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

TRAUMATIC BRAIN INJURY (TBI) Waiver
CASE MANAGEMENT MONTHLY REPORT

The report must be submitted to KEPRO by every Case Management Agency by the 6th business day of every month. It can be submitted in the following ways:

By Mail: **KEPRO**
1007 Bullitt Street, Suite 200
Charleston, WV 25301

By Fax: 1.866.607.9903

To Complete this Form:

1. Complete the top section of the form with the current month, year, provider name, phone number, agency address, and the name of the person submitting the form.
2. If you have had no new program participants open for the reporting month, no transfers to or from your agency during the reporting month or no closures from the TBI Waiver Program for the reporting month – mark No Activity this month.
3. If you have had new program participants open, transfers or closures from the TBI Waiver Program for the reporting month, you will need to fill out the program participant information section of each of these.
4. New TBI W Enrollments – these are individuals opened by your agency that are new to the TBI program. The Enrollment Date is the date on the Enrollment Confirmation Notice you received from KEPRO.
5. Transfers Received From – If you received a transfer from another agency during the month, complete the agency's name you received the transfer from and the date you received the transfer.
6. Transferred To – If you had a program participant transfer from your agency to another agency – complete agency's name they transferred to and the date they were transferred.
7. Closures – These are individuals that have closed from the TBI program. List the reason they were closed – these reasons must be consistent with policy and accurate. (Ex. 180 days without service, unsafe environment, and program participant no longer desire services, death, moved out of state, loss of financial eligibility, loss of medical eligibility).
8. No Personal Attendant Services used this month-Please mark if the program participant did not access any of his/her Personal Attendant Services during the month and why
9. Comment Section – list any additional information KEPRO, may need to know.

BUREAU FOR MEDICAL SERVICES

TRAUMATIC BRAIN INJURY (TBI) Waiver
CASE MANAGEMENT MONTHLY REPORT

Month: **Year:**

Provider Name:	Provider Number:	Phone:	
Address:	City:	Zip:	☐ No activity this month
Submitted by:			

PROGRAM PARTICIPANT INFORMATION

Name:____
Address: ____
____
County:__________________________ Birthdate:__/__/_____
Medicaid#: _ _ _ _ _ _ _ _ _ _ _
New TBI Enrollment Date: __/__/______
Transfer Received From:________________________________
(Agency Name)
Date: __/__/______
Transferred To:______________________________________
(Agency Name)
Date: __/__/______
Date Closed: __/__/_____ Reason:______________________
☐ No Personal Attendant Services used this month
Comments: ____
____

Name:____
Address: ____
____
County:__________________________ Birthdate:__/__/_____
Medicaid#: _ _ _ _ _ _ _ _ _ _ _
New TBI Enrollment Date: __/__/______
Transfer Received From:________________________________
(Agency Name)
Date: __/__/______
Transferred To:______________________________________
(Agency Name)
Date: __/__/______
Date Closed: __/__/_____ Reason:______________________
☐ No Personal Attendant Services used this month
Comments: ____
____

Name:____
Address: ____
____
County:__________________________ Birthdate:__/__/_____
Medicaid#: _ _ _ _ _ _ _ _ _ _ _
New TBI Enrollment Date: __/__/______
Transfer Received From:________________________________
(Agency Name)
Date: __/__/______
Transferred To:______________________________________
(Agency Name)
Date: __/__/______
Date Closed: __/__/_____ Reason:______________________
☐ No Personal Attendant Services used this month
Comments: ____
____

Name:____
Address: ____
____
County:__________________________ Birthdate:__/__/_____
Medicaid#: _ _ _ _ _ _ _ _ _ _ _
New TBI Enrollment Date: __/__/______
Transfer Received From:________________________________
(Agency Name)
Date: __/__/______
Transferred To:______________________________________
(Agency Name)
Date: __/__/______
Date Closed: __/__/_____ Reason:______________________
☐ No Personal Attendant Services used this month
Comments: ____
____

Name:____
Address: ____
____
County:__________________________ Birthdate:__/__/_____
Medicaid#: _ _ _ _ _ _ _ _ _ _ _
New TBI Enrollment Date: __/__/______
Transfer Received From:________________________________
(Agency Name)
Date: __/__/______
Transferred To:______________________________________
(Agency Name)
Date: __/__/______
Date Closed: __/__/_____ Reason:______________________
☐ No Personal Attendant Services used this month
Comments: ____
____

Name:____
Address: ____
____
County:__________________________ Birthdate:__/__/_____
Medicaid#: _ _ _ _ _ _ _ _ _ _ _
New TBI Enrollment Date: __/__/______
Transfer Received From:________________________________
(Agency Name)
Date: __/__/______
Transferred To:______________________________________
(Agency Name)
Date: __/__/______
Date Closed: __/__/_____ Reason:______________________
☐ No Personal Attendant Services used this month
Comments: ____
____