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

TRAUMATIC BRAIN INJURY WAIVER
PERSON-CENTERED SERVICE PLAN ADDENDUM

| **Last Name:** | **First Name:** | **Medicaid #:** |
|---|---|---|
| **Case Management Agency:** | | **Dual Services: Yes ☐ No ☐** |

| **CHANGE IN NEED ☐**<br>**TRANSFER ☐** | | **DATE:** | |
|---|---|---|---|

| ***Complete this section for change in the member's need and/or member transfer .*** | |
|---|---|
| Describe how the participant's needs have changed. | |
| Describe any changes in services. | |
| Responsibility Agreement in place | Include the signed Responsibility Agreement with the addendum |
| Other | |

Case Manager Signature Date

Member/Legal Representative Signature Date

Copy sent to Personal Attendant Agency/PPL on:

Copy sent to Member /Legal Representative on:

04/2021
Revised V2 8/2023

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

TRAUMATIC BRAIN INJURY WAIVER
PERSON-CENTERED SERVICE PLAN ADDENDUM

Copy faxed to UMC on: _____

Copy sent to Personal Care Agency on: _____

Copy sent to Home Health Services Agency on: _____

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