Map 10
(Rev 06/15)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
WAIVER SERVICES
PHYSICIAN'S RECOMMENDATION

PLEASE RETURN TO THE REQUESTOR LISTED BELOW.

KIPDA Area Agency on Aging and Independent Living
(Requestor's Name)

11520 Commonwealth Drive
(Address)

Louisville **KY** 40299 (502) 266-5571
(City) **(Zip)** **(Phone)**

PHYSICIAN'S RECOMMENDATION

I recommend Waiver services for:

_____ _____
(Member) **(Medicaid Member ID #)**

_____
(Address)

_____ **KY** _____ _____
(City) **(Zip)** **(Phone)**

DIAGNOSIS (ES):
ICD-10 Codes Required: _____

Recommended Waiver Program:

- ☐ HCBW (APRN, PA or Physician signature)
- ☐ ABI Waiver – Services to adults with a **primary** diagnosis of an acquired brain injury (18 yrs and older) with a potential for rehabilitation and retraining (**Physician signature**)
- ☐ ABI Long Term Care Waiver – Services to adults (18 yrs and older) with a **primary** diagnosis of an acquired brain injury who has reached a plateau in their rehabilitation level and require maintenance services. (**Physician signature**)
- ☐ SCL Waiver (SCL IDP or Physician signature)
- ☐ Michelle P. Waiver – Non-residential Services to children and adults **with intellectual or developmental disabilities. (APRN, IDP, PA or Physician signature**)

I certify that if Waiver services were not available, institutional placement in a Nursing Facility (NF) or Intermediate Care Facility for Individuals with an Intellectual Disability shall be appropriate for this member.

_____ _____
(Authorized Signature) **(NPI #)**

_____
(Address)

_____ **KY** _____ _____
(City) **(Zip)** **(Phone)**

_____
(Date)

DOB: _____
SS#: _____
Medicaid ID #: _____

Kentucky UNBRIDLED SPIRIT

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

Application Intake – Participant Authorization

Participant

- ☐ I understand that my medical information will be shared with the Commonwealth of Kentucky, and its contract employees, in order to be a participant in the Medicaid Waiver Program
- ☐ I consent that all of the information is correct
- ☐ I consent that the Application Initiator has the authority to apply on behalf of this person

First Name _____ Middle Initial _____ Last Name _____

Signature _____

Authorized Representative

Is the Authorized Representative applying on behalf of the individual?

- ☐ Yes
- ☐ No

First Name _____ Middle Initial _____ Last Name _____

Signature _____

TEAM KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES

KENTUCKY MEDICAID WAIVER APPLICATION

'THINGS FOR YOU TO KNOW'

Purpose of this form:	Completing and submitting this form is the next step to see if you qualify for services from one of Kentucky Medicaid's waiver programs. These programs offer services and supports that individuals with disabilities need to live more independently. The programs are: • Acquired Brain Injury (ABI) • Acquired Brain Injury-Long Term Care (ABI-LTC) • Supports for Community Living (SCL) • Michelle P. Waiver (MPW) • Model II Waiver (MIIW) • Home and Community Based Waiver (HCB) Learn more about each program at: https://chfs.ky.gov/agencies/dms/dca/Pages/default.aspx
Using this Medicaid Waiver Application:	Before applying for a Medicaid waiver program, you need to obtain financial eligibility. This can be done online at kynect.ky.gov/benefits, by visiting a Department for Community Based Services (DCBS) office or by calling DCBS at 855-306-8959. To find a DCBS office, visit: https://prd.webapps.chfs.ky.gov/Office_Phone/ Once you have completed financial eligibility for Medicaid, you can apply for waiver services at kynect.ky.gov/benefits or by visiting a Community Health Center (CMHC) or Aging and Disability Resource Center (ADRC). To find a CMHC, visit: http://dbhdid.ky.gov/cmhc/default.aspx To find an ADRC, visit https://chfs.ky.gov/agencies/dail/Pages/adrc.aspx

What you may need to apply:	• Individual contact information; • Information related to authorized representatives or legal guardian, if applicable; • Caregiver contact information • Documentation to verify answers given on thisapplication, including any relevant medical records; • Your social security number (SSN) If you need help getting an SSN, call 1-800-772-1213 or visit www.socialsecurity.gov. TTY users should call 1-800-325-0778
Why do we ask for this information?	The information you provide helps Medicaid figure out what Medicaid waiver program you may qualify for.
To get help:	If you have questions about the waiver programs or applying for waiver services, call 844-784-5614 If you have technical problems while applying online, call 800-635-2570.

KENTUCKY MEDICAID WAIVER INTAKE APPLICATION

APPLICATION FOR SINGLE APPLICANT

TEAM KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES

Note: It is important to be VERY thorough in your responses so that reviewers have as much information as possible to make appropriate determinations.

Please provide the following information: (Fields marked with (*) are mandatory.)

Individual Details

1. ***First name, Middle initial, Last name & Suffix, if applicable:**

2. ***Date of Birth: (MM/DD/YYYY)**
_____/___/_____

3. ***Gender:** ☐Male ☐Female

4. **Social Security Number:** *(giving your Social Security Number now will reduce time and effort later)*
_____-_____- _____

Contact Information

5. ***What is your Main Phone Number**:☐Home ☐Work ☐Cell
* If you don't have a phone number provide a number where you can be reached
( ) -

6. **Other Phone Number:**
☐ Home ☐ Work ☐ Cell
( ) -

7. ***What is the address where you live:**

8. ***City**

9. ***State:**

10. ***Zip Code:**

11 .* **County**

12. ***Mailing Address:** ☐ (please select this check box if your mailing address and address where you are living is the same)

13. **City :**

14. **State:**

15. **Zip Code:**

16. **County**

17. **Email Address:**

18. **Preferred Spoken Language:**
☐ English ☐Spanish ☐Other:

19. **Preferred Written Language:**
☐ English ☐Spanish ☐Other:

20. **Interpreter needed?**
☐Yes ☐No

21. **Comments:**

Representative Information

20. ***Do you have an Authorized Representative?** ☐ Yes ☐ No (If 'Yes' answer questions for 'Authorized Representative' section below)

An Authorized Representative is someone you name to help you. For more information you can visit the following website: https://legislature.ky.gov/Pages/index.aspx

21. ***Do you have a Legal Guardian?** ☐Yes ☐No (If 'Yes' answer questions for 'Legal Guardian' section below)

A Legal Guardian is a court-appointed adult who assumes the responsibility for decisions for you. For more information you can visit the following website: https://legislature.ky.gov/Pages/index.aspx

Additionally, if you need more information on State Guardianship, you can visit the following website: https://chfs.ky.gov/agencies/dail/dg/Pages/default.aspx

Authorized Representative

22. * First name, Middle initial, Last name & Suffix, if applicable:

23. *Date of Birth: (MM/DD/YYYY)	**24. *How is this person related to you?**
_____/____/_____	☐ Mother ☐Father ☐Sister ☐ Other:_____
25. *Main Phone Number:☐Home ☐Work ☐ Cell ( ) -	**26. Other Phone Number**: ☐ Home☐ Work☐ Cell ( )

27. *Do you and your representative live at the same place? ☐Yes ☐ No (If 'No' answer # 28 - #32)

28. Address where the representative lives:

29. City:	**30. State:**	**31. Zip Code:**	**32. County:**

33. *Mailing Address: ☐ (please select this check box if the representative's mailing address and address where the representative lives is the same)

34. City:	**35. State:**	**36. Zip Code:**	**37. County:**

38. Email Address:

39. Preferred Language:
☐ English ☐Spanish ☐Other:_____

40. *Is this Individual also your Legal Guardian?
☐ Yes ☐ No

Legal Guardian

41. *First name, Middle initial, Last name & Suffix, if applicable:

42. *Date of Birth: (MM/DD/YYYY)	**43. *How is this person related to you?**
____/____/_____	☐Mother ☐Father ☐Sister ☐ Other:_____
44. *Main Phone Number:☐ Home ☐ Work ☐ Cell ( ) - -	**45. Other Phone Number** ☐ Home ☐ Work ☐ Cell ( ) -

46. *Do you and your guardian live at the same place? ☐ Yes ☐ No (If 'No' answer # 47 - # 51)

47. Address where the guardian lives:

48. City:	**49. State:**	**50. Zip Code:**	**51. County:**

52. *Mailing Address: ☐(please select this check box if the guardian mailing address and address where the guardian lives is the same)

53. City:	54. State:	55. Zip Code:	56. County:

57. Email Address: _____

58. Preferred Language:

□ English □ Spanish □Other: _____

Services

What Services Are You Getting Now?

59. *What services are you getting now?
(check all that apply)

For each service you check below, from the right column, labeled '59A. What Program?' add program # that provided you the service you selected:

Examples: ☒ Behavior Support:_____11_____
☒ Personal Assistance:_____15_____

☐ Attendant Care Services: _____
☐ Behavior Support:_____
☐ Case Management: _____
☐ Community Access/Community Living Support: _____
☐ Day Program/Day Training: _____
☐ Homemaking:_____
☐ Mental Health Counseling/Medication/Psychological Services:_____
☐ Nursing:_____
☐ Occupational Therapy: _____
☐ Personal Assistance/Companion Services/Personal Care:_____
☐ Physical Therapy: _____
☐ Residential: _____
☐ Respite: _____
☐ Speech Therapy: _____
☐ Supported Employment: _____
☐ None
☐ Other:

59A.*What Program?

1. Acquired Brain Injury Waiver (ABI)
2. Acquired Brain Injury-Long Term Care Waiver(ABI-LTC)
3. Community Mental Health Center Programs (CMHC)
4. Durable Medical Equipment (DME)
5. Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) (if under 21)
6. First Steps
7. Health Access Nurturing Development Services (HANDS)
8. Hart Supported Living Program
9. Home Health Services (HHS)
10. Home and Community Based Waiver Program (HCB)
11. Hos pic e
12. Hospital Inpatient
13. Hospital Outpatient
14. IMP ACT
15. Modell II (Ventilator) Waiver (MIIW)
16. Kentucky Children's Health Insurance Program(KY CHIP)
17. Michelle P. Waiver (MPW)
18. Money Follows the Person (MFP)
19. Personal Care Attendant Program (PCAP)
20. Private Paid Service
21. School Based Services
22. State Supplementation
23. Supports for Community Living Waiver (SCL)
24. Transportation
25. Traumatic Brain Injury Trust Fund
26. Vocational Rehabilitation (OVR)
27. Other

60.*Please list services needed, whether you get them now or not: (check all the services you need)

☐ Attendant Care Services
☐ Behavior Support
☐ Case Management
☐ Community Access/Community Living Support
☐ Day Program/Day Training
☐ Homemaking
☐ Mental Health Counseling/Medication/Psychological Services
☐ Nursing
☐ Occupational Therapy
☐ Personal Assistance/Companion Services/Personal Care
☐ Physical Therapy
☐ Residential
☐ Respite
☐ Speech Therapy
☐ Supported Employment
☐ None
☐ Other:_____

61. *Please describe why the above services are needed. Note: Provide thorough information so the reviewer can make an appropriate determination

_____
_____
_____

62. *How soon are the services needed?

_____
_____
_____

63. *Are you currently on a waiting list for any of these Medicaid waiver programs? ☐ Yes ☐ No (If "Yes", what list(s) are you on? Check all that apply)

☐ Acquired Brain Injury Waiver (ABI)
☐ Acquired Brain Injury-Long Term Care Waiver (ABI-LTC)
☐ Home & Community Based Waiver (HCB)
☐ Model II Waiver (MIIW)
☐ Michelle P. Waiver (MPW)
☐ Supports for Community Living Waiver (SCL)
☐ Other: _____

64. Have you previously accessed services for a Waiver Program? ☐ Yes ☐No (If "Yes", for which program(s) have you accessed services? (check all that apply)

☐ Supports for Community Living Waiver (SCL)
☐ Model II Waiver (MIIW)
☐ Acquired Brain Injury Waiver (ABI)
☐ Acquired Brain Injury-Long Term Care Waiver (ABI-LTC)
☐ Home & Community Based Waiver (HCB)
☐ Michelle P. Waiver (MPW)

Clinical Information

65. *Do you have a physically disability? ☐ Yes ☐ No

66. *Do you have an intellectual disability? ☐ Yes ☐ No

In order to make a determination regarding eligibility for a waiver related to intellectual disability, a full thorough psychological evaluation including adaptive behavior analysis is required. Intellectual disability is recorded on a psychological evaluation. Please refer to the psychological evaluation for a determination regarding disability and age of onset. Intellectual disability is a disability characterized by significant limitations in both intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. This disability originates before the age of 18. Definition: http://aaidd.org/intellectual-disability/definition#

a. *If yes, was the onset prior to age 18? ☐ Yes ☐ No
b. What is your IQ score?:_____(Optional)

IQ score is recorded on the psychological evaluation. Please refer to the document and record the score here.

67. *Do you have a developmental disability? ☐ Yes ☐ No

Developmental disability is recorded on a psychological evaluation. Please refer to the psychological evaluation for a determination regarding disability and age of onset. Developmental Disability is an umbrella term that includes intellectual disability, but also includes other disabilities that are apparent during childhood. Developmental disability is a diverse group of chronic conditions due to impairments that are present at birth or occur during the developmental years. Developmental disabilities cause individuals living with them many difficulties in areas of life, especially in language, mobility, learning, self-help, and independent living. Developmental disabilities can be detected early on and persist throughout an individual's life.
http://www.gpo.gov/fdsys/pkg/CFR-2002-title45-vol4/xml/CFR-2002-title45-vol4-sec1385-3.xml

a. If yes, is onset prior to age 22? ☐ Yes ☐ No
b. Please describe the developmental disability.

_____
_____

68. *Are you dependent on a ventilator? ☐Yes ☐ No (This excludes CPAP and BiPAPmachines settings) (If "Yes" please answer questions # 69 - # 71)
A **ventilator** is a machine designed to mechanically move breathable air into and out of the lungs, to provide the mechanism of breathing for a person who is physically unable to breathe, or who breathes insufficiently.

69. *Is the ventilator used for more than 12 hours per day? ☐Yes ☐ No

70. *Does the ventilator stimulate respirations? ☐ Yes ☐No

71. *Do you have a permanent tracheostomy? ☐Yes ☐No

72. *Do you require 24 hours of daily high-intensity nursing care? ☐Yes ☐ No (If 'Yes' answer # 73)

73. *List the needs for requiring high intensity nursing care: (check all that apply)

☐ Intravenous, intramuscular, or subcutaneous injections and hypodermoclysis or intravenous feeding
☐ Nasogastric or gastrostomy tube feedings
☐ Nasopharyngeal and tracheotomy aspiration
☐ Recent or complicated ostomy requiring extensive care and self-help training
☐ In-dwelling catheter for therapeutic management of a urinary tract condition
☐ Bladder irrigations in relation to previously indicated stipulation
☐ Special vital signs evaluation necessary in the management of related conditions
☐ Sterile dressings
☐ Changes in bed position to maintain proper body alignment, for individuals who are unable to self-position related to physical condition(s) such, but not limited to, a comatose state or a minimally conscious state, paralysis, locked-in syndrome, etc.
☐ Treatment of extensive decubitus ulcers or other widespread skin disorders
☐ Receiving medication recently initiated, which requires high-intensity observation to determine desired or adverse effects or frequent adjustment of dosage

74. *Do you have an Acquired Brain Injury? ☐ Yes ☐ No (If "Yes," answer # 75-#76)

Acquired brain injury is brain damage caused by events after birth including

a. An injury from physical trauma;
b. Damage from anoxia or from a hypoxic episode; or
c. Damage from an allergic condition, toxic substance, or another acute medical incident

http://biau.org/types-and-levels-of-brain-injury/

75. *What is the date of the Acquired Brain Injury? (MM/DD/YYYY)

_____/___/_____

76. *Do you have an Acquired Brain Injury of the following nature? (check all that apply; if you 'check' any of the following, answer # 77 - # 78)

☐ Injury from physical trauma
☐ Damage from anoxia or from hypoxic episode
☐ Damage from allergic condition, toxic substance, or other acute medical incident
☐ A stroke treatable in a nursing facility providing routine rehabilitation services
☐ A spinal cord injury for which there is no known or obvious injury to the intracranial central nervous system
☐ Progressive dementia or another condition related to mental impairment that is of a chronic degenerative nature, including senile dementia, organic brain disorder, Alzheimer's disease, alcoholism or another addiction
☐ A depression or a psychiatric disorder in which there is no known or obvious central nervous system damage
☐ A birth defect
☐ Intellectual disability without an etiology to an acquired brain injury
☐ A condition which causes an Individual to pose a level of danger or an aggression which is unable to be managed and treated in the community
☐ Determination that the recipient has met his or her maximum rehabilitation potential
☐ Unknown

77. *Do you have an Acquired Brain Injury that requires any of the following? (check all that apply)

☐ Supervision
☐ Long term supports
☐ Intensive rehab services
☐ Therapy to maintain current level of functioning

78. *What problems has the Acquired Brain Injury caused? (check all that apply)

☐ Cognition
☐ Behavior
☐ Motor Skills
☐ Sensory
☐ Inability to initiate, sequence or complete everyday activities (i.e. brushing teeth, feeding dressing) even though physically able. May need step-by-step instructions to initiate or complete task;
☐ Inability to focus or concentrate due to situational distractions (i.e. high noise levels) or to complete activities that involve many steps;
☐ Short-term memory deficits
☐ Changes in cognition involving executive functions such as problem solving, impulse control, self-monitoring, attention, short-term memory and learning, speed of information processing and speech and language functions
☐ Lack of awareness of illness and/or need of medical attention or lack of awareness of deficits and/or loss of abilities; (dressing, eating, hygiene, grooming)
☐ Organizational deficits - putting items together, making associations; (i.e. cooking. dressing, eating, hygiene, grooming);
☐ Visual-spatial skills (inability to judge distance, place of object in space, depth perception) - may affect: grooming, cooking, hygiene, safety
☐ Information processing (speed of ability to take in information - auditorily or graphically, ability to assign meaning to information - make choices) - may affect: safety, cooking, dressing, eating
☐ Expressive/receptive language deficits (wording finding difficulties, comprehension deficits, communication of wants and needs, reading and writing difficulties) – may affect: safety, medication management, cooking

Living Situation

79. *Where do you live?

☐ Living with family/relatives
☐ Living in own home or apartment
☐ Child Foster Care
☐ Adult Foster Care
☐ Group Home
☐ Personal Care Home
☐ Nursing Home
☐ Psychiatric Facility
☐ Intermediate Care Facility (ICF/IDD)
☐ Living with a friend
☐ Jail
☐ Homeless shelter
☐ *Other (If selected, Explain your living situation:

_____

80. * Is living situation permanent? ☐Yes ☐ No

a. *If No (i.e. living situation is temporary), then explain.

_____

_____

_____

81. *Where do you prefer to live?

☐ Where you are currently living
☐ At home with a family member with someone to come in and help
☐ In your own home with support
☐ In residential services in the community, living with a family
☐ In residential services in a community home with staff
☐ *Other (If selected, please answer # 82)

82. *Explain where you prefer to live: Note: Provide thorough information so the reviewer can make an appropriate determination.

_____
_____
_____

Caregiver Status

83. *Do you have a Main Caregiver? ☐ Yes ☐ No (if "Yes" answer questions # 84 - # 90)

84. *Is your Main Caregiver also the Legal Guardian? ☐ Yes ☐ No

85. *Name of Main Caregiver:
First Name:_____ **Middle Initial:**___ **Last Name:**_____ **Suffix:**_____

86. How would your Main Caregiver like to be contacted? ☐ Phone ☐ Email ☐ Postal Mail(Please provide contact details)

_____

87. *Is your Main Caregiver related to you? ☐ Yes ☐ No (If "Yes" explain the Main Caregiver's relationship with the Individual. If "No", explain who the Main Caregiver is)

_____
_____

88. *What is your Main Caregiver's age?

☐ Less than 30 years old
☐ 31-50 years old
☐ 51-60 years old
☐ 61-70 years old
☐ 71-80 years old
☐ Over 80 years old

89. *Is the main caregiver able to provide and meet all the individual's needs? ☐ Yes ☐ No (If "No" is selected answer question # 90)

90. *Please explain why the main caregiver is unable to provide care.

_____
_____

91. *Do you have another caregiver? ☐ Yes ☐ No (If "Yes" answer questions # 92 - # 97)

92. *Is this caregiver also your Legal Guardian? ☐ Yes ☐ No

93. *Name of other caregiver:
First Name:_____Middle Initial:_____Last Name:_____Suffix:__

94. *How would this caregiver like to be contacted? ☐ Phone ☐ Email ☐Postal Mail (Please provide contact details)

_____

95. *Is this caregiver related to you? ☐ Yes ☐ No (If "Yes", explain the Other Caregiver's relationship with the Individual. If "No", explain who the Other Caregiver is)

_____
_____
_____

96. *What is this caregiver's age?

☐ Less than 30 years old
☐ 31-50 years old
☐ 51-60 years old
☐ 61-70 years old
☐ 71-80 years old
☐ Over 80 years old

97. *Is this Caregiver available to provide and meet the individual's needs? ☐ Yes ☐ No (If "No" is selected answer question # 98)

98. *Please explain why this Caregiver is unable to provide care.

_____
_____

99. *Do you have family that is or could be involved in your life? ☐ Yes ☐ No (If "Yes" answer # 100)

100. *Is this family member available to provide care? ☐ Yes ☐ No (If "Yes" answer #101, if "No" answer #102)

101. *Please discuss the care provided by this family member. Note: Provide thorough information so the reviewer can make an appropriate determination.

_____
_____
_____

102. *Please explain why this family member is unable to provide care. Note: Provide thorough information so the reviewer can make an appropriate determination.

_____
_____
_____

Current Conditions

103. *How are you able to get around?

☐ Walk independently
☐ Use wheelchair & need help
☐ Walk with supportive devices
☐ Use wheelchair operated by self

☐ Total assistance is needed with help from one person
☐ Total assistance is needed with help from two or more people

104. *How much help do you need each day? Please check all that apply. (If any option other than "None" is selected for question #104, answer question #105)

☐ None
☐ Monitoring
☐ Verbal/gestural prompting
☐ Partial physical assistance
☐ Full physical assistance

105. *Please describe the type of assistance needed.

106. *How do you communicate? Please check all that apply. (If "Other" is selected for question #106, answer question #107)

☐ Use verbal communication
☐ Use communication board or device
☐ Use gestures
☐ Use sign language
☐ Use an interpreter
☐ Needs time to process questions/commands
☐ Other

107. * If 'Other', please explain how do you communicate.

108. *Check each of the challenges you have: (If any option other than "None" is selected for question #107, answer question #108)

☐ Self-Injury
☐ Property destruction
☐ Physically/verbally aggressive towards others
☐ Inappropriate sexual behavior
☐ Inappropriate social behavior/lack of emotional control
☐ Life threatening (threat of death or severe injury to self or others)
☐ Committed a crime and been arrested
☐ Elopement/runs away
☐ Resistive behaviors
☐ None

109. *Please describe the challenge(s) in detail (include frequency, severity and last occurrence)

110. *How much time is needed to make sure you are safe?

☐ Requires less than 12 hours
☐ Requires 12-18 hours on a day average
☐ Requires 24 hours (does not require an awake person overnight)

☐ Requires 24 hours (with an awake person overnight)

111. *Explain the care needed to ensure you are safe.

112. *Have you been abused, neglected, or taken advantage of? ☐ Yes ☐ No (If "Yes" is selected, answer question #112 and #113)

113. *Please describe the incident.

114. *When did this occur?

115. You may add other comments here:

Include the name and contact information for the person(s) able to provide additional information/clarification. Note: Complete documentation must accompany the application.

Note: It is important to be VERY thorough in your responses so that reviewers have as much information as possible to make appropriate determinations. Complete documents must accompany the application.

Diagnosis

NOTE: Adding a Diagnosis Description (nature of illness or disability - ex. high blood pressure) is helpful during the application review process.

116. Diagnosis Codes:

117. Diagnosis Description:

Application Confirmation

☐ **I consent that I have the authority to apply on behalf of the person**

☐ **I certify the information contained above is accurate and correct to the best of my knowledge**

☐ **I certify that this application was completed by the Individual or his/her Authorized Representative.**

*Individual's First Name: _____ Individual's Middle Initial:_____
*Individual's Last Name: _____ Individual's Suffix code : _____

Signature:_____

118. Is the Authorized Representative applying on behalf of the Individual? ☐ Yes ☐ No (If "Yes" , enter details below)

Auth Rep's First Name: _____ Auth Rep's Middle Initial:_____
Auth Rep's Last Name: _____ Auth Rep's Suffix code : _____

Signature:_____

DAIL –GA-01 PRIORITY SCREENING TOOL

CONSUMER: _____ **DATE:** _____

ADLs **Please check level of assistance required and level of provided supports.**

	None	Minor	Moderate	Total	*Who Provides this Assistance? Frequency*	*Formal/Informal Supports* Need Met	Partially	Unmet
Eating	☐0	☐1	☐2	☐3	_____	☐0	☐1	☐2
Transfers	☐0	☐1	☐2	☐3	_____	☐0	☐1	☐2
Toileting	☐0	☐1	☐2	☐3	_____	☐0	☐1	☐2
Bathing	☐0	☐1	☐2	☐3	_____	☐0	☐1	☐2
Dressing	☐0	☐1	☐2	☐3	_____	☐0	☐1	☐2
Ambulation	☐0	☐1	☐2	☐3	_____	☐0	☐1	☐2
Grooming	☐0	☐1	☐2	☐3	_____	☐0	☐1	☐2
Bed Mobility	☐0	☐1	☐2	☐3	_____	☐0	☐1	☐2

TOTAL _____

IADLs **Please check level of assistance required and level of provided supports.**

	None	Minor	Moderate	Total	*Who Provides this Assistance? Frequency*	*Formal/Informal Supports* Need Met	Partially	Unmet
Meal Preparation	☐0	☐1	☐2	☐3	_____	☐0	☐1	☐2
Shopping	☐0	☐1	☐2	☐3	_____	☐0	☐1	☐2
Housekeeping	☐0	☐1	☐2	☐3	_____	☐0	☐1	☐2
Laundry	☐0	☐1	☐2	☐3	_____	☐0	☐1	☐2
Heavy Housework	☐0	☐1	☐2	☐3	_____	☐0	☐1	☐2
Finances	☐0	☐1	☐2	☐3	_____	☐0	☐1	☐2
Telephone Usage	☐0	☐1	☐2	☐3	_____	☐0	☐1	☐2
Medication Mgmt.	☐0	☐1	☐2	☐3	_____	☐0	☐1	☐2
Transportation	☐0	☐1	☐2	☐3	_____	☐0	☐1	☐2

TOTAL _____

NUTRITION RISK ASSESSMENT

☐ 2	Illness or condition that made me change the kind and/or amount of food I eat
☐ 3	Eats fewer than 2 meals per day
☐ 2	Eats few fruits, vegetables, or milk products
☐ 2	Drinks 3 or more alcoholic beverages almost everyday
☐ 2	Tooth/Mouth Problems make it difficult to eat
☐ 4	Doesn't have enough money to buy food
☐ 1	Eats alone most of the time
☐ 1	Take 3 or more prescribed or OTC medications per day
☐ 2	Without wanting to, lost or gained 10 pounds over last six months
☐ 2	Not always physically able to shop, cook, and/or feed self

Nutrition Risk Total _____ **If score is 6 or greater, this section receives 3 points** ☐3

TARGETING SPECIAL POPULATIONS

☐2	Low Income
☐2	Rural
☐2	Minority
☐2	Limited English Proficiency
☐2	Socially Isolated
☐2	Lives Alone

TOTAL _____

OVERALL TOTAL _____**/100**

Homecare _____ **Nutrition** _____**IIIB** _____ **Caregiver** _____ **Other**_____

_____

Signature of Staff Person

TEAM KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES

How to Apply for Waiver Services

1915(c) Home and Community Based Services (HCBS) waiver programs offer services that can help someone live at home or in the community instead of a nursing home or other type of facility. The Kentucky Department for Medicaid Services (DMS) has six waivers that meet a variety of support needs.

For individuals with an acquired brain injury	•**Acquired Brain Injury (ABI)** •**Acquired Brain Injury Long Term Care (ABI LTC)**
For the aged or individuals with a physical disability	•**Home and Community Based (HCB)**
For individuals who are ventilator dependent	•**Model II Waiver (MIIW)**
For individuals with an intellectual or developmental disability	•**Michelle P. Waiver (MPW)** •**Supports for Community Living (SCL)**

How Do I Apply? There are two steps to apply for waiver services.

Step 1: Apply for the type of Medicaid that pays for waiver services. This is called **waiver-supportive Medicaid**. You have three options for submitting this application. **Applications are not accepted by mail**.

Online: Go to kynect.ky.gov on your computer, phone, or tablet. To get started, look for the purple **Benefits** icon and choose **Apply for All Programs**.

You must sign up for a Kentucky Online Gateway (KOG) account if you have never used kynect before. Select the link at the bottom of the page that says **Sign Up** to create a KOG account. Videos and user guides for creating a KOG account and using kynect are available at https://www.chfs.ky.gov/agencies/dms/kynect/kbQRGKOGAccount.pdf.

Once you are signed up for a KOG account, click the purple **Apply for Benefits** button and kynect will walk you through the process of applying. If you have used kynect before, you can skip this step and use the email address and password you already have.

By Phone: Call the Department for Community Based Services (DCBS) at (855) 306-8959. Follow the prompts to select your preferred language. When you are given a list of options, select **healthcare and food benefits**, followed by **waiver-supportive Medicaid**.

In-Person: Go to a DCBS office. You can find your local DCBS office at https://kynect.ky.gov/benefits/s/find-dcbs-office?language=en_US.

How to Apply for Waiver Services

Tips for Applying for Waiver-Supportive Medicaid

- You can apply for yourself or someone else.
- If applying by phone or at a DCBS office, tell them you are applying for Medicaid for waiver.
- Having the following documents can make the application process easier.
  - Identification
  - Social Security number
  - Income information
  - Resource information
  - Health insurance card and premiums
  - Medical bills
  - Proof of citizenship (if applicable)

Step 2: Once you have completed your Medicaid application, apply for waiver services. You have two options for submitting a waiver application. **Applications are not accepted by mail**.

Online: Go to kynect.ky.gov and follow the same steps as when you applied for Medicaid.

In-Person: You can apply in person by going to an **Aging and Disability Resource Center (ADRC)** or a **Community Mental Health Center (CMHC).**

- Find an **ADRC** at https://chfs.ky.gov/agencies/dail/Pages/adrc.aspx or call (877) 925-0037.
- Find a **CMHC** near you at https://dbhdid.ky.gov/cmhc/default.aspx.

Tips for Applying for Waiver Services

- You can apply for yourself or someone else.
- Make sure you have any documentation that supports the need for waiver services. Below is a list of helpful documents by waiver. **These documents are not required to apply**; however, they can help our reviewers when determining if you or your loved one qualifies for waiver services.

ABI	ABI LTC	HCB	Model II	MPW	SCL
MAP-10 and hospital discharge summary from brain injury occurrence with CT or MRI results	MAP-10 and original medical documentation from brain injury occurrence	MAP-10	MAP-10 and physician's notes or orders for ventilator use 12+ hours a day	Documentation showing intellectual or developmental disability, such as individualized education plan, psychological evaluation, First Steps evaluation, or physician's order	Psychological evaluation with full-scale intelligence quotient (FSIQ) and Adaptive behavior assessment

How to Apply for Waiver Services

What Happens After I Submit a Waiver Application?

Medicaid will review your application to see if you or the person you applied for qualifies for waiver services and which waiver is the best fit. Medicaid will send a letter to the applicant letting them know if they meet the requirements and what to do next.

What If I Have Questions?

Additional information about applying for Medicaid and waiver services using kynect is available at https://chfs.ky.gov/agencies/dms/Pages/kynectben.aspx.

For questions about **applying for waiver-supportive Medicaid**, contact DCBS at (855) 306-8959 or DFS.Medicaid@ky.gov.

For questions about **applying for waiver services**, contact the 1915(c) Waiver Help Desk at (844) 784-5614 or 1915cWaiverHelpDesk@ky.gov.