TRAUMATIC BRAIN INJURY WAIVER (TBIW)
Risk Analysis and Mitigation Plan

PARTICIPANT INFORMATION											
Last name:		**First Name:**		**Medicaid No.**		**DOB**		**SDM (PO/T)**		**Date of SP Meeting**	

1. HEALTH, MEDICAL & NUTRITION

- ☐ Chronic health conditions
- ☐ Mental health
- ☐ Access to medical care
- ☐ Treatment compliance
- ☐ ER visits and/or hospitalizations
- ☐ Nutrition and/or special diets
- ☐ Skin breakdown
- ☐ Seizures
- ☐ Elimination
- ☐ Aspirations
- ☐ Other

2. ADLs and SAFETY

- ☐ Food and liquid intake
- ☐ Meal preparation
- ☐ Dressing and Grooming
- ☐ Ambulation
- ☐ Transfers
- ☐ Toileting
- ☐ Bathing
- ☐ Communication
- ☐ Falls
- ☐ Injuries
- ☐ Victimization
- ☐ Emergency response
- ☐ Home maintenance
- ☐ Other

3. BEHAVIORAL AND LIFESTYLE

- ☐ Endangering self (or self-neglect)
- ☐ Endangering others
- ☐ Destruction of property
- ☐ Aggression
- ☐ Substance abuse
- ☐ Victimization or exploitation
- ☐ Justice system involvement
- ☐ Isolation
- ☐ Inappropriate sexual behavior
- ☐ Finances
- ☐ Homelessness
- ☐ Other

4. MEDICATION

- ☐ Multiple prescriptions
- ☐ Medication complications
- ☐ Psychotropic medications
- ☐ Use of OTC or herbal medicines
- ☐ Medication compliance
- ☐ Medication administration
- ☐ Medication allergies
- ☐ Other

5. HOME AND INFORMAL SUPPORTS

- ☐ Informal support capacity
- ☐ Limited support system
- ☐ Service refusal
- ☐ Social opportunities
- ☐ Isolation
- ☐ Home stability and situation
- ☐ Housemate compatibility
- ☐ Other

6. OTHER POSSIBLE RISKS

- ☐ Hazardous dwelling
- ☐ Sanitation
- ☐ Neighborhood
- ☐ Accessibility
- ☐ Community access
- ☐ Other

7. ANY ABUSE, NEGLECT OR EXPLOITATION CONCERNS (PAST OR FUTURE)? (If yes, explain in Question #8 Notes section)

☐ Yes ☐ No

8. ADDITIONAL INFORMATION

Question #8 Notes

Insert text here

Last Name	First Name	Medicaid No.

SECTION B. RISK EVALUATION

SEVERITY OF OUTCOME: 1) Possibility harmful to health/welfare 2) Likely harmful to health/welfare 3) Immediately harmful to health/welfare 4) Debilitating or death

FREQUENCY OF RISK: 1) Rarely or Annually 2) Seasonally 3) Monthly 4) Weekly 5) Daily 6) More than daily

SIGNIFICANT RISK FACTOR(S) (from Section A)	SEVERITY OF OUTCOME	FREQUENCY OF RISK	DESCRIPTION OF CIRCUMSTANCES	COULD THIS POTENTIALLY JEOPARDIZE SERVICES?

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SIGNIFICANT RISK FACTOR(S) (from Section A)	SEVERITY OF OUTCOME	FREQUENCY OF RISK	DESCRIPTION OF CIRCUMSTANCES	COULD THIS POTENTIALLY JEOPARDIZE SERVICES?

Last Name First Name Medicaid No.

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SIGNIFICANT RISK FACTOR(S) (from Section A)	SEVERITY OF OUTCOME	FREQUENCY OF RISK	DESCRIPTION OF CIRCUMSTANCES	COULD THIS POTENTIALLY JEOPARDIZE SERVICES?

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SIGNIFICANT RISK FACTOR(S) (from Section A)	SEVERITY OF OUTCOME	FREQUENCY OF RISK	DESCRIPTION OF CIRCUMSTANCES	COULD THIS POTENTIALLY JEOPARDIZE SERVICES?

SECTION C. RISK MITIGATION PLAN

SIGNIFICANT RISK FACTOR(S)	WHAT CAN BE DONE TO PREVENT OR MITIGATE RISK	WHAT STRENGHTS OR ASSETS DOES THE MEMBER HAVE TO REDUCE THE RISK?	WHAT ADDITIONAL SUPPORTS WOULD BE HELPFUL IN REDUCING THE RISK?	WHO CAN HELP WITH PREVENTION OR MITIGATION OF THE RISK?	ADDRESSED IN SERVICE PLAN? (Y/N)

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Last Name	First Name	Medicaid No.

SECTION D. CONTACTS

If TBIW Providers/PPL staff are unable to reach me for a regularly scheduled Monthly Contact or other purpose, please contact the following individuals, who will know how I can always be reached:

Last Name	First Name	Home Phone	Cell Phone	Work Phone	Relationship

Last Name	First Name	Home Phone	Cell Phone	Work Phone	Relationship

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AUTHORIZING SIGNATURES

This member agrees to the Risk Mitigations Plan. ☐ Yes ☐ No

Signature of Member or Legal Representative	Date of Signature

Signature of TBIW Case Manager	Date of Signature