

## TRAUMATIC BRAIN INJURY WAIVER SERVICE PLAN

Member Name: \_\_\_\_\_

Date: \_\_\_\_\_

Initial   
  6-Month   
  Annual   
  Change in Need   
  Transfer   
  Discharge   
 Begin Date: \_\_\_/\_\_\_/\_\_\_

**(If change in need occurs mark appropriate box and a Service Plan Addendum must be attached.)**

End Date: \_\_\_/\_\_\_/\_\_\_

Last Name:	First Name:	Middle Initial:	Medicaid #:
Case Manager Provider:		Phone:	
Personal Attendant Service Agency or PPL:		Phone:	
Dual Service Provider Agency (if applicable):		Phone:	
Service Model Choice: <input type="checkbox"/> Traditional <input type="checkbox"/> Personal Options		Check Attachments: <input type="checkbox"/> Personal Options Spending Plan (if applicable) <input type="checkbox"/> Prior Authorization Cover Letter <input type="checkbox"/> Other: _____	

What do I expect from this program?

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Member Name: \_\_\_\_\_

Date: \_\_\_\_\_

**PERSONAL PREFERENCES**

1. What would you like your personal attendant to do for you?

**I Prefer These Activities, on These Days, During These Times: (bathing, dressing, grooming, community activities, etc.)**

Day	Activity	Time (in minutes)	Formal Support	Informal Support
<b>Monday</b>				
<b>Tuesday</b>				
<b>Wednesday</b>				
<b>Thursday</b>				

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Member Name: \_\_\_\_\_

Date: \_\_\_\_\_

Day	Activity	Time (in minutes)	Formal Support	Informal Support
<b>Friday</b>				
<b>Saturday</b>				
<b>Sunday</b>				

## TRAUMATIC BRAIN INJURY WAIVER SERVICE PLAN

Member Name: \_\_\_\_\_

Date: \_\_\_\_\_

**2. Are there any things you prefer the Personal Attendant not do for you?**

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**Risk Reduction (Health and Safety)**

Identified Problem/ Risk as Noted in Member Assessment	Service(s) Needed to Address Problem/Risk	Provider	Date of Contact	Date Problem/Risk Addressed	Outcome(s) and Date

## TRAUMATIC BRAIN INJURY WAIVER SERVICE PLAN

Member Name: \_\_\_\_\_

Date: \_\_\_\_\_

Evaluation	Date of Evaluation	Summary of Assessment/ Evaluation Results and Identified Needs	Recommendations	Outcome(s)
<b>PAS</b>				
<b>Rancho Los Amigos</b>				
<b>Psychological/ Psychiatric</b>				
<b>Medical</b>		List all physicians, date of last appointment		
<b>Cognitive Rehabilitation Therapy</b>				
<b>Therapy (PT, OT, ST, etc.)</b>				
<b>Member Assessment</b>				
<b>Other</b>				
<b>Other</b>				

# TRAUMATIC BRAIN INJURY WAIVER SERVICE PLAN

Member Name:

Date:

<b>PRIMARY CARE PHYSICIAN</b>
Name:
Specialty:
Address:
City/State/Zip:
Phone
Fax:
Frequency: Last Visit:

<b>Other: Specialists, PT, OT, ST, Counselors, Psychiatrist, etc</b>
Name:
Specialty:
Address:
City/State/Zip:
Phone
Fax:
Frequency: Last Visit:

<b>Other: Specialists, PT, OT, ST, Counselors, Psychiatrist, etc</b>
Name:
Specialty:
Address:
City/State/Zip:
Phone
Fax:
Frequency: Last Visit:

<b>Other: Specialists, PT, OT, ST, Counselors, Psychiatrist, etc</b>
Name:
Specialty:
Address:
City/State/Zip:
Phone
Fax:
Frequency: Last Visit:

# TRAUMATIC BRAIN INJURY WAIVER SERVICE PLAN

Member Name: \_\_\_\_\_

Date: \_\_\_\_\_

<b>Other: Specialists, PT, OT, ST, Counselors, Psychiatrist, etc</b>
Name:
Specialty:
Address:
City/State/Zip:
Phone
Fax:
Frequency: Last Visit:
<b>Other: Specialists, PT, OT, ST, Counselors, Psychiatrist, etc</b>
Name:
Specialty:
Address:
City/State/Zip:
Phone
Fax:
Frequency: Last Visit:

<b>INFORMAL SUPPORTS</b>
Name:
Relationship:
Address:
City/State/Zip:
Phone:

<b>INFORMAL SUPPORTS</b>
Name:
Relationship:
Address:
City/State/Zip:
Phone:

Add additional pages if needed.

# TRAUMATIC BRAIN INJURY WAIVER SERVICE PLAN

Member Name: \_\_\_\_\_

Date: \_\_\_\_\_

## MY EMERGENCY BACK UP PLAN PERSONAL ATTENDANT SERVICES AVAILABILITY

1. I will accept substitute Personal Attendants if my assigned Attendant is not available.  Yes  No
2. I will use my informal supports when a Personal Attendant is not available.  Yes  No
3. I understand that no services within 180 days may result in my TBI Waiver case being closed.  Yes  No
4. When no Personal Attendant is available, I prefer that you contact:  Me  Someone else

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

5. If no one is available to assist me, I need the following things to occur: **(Describe member's urgent needs and any actions that need to take place).**

## ACCESS TO EMERGENCY ASSISTANCE

If I am **unable** to answer the door when the Personal Attendant or Case Manager arrives please contact:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ for access to my home (key)

I can access emergency assistance by dialing 911  Yes  No

I need additional assistance such as Lifeline, Alert, or Safe Link.  Yes  No

## DISASTER EMERGENCY PLAN

I have a plan in place for: floods, extended power outage, snow, fire, etc. **(Describe member's urgent needs and any actions that need to take place.)**

## TRAUMATIC BRAIN INJURY WAIVER SERVICE PLAN

Member Name: \_\_\_\_\_

Date: \_\_\_\_\_

### SUMMARY PAGE

Service Code	Service Description	Provider	Needed?	Frequency
<b>T1016 UB</b>	<b>Case Management</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>S5125 UB</b>	<b>Personal Attendant Services</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>97532 UB</b>	<b>Cognitive Rehabilitation Therapy</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>A0160 UB</b>	<b>Transportation</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>T2028 UB</b>	<b>Participant-directed Good and Services</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Additional Services (include all State Medicaid Plans, Personal Care Services, and other services member is/will be receiving)	Service Description	Provider

# TRAUMATIC BRAIN INJURY WAIVER SERVICE PLAN

Member Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Signature Page

In order to be a valid Service Plan **all** involved persons are to sign and date this document. If a member is unable to sign please provide justification as to why s/he could not sign and verification that s/he was in attendance.

*By signing, I certify that the reported information is complete and accurate. Assessments were reviewed with the member and were considered in the development of this plan. I understand that payment for the services certified on this form will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under Medicaid Fraud.*

**Signatures:**

Relationship	Signature	Date
Member		
Legal Representative		
Case Manager		
Personal Attendant Service Agency		
Other:		
Other		
Other:		
Other:		
Other:		

Start time of Service Plan meeting: \_\_\_\_\_

End time of Service Plan meeting: \_\_\_\_\_

Copy of Service Plan was provided to the member on : \_\_\_\_/\_\_\_\_/\_\_\_\_

Copy of Service Plan was provided to Personal Attendant Services Agency on: \_\_\_\_/\_\_\_\_/\_\_\_\_

Copy of Service Plan was provided to PPL on: \_\_\_\_/\_\_\_\_/\_\_\_\_ or NA

Copy of Service Plan was provided to CRT on: \_\_\_\_/\_\_\_\_/\_\_\_\_ or NA

TRAUMATIC BRAIN INJURY WAIVER  
SERVICE PLAN

Member Name: \_\_\_\_\_

Date: \_\_\_\_\_