

Map 10  
(Rev 08/14)

**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 IDP or Physician signature)
- Michelle P. Waiver – Non-residential Services to children and adults **with intellectual or developmental disabilities.** (APRN, IDP, 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 Intellectual/Developmentally Disabled shall be appropriate for this member.**

\_\_\_\_\_  
(Authorized Signature)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City) **KY** (Zip) (Phone)

\_\_\_\_\_  
(Date)

