

TRAUMATIC BRAIN INJURY (TBI) WAIVER CASE MANAGEMENT MONTHLY CONTACT

Participant Name: _____ Person spoken to: _____ <small>Note in comments section below reason why participant was not available</small>	Medicaid Number: _____ _____	<input type="checkbox"/> Face to Face Contact <input type="checkbox"/> Telephone Contact
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Question	Circle		Comments and Follow-up
1. Did you get all the services you were supposed to get last month? If not, then what services did you not receive?	Yes	No	
2. Have you had any disagreements or problems with the people who come into your home to provide you services? If yes, who is the person and what types of problems are you having?	Yes	No	
3. Are there times when you needed help and you didn't get it? If yes, what happened?	Yes	No	
4. Have your needs for assistance changed since we last talked? If so, how?	Yes	No	
5. Have you visited a physician, hospital or nursing home as a patient since we last talked? If so, what was the reason for the visit?	Yes	No	
6. Do you need help in making any appointments? If yes, with whom and when?	Yes	No	
7. Do you need any additional medical equipment, services or resources? If yes, what?	Yes	No	
8. Are you having any problems paying for or getting food, housing, utilities or medications?	Yes	No	
9. Have there been any changes in your life that affect your need for service (death, loss, divorce, etc.)?	Yes	No	
10. If anything happens, do you know how to report problems (services or abuse, neglect or exploitation?)	Yes	No	
11. Is there anything that I can help you with?	Yes	No	
12. Did you receive your Medicaid card this month?	Yes	No	
13. Have there been any changes to your prescribed medications?	Yes	No	
14. Did you use your Personal Attendant Services this month? If no, why?	Yes	No	
Comments			

By signing, I certify that the reported information is complete and accurate. 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

Case Manager Signature, Credentials

Date

Start Time

End Time