

TRAUMATIC BRAIN INJURY (TBI) WAIVER
CASE MANAGEMENT MONTHLY CONTACT

Participant Name: _____		Medicaid Number: _____	
Person spoken to: _____		<input type="checkbox"/> Face to Face <input type="checkbox"/> Telephone	
Question	Circle	Comments and Follow-up	
1. Did you get all of your Personal Attendant Services last month? (ADLs, Community outings, cleaning) 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, dentist, 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		
13. Have there been any changes to your prescribed medications?	Yes No		
14. Name of Staff who provided your Personal Attendant Services this month?	Case Manager confirmed with PA provider		
15. Do you feel you have privacy in your home?	Yes No		
16. Is there anything else you would like to tell me? If yes, please explain.	Yes No		
* If the participant was unavailable, please note reason why and document contact attempts in the comment section below.			
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