

Map 10
(Rev 08/10)

**Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
WAIVER SERVICES
PHYSICIAN'S RECOMMENDATION**

PLEASE RETURN TO THE REQUESTOR LISTED BELOW.

(Requestor's Name)

(Address)

(City) **KY** (Zip) (Phone)

PHYSICIAN'S RECOMMENDATION

I recommend Waiver services for:

(Member) (Medicaid Member ID #)

(Address)

(City) **KY** (Zip) (Phone)

DIAGNOSIS (ES):

Recommended Waiver Program:

- HCBW (APRN, PA or Physician signature)
- ABI Waiver – Services to adults with acquired brain injury (18 yrs and older) with a potential for rehabilitation and retraining (Physician signature)
- ABI Long Term Care Waiver – Services to adults (18 yrs and older) with acquired brain injury who have reached a plateau in their rehabilitation level and require maintenance services. (Physician signature)
- SCL Waiver (SCL QMRP or Physician signature)
- Michelle P. Waiver – Non-residential Services to children and adults **with mental retardation or developmental disabilities.** (APRN, QMRP, PA or Physician signature)

I certify that if Waiver services were not available, institutional placement in a Nursing Facility (NF) or Intermediate Care Facility for the Mentally Retarded/Developmentally Disabled shall be appropriate for this member.

(Authorized Signature) (UPIN#)

(Address)

(City) **KY** (Zip) (Phone)

(Date)

