:___/___/____

_____ Title:_____ Date:___/___/____

MAID/SS#:_____ Name:_____ Date of Incident:___/___/___

Incident Codes (Check ALL that apply)

A SUSPECTED/ALLEGED ABUSE
- 1 Emotional, Community Person to Individual
- 2 Emotional, Parent/Family to Individual
- 3 Emotional, Individual to Individual
- 4 Emotional, Staff to Individual
- 5 Physical, Community Person to Individual
- 6 Physical, Parent/Family to Individual
- 7 Physical, Individual to Individual
- 8 Physical, Staff to Individual
- 9 Sexual, Community Person to Individual
- 10 Sexual, Parent/Family to Individual
- 11 Sexual, Individual to Individual
- 12 Sexual, Staff to Individual
- 13 Verbal, Community Person to Individual
- 14 Verbal, Parent/Family to Individual
- 15 Verbal, Individual to Individual
- 16 Verbal, Staff to Individual
- 17 Unknown

B SUSPECTED/ALLEGED NEGLECT
- 1 Community Person to Individual
- 2 Parent/Family to Individual
- 3 Staff to Individual
- 4 Unknown

C SUSPECTED/ALLEGED EXPLOITATION
- 1 Community Person to Individual
- 2 Parent/Family to Individual
- 3 Individual to Individual
- 4 Staff to Individual
- 5 Unknown

D DEATH OF PERSON
- 1 Accident
- 2 Criminal Act
- 3 Illness
- 4 Natural Causes
- 5 Suicide

E RESTRAINT
- 1 Unnecessary Restraint
- 2 Emergency Chemical Restraint
- 3 Emergency Physical Restraint
- 4 Emergency Mechanical Restraint

F SEVERE BEHAVIORAL ISSUES
- 1 Sexual Contact
- 2 Threatened Suicide
- 3 Attempted Suicide
- 4 Severe Behavior Outburst
- 5 Property Damage
- 6 Self Abuse
- 7 Individual aggressed to Staff
- 8 Peer to Peer aggression

G SERVICE SITE/RESIDENCE UNINHABITABLE
- 1 Loss of Electric
- 2 Loss of Heat
- 3 Loss of Water
- 4 Other Safety Issues

H SERVICE SITE/RESIDENTIAL FIRE
- 1 Requiring Relocation
- 2 Resulting in Personal Injury
- 3 Resulting in Property Loss

I ACT UNACCEPTABLE BY PUBLIC
- 1 Individual
- 2 Staff

J HOSPITAL VISIT/ADMISSION
- 1 Emergency Room
- 2 In-patient
- 3 Medical
- 4 Medical, Medication Therapy IV
- 5 Medical, Surgery
- 6 Psychiatric, Behavior reasons
- 7 Psychiatric, Medication Adjustment
- 8 Psychiatric, Suicidal
- 9 Psychiatric, Threat to Others
- 10 Physician's Office/Clinic

K PERSON MISSING FROM
- 1 Community Habilitation Site
- 2 Residence
- 3 Community
- 4 Other

L ADMISSION TO NURSING FACILITY
- 1 Medical Needs
- 2 Rehabilitative Needs

M SERIOUS INJURY RESULTING IN
- 1 Cast Applied
- 2 Medical Procedure (MRI, Xray)
- 3 Medication
- 4 Referral to other Physician
- 5 Splints
- 6 Stitches/Staples
- 7 Wrapping
- 8 Other

N MEDICATION ERROR
- 1 Dose(s) Missed Entirely
- 2 Not within admin window when due
- 3 Wrong Dose Given
- 4 Wrong Medication Given
- 5 Wrong Route
- 6 Other

O CRIMINAL ACTION AS VICTIM/PERPETRATOR
- 1 Arrested
- 2 Victim of a Crime
- 3 Other

P INJURED PART OF BODY
- 1 Abdomen
- 2 Ankle Left
- 3 Ankle Right
- 4 Anus
- 5 Arm Left
- 6 Arm Right
- 7 Back Left
- 8 Back Right
- 9 Buttocks
- 10 Chest Left
- 11 Chest Right
- 12 Chin
- 13 Collarbone
- 14 Ears
- 15 Eyes
- 16 Face
- 17 Fingers Left Hand
- 18 Fingers Right Hand
- 19 Foot Left
- 20 Foot Right
- 21 Genitals
- 22 Groin Area
- 23 Hand Left
- 24 Hand Right
- 25 Head Back
- 26 Head Front
- 27 Knee Left
- 28 Knee Right
- 29 Leg Left
- 30 Leg Right
- 31 Lips
- 32 Mouth
- 33 Neck
- 34 Nose
- 35 Rib
- 36 Shoulder Left
- 37 Shoulder Right
- 38 Teeth
- 39 Throat
- 40 Toes Left
- 41 Toes Right
- 42 Other
- 43 Hip
- 44 Wrist Left
- 45 Wrist Right

Q CAUSE OF INJURY
- 1 Accident
- 2 Bite/Sting
- 3 Equipment Failure
- 4 Equipment Operator Error
- 5 Fall
- 6 Individual's Behavior
- 7 Lift/Transfer Error
- 8 Medical Condition
- 9 Scalding
- 10 Staff Person
- 11 Unsafe Condition, Service Site
- 12 Unsafe Condition, Home
- 13 Other

R TYPE OF INJURY/EMERGENCY CONDITIONS
- 1 No Apparent Injury
- 2 Abrasions
- 3 Allergic Reaction
- 4 Angina/Chest Pain
- 5 Aspiration
- 6 Asthma
- 7 Bedsores
- 8 Blister
- 9 Blood Clot
- 10 Bone Breaks/Fractures
- 11 Bowel Blockage
- 12 Bronchitis
- 13 Bruises/contusions
- 14 Burns
- 15 Chafed/Chapped
- 16 Choking
- 17 Communicable Disease
- 18 Concussion
- 19 Constipation
- 20 Cracked/Missing Tooth
- 21 Dehydration
- 22 Diarrhea
- 23 Dislocation
- 24 Gout
- 25 Heart Rhythm Irregularities
- 26 Hematoma
- 27 Hepatitis
- 28 High Blood Pressure
- 29 High Blood Sugar
- 30 Irritation/Rash
- 31 Laceration
- 32 Lesion
- 33 Low Blood Sugar
- 34 Malnutrition
- 35 Nausea/Vomiting
- 36 Pneumonia
- 37 Puncture
- 38 Scabies
- 39 Seizures
- 40 Significant Infection
- 41 Skin Ulcers
- 42 Soft Tissue Swelling
- 43 Spasms
- 44 Sprains
- 45 Strains
- 46 Stroke
- 47 Sunburn
- 48 Swallowing Objects
- 49 Ulcers
- 50 Upper Respiratory Infection
- 51 Urinary Tract Infection
- 52 Other
- 53 pain

Revision 3/03

PROVIDER NAME
WAIVER SERVICE

Client Name: _____ Maid Number: _____

Month and Year: _____

Goal: _____

_____

Outcomes:	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
1.																															
2.																															
3.																															
4.																															

Key:

I: Independently
A: With Assistance
R: Refused
N: Not Offered
W: Weekend
H: Holiday
O: Absent

Comments:

_____
_____
_____

Summary:

_____
_____
_____
_____
_____
_____

_____ Signature

_____ Title

_____ Date note written

Assessment Scales

Rancho Los Amigos - Revised

Levels of Cognitive Functioning

Level I - No Response: Total Assistance

- Complete absence of observable change in behavior when presented visual, auditory, tactile, proprioceptive, vestibular or painful stimuli.

Level II - Generalized Response: Total Assistance

- Demonstrates generalized reflex response to painful stimuli.
- Responds to repeated auditory stimuli with increased or decreased activity.
- Responds to external stimuli with physiological changes generalized, gross body movement and/or not purposeful vocalization.
- Responses noted above may be same regardless of type and location of stimulation.
- Responses may be significantly delayed.

Level III - Localized Response: Total Assistance

- Demonstrates withdrawal or vocalization to painful stimuli.
- Turns toward or away from auditory stimuli.
- Blinks when strong light crosses visual field.
- Follows moving object passed within visual field.
- Responds to discomfort by pulling tubes or restraints.
- Responds inconsistently to simple commands.
- Responses directly related to type of stimulus.
- May respond to some persons (especially family and friends) but not to others.

Level IV - Confused/Agitated: Maximal Assistance

- Alert and in heightened state of activity.
- Purposeful attempts to remove restraints or tubes or crawl out of bed.
- May perform motor activities such as sitting, reaching and walking but without any apparent purpose or upon another's request.
- Very brief and usually non-purposeful moments of sustained alternatives and divided attention.

- Absent short-term memory.
- May cry out or scream out of proportion to stimulus even after its removal.
- May exhibit aggressive or flight behavior.
- Mood may swing from euphoric to hostile with no apparent relationship to environmental events.
- Unable to cooperate with treatment efforts.
- Verbalizations are frequently incoherent and/or inappropriate to activity or environment.

Level V - Confused, Inappropriate Non-Agitated: Maximal Assistance

- Alert, not agitated but may wander randomly or with a vague intention of going home.
- May become agitated in reponse to external stimulation, and/or lack of environmental structure.
- Not oriented to person, place or time.
- Frequent brief periods, non-purposeful sustained attention.
- Severely impaired recent memory, with confusion of past and present in reaction to ongoing activity.
- Absent goal directed, problem solving, self-monitoring behavior.
- Often demonstrates inappropriate use of objects without external direction.
- May be able to perform previously learned tasks when structured and cues provided.
- Unable to learn new information.
- Able to respond appropriately to simple commands fairly consistently with external structures and cues.
- Responses to simple commands without external structure are random and non-purposeful in relation to command.
- Able to converse on a social, automatic level for brief periods of time when provided external structure and cues.
- Verbalizations about present events become inappropriate and confabulatory when external structure and cues are not provided.

Level VI - Confused, Appropriate: Moderate Assistance

- Inconsistently oriented to person, time and place.
- Able to attend to highly familiar tasks in non-distracting environment for 30 minutes with moderate redirection.
- Remote memory has more depth and detail than recent memory.

- Vague recognition of some staff.
- Able to use assistive memory aide with maximum assistance.
- Emerging awareness of appropriate response to self, family and basic needs.
- Moderate assist to problem solve barriers to task completion.
- Supervised for old learning (e.g. self care).
- Shows carry over for relearned familiar tasks (e.g. self care).
- Maximum assistance for new learning with little or nor carry over.
- Unaware of impairments, disabilities and safety risks.
- Consistently follows simple directions.
- Verbal expressions are appropriate in highly familiar and structured situations.

Level VII - Automatic, Appropriate: Minimal Assistance for Daily Living Skills

- Consistently oriented to person and place, within highly familiar environments. Moderate assistance for orientation to time.
- Able to attend to highly familiar tasks in a non-distraction environment for at least 30 minutes with minimal assist to complete tasks.
- Minimal supervision for new learning.
- Demonstrates carry over of new learning.
- Initiates and carries out steps to complete familiar personal and household routine but has shallow recall of what he/she has been doing.
- Able to monitor accuracy and completeness of each step in routine personal and household ADLs and modify plan with minimal assistance.
- Superficial awareness of his/her condition but unaware of specific impairments and disabilities and the limits they place on his/her ability to safely, accurately and completely carry out his/her household, community, work and leisure ADLs.
- Minimal supervision for safety in routine home and community activities.
- Unrealistic planning for the future.
- Unable to think about consequences of a decision or action.
- Overestimates abilities.
- Unaware of others' needs and feelings.
- Oppositional/uncooperative.

- Unable to recognize inappropriate social interaction behavior.

Level VIII - Purposeful, Appropriate: Stand-By Assistance

- Consistently oriented to person, place and time.
- Independently attends to and completes familiar tasks for 1 hour in distracting environments.
- Able to recall and integrate past and recent events.
- Uses assistive memory devices to recall daily schedule, "to do" lists and record critical information for later use with stand-by assistance.
- Initiates and carries out steps to complete familiar personal, household, community, work and leisure routines with stand-by assistance and can modify the plan when needed with minimal assistance.
- Requires no assistance once new tasks/activities are learned.
- Aware of and acknowledges impairments and disabilities when they interfere with task completion but requires stand-by assistance to take appropriate corrective action.
- Thinks about consequences of a decision or action with minimal assistance.
- Overestimates or underestimates abilities.
- Acknowledges others' needs and feelings and responds appropriately with minimal assistance.
- Depressed.
- Irritable.
- Low frustration tolerance/easily angered.
- Argumentative.
- Self-centered.
- Uncharacteristically dependent/independent.
- Able to recognize and acknowledge inappropriate social interaction behavior while it is occurring and takes corrective action with minimal assistance.

Level IX - Purposeful, Appropriate: Stand-By Assistance on Request

- Independently shifts back and forth between tasks and completes them accurately for at least two consecutive hours.
- Uses assistive memory devices to recall daily schedule, "to do" lists and record critical information for later use with assistance when requested.
- Initiates and carries out steps to complete familiar personal, household,

work and leisure tasks with assistance when requested.

- Aware of and acknowledges impairments and disabilities when they interfere with task completion and takes appropriate corrective action but requires stand-by assist to anticipate a problem before it occurs and take action to avoid it.
- Able to think about consequences of decisions or actions with assistance when requested.
- Accurately estimates abilities but requires stand-by assistance to adjust to task demands.
- Acknowledges others' needs and feelings and responds appropriately with stand-by assistance.
- Depression may continue.
- May be easily irritable.
- May have low frustration tolerance.
- Able to self monitor appropriateness of social interaction with stand-by assistance.

Level X - Purposeful, Appropriate: Modified Independent

- Able to handle multiple tasks simultaneously in all environments but may require periodic breaks.
- Able to independently procure, create and maintain own assistive memory devices.
- Independently initiates and carries out steps to complete familiar and unfamiliar personal, household, community, work and leisure tasks but may require more than usual amount of time and/or compensatory strategies to complete them.
- Anticipates impact of impairments and disabilities on ability to complete daily living tasks and takes action to avoid problems before they occur but may require more than usual amount of time and/or compensatory strategies.
- Able to independently think about consequences of decisions or actions but may require more than usual amount of time and/or comepensatory strategies to select the appropriate decision or action.
- Accurately estimates abilities and independently adjusts to task demands.
- Able to recognize the needs and feelings of others and automatically respond in appropriate manner.
- Periodic periods of depression may occur.
- Irritability and low frustration tolerance when sick, fatigued and/or under emotional stress.

- Social interaction behavior is consistently appropriate.

Original Scale co-authored by Chris Hagen, Ph.D., Danese Malkmus, M.A., Patricia Durham, M.A. Communication Disorders Service, Rancho Los Amigos Hospital, 1972. Revised 11/15/74 by Danese Malkmus, M.A., and Kathryn Stenderup, O.T.R.

Glasgow Coma Scale . Disability Rating Scale (DRS)