WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES

TRAUMATIC BRAIN INJURY WAIVER (TBIW)
CASE MANAGEMENT MONTHLY CONTACT

Member name: _____ **Person spoken to:** _____		**Medicaid Number:** _____ ☐ **Face to Face**
Question	**Circle**	**Comments and Follow-up**
1. Did you get all 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. Do you need help in making any appointments? If yes, with whom and when?	Yes No	
6. Do you need any additional medical equipment, services or resources? If yes, what?	Yes No	
7. Are you having any problems paying for or getting food, housing, utilities or medications?	Yes No	
8. Have there been any changes in your life that affect your need for service (death, loss, divorce, etc.)?	Yes No	
9. If anything happens, do you know how to report problems (services or abuse, neglect or exploitation?)	Yes No	
10. Have there been any changes to your prescribed medications?	Yes No	
11. Name of Staff who provided your Personal Attendant Services this month?	Case Manager confirmed with PA provider	
12. Do you feel you have privacy in your home?	Yes No	
13. Would you like information about the WV ABLE program?	Yes No	
* If the member was unavailable, please note reason why and document contact attempts in the comment section below.		

CASE MANAGER OBSERVATION
Describe the appearance of the member (e.g., safe, neat, clean) and the condition of the home (e.g., safe and clean). Were any needs observed?

HEALTH AND INCIDENT INTERVIEW
Include questions, comments, concerns, and activities for the past month. Have they visited a hospital or nursing home as a patient since last visit? If so, what was the reason for the visit?
If applicable -review any incidents reported in the previous month with the Member. Was emergency back-up plan used?
CASE MANAGEMENT FOLLOW UP/ACTION
Status of previous requests, new request, unmet needs:
Is there anything else you would like to tell me? If yes, please explain.

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