TRAUMATIC BRAIN INJURY WAIVER (TBIW)
CASE MANAGEMENT MONTHLY CONTACT

Member name: _____ **Person spoken to: _____**			**Medicaid Number: _____** ☐ **Face to Face** ☐ **Phone Call**
Question	**Yes**	**No**	**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?	☐	☐	
2. Have you had any disagreements or problems with the people who come into your home to provide your services? If yes, who is the person and what types of problems are you having?	☐	☐	
3. Are there times when you needed help and you did not get it? If yes, what happened?	☐	☐	
4. Have your needs for assistance changed since we last talked? If so, how?	☐	☐	
5. Do you need help with making any appointments? If yes, with whom and when?	☐	☐	
6. Do you need any additional medical equipment, services, or resources? If yes, what?	☐	☐	
7. Are you having any problems paying for or getting food, housing, utilities, or medications?	☐	☐	
8. Have there been any changes in your life that affect your need for service (death, loss, divorce, etc.)?	☐	☐	
9. If anything happens, do you know how to report problems (services or abuse, neglect, or exploitation?)	☐	☐	
10. Have there been any changes to your prescribed medications?	☐	☐	
11. Name of Staff who provided your Personal Attendant Services this month?		Case Manager confirmed with PA provider	
12. Has installation of FOB completed If they are not using FOB for EVV this question can be skipped.		FOB installation confirmed Y/N	
13. Have you moved? If yes, where? *Please ask member if move resulted in a lease and name on the lease.	☐	☐	Address_____ Name on lease /NA_____
* If the member was unavailable, please note reason 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 their 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