

## TRAUMATIC BRAIN INJURY WAIVER (TBIW) CASE MANAGEMENT MONTHLY CONTACT

<b>Member name:</b> _____ <b>Person spoken to:</b> _____	<b>Medicaid Number:</b> _____ <input type="checkbox"/> Face to Face <input type="checkbox"/> 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?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Are there times when you needed help and you didn't get it? If yes, what happened?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Have your needs for assistance changed since we last talked? If so, how?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Do you need help in making any appointments? If yes, with whom and when?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Do you need any additional medical equipment, services or resources? If yes, what?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Are you having any problems paying for or getting food, housing, utilities, or medications?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Have there been any changes in your life that affect your need for service (death, loss, divorce, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	
9. If anything happens, do you know how to report problems (services or abuse, neglect, or exploitation?)	<input type="checkbox"/>	<input type="checkbox"/>	
10. Have there been any changes to your prescribed medications?	<input type="checkbox"/>	<input type="checkbox"/>	
11. Name of Staff who provided your Personal Attendant Services this month?	Case Manager confirmed with PA provider		
12. Have you moved? If yes, where? *Please ask member if move resulted in a lease and name on the lease.	<input type="checkbox"/>	<input type="checkbox"/>	Address _____ Name on lease /NA _____
* If the member was unavailable, please note reason why 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 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