

DSM Diagnosis:

Axis I (Mental Health): _____

Axis II (Mental Retardation/Developmental Disability) : _____

Axis III (Physical Health): _____

Age Disability Identified: _____

Physician/SCL MRP Signature

Date

SCL Waiver

CMHC MR/DD Director Signature

Date

ICF/MR

Section 5

Applicant's Signature _____ **Date** _____

PLEASE TELL US ABOUT THE APPLICANT BY CHECKING ONE BOX UNDER EACH HEADING.

6. MOBILITY

- Walks independently
- Walks with supportive devices
- Walks unaided with difficulty
- Uses wheelchair operated by self
- Uses wheelchair & needs help
- No mobility

Comments: _____

7. COMMUNICATION

- Speaks and can be understood
- Speaks and is difficult to understand
- Uses gestures
- Uses sign language
- Uses communication board or device
- Does not communicate

Comments: _____

8. HOW MUCH TIME IS REQUIRED FOR ASSURING SAFETY?

- Requires less than 8 hours per day on average
- Requires 9-16 hours daily on average
- Requires 24 hours (does not require awake person overnight)
- Requires 24 hours with awake person overnight
- Extreme Need:** Requires 24 hours, awake person trained to meet individual's particular needs; continuous monitoring

COMMENTS: _____

9. HOW MUCH ASSISTANCE IS NEEDED FOR DAILY LIVING TASKS? (Choose only ONE box)

- No assistance** needed in **most** self-help and daily living areas, and **Minimal assistance (use of verbal prompts or gestures as reminders)** needed in **some** self-help and daily living areas, and **Minimal to complex assistance** needed to complete complex skills such as financial planning and health planning.

No assistance in **some** self-help, daily living areas, and **Minimal assistance** for many skills, and **Complete assistance (caregiver completes all parts of task)** needed in **some** basic skills and all **complex** skills.

Partial (use of hands on guidance for part of task) to complete assistance needed in **most** areas of self-help, daily living, and decision making, and Cannot complete **complex** skills.

Partial to complete assistance is needed in **all areas** of self-help, daily living, decision making, and complex skills

Extreme Need: All tasks must be done for the individual, with no participation from the individual

10. HOW OFTEN ARE DOCTOR VISITS NEEDED?

- For routine health care only / once per year
- 2-4 times per year for consultation or treatment for chronic health care need
- More than 4 times per year for consultation or treatment
- Extreme Need:** Chronic medical condition requires immediate availability and frequent monitoring

COMMENTS: _____

11. HOW OFTEN ARE NURSING SERVICES NEEDED?

- Not at all
- For routine health care only
- 1-3 times per month
- Weekly
- Daily
- Extreme Need:** Several times daily or continuous availability

COMMENTS: _____

12. ARE THERE BEHAVIORAL PROBLEMS? Yes No

IF YES-PLEASE CHECK ALL THAT APPLY.

- Self Injury
- Aggressive towards others
- Inappropriate sexual behavior
- Property destruction
- Life threatening (threat of death or severe injury to self or others)
- Takes prescribed medications for behavior control

PLEASE CHECK ONE ANSWER UNDER EACH QUESTION, UNLESS OTHERWISE INDICATED.

13. WHERE IS THE INDIVIDUAL CURRENTLY LIVING?

- | | | |
|--|--|---|
| <input type="checkbox"/> Living with family/relative | <input type="checkbox"/> Living in own home or apartment | <input type="checkbox"/> Foster Care |
| <input type="checkbox"/> Group home or personal care home | <input type="checkbox"/> Nursing home | <input type="checkbox"/> Psychiatric Facility |
| <input type="checkbox"/> ICF/MR (Intermediate Care Facility) | <input type="checkbox"/> Living with a friend | <input type="checkbox"/> Other _____ |

14. DOES THE INDIVIDUAL CURRENTLY RECEIVE ANY OF THE FOLLOWING SERVICES? (CHECK ALL THAT APPLY)

- | | |
|---|---|
| <input type="checkbox"/> Supported Living | <input type="checkbox"/> Medicaid EPSDT (if under 21) |
| <input type="checkbox"/> Medicaid Acquired Brain Injury | <input type="checkbox"/> Medicaid Home & Community Based Waiver |
| <input type="checkbox"/> Supported Employment | <input type="checkbox"/> Mental Health Counseling or Medication for a mental health condition |
| <input type="checkbox"/> Home Health | <input type="checkbox"/> In home Support |
| <input type="checkbox"/> Other Medicaid Services | <input type="checkbox"/> Residential |
| <input type="checkbox"/> Day Program | <input type="checkbox"/> Respite |
| <input type="checkbox"/> School | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Behavior Support | <input type="checkbox"/> Case Management |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Speech Therapy | |
| <input type="checkbox"/> Physical Therapy | |

15. WHAT SERVICES ARE NEEDED NOW OR IN THE FUTURE?

- | | |
|---|---|
| <input type="checkbox"/> Day Program | <input type="checkbox"/> In home Support |
| <input type="checkbox"/> School | <input type="checkbox"/> Residential |
| <input type="checkbox"/> Respite | <input type="checkbox"/> Behavior Support |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Speech Therapy | <input type="checkbox"/> Case Management |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Supported Employment |

16. THE FOLLOWING ARE 5 CHOICES FOR FUTURE LIVING ARRANGEMENTS. WHERE WOULD THE APPLICANT PREFER TO LIVE IN THE FUTURE? CHOOSE ONLY ONE (1):

- At home with a family member with someone to come in and help
 In the person's own home with minimal supports
 In a 24 hour staffed residence in the community
 In a 24 hour supervised family home in the community
 In a 24 hour staffed group home in the community
 In an ICF/MR

17. WHO IS THE PRIMARY CAREGIVER? (If staff, do not answer questions 18 & 19.)

- Mother Father Grandmother Grandfather Aunt Uncle Staff
 Sister Brother Friend Neighbor Other: Who? _____

18. WHAT IS THE AGE OF THE PRIMARY CAREGIVER?

- Less than 30 years old 31-50 years old 51-60 years old 61-70 years old
 71-80 years old Over 80 years old

19. THE PRIMARY CAREGIVER'S HEALTH STATUS COULD BE CLASSIFIED AS:

- Poor Stable Good Very Good



Cabinet for Health and Family Services
Department for Medicaid Services

MAP-620
ev. 6/07)

Page 5

Comments: _____

Person Completing Application: _____

Print Name

Relationship to Individual (if not individual)

Phone Number

Signature

Date

Additional Comments: _____

Mail to:
The Division of Mental Retardation
100 Fair Oaks Lane, 4W-C
Frankfort, Kentucky 40621



SCL APPLICATION INSTRUCTIONS

Read these Instructions before completing the enclosed application

*** DO NOT LEAVE BLANK OR YOUR APPLICATION WILL BE RETURNED TO YOU AS INCOMPLETE**

Section 1

- ***Name**- Please print first, middle and last name of applicant legibly
- ***Sex**- Check M for male and F for female
- ***SS#**- Should only have 9 numbers
- ***Medical Assistance #**- This is the # on your MEDICAID card
- ***DOB**- example: 08/18/1966
- Phone #**- Always include area code. If no phone, please indicate this
- ***Present Address**- Please print legibly.

Section 2

Complete this section only if you are the **LEGAL** representative or guardian

If applicant is a minor there must be a legal guardian

If you complete this section you **MUST** sign your name in this section

Section 3

Complete this section if you currently have a case manager . This is someone who coordinates services. This could be a person or an agency such as the local comprehensive care center in your area. If you do not have a case manager leave blank.

Section 4

*This section **MUST** be completely filled out and signed by a Physician or a SCL MRP (mental retardation professional).

If applying for placement on the SCL waiting list, you **must** attach supporting documentation for the MR/DD diagnosis, this may be a psychological, report of school testing or any other reports that verify the diagnosis listed.

CMHC MR/DD Director Signature is **NOT** required unless you are applying for ICF/MR (facility) placement.

If applying for ICF/MR placement you **must** attach a copy of applicant's current Individual Support Plan, current Psychological, social history, crisis plan, behavior support plan, a current needs assessment, and minutes from the team meeting with a recommendation for ICF/MR admission. A MR/DD director's signature indicates that all community options have been exhausted and an ICF/MR is the least restrictive placement available.

* Axis I (if there is no diagnosis put "none")

* Axis II (if there is no diagnosis put "none")

* Axis III (if there is no diagnosis put "none")

* Axis IV (if there is no diagnosis put "none")

* Age disability identified-this is the age the applicant was diagnosed with mental retardation or a developmental disability (Ex: birth, 1 yr old, etc.) Mental Retardation must be present prior to age 18; Developmental Disabilities must be present prior to age 22.

Section 5

Applicant **MUST** sign this section if he/she does **NOT** have a legal guardian

If unable to sign, a mark or "X" is acceptable

*Questions 6, 7, 8, 9, 10, 11, 13, 16

Please check only **ONE** box that best describes the applicant

Person completing Application

***Name** of person completing this form

What is your **relationship** to the applicant?

Phone # of person completing this form

Signature and Date

MEDICAID WAIVER ASSESSMENT

SECTION I – MEMBER DEMOGRAPHICS		
Name <i>(last, first, middle)</i>	Date of birth <i>(mo., day, yr.)</i> / /	Medicaid number
Street address	County code	Sex <i>(check one)</i> <input type="checkbox"/> Male <input type="checkbox"/> Female
City, state and zip code	Emergency contact <i>(name)</i>	Marital status <i>(check one)</i> <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed
Member phone number () -	Is member able to read and write <input type="checkbox"/> Yes <input type="checkbox"/> No	Emergency contact <i>(phone #)</i> () -
SECTION II – MEMBER WAIVER ELIGIBILITY		
Type of program applied for <i>(check one)</i> <input type="checkbox"/> Home and Community Based Waiver <input type="checkbox"/> Model Waiver II <input type="checkbox"/> Acquired Brain Injury Waiver <input type="checkbox"/> Supports for Community Living Waiver <input type="checkbox"/> Consumer Directed Option <input type="checkbox"/> Blended	Adjudicated <input type="checkbox"/> / Nonadjudicated <input type="checkbox"/> Type of application <i>(check one)</i> <input type="checkbox"/> Certification <input type="checkbox"/> Re-certification <input type="checkbox"/> Re-application	
Member admitted from <i>(check one)</i> <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing facility <input type="checkbox"/> ICF/MR/DD <input type="checkbox"/> Other _____	Certification period <i>(enter dates below)</i> Begin date / / End date / / Certification number: _____	
Has member's freedom of choice been explained and verified by a signature on the MAP 350 Form <input type="checkbox"/> Yes <input type="checkbox"/> No	Has member been informed of the process to make a complaint <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(see instructions)</i>	
Physician's name	Physician's license number <i>(enter 5 digit #)</i>	Physician's phone number () -
Enter member's primary diagnosis: HCB (ICD-9 code); SCL (DSM code); ABI (ICD-9 and/or DSM)		
Enter all diagnoses including DSM or ICD-9 codes: AXIS I: (mental illness) AXIS II: (MR/DD) AXIS III: (Medical)	Is the member diagnosed with one of the following? <input type="checkbox"/> Mental Retardation/ IQ= (Date-of-onset / /) <input type="checkbox"/> Developmental Disability (Date-of-onset / /) <input type="checkbox"/> Mental Illness (Date-of-onset / /) <input type="checkbox"/> Brain Injury Cause of Brain Injury: Date of Brain Injury: / / Rancho Scale _____	
SECTION III – ASSESSMENT PROVIDER INFORMATION		
Assessment/Reassessment provider name:	Provider number	Provider phone number () -
Street address	City, state and zip code	
Provider contact person		

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SECTION IV SELF ASSESSMENT	
*For SCL and ABI waivers only *add additional pages as needed	
Community Inclusion (what do you like to do or where would you like to go in the community, where do you go for recreation, do you not get to go somewhere that you would like to)	
Relationships (How do you stay in contact with your friends and family, do you need assistance in making or keeping friends, who are your friends)	
Rights (do you understand your rights, are any of your rights restricted, do you know what is abuse or neglect)	
Dignity and Respect (how are you treated by staff, do you have a place you can go to be with friends or to be alone or have privacy)	
Health (who are your doctors ,do you have any health concerns, what medicine do you take, how do they make you feel,)	
Lifestyle (do you have a job, do you want to work, do you want to go to school, do you go to the bank, do you have spending money to carry)	
Satisfaction with supports (are you satisfied with your services and supports, what do you like about them, what do you dislike about them, do you feel like you have choices about what you can do, are you happy with your life, what are you happy about, what are you unhappy about)	

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SECTION V – ACTIVITIES OF DAILY LIVING	
<p>1) Is member independent with dressing/undressing</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No (If no, check below all that apply and comment)</p> <p><input type="checkbox"/> Requires supervision or verbal cues</p> <p><input type="checkbox"/> Requires hands-on assistance with upper body</p> <p><input type="checkbox"/> Requires hands-on assistance with lower body</p> <p><input type="checkbox"/> Requires total assistance</p>	Comments:
<p>2) Is member independent with grooming</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No (If no, check below all that apply and comment)</p> <p><input type="checkbox"/> Requires supervision or verbal cues</p> <p>Requires hands-on assistance with</p> <p><input type="checkbox"/> oral care <input type="checkbox"/> shaving</p> <p><input type="checkbox"/> nail care <input type="checkbox"/> hair</p> <p><input type="checkbox"/> Requires total assistance</p>	Comments:
<p>3) Is member independent with bed mobility</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No (If no, check below all that apply and comment)</p> <p><input type="checkbox"/> Requires supervision or verbal cues</p> <p><input type="checkbox"/> Occasionally requires hands-on assistance</p> <p><input type="checkbox"/> Always requires hands-on assistance</p> <p><input type="checkbox"/> Bed-bound</p> <p><input type="checkbox"/> Required bedrails</p>	Comments:
<p>4) Is member independent with bathing</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No (If no, check below all that apply and comment)</p> <p><input type="checkbox"/> Requires supervision or verbal cues</p> <p><input type="checkbox"/> Requires hands-on assistance with upper body</p> <p><input type="checkbox"/> Requires hands-on assistance with lower body</p> <p><input type="checkbox"/> Requires Peri-Care</p> <p><input type="checkbox"/> Requires total assistance</p>	Comments:
<p>5) Is member independent with toileting</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No (If no, check below all that apply and comment)</p> <p><input type="checkbox"/> Bladder incontinence</p> <p><input type="checkbox"/> Bowel incontinence</p> <p><input type="checkbox"/> Occasionally requires hands-on assistance</p> <p><input type="checkbox"/> Always requires hands-on assistance</p> <p><input type="checkbox"/> Requires total assistance</p> <p><input type="checkbox"/> Bowel and bladder regimen</p>	Comments:
<p>6) Is member independent with eating <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(If no, check below all that apply and comment)</p> <p><input type="checkbox"/> Requires supervision or verbal cues</p> <p><input type="checkbox"/> Requires assistance cutting meat or arranging food</p> <p><input type="checkbox"/> Partial/occasional help</p> <p><input type="checkbox"/> Totally fed (by mouth)</p> <p><input type="checkbox"/> Tube feeding (type and tube location)</p>	Comments:

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<p>7) Is member independent with ambulation <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and comment)</i> <input type="checkbox"/> Dependent on device <input type="checkbox"/> Requires aid of one person <input type="checkbox"/> Requires aid of two people <input type="checkbox"/> History of falls (number of falls, and date of last fall)</p>	Comments:
<p>8) Is member independent with transferring <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and comment)</i> <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Hands-on assistance of one person <input type="checkbox"/> Hands-on assistance of two people <input type="checkbox"/> Requires mechanical device <input type="checkbox"/> Bedfast</p>	Comments:
SECTION VI - INSTRUMENTAL ACTIVITIES OF DAILY LIVING	
<p>1) Is member able to prepare meals <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Arranges for meal preparation <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance with meal preparation <input type="checkbox"/> Requires total meal preparation</p>	Comments:
<p>2) Is member able to shop independently <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Arranges for shopping to be done <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance with shopping <input type="checkbox"/> Unable to participate in shopping</p>	Comments:
<p>3) Is member able to perform light housekeeping <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Arranges for light housekeeping duties to be performed <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance with light housekeeping <input type="checkbox"/> Unable to perform any light housekeeping</p>	Comments:
<p>4) Is member able to perform heavy housework <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Arranges for heavy housework to be performed <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance with heavy housework <input type="checkbox"/> Unable to perform any heavy housework</p>	Comments:

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<p>5) Is member able to perform laundry tasks <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Arranges for laundry to be done <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance with laundry tasks <input type="checkbox"/> Unable to perform any laundry tasks</p>	Comments:
<p>6) Is member able to plan/arrange for pick-up, delivery, or some means of gaining possession of medication(s) and take them independently <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Arranges for medication to be obtained and taken correctly <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance with obtaining and taking medication correctly <input type="checkbox"/> Unable to obtain medication and take correctly</p>	Comments:
<p>7) Is member able to handle finances independently <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Arranges for someone else to handle finances <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance with handling finances <input type="checkbox"/> Unable to handle finances</p>	Comments:
<p>8) Is member able to use the telephone independently <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Requires adaptive device to use telephone <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance when using telephone <input type="checkbox"/> Unable to use telephone</p>	Comments:
SECTION VII-NEURO/EMOTIONAL/BEHAVIORAL	
<p>1) Does member exhibit behavior problems <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, check below all that apply and explain the frequency in comments)</i> <input type="checkbox"/> Disruptive behavior <input type="checkbox"/> Agitated behavior <input type="checkbox"/> Assaultive behavior <input type="checkbox"/> Self-injurious behavior <input type="checkbox"/> Self-neglecting behavior</p>	<p>Comments: Date of functional analysis: / / and/or Date of behavior support plan: / /</p>

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<p>2) Is member oriented to person, place, time <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and comment)</i> <input type="checkbox"/> Forgetful <input type="checkbox"/> Confused <input type="checkbox"/> Unresponsive <input type="checkbox"/> Impaired Judgment</p>	Comments:
<p>3) Has member experienced a major change or crisis within the past twelve months <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, describe)</i></p>	Description:
<p>4) Is the member actively participating in social and/or community activities <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, describe)</i></p>	Description:
<p>5) Is the member experiencing any of the following <i>(For each checked, explain the frequency and details in the comments section)</i> <input type="checkbox"/> Difficulty recognizing others <input type="checkbox"/> Loneliness <input type="checkbox"/> Sleeping problems <input type="checkbox"/> Anxiousness <input type="checkbox"/> Irritability <input type="checkbox"/> Lack of interest <input type="checkbox"/> Short-term memory loss <input type="checkbox"/> Long-term memory loss <input type="checkbox"/> Hopelessness <input type="checkbox"/> Suicidal behavior <input type="checkbox"/> Medication abuse <input type="checkbox"/> Substance abuse <input type="checkbox"/> Alcohol Abuse</p>	Comments:

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<p>6) Cognitive functioning (Participant's current level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands)</p> <p><input type="checkbox"/> Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.</p> <p><input type="checkbox"/> Requires prompting (cueing, repetition, reminders) only under stressful or unfamiliar conditions.</p> <p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.</p>	Comments:
<p>7) When Confused (Reported or Observed):</p> <p><input type="checkbox"/> Never</p> <p><input type="checkbox"/> In new or complex situations only</p> <p><input type="checkbox"/> On awakening or at night only</p> <p><input type="checkbox"/> During the day and evening, but not constantly</p> <p><input type="checkbox"/> Constantly</p> <p><input type="checkbox"/> NA (non-responsive)</p>	Comments:
<p>8) When Anxious (Reported or Observed):</p> <p><input type="checkbox"/> None of the time</p> <p><input type="checkbox"/> Less often than daily</p> <p><input type="checkbox"/> Daily, but not constantly</p> <p><input type="checkbox"/> All of the time</p> <p><input type="checkbox"/> NA (non-responsive)</p>	Comments:
<p>9) Depressive Feelings (Reported or Observed):</p> <p><input type="checkbox"/> Depressed mood (e.g., feeling sad, tearful)</p> <p><input type="checkbox"/> Sense of failure or self-reproach</p> <p><input type="checkbox"/> Hopelessness</p> <p><input type="checkbox"/> Recurrent thoughts of death</p> <p><input type="checkbox"/> Thoughts of suicide</p> <p><input type="checkbox"/> None of the above feelings reported or observed</p>	Comments:

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<p>10) Member Behaviors (Reported or Observed):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Indecisiveness, lack of concentration <input type="checkbox"/> Diminished interest in most activities <input type="checkbox"/> Sleep disturbances <input type="checkbox"/> Recent changes in appetite or weight <input type="checkbox"/> Agitation <input type="checkbox"/> Suicide attempt <input type="checkbox"/> None of the above behaviors observed or reported 	<p>Comments:</p>
<p>11) Behaviors Demonstrated at Least Once a Week:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24-hours, significant memory loss so that supervision is required. <input type="checkbox"/> Impaired decision-making: failure to perform usual ADL's, inability to inappropriately stop activities, jeopardizes safety through actions. <input type="checkbox"/> Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc. <input type="checkbox"/> Physical aggression: aggressive or combative to self and others (e.g. hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects). <input type="checkbox"/> Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions). <input type="checkbox"/> Delusional, hallucinatory, or paranoid behavior. <input type="checkbox"/> None of the above behaviors demonstrated. 	<p>Comments:</p>
<p>12) Frequency of Behavior Problems (Reported or Observed) such as wandering episodes, self abuse, verbal disruption, physical aggression, etc.:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> Once a month <input type="checkbox"/> Several times each month <input type="checkbox"/> Several times a week <input type="checkbox"/> At least daily 	

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<p>13) Mental Status:</p> <p><input type="checkbox"/> Oriented</p> <p><input type="checkbox"/> Forgetful</p> <p><input type="checkbox"/> Depressed</p> <p><input type="checkbox"/> Disoriented</p> <p><input type="checkbox"/> Lethargic</p> <p><input type="checkbox"/> Agitated</p> <p><input type="checkbox"/> Other</p> <p>_____</p> <p>_____</p>	<p>Comments:</p>
<p>14) Is this member receiving Psychiatric Nursing Services at home provided by a qualified psychiatric nurse?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	<p>Comments:</p>
SECTION VIII-CLINICAL INFORMATION	
<p>1) Is member's vision adequate (<i>with or without glasses</i>)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined</p> <p><i>(If no, check below all that apply and comment)</i></p> <p><input type="checkbox"/> Difficulty seeing print</p> <p><input type="checkbox"/> Difficulty seeing objects</p> <p><input type="checkbox"/> No useful vision</p>	<p>Comments:</p>
<p>2) Is member's hearing adequate (<i>with or without hearing aid</i>)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined</p> <p><i>(If no, check below all that apply, and comment)</i></p> <p><input type="checkbox"/> Difficulty with conversation level</p> <p><input type="checkbox"/> Only hears loud sounds</p> <p><input type="checkbox"/> No useful hearing</p>	<p>Comments:</p>
<p>3) Is member able to communicate needs</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and comment)</i></p> <p><input type="checkbox"/> Speaks with difficulty but can be understood</p> <p><input type="checkbox"/> Uses sign language and/or gestures/communication device</p> <p><input type="checkbox"/> Inappropriate context</p> <p><input type="checkbox"/> Unable to communicate</p>	<p>Comments:</p>



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Name (<i>last, first</i>)	Medicaid Number
<p>4) Does member maintain an adequate diet <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If no, check all that apply and comment</i>) <input type="checkbox"/> Uses dietary supplements <input type="checkbox"/> Requires special diet (low salt, low fat, etc.) <input type="checkbox"/> Refuses to eat <input type="checkbox"/> Forgets to eat <input type="checkbox"/> Tube feeding required (<i>Explain the brand, amount, and frequency in the comments section</i>) <input type="checkbox"/> Other dietary considerations (<i>PICA, Prader-Willie, etc.</i>)</p>	<p>Comments:</p>
<p>5) Does member require respiratory care and/or equipment <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If yes, check all that apply and comment</i>) <input type="checkbox"/> Oxygen therapy (Liters per minute and delivery device) <input type="checkbox"/> Nebulizer (Breathing treatments) <input type="checkbox"/> Management of respiratory infection <input type="checkbox"/> Nasopharyngeal airway <input type="checkbox"/> Tracheostomy care <input type="checkbox"/> Aspiration precautions <input type="checkbox"/> Suctioning <input type="checkbox"/> Pulse oximetry <input type="checkbox"/> Ventilator (list settings)</p>	<p>Comments:</p>
<p>6) Does member have history of a stroke(s) <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If yes, check all that apply and comment</i>) <input type="checkbox"/> Residual physical injury(ies) <input type="checkbox"/> Swallowing impairments <input type="checkbox"/> Functional limitations (Number of limbs affected)</p>	<p>Comments:</p>
<p>7) Does member's skin require additional, specialized care <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, check all that apply and comment)</i> <input type="checkbox"/> Requires additional ointments/lotions <input type="checkbox"/> Requires simple dressing changes (i.e. band-aids, occlusive dressings) <input type="checkbox"/> Requires complex dressing changes (i.e. sterile dressing) <input type="checkbox"/> Wounds requiring "packing" and/or measurements <input type="checkbox"/> Contagious skin infections <input type="checkbox"/> Ostomy care</p>	<p>Comments:</p>
<p>8) Does member require routine lab work <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If yes, what type and how often</i>)</p>	<p>Comments:</p>
<p>9) Does member require specialized genital and/or urinary care <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, check all that apply and comment)</i> <input type="checkbox"/> Management of reoccurring urinary tract infection <input type="checkbox"/> In-dwelling catheter <input type="checkbox"/> Bladder irrigation <input type="checkbox"/> In and out catheterization</p>	<p>Comments:</p>

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

Name (last, first)		Medicaid Number	
10) Does member require specific, physician-ordered vital signs evaluation necessary in the management of a condition(s) <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, explain in the comments section)</i>		Comments:	
11) Does member have total or partial paralysis <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, list limbs affected and comment)</i>		Comments:	
12) Does member require assistance with changes in body position <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, check all that apply and comment)</i> <input type="checkbox"/> To maintain proper body alignment <input type="checkbox"/> To manage pain <input type="checkbox"/> To prevent further deterioration of muscle/joints/skin		Comments:	
13) Does member require 24 hour caregiver <input type="checkbox"/> Yes <input type="checkbox"/> No			
14) Does member require respite services <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, how often)</i>			
15) Does the member require intravenous fluids, intravenous medications or intravenous alimentation <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, check below all that apply and list solution, location, amount, rate, frequency and prescribing physician)</i>			
<input type="checkbox"/> Peripheral IV Solution:		Location	Amount/dosage
Frequency		Rate	
<input type="checkbox"/> Central line Solution:		Location	Amount/dosage
Frequency		Rate	
16) Drug allergies (list)		17) Other allergies (list)	
17) Does the member use any medications <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, list below) *add additional pages if needed</i>			
Name of medication		Dosage/Frequency/Route	Administered by



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

Name (<i>last, first</i>)	Medicaid Number
SECTION IX-ENVIRONMENT INFORMATION	
<p>1) Answer the following items relating to the member's physical environment (<i>Comment if necessary</i>)</p> <p>Sound dwelling <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Adequate furnishings <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Indoor plumbing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Running water <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hot water <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Adequate heating/cooling <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tub/shower <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stove <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Refrigerator <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Microwave <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Telephone <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>TV/radio <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Washer/dryer <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Adequate lighting <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Adequate locks <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Adequate fire escape <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Smoke alarms <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Insect/rodent free <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Accessible <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Safe environment <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Trash management <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Comments:</p>
<p>2) Provide an inventory of home adaptations <u>already present</u> in the member's dwelling. (<i>Such as wheelchair ramp, tub rails, etc.</i>)</p>	
SECTION X – HOUSEHOLD INFORMATION	
<p>1) Does the member live alone <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, does the member receive any assistance from others <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>Explain</i>)</p>	<p>Comments:</p>

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

Name (last, first)	Medicaid Number		
2) Household Members (Fill in household member info below)			
a) Name	Relationship	Age	Are they functionally able to provide care <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, explain in the comments section)
Comments:	Care provided/frequency		
b) Name	Relationship	Age	Are they functionally able to provide care <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, explain in the comments section)
Comments:	Care provided/frequency		
c) Name	Relationship	Age	Are they functionally able to provide care <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, explain in the comments section)
Comments:	Care provided/frequency		
d) Name	Relationship	Age	Are they functionally able to provide care <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, explain in the comments section)
Comments:	Care provided/frequency		

SECTION XI-ADDITIONAL SERVICES

1) Has the member had any hospital, nursing facility or ICF/MR/DD admissions in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please list below)		
a-Facility name	Facility address	
Reason for admission	Admission date / /	Discharge date / /
b-Facility name	Facility address	
Reason for admission	Admission date / /	Discharge date / /

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Name (last, first)	Medicaid Number	
2) Does the member receive services from other agencies (Example: Both Waiver and Non-waiver Services.) <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, list services already provided and to be provided in accordance with a plan of care by an agency/organization, include Adult Day Health Care and traditional Home health services covered by Medicare/Third party insurance)</i>		
a-Service(s) received	Agency/worker name	Phone number () -
Agency address	Frequency	Number of units
b-Service(s) received	Agency/worker name	Phone number () -
Agency address	Frequency	Number of units
c-Service(s) received	Agency/worker name	Phone number () -
Agency address	Frequency	Number of units
SECTION XII-CONSUMER DIRECTED OPTION		
Has the member been provided information on Consumer Directed Option (CDO) and their right to choose CDO, traditional or blended services? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, give reason:		
Has the member chosen Consumer Direction Option? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, include form MAP 2000		
SECTION XIII-SIGNATURES		
Person(s) performing assessment or reassessment:		
Signature:	Title:	Date / /
Signature:	Title:	Date / /
Verbal Level of Care Confirmation:		
Date: / /	Time: am/pm	
Assessment/Reassessment forwarded to Support Broker/Case Management provider:		
Date Forwarded: / /	Time Forwarded: am/pm	
Name of Person Forwarding:	Title of Person Forwarding:	
Receipt of assessment/reassessment by Support Broker/case management provider:		
Date Received: / /	Time Received: am/pm	
Name of Person Logging Receipt:	Title of Person Logging Receipt:	
QIO Signature:		
Level of Care Date / /	Approval dates From: / / To: / /	

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

MAID NUMBER: () INITIAL () CORRECTION
PROGRAM: COUNTY: () 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: SINGLE SPOUSE STATUS:

INCOME COMPUTATION

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

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

TOTAL INCOME \$

DEDUCTIONS	AMOUNT
PERSONAL NEEDS ALLOWANCE	\$
INCREASE PNA	\$
SPOUSE/FAMILY MAINT.	\$
SMI	\$
HEALTH INSURANCE	\$
INCURRED MEDICAL EXPENSES	\$
TOTAL DEDUCTION	\$

THIRD PARTY PAYMENTS \$

AVAILABLE INCOME	\$
AVAILABLE INCOME (ROUNDED)	\$
AVAILABLE MONTHLY INCOME:	\$

CASE STATUS
ACTIVE CASE: NO
IF ACTIVE, EFF. MA DATE:
IF DISC, EFF. MA DISC:

NOTIF. FORM: CONFIRMATION NOTICE
DATE PATIENT STATUS MET:

EFF. DATE OF CORR:
ENDING DATE OF CORR:

PRIVATE PAY PATIENT
FROM: THRU:

WORKER CODE: CASELOAD CODE:

UPDATE DATE:

Member Name: _____ MAID Number: _____

Identification of Needs/Outcomes/Services/Providers

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

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: _____

**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

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

I. ESTATE RECOVERY

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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

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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: _____

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

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Date

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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: _____

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

REQUEST FOR EQUIPMENT FORM

RECIPIENTS NAME: _____ DOB: _____

MAID or MEMBER #: _____ DX: _____

Estimated Time Needed: Months _____ Indefinitely _____ Permanently _____
One Time Only _____

Procedure Code: _____ Date: _____

ITEM	ESTIMATE 1	ESTIMATE 2	ESTIMATE 3	TOTAL COST (includes shipping)

AGENCY NAME: _____

PROVIDER NUMBER: _____

CASE MANAGER/SUPPORT BROKER: _____

TELEPHONE NUMBER: _____

AUTHORIZED DMS SIGNATURE: _____

DATE APPROVED: _____



SUPERVISOR/CASE MANAGER/SUPPORT BROKER FOLLOW-UP

(Add additional pages if necessary)

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

I. Why did the incident occur? What staff action was effective in diffusing the incident or redirecting problem behavior? What staff action may have contributed to or aggravated the incident? Was treatment obtained in a timely fashion? Was a Behavior Plan followed? Was a Crisis Plan followed? Were they effective?

II. How could this incident have been prevented? How will the agency ensure that the incident does not occur again? What specific changes will be made in the person's life (home, work, day, etc.)? What will staff do differently? Does the person's team need to meet? What systems changes need to occur? How will management's role change?

III. What staff training needs were identified? On what date will the training occur? Who will provide the training?

IV. Are any changes necessary that will be made to the Individual Plan of Care, Crisis Prevention Plan, and/or the Behavior Support Plan? How will these changes support the person to achieve his/her vision and cope effectively? What other positive changes can be made to enhance the person's life? (such as, more choice, pursuing the person's vision, variety, developing relationships, developing and enhancing communications)

V. What is the individual's current status? What kind of impact has the incident had on the individual's life?

Submitted by: _____ Title: _____ Date: _____

Additional Signatures:

_____ Title: Case Mgr./Support Broker Date: _____

_____ Title: _____ Date: _____

_____ Title: _____ Date: _____

TO: (1) _____ County Office
Department for Community Based Services

(2) Quality Improvement Organization (QIO)

(3) Department for Mental Health/Mental Retardation for SCL or
Department for Medicaid Services/Brain Injury Services Branch for ABI

FROM: (4) _____
Case Management Agency/Support Broker

DATE: (5) _____

A. SCL or ABI WAIVER PROGRAM ADMISSION

(1) _____
(Last Name) (First Name) (MI) (Social Security Number)

_____ KY _____
(Address) (City) (Zip) (Phone number)

(2) Was admitted to the SCL or ABI Waiver Program on _____
(Circle SCL or ABI) (Date)

(3) Case Management Agency/Support Broker _____

(Phone Number) (Provider #)

_____ KY _____
(Address) (City) (Zip Code)

(4) Primary Provider _____

(Phone) (Provider #)

_____ KY _____
(Address) (City) (Zip Code)

B. SCL or ABI WAIVER PROGRAM DISCHARGE

(1) _____
(Last Name) (First Name) (MI) (Social Security Number)
_____ KY _____
(Address) (City) (Zip) (Phone number)

(2) Discharged from the SCL or ABI Program on _____
(Date)

(3) Case Management Agency/Support Broker _____

(Phone Number) (Provider #)
_____ KY _____
(Address) (City) (Zip Code)

(4) Primary Provider _____

(Phone) (Provider #)
_____ KY _____
(Address) (City) (Zip Code)

C. SCL or ABI WAIVER PROGRAM TRANSFER

(1) _____
(Last Name) (First Name) (MI) (Social Security Number)
_____ KY _____
(Address) (City) (Zip) (Phone number)

(2) Transferred on _____ from _____
(Date)

(3) Case Management Agency/Support Broker _____

(Phone Number) (Provider #)
_____ KY _____
(Address) (City) (Zip Code)



(4) To Case Management Agency/Support Broker _____

(Phone Number) (Provider #) KY _____

(Address) (City) (Zip Code)

(5) From Primary Provider _____

(Phone) (Provider #) KY _____

(Address) (City) (Zip Code)

(6) To Primary Provider _____

(Phone) (Provider #) KY _____

(Address) (City) (Zip Code)

(7) To Hospital, Nursing Facility, or other facility _____
(Name of facility)

(Phone) (Provider #) KY _____

(Address) (City) (Zip Code)

PROCEDURAL INSTRUCTIONS FOR MAP-24C

Upon admittance/discharge/transfer of an individual in the Supports for Community Living Waiver or Acquired Brain Injury Waiver Program, the case manager/support broker shall forward a MAP-24C form to the local Department for Community Based Services Office in the county in which the member resides, the Quality Improvement Organization (QIO), the Department for Mental Health/Mental Retardation Services for the SCL waiver program or to the Department for Medicaid Services/Brain Injury Services Branch for the ABI waiver program. The case manager/support broker shall complete the form.

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

INITIATION OF FORM

- Line One (1) Enter the name of the County of the Department for Community Based Services the form will be sent to.
- Line Two (2) Send the form to the Quality Improvement Organization.
- Line Three (3) Send the form to the Department for Mental Health/Mental Retardation for the SCL waiver program or to the Department for Medicaid Services/Brain Injury Services Branch for the ABI waiver program.
- Line Four (4) Enter the name of the Case Management Agency/Support Broker filling out the form.
- Line Five (5) Enter the date the form was completed.

A. FOR INITIAL ADMISSION TO THE SUPPORTS FOR COMMUNITY LIVING WAIVER PROGRAM OR THE ACQUIRED BRAIN INJURY WAIVER PROGRAM

- Line One (1) Enter the name, social security number, address and phone number of the member.
- Line Two (2) Enter the date the member entered the program.
- Line Three (3) Enter the name of the case management agency/support broker, phone number, and provider number.
- Line Four (4) Enter the name, phone number, and provider number of the primary provider. If the member has a residential provider, then the residential provider will be the primary provider. If the member **does not** have a residential provider, then the case management agency will be the primary provider. If the member chooses the Consumer Directed Option, then the Department of Aging and Independent Living will be the primary provider.

**B. FOR DISCHARGE FROM THE SUPPORTS FOR COMMUNITY LIVING
WAIVER PROGRAM OR THE ACQUIRED BRAIN INJURY WAIVER
PROGRAM**

- Line (1) Enter the name, social security number, address and phone number of the member.
- Line (2) Enter the date the discharge.
- Line (3) Enter the case management agency/support broker, phone number, provider number and address.
- Line (4) Enter the name, phone number, provider number of the primary provider. If the member has a residential provider, then the residential provider will be the primary provider. If the member **does not** have a residential provider, then the case management agency will be the primary provider. If the member chose the Consumer Directed Option, then the Department for Aging and Independent Living will be the primary provider.

**C. FOR TRANSFER WITHIN THE SUPPORTS FOR COMMUNITY
LIVING WAIVER PROGRAM OR THE ACQUIRED BRAIN INJURY
WAIVER PROGRAM**

- Line (1) Enter the name, social security number, address and phone number of the member.
- Line (2) Enter the date the transfer took place.
- Line (3) Enter the previous case management agency/support broker, phone number, provider number and address.
- Line (4) Enter the new case management agency/support broker, phone number, provider number and address.
- Line (5) Enter the name, phone number, provider number of the current primary provider. If the member has a residential provider, then the residential provider will be the primary provider. If the member **does not** have a residential provider, then the case management agency will be the primary provider. If the member chooses the Consumer Directed Option, then the Department for Aging and Independent Living will be the primary provider.
- Line (6) Enter the name, phone number, provider number of the new primary provider. If the member has a residential provider, then the residential provider will be the primary provider. If the member **does not** have a residential provider, then the case management agency will be the primary provider. If the member chooses the Consumer Directed Option, then the Department for Aging and Independent Living will be the primary provider.
- Line (7) Enter the name, phone number, provider number and address of the facility that the waiver member has been transferred to on a temporary basis.

INITIATION/TERMINATION OF CONSUMER DIRECTED OPTION (CDO)

<input type="checkbox"/> SCL <input type="checkbox"/> HCB <input type="checkbox"/> ABI
--

Consumer's Name: _____ MAID #: _____

Case Manager/Support Broker: _____
Name Phone

Provider Number: _____

Addition of CDO Services Date: _____ Initials: _____

I understand that I have the freedom to choose the Consumer Directed Option for some or all of my waiver services. This has been explained to me and I choose consumer directed services. In making this decision, I understand the following terms of the program:

I understand that I may:

- Train or arrange training for employees necessary for providing care.
- Ask for a change in my POC/SSP if I feel my needs have changed.
- Select a representative to help me with decisions about the CDO.
- Bring whomever I want to all meetings pertaining to the CDO.
- Complain or ask for a hearing if I have problems with my health care.
- Voluntarily dis-enroll from the CDO Program at any time and receive my services through the traditional waiver program.

I understand that I shall:

- Develop a Plan of Care (POC)/Support Spending Plan (SSP) to meet my needs within the Consumer Directed Options (CDO) according to program guidelines and my individual budget.
- Hire, supervise, and when necessary, fire my providers.
- Submit timesheets, paperwork required for my employees.
- Treat my providers and others that work for the CDO program the same way I want to be treated.
- Participate in the development of my POC/SSP and manage my individual budget.
- Complete all the paperwork necessary to participate in the CDO program, and follow all tax and labor laws.
- Be treated with respect and dignity and to have my privacy respected.
- Keep all my scheduled appointments.
- Pay my patient liability as determined by Department for Community Based Services (DCBS), failure to do so will result in termination from CDO.

*For addition of CDO services, attach revised MAP 109 Plan of Care.

Date traditional case management ends and Support Broker begins ____/____/____

Date traditional services end and CDO services begin: ____/____/____



INITIATION/TERMINATION OF CONSUMER DIRECTED OPTION (CDO)

Member Name: _____ MAID# _____

Representative Designation Date: _____ Initials: _____

I appoint _____ as my representative for the Consumer Directed Option (CDO) Program.

Representative Address: _____ Phone: _____

Relationship to Consumer: _____

My representative and I understand the following requirements

A CDO representative must:

- Be at least 21 years of age
- Not be paid for this role or for providing any other service to me
- Be responsible for assisting me in managing my care and individual budget
- Participate in training as directed by me and/or my support broker
- Have a strong personal commitment to me and know my preferences
- Have knowledge of me and be willing to learn about resources available in my community
- Be chosen by me

*For voluntary or involuntary termination of CDO service, attach revised MAP 109-Plan of Care.

Voluntary Termination of CDO Services Date: _____ Initials: _____

I choose to terminate my services through the Consumer Directed Option and choose to receive my services through the traditional waiver program.

Involuntary Termination of CDO Services
(To be completed by the Support Broker)

Reason for termination of CDO:

- Health and Safety Concerns
- Exceeding Individual Budget
- Inappropriate Utilization of Funds
- Other (Describe)

Traditional Provider Agency _____
Traditional Provider Number _____

Consumer/Guardian Signature Date

Representative Signature Date

Case Manager/Support Broker Signature Date



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

WAIVER SERVICES

TO: _____

AGENCY: _____

ADDRESS: _____

_____ KY _____ PHONE: () _____
(City) (Zip)

PHYSICIAN'S RECOMMENDATION

I recommend Wavier Services for:

MEMBER: _____

MAID NUMBER: _____

ADDRESS: _____

_____ KY _____ PHONE () _____
(City) (Zip)

DIAGNOSIS(ES): _____

- Recommended Wavier Program: HCBW (ARNP, PA or Physician signature)
 ABI
 SCL (SCL MRP or Physician signature)

I certify that if Wavier Services were not available, institutional placement (nursing facility or Intermediate Care Facility for Individuals with Mental Retardation or Developmental Disability [ICF/MR/DD]) shall be appropriate for this member in the near future.

PHYSICIAN or SCL MRP NAME: _____ UPIN#: _____

ADDRESS: _____

_____ KY _____ PHONE () _____
(City) (Zip)

SIGNATURE DATE



- HBCW
- SCL
- ABI

Kentucky Consumer Directed Option Employee/Provider Contract

I (*employee name*) _____, have agreed to work
under the employment of (*employer name*) _____.

Duties under this contract will consist of the following:

Home and Community Supports:

- Respite (*HCB, SCL, and ABI*)**
Total Approved Hours per month _____
- Personal Care (*HCB and ABI*)**
Total Approved Hours per month _____
- Homemaker (*HCB only*)**
Total Approved Hours per month _____
- Attendant Care (*HCB only*)**
Total Approved Hours per month _____
- Community Living Supports (*SCL only*)**
Total Approved Hours per month _____
- Companion Services (*ABI only*)**
Total Approved Hours per month _____

Community Day Support Services:

- Adult Day Training (*SCL only*)**
Total Approved Hours per month _____
- Support Employment (*SCL only*)**
Total Approved Hours per month _____

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Department for Aging and Independent Living

I agree to provide the above listed services as required by my employer at the rate of \$_____ per hour. I will not exceed the total approved amount noted above.

I accept the check(s) as payment in full for the service(s) or items purchased. I will not make additional charges to or accept additional payments from the consumer(s).

I understand there may be civil or criminal penalties if I intentionally defraud the Department for Medicaid Services.

I understand that DMS will not be liable for any injuries or losses incurred while providing services.

I understand that I may not be approved as a CDO provider if my background check detects that I have pled guilty to or been convicted of committing a sex crime or a violent crime.

I understand that I may not be approved as a CDO provider if my name is listed on the Kentucky Nurse Aid Abuse Registry.

For the Supports for Community Living (SCL) and Acquired Brain Injury (ABI) programs **only**, I understand that I may not be approved as a CDO provider if my name is listed on the Department for Community Based Services Division of Protection and Permanency's Central Registry.

I understand that I must maintain employee/employer confidentiality.

I understand this is an at-will contract and either party may terminate this agreement at any time.

I understand that I must notify my employer of the contraction of any infectious disease(s) and I shall abstain from work until the infectious disease can no longer be transmitted as documented by a medical professional.

I have received any and all training required by my employer in order to provide the necessary services as described in this contract.

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Department for Aging and Independent Living

I have received and fully understand the list of employment guidelines and will follow them to the best of my ability. I further understand that any or all items of this contract may be subject to renewal or change upon agreement by my employer and myself.

<u>Employee/Provider</u>	<u>Date</u>	<u>Employer/Member</u>	<u>Date</u>
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