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

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

REVIEW DATE: _____

☐ 6 Month

☐ Initial

☐ Annual

SERVICE PLAN BEGIN DATE: __/__/____

SERVICE PLAN END DATE: __/__/____

Anchor Date: _____

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

CASE MANAGER PROVIDER AGENCY:	PHONE:
SERVICE MODEL CHOICE ☐ TRADITIONAL ☐ PERSONAL OPTIONS	PHONE:
PERSONAL ATTENDANT PROVIDER AGENCY/PPL:	PHONE:
OTHER SERVICE PROVIDER AGENCIES (If Applicable): ☐ Personal Care/Dual Services ☐ Home Health Services ☐ Other: Describe: _____	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.)

TYPES OF PERSONAL ATTENDANT SERVICES– Describe *activities, type of assistance, list days of week.*							
Direct Care Assistance for Activities of Daily Living (ADLs)							
Describe Activities **S=Supervised; P=Partial; T=Total**	**Days/ Amount of time in minutes**						
Bath: S ☐ P ☐ T ☐							
Skin Care: S ☐ P ☐ T ☐							
Hair: S ☐ P ☐ T ☐							
Nails: S ☐ P ☐ T ☐							
Mouth Care: S ☐ P ☐ T ☐							
Dressing: S ☐ P ☐ T ☐							
Ambulation: S ☐ P ☐ T ☐							
Transfer: S ☐ P ☐ T ☐							
Toileting: S ☐ P ☐ T ☐							
Positioning: Turn Every ____Hrs. Up in Chair							
Eating: S ☐ P ☐ T ☐ B _____ L _____ D _____ Snack _____							
Medication Prompt:							
Incidental Services							
Meals: Preparations B☐ L☐ D☐ Snack ☐							
Laundry: S ☐ P ☐ T ☐							
Vacuum/Sweep: S ☐ P ☐ T ☐							
Mop: S ☐ P ☐ T ☐							
Dust: S ☐ P ☐ T ☐							
Straighten: S ☐ P ☐ T ☐							
Bed Making: S ☐ P ☐ T ☐							

Essential Errands: *(include purpose, destination, frequency, and day of week):*
Community Activities: *(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			

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Identified Needs on the Person-Centered Assessment	Service(s)/Supports to address Needs	Provider	Outcome(s)/Date
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	

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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
Medications			☐ Yes ☐ Not at this time	
Fall Risks			☐ Yes ☐ Not at this time	
Behavioral Risks			☐ Yes ☐ Not at this time	
Cognitive Impairments			☐ Yes ☐ Not at this time	
Other			☐ Yes ☐ Not at this time	

EVALUATION	DATE OF EVALUATION	SUMMARY OF ASSESSMENT/EVALUATION RESULTS AND IDENTIFIED NEEDS	RECOMMENDATIONS	OUTCOMES
PAS				

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EVALUATION	DATE OF EVALUATION	SUMMARY OF ASSESSMENT/EVALUATION RESULTS AND IDENTIFIED NEEDS	RECOMMENDATIONS	OUTCOMES
RANCHOS LOS AMIGOS SCALE or Rancho Los Amigos Pediatric Levels of Consciousness				
Person-Centered Assessment				
IEP/504 Plan				
Specialists PT/OT/ST				
Member Setting Controlled Assessment				
Good Day/Bad Day				
Morning Ritual				

(If needed, add another sheet with physician/specialist information)

INFORMAL SUPPORTS			
Name: _____ Relationship: _____	Address: _____ _____ Home Phone Number: _____ Cell Phone Number: _____ Emergency Contact Number: _____	Name: _____ Relationship: _____	Address: _____ _____ Home Phone Number: _____ Cell Phone Number: _____ Emergency Contact Number: _____

	Alternative Phone Number: _____		Alternative Phone Number: _____
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: _____

School Information (If Applicable)		
Name of School:	County:	Grade/Hours in School:
Address of School:		
Phone Number:		Teacher's Name:

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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, please contact:

NAME:_____ PHONE:_____
for access to my home (key).

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).**

CRITICAL HEALTH-SUPPORTIVE SERVICES /EQUIPMENT MAINTENANCE ☐ YES ☐ NO ☐ NA
I have a plan for issues with Home Health, 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 are 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.)**

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SUMMARY PAGE

SERVICE CODE	SERVICE DESCRIPTION	PROVIDER	NEEDED	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/S5125 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	

G9002 U2-Case Management Code used for both models

UB, U2 and U5 codes used for Traditional Service Model.

UC/U2 and, U3 U5UK Codes used for Personal Options Model.

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ADDITIONAL SERVICES: (Include all State Medicaid Plans, Personal Care Services, Home Health, Special Education, and other services the member is/will be receiving.

ADDITIONAL SERVICES	SERVICE DESCRIPTION	PROVIDER

Signature Page

To be a valid Service Plan **all** involved persons are to sign and date this document. If a member is unable to sign, please provide justification as to why s/he could not sign and verification that s/he was in attendance.

The right to address dissatisfaction with services through the provider agency's or Personal Options' grievance procedure and information on how to access the West Virginia DHHR 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		

Personal Attendant Service Agency		
Other:		
Other:		

Start time of Service Plan meeting: _____ End time of Service Plan meeting: _____

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 in the UMC web portal . Servicing Providers are responsible for retrieving all necessary Service Planning documents and authorizations from the UMC web portal.

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6 Month Service Plan Review

☐ Service Plan reviewed with no changes noted

☐ Service Plan reviewed with changes noted - (List Changes/Revisions Below)

Changes/Revisions Noted During Review		
Service Plan Page Number	**Changes / Revisions That Were Made**	**Date Change / Revision Occurred**

Signature Page
6 Month Service Plan Review

To be a valid 6 Month Service Plan Review **all** involved people are to sign and date this document. If a member is unable or unwilling to sign, please provide justification as to why s/he could not sign and verification that s/he was in attendance.
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Signatures:

Relationship	**Signature**	**Date**
Member/ Court Appointed Legal Guardian ☐ **Phone-must obtain signature**		
Legal Representative		
Case Manager		
Personal Attendant Service Agency		
Other:		
Other:		

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