TBI WAIVER PROGRAM
MEMBER ENROLLMENT REQUEST FORM

Please use this form to request Member Enrollment in the Medicaid TBI Waiver Program. Fax the completed form to APS Healthcare, Inc. at 1.866.607.9903. This form will only be accepted via fax.

Once the member has been enrolled, the member will be notified and you will be faxed a Member Enrollment Confirmation Notice.

There will be no Medicaid reimbursement for services provided before the date of the Member Enrollment Confirmation Notice.

Name: _____

Date: ____/____/_____ Date of Birth: ____/____/_____

Address: _____

County: _____

Medicaid Number: __ __ __ __ __ __ __ __ __ __ __

(Note: There are 11 digits in a Medicaid Number)

I, _____ ,confirm that _____ is at least
(Print Case Manager's Name) (Print Member's Name)

22 years of age, a permanent resident of West Virginia, medically and financially eligible for the Program and has chosen to participate in the Medicaid TBI Waiver Program as an alternative to Nursing Care Facility. Documentation verifying this is maintained in the member's file.

Case Manager Signature _____

CM Agency Name _____

CM Agency Fax Number _____

***Note – The Case Management Agency and the Personal Attendant Services Agency is responsible for maintaining a copy of this request form, the fax confirmation that verifies the date/time you faxed the request and the Member Enrollment Confirmation Notice sent from APS Healthcare, Inc. when a member has been enrolled. These are kept in the member file. If providing Cognitive Rehabilitation Therapy, the Licensed Behavioral Health Center is responsible for maintaining a copy of the Member Enrollment Confirmation Notice.**