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

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

Anchor Date: _____

☐ Initial
☐ Annual

SERVICE PLAN BEGIN DATE: __/__/____

SERVICE PLAN END DATE: __/__/____

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

SERVICE MODEL CHOICE ☐ TRADITIONAL ☐ PERSONAL OPTIONS	PHONE:
CASE MANAGEMENT PROVIDER AGENCY:	PHONE:
PERSONAL ATTENDANT PROVIDER AGENCY/PPL:	PHONE:
OTHER SERVICE PROVIDER AGENCIES (If Applicable): ☐ Personal Care/Dual Services ☐ Home Health Services ☐ Other:	OTHER SERVICE PROVIDER NAME (If Applicable): PHONE:
☐ TMH Member	

What do I expect from the TBIW Program?

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PERSONAL PREFERENCES: **1.** What would you like your Personal Attendant to do for you?

I PREFER THESE ACTIVITIES, ON THESE DAYS, DURING THESE TIMES: (BATHING, DRESSING, GROOMING, ETC.)

Direct Care Assistance for Activities of Daily Living (ADLs)							
Specify Level of Care Needed for Each Activity **I=Independent S=Supervised P=Partial T=Total**	**Specify Amount of Time (in minutes) Spent on Each Activity Per Day**						
	Sunday	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
Bath: ☐ **I** ☐ **S** ☐ **P** ☐ **T**							
Skin Care: ☐ **I** ☐ **S** ☐ **P** ☐ **T**							
Hair: ☐ **I** ☐ **S** ☐ **P** ☐ **T**							
Nails: ☐ **I** ☐ **S** ☐ **P** ☐ **T**							
Mouth Care: ☐ **I** ☐ **S** ☐ **P** ☐ **T**							
Dressing: ☐ **I** ☐ **S** ☐ **P** ☐ **T**							
Ambulation: ☐ **I** ☐ **S** ☐ **P** ☐ **T**							
Transfer: ☐ **I** ☐ **S** ☐ **P** ☐ **T**							
Toileting: ☐ **I** ☐ **S** ☐ **P** ☐ **T**							
Positioning: Turn Every ____Hrs. Up in Chair							
Eating: B ____ L ____ D ____ Snack ____ ☐ **I** ☐ **S** ☐ **P** ☐ **T**							
Medication Administration: ☐ **I** ☐ **S** ☐ **Prompt** ☐ **Informal Assists**							
Incidental Services							
Meals: Preparations B _____ L _____ D _____ Snack _____							
Laundry: ☐ **I** ☐ **S** ☐ **P** ☐ **T**							
Vacuum/Sweep: ☐ **I** ☐ **S** ☐ **P** ☐ **T**							
Mop: ☐ **I** ☐ **S** ☐ **P** ☐ **T**							
Dust: ☐ **I** ☐ **S** ☐ **P** ☐ **T**							
Straighten: ☐ **I** ☐ **S** ☐ **P** ☐ **T**							
Bed Making: ☐ **I** ☐ **S** ☐ **P** ☐ **T**							
Essential Errands: *(MUST include purpose, destination, frequency, and day of week):*							
Community Activities: *(MUST include purpose, destination, frequency, and day of week):*							

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

_____
_____
_____

3. Identified Needs from Person Centered Assessment

Identified Needs on the Person-Centered Assessment	Service(s)/Supports to address Needs	Provider	Outcome(s)/Date
Medical Needs			
Environment Needs			
Social Needs			
Emotional Needs			
Educational Needs			
ADL/IADL Needs			
Additional Identified Needs			

4. Identify Risks from the Person-Centered Assessment. If a category does not apply to member, indicate NA.

Identified Problem/Risk Areas	What strengths/assets does the member have to reduce the risk	What additional Service(s)/Supports would be helpful in reducing the risk	Member agrees with the additional supports/services	Formal Services/Supports - Name of Provider
Medical Risks			☐ Yes ☐ Not at this time ☐ NA	
Medications			☐ Yes ☐ Not at this time ☐ NA	
Fall Risks			☐ Yes ☐ Not at this time ☐ NA	
Behavioral Risks			☐ Yes ☐ Not at this time ☐ NA	
Cognitive Impairments			☐ Yes ☐ Not at this time ☐ NA	

Identified Problem/Risk Areas	What strengths/assets does the member have to reduce the risk	What additional Service(s)/Supports would be helpful in reducing the risk	Member agrees with the additional supports/services	Formal Services/Supports - Name of Provider
Other			☐ Yes ☐ Not at this time	

Please review all completed assessments to identify ***any*** additional unmet needs/services to be addressed on the member's service plan.

EVALUATION	DATE OF EVALUATION	IDENTIFIED UNMET NEEDS	Member agrees with the additional supports/services
PAS			☐ Yes ☐ Not at this time
RANCHOS LOS AMIGOS SCALE **(Or Rancho Los Amigos Pediatric Levels of Consciousness)**			☐ Yes ☐ Not at this time
Person-Centered Assessment			☐ Yes ☐ Not at this time
Member Setting Controlled Assessment			☐ Yes ☐ Not at this time
Good Day/Bad Day			☐ Yes ☐ Not at this time
Morning Ritual			☐ Yes ☐ Not at this time
IEP/504 Plan			☐ Yes ☐ Not at this time ☐ NA

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EVALUATION	DATE OF EVALUATION	IDENTIFIED UNMET NEEDS	Member agrees with the additional supports/services
Primary Care Physician			☐ Yes ☐ Not at this time
Specialists **(PT/OT/ST/Medical – ie. Neurology, Orthopedics, Psychology, etc.)**			☐ Yes ☐ Not at this time

(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)
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School Information ☐ NA		
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 support 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, for access to my home (key) please contact:

NAME: _____ PHONE: _____

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).

Flood - _____

Extended Power Outage - _____

Snow - _____

Fire - _____

CRITICAL HEALTH-SUPPORTIVE SERVICES /EQUIPMENT MAINTENANCE ☐ **YES** ☐ **NO** ☐ **NA**

I have a plan for issues with Home Health and/or Durable Medical Equipment (DME).
(Describe the member's needs and any action that may need to take place.)

TRANSPORTATION ☐ **YES** ☐ **NO** ☐ **NA**

I have a plan if there is an issue with my transportation or my transportation provider does not show.
(Describe the member's needs and any action that may need to take place.)

ADDITIONAL SERVICES ☐ **YES** ☐ **NO** ☐ **NA**
(Include all State Medicaid Plans, Personal Care Services, Home Health, Special Education, and other services the member is/will be receiving.)

PROVIDER	ADDITIONAL SERVICE DESCRIPTION / PURPOSE	PAYOR SOURCE

SUMMARY PAGE

SERVICE CODE	SERVICE DESCRIPTION	PROVIDER	NEED	FREQUENCY
G9002 U2	Case Management		☐ YES ☐ NO	
S5125 UB S5125 UC	Personal Attendant Services		☐ YES ☐ NO	
S5125 UB UK S5125 UC UK	Personal Attendant Services Living in the Home		☐ YES ☐ NO	
A0160 UB A0160 U2	Non-Medical Transportation		☐ YES ☐ NO	
S5161 U5 S5161 U5 UK	Personal Emergency Response Unit		☐ YES ☐ NO	
S5165 U2-Home T2039 U2-Vehicle	Environmental Accessibility Adaption (Home/Vehicle) Traditional		☐ YES ☐ NO	
S5165 U3-Home T2039 U3-Vehicle	Environmental Accessibility Adaption (Home/Vehicle) (PO)		☐ YES ☐ NO	
S5121 U2 S5121 U3	Pest Eradication		☐ YES ☐ NO	

G9002 U2 – Case Management Code used for both models
UB, U2 and U5 codes – Used for Traditional Service Delivery Model
UC, U2, U3, U5 and UK codes – Used for Personal Options Service Delivery Model

Signature Page

To be a valid Service Plan **all** involved persons are to sign and date this document. Unless the member has a legal guardian or a physical/cognitive impairment that inhibits their ability to sign, member's signature/mark is required. If a member is unable to sign, please provide justification as to why and verification that s/he was in attendance. Justification member is not able to sign: _____

The right to address dissatisfaction with services through the provider agency or Personal Options grievance procedure and information on how to access the West Virginia DHoS 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/legal guardian 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 Agency Name/phone number:		
Personal Attendant Service Agency		
Other:		
Other:		

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

It is the Case Management Agency's responsibility to create and upload the Assessment and Service Planning Documents onto the UMC web portal. Servicing Providers are responsible for retrieving all necessary Service Planning documents and authorizations from the UMC web portal.