

**WV Department of Health and Human Resources  
Referral Form for Medicaid Traumatic Brain Injury Waiver Program**

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DATE: \_\_\_\_\_

TO: \_\_\_\_\_, Income Maintenance Worker

FROM: \_\_\_\_\_  
Case Management Agency or APS Healthcare

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

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Applicant Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ County: \_\_\_\_\_ SSN: \_\_\_\_\_

\_\_\_\_\_ has been medically approved for the Medicaid Traumatic Brain Injury Waiver Program. The cost of services and the medical determination substantiate the need for the long-term care services that will be provided.

Please determine this person's financial eligibility for the Medicaid Traumatic Brain Injury Waiver Program and return one copy of this completed form to the applicant and one copy to the Case Management Agency or APS Healthcare, as applicable.

\_\_\_\_\_  
Case Manager Date

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**Economic Service Worker Response**

\_\_\_\_\_ (Name) is financially eligible for this program.

**YES:** \_\_\_\_\_ **Effective Date:** \_\_\_\_\_ **Medicaid #** \_\_\_\_\_  
**NO:** \_\_\_\_\_

\_\_\_\_\_  
Economic Service Worker Date

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**Terminal Operator**

Case Number: \_\_\_\_\_

\_\_\_\_\_  
Date Transmitted Terminal Operator