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

TRAUMATIC BRAIN INJURY (TBI) WAIVER
CASE MANAGEMENT MONTHLY CONTACT

Participant Name:_______________________________

Person spoken to: _______________________________

Medicaid Number: ____

☐ **Face to Face** ☐ **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	
11. Have there been any changes to your prescribed medications?	Yes	No	
12. Name of Staff who provided your Personal Attendant Services this month?		Case Manager confirmed with PA provider	
13. Do you feel you have privacy in your home?	Yes	No	
14. 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