Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
PROGRAM APPLICATION
KENTUCKY MEDICAID PROGRAM
ACQUIRED BRAIN INJURY (ABI) WAIVER SERVICES PROGRAM

For placement on the Acquired Brain Injury or Acquired Brain Injury Long Term Care Medicaid Waiver waiting list, an individual must first submit this application and a signed MAP10 - Physician Recommendation Form. A copy of the Physician Recommendation form is enclosed for your use.

Please mail the completed application and the signed Physician's Certification form to:

Acquired Brain Injury Branch
275 East Main Street 6W-B
Frankfort, Kentucky 40621

It may also be faxed to: 502-564-6568

An individual will be placed in the waiting list in the order in which the application and the Physician Recommendation form are received in the office of the Acquired Brain Injury Branch. Available funding will be allocated to individuals having emergency status on the waiting list prior to allocating funding to individuals having non-emergency status. Emergency status criteria are:

1. The individual is *currently demonstrating behavior* ***related to his/her acquired brain injury*** that places himself/herself, the caregiver, or others at risk of significant harm; OR

2. The individual is *currently demonstrating behavior* **related to his/her acquired brain injury** which has resulted in arrest.

***If the individual is applying for emergency status, a written statement by a Physician or other Qualified Mental Health Professional shall be required to support the validation of risk of significant harm to a recipient or caregiver. Written documentation by law enforcement or court personnel shall be required to support the validation of a history of arrest. Supporting documentation will be reviewed by the Emergency Review Committee of the ABI Branch for determination of emergency status.**

Qualified Mental Health Professional:

- **Physician**
- **Psychiatrist**
- **Psychologist or Psychological Associate**
- **RN with a masters degree in psychiatric nursing and 2 years professional experience with mentally ill persons or a Licensed Registered Nurse who has 3 years experience in psychiatric nursing and is currently employed by a hospital or company engaged in the provision of mental health services.**
- **LCSW**
- **Marriage and family therapist with 3 years of clinical experience in psychiatric mental health practice and currently employed by a hospital or company engaged in the provision of mental health services.**
- **Professional counselor with 3 years clinical experience in psychiatric mental health practice and currently employed by a hospital or company engaged in the provision of mental health services.**

Authorization to Use or Disclose My Health Information

Applicant name: _____ **Date of birth:** _____

I. My Authorization

The Acquired Brain Injury Branch (ABIB), Department for Medicaid Services may use or disclose the following health care information:

☐ All information regarding my application for services, services provided, or information submitted to the ABIB in relation to the Acquired Brain Injury Waiver or Acquired Brain Injury Long Term Care Waiver

☐ Other: _____

You may disclose this health information to (check all that apply):

☐ All Acquired Brain Injury Providers

☐ The specific Acquired Brain Injury Case Management Provider(s) listed below:

_____

☐ The specific Acquired Brain Injury Provider(s) listed below:

_____

II. My Rights

I understand that:

- I may refuse to sign this authorization.
- Refusing to sign this authorization will not affect my treatment, payment, enrollment, or eligibility for benefits.
- I may take back (revoke) this authorization in writing, except for any actions already taken based upon it.
- Once the office discloses health information, the person or organization that receives it may re-disclose it and it may no longer be protected by privacy laws.

_____ _____ _____

Client or legally authorized individual signature (Guardianship paperwork must be attached) | Date | Time

_____ _____

Printed Name if signed on behalf of the client | Relationship (parent, legal guardian, personal representative, etc.)

Map -26
(Rev. 09/10)

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For program use only
Date Received: _____
Time Received: _____
Notice Sent: _____

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

Check the Program the individual is applying for: ABI: ☐ ABI/Long Term Care: ☐

A. Client Information

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

_____
(Street Address)

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

_____ _____
(Date of Birth) (Date of Brain Injury)

Cause of Brain Injury: _____

B. Guardian Information (if Applicable)

_____ _____
(Name) (Relationship to individual)

_____
(Street Address)

_____ _____ _____ _____
(City) (State) ZIP (Phone)

C. Caregiver Information (if Applicable)

_____ _____
(Name) (Relationship to individual)

_____
(Street Address)

_____ _____ _____ _____
(City) (State) ZIP (Phone)

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Please answer the following questions.

1. Has a case management provider been identified to assist in securing and coordinating services once ABI waiver program funding is received? ☐ Yes ☐ No

2. If yes, please provide the name of the organization that will provide case management services:

3. Is Emergency Status consideration requested for this individual? ☐ Yes ☐ No

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

   OR

   If the individual is demonstrating behavior **related to his acquired brain injury** which has resulted in arrest, you must attach an arrest record or a statement from law enforcement or the court indicating the offense(s) for which the individual has been arrested.

_____ _____
Name of Person completing application (please print clearly) | Relationship to Applicant

_____ _____
Signature of Person Completing Application | Date

_____
Telephone # of person completing application

CLEAR FORM

Questions about individual referrals or the Acquired Brain Injury Medicaid Waiver or the Acquired Brain Injury Long Term Care Waiver program may be directed to the Acquired Brain Injury Branch by calling, toll free, (866) 878-2626. Thank you.