TRAUMATIC BRAIN INJURY WAIVER (TBIW)
PERSON-CENTERED SERVICE PLAN

SERVICE PLAN BEGIN DATE: __/__/____

SERVICE PLAN END DATE: __/__/____

☐ Initial ☐ 6-Month ☐ Annual ☐ Transfer ☐ Discharge

LAST NAME:	FIRST NAME:	MIDDLE INTIAL:	DOB:	MEDICAID NUMBER:

CASE MANAGER PROVIDER AGENCY:	PHONE:
SERVICE MODEL CHOICE ☐ TRADITIONAL ☐ PERSONAL OPTIONS	PHONE:
PERSONAL ATTENDANT PROVIDER AGENCY/PPL:	PHONE:
OTHER SERVICE PROVIDER AGENCIES (If Applicable): ☐ Personal Care/Dual Services ☐ Home Health Services ☐ Other: Describe: ______________________	PHONE:
CHECK ATTACHMENTS: ☐ Personal Options Spending Plan (If Applicable) ☐ Prior Authorization Cover Letter ☐ Other (IEP)	FOR OTHER-DESCRIBE:
☐ TMH Member	

What do I expect from the TBIW Program?

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PERSONAL PREFERENCES:

1. What would you like for your Personal Attendant to do for you?
   I PREFER THESE ACTIVITIES, ON THESE DAYS, DURING THESE TIMES: (BATHING, DRESSING, GROOMING, ETC.)

TYPLES OF PERSONAL ATTENDANT SERVICES– Describe *activities, circle type of assist, list days of week.* All services listed must be reflected on the Service Plan.							
Direct Care Assistance for Activities of Daily Living (ADLs)							
Describe Activities **S=Supervised; P=Partial; T=Total**	**Days/ Amount of time in minutes**						
Bath: S P T							
Skin Care: S P T							
Hair: S P T							
Nails: S P T							
Mouth Care: S P T							
Dressing: S P T							
Ambulation: S P T							
Transfer: S P T							
Toileting: S P T							
Positioning: Turn Every ____Hrs. Up in Chair							
Eating: S P T B _____ L ______ D _____ Snack _____							
Medication Prompt:							
Incidental Services							
Meals: Preparations B _____ L ______ D _____ Snack _____							
Laundry:							
Vacuum/Sweep:							
Mop:							
Dust:							
Straighten:							
Bed Making:							
Essential Errands: *(include purpose, destination, frequency, and day of week):*							
Community Activities: *(include purpose, destination, frequency, and day of week):*							

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TBIW – Personal Attendant Worksheet

Member's First and Last Name: ___________________________ Begin Date: ______________

Personal Attendant's(PA) Name: ___________________________ End Date: ______________

Month:																	**Reflect Month and Day of the Week**
Date: PA Circle correct day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		
Time Arrive:																	**Supervisor Comments:**
Time Left:																	
Total Hours:																	
PA Initials:																	
Member's Initials:																	

Personal Attendant Comments and Notes for the 2-week period: (notes should reflect services provided and member's response to the services)

By signing, I certify that the reported information is complete and accurate on all the pages. I understand that payment for 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.

______________________ Personal Attendant Signature and Date

______________________ Member Signature and Date

______________________ Supervisor Signature and Date

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TBIW – Personal Attendant Worksheet

					MEMBER NAME:				
Attendant Name:					**Begin Date:**		**End Date:**		

Personal Attendant must enter date and initial each block to show services were provided as planned. All services listed must be reflected on the Service Plan.

Description of Service/Care ADLs/IADLs								
COMMUNITY ACTIVITIES W/MEMBER								
ESSENTIAL ERRANDS								

TBIW – Personal Attendant Worksheet

Personal Attendant Non – Medical Transportation Log
Special instructions for Transportation:

Date	Total Miles Driven	Travel Time	Destination and Purpose of Travel	Type of Travel (EE or CA)	Starting Location	Ending Location	Was Person with You? Yes	No	Member's Initials
Total Miles:						Supervisor's signature and date on page 1 indicates that this transportation log has been reviewed and approved.			

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

____
____
____
____
____
____
____
____
____

3. RISK REDUCTION (Health and Safety)

Identified Problem/Risk as Noted in the Person-Centered Assessment	Service(s) Needed to Address Problem(s)/Risk(s)	Provider	Date of Contact	Date Problem/Risk Addressed	Outcome(s)/Date

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EVALUATION	DATE OF EVALUATION	SUMMARY OF ASSESSMENT/EVALUATION RESULTS AND IDENTIFIED NEEDS	RECOMMENDATIONS	OUTCOMES
PAS				
RANCHOS LOS AMIGOS SCALE				
Rancho Los Amigos Pediatric Levels of Consciousness				
Person-Centered Assessment				
IEP/504 Plan				
Specialists PT/OT/ST				
Medical				

(If needed, add another sheet with physician/specialist information)

INFORMAL SUPPORTS			
Name: ____________________________ Relationship: ____________________________	Address: ____________________________ ____________________________ Home Phone Number: ____________________________ Cell Phone Number: ____________________________ Emergency Contact Number: ____________________________ Alternative Phone Number: ____________________________	Name: ____________________________ Relationship: ____________________________	Address: ____________________________ ____________________________ Home Phone Number: ____________________________ Cell Phone Number: ____________________________ Emergency Contact Number: ____________________________ Alternative Phone Number: ____________________________

TRAUMATIC BRAIN INJURY WAIVER (TBIW)
PERSON-CENTERED SERVICE PLAN

Name: __________________________ Relationship: __________________________	Address: __________________________ __________________________ Home Phone Number: __________________________ Cell Phone Number: __________________________ Emergency Contact Number: __________________________ Alternative Phone Number: __________________________	Name: __________________________ Relationship: __________________________	Address: __________________________ __________________________ Home Phone Number: __________________________ Cell Phone Number: __________________________ Emergency Contact Number: __________________________ Alternative Phone Number: __________________________

School Information (If Applicable)		
Name of School:	County:	Grade/Hours in School:
Address of School:		
Phone Number:		Teacher's Name:

MY EMERGENCY BACK UP PLAN FOR PERSONAL ATTENDANT AVAILABILITY

1. I will accept substitute Personal Attendants if my assigned Personal 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 Services 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 the member's urgent needs and any actions that may 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 **Personal Emergency Response Unit** ☐ **YES** ☐ **NO**
DISASTER EMERGENCY PLAN

I have a plan in place for: Floods, Extended Power Outages, Snow, Fire, etc. **(Describe the member's urgent needs and any actions that may need to take place).**

SUMMARY PAGE

SERVICE CODE	SERVICE DESCRIPTION	PROVIDER	NEEDED	FREQUENCY
G9002 U2	Case Management		☐ YES ☐ NO	
S5125 UB/S5125 UC	Personal Attendant Services		☐ YES ☐ NO	
A0160 UB/A0160 U2	Non-Medical Transportation		☐ YES ☐ NO	
S5161 U5/S5125 U5 UK	Personal Emergency Response Unit		☐ YES ☐ NO	

G9002 U2-Case Management Code used for both models
UB and U5 codes used for Traditional Service Model.
UC/U2 and UK Codes used for Personal Options Model.

ADDITIONAL SERVICES: (Include all State Medicaid Plans, Personal Care Services, Home Health, Special Education and other services the member is/will be receiving.

ADDITIONAL SERVICES	SERVICE DESCRIPTION	PROVIDER

Signature Page

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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.

The right to address dissatisfaction with services through the provider agency's or Personal Options' grievance procedure and information on how to access the West Virginia DHHR Fair Hearing process has been explained to me. Member's/Legal Guardian's Initials ________

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/Court Appointed Legal Guardian		
Legal Representative		
Case Manager		
Personal Attendant Service Agency		
Other:		
Other:		

Start time of Service Plan meeting: ________________ End time of Service Plan meeting: ________________

Copy of Service Plan was provided to Member /Legal Guardian on: _____/____/______

Copy of Service Plan was provided to Personal Attendant Services Agency on: _____/____/______

Copy of Service Plan was provided to PPL on: _____/____/_____________ or NA

It is the Case Management Agency's responsibility to send a copy of the Service Plan and the approved final Budget to the member and/or their legal representative (if applicable) within seven (7) business days from receipt of approval from the UMC.