MAP- 4100A
(Rev. 09/2010)

ACQUIRED BRAIN INJURY WAIVER PROGRAM PROVIDER INFORMATION AND SERVICES

PROVIDER NUMBER _____

NPI (National Provider Identifier) Number:_____

AGENCY NAME: _____

AGENCY ADDRESS: _____

CITY _____ STATE _____ ZIP CODE _____

COVERED SERVICES (Check all that apply)

ABI WAIVER

- ☐ Case Management
- ☐ Personal Care Services
- ☐ Respite Care Services
- ☐ Companion Care Services
- ☐ Adult Day Training
- ☐ Supported Employment Services
- ☐ Behavior Programming
- ☐ Psychological Rehab Services
- ☐ Therapeutic Activities/Occupational Therapy
- ☐ Speech, Hearing and Language Services
- ☐ Durable Medical/ Specialized Medical Equipment
- ☐ Home Modification/ Environmental Modification
- ☐ Supervised Residential Care
- ☐ Assessment and Re-Assessment

ABI LONG TERM CARE WAIVER

- ☐ Case Management
- ☐ Community Living Supports
- ☐ Respite Care Service
- ☐ Adult Day Health Care
- ☐ Adult Day Training
- ☐ Supported Employment Services
- ☐ Behavior Programming
- ☐ Psychological Rehab Services
- ☐ Therapeutic Activities/Occupational Therapy
- ☐ Speech, Hearing and Language Services
- ☐ Durable Medical/ Specialized Medical Equipment
- ☐ Home Modification/ Environmental Modification
- ☐ Supervised Residential Care
- ☐ Nursing Supports
- ☐ Family Training
- ☐ Physical therapy
- ☐ Assessment and Re-Assessment

By signing below I, _____, certify that this agency is capable of and agrees to comply with the conditions for participation established in the Acquired Brain Injury Services regulation (907 KAR 3:090) and/or the Acquired Brain Injury Long Term Care Waiver Services regulation (907 KAR 3:210). In addition, I certify that all staff shall meet all training requirements prior to the provision of services.

_____
Signature of Authorized Representative

_____ _____
Title Date

Please return forms to:
KY Medicaid Provider Enrollment
P.O. Box 2110
Frankfort, KY 40602-2110 9/2010

CLEAR FORM