benefind
Assistance & Support Programs for Kentuckians

KENTUCKY MEDICAID WAIVER INTAKE APPLICATION
APPLICATION FOR SINGLE APPLICANT
'THINGS FOR YOU TO KNOW'

Use this Medicaid Waiver Application to see what Medicaid Waiver Programs you may qualify for:

Welcome to Kentucky's Medicaid Waiver Management Application (MWMA). This form allows you to apply for Medicaid waiver program services and supports in Kentucky. When the application is complete it will be reviewed to see if you could get services from one of Kentucky's Medicaid waiver programs:

- Acquired Brain Injury-Program (ABI)
- Acquired Brain Injury-Long Term Care Program (ABI-LTC)
- Supports for Community Living Program (SCL2)
- Michelle P. Waiver Program (MPW)
- Model II Waiver Program (MIIW)
- Home and Community Based Waiver Program (HCB)

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html

Who can use this Medicaid Waiver Application?

- Anyone who needs Kentucky Medicaid waiver program services can fill out this application.

Apply faster online:

- Apply faster online by going to http://chfs.ky.gov/dms/mwma and logging into the MWMA system.

What you may need to apply:

- Individual Contact Information;
- Information related to Authorized Representatives or Legal Guardian, if applicable;
- Caregiver Contact Information;
- Documentation to verify answers given on this Medicaid waiver intake application; and
- Your Social Security Number.

If you need help getting an SSN, call 1-800-772-1213 or visit www.socialsecurity.gov. TTY users should call 1-800-325-0778.

Why do we ask for this information?

- We ask about the information above as well as additional information to let you know what Kentucky Medicaid Waiver Program you may qualify for.

To get help:

- By phone: Call the Contact Center at 1(800) 635-2570

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APPLICATION FOR SINGLE APPLICANT

Note: It is important to be VERY thorough in your responses so that reviewers have as much information as possible to make appropriate determinations.

Please Provide The Following Information: Fields Marked With (*) Are Mandatory

Individual Details

1. ***First name, Middle initial, Last name & Suffix, if applicable:**

2. ***Date of Birth: (MM/DD/YYYY)**
_____/____/_____

3. ***Gender:** ☐Male ☐Female

4. **Social Security Number:** *(giving your Social Security Number now will reduce time and effort later)*
______________ - _________ - __________________

Contact Information

5. ***What is your Main Phone Number**:☐Home ☐Work ☐Cell
* If you don't have a phone number provide a number where you can be reached
( ) -

6. **Other Phone Number:**
☐ Home ☐ Work ☐ Cell
( ) -

7. ***What is the address where you live:**

8. *City	9. *State:	10.*Zip Code:	11.*County

12. ***Mailing Address:** ☐ (please select this check box if your mailing address and address where you are living is the same)

13. City:	14.State:	15. Zip Code:	16.County

17. **Email Address:**

18. **Preferred Spoken Language:**
☐English ☐Spanish ☐Other:

19. **Preferred Written Language:**
☐English ☐Spanish ☐

Representative Information

20. ***Do you have an Authorized Representative?** ☐ Yes ☐ No (If 'Yes' answer questions for 'Authorized Representative' section below)

An Authorized Representative is someone you name to help you. For more information you can visit the following website: http://www.lrc.ky.gov/kar/907/001/563.htm

21. ***Do you have a Legal Guardian?** ☐Yes ☐ No (If 'Yes' answer questions for 'Legal Guardian' section below)

A Legal Guardian is a court-appointed adult who assumes the responsibility for decisions for you. For more information you can visit the following website: http://www.lrc.ky.gov/Statutes/chapter.aspx?id=39181

Additionally, if you need more information on State Guardianship, you can visit the following website: http://chfs.ky.gov/dail/guardianship.htm

Authorized Representative

22. * First name, Middle initial, Last name & Suffix, if applicable:

23. *Date of Birth: (MM/DD/YYYY)

_____/____/_____

24. *How is this person related to you?
☐ Mother ☐ Father ☐ Sister
☐ Other: _____

25. *Main Phone Number: ☐ Home ☐ Work ☐ Cell
( ) -

26. Other Phone Number: ☐ Home ☐ Work ☐ Cell
( ) -

27. *Do you and your representative live at the same place? ☐ Yes ☐ No (If 'No' answer # 28 - # 32)

28. Address where the representative lives:

29. City:	30. State:	31. Zip Code:	32. County:

33. *Mailing Address: ☐ (please select this check box if the representative's mailing address and address where the representative lives is the same)

34. City:	35. State:	36. Zip Code:	37. County:

38. Email Address:

39. Preferred Language:
☐ English ☐ Spanish ☐ Other: _____

40. *Is this Individual also your Legal Guardian?
☐ Yes ☐ No

Legal Guardian

41. *First name, Middle initial, Last name & Suffix, if applicable:

42. *Date of Birth: (MM/DD/YYYY)

____/____/______

43. *How is this person related to you?
☐ Mother ☐ Father ☐ Sister
☐ Other: _____

44. *Main Phone Number: ☐ Home ☐ Work ☐ Cell
( ) - -

45. Other Phone Number ☐ Home ☐ Work ☐ Cell
( ) -

46. *Do you and your guardian live at the same place? ☐ Yes ☐ No (If 'No' answer # 47 - # 51)

47. Address where the guardian lives:

48. City:	49. State:	50. Zip Code:	51. County:

52. *Mailing Address: ☐ (please select this check box if the guardian mailing address and address where the guardian lives is the same)

53. City:	54. State:	55. Zip Code:	56. County:

57. Email Address: ____

58. Preferred Language:
☐English ☐ Spanish ☐Other: _______________

Services

What Services Are You Getting Now?

59.*Check the services you are getting now:
(check all that apply)

For each service you check below, from the right column, labeled '59A. What Program?' add program # that provided you the service you selected:

Examples: ☒ **Behavior Support:____11________**
☒ **Personal Assisstance:____15_____**

☐ Attendant Care Services: ______________________
☐ Behavior Support:_____________________________
☐ Case Management: _________________________
☐ Community Access/Community Living Support: ___________________________________
☐ Day Program/Day Training: ___________________
☐ Homemaking:_________________________
☐ Mental Health Counseling/Medication/Psychological Services:__________________________
☐ Nursing:________________________
☐ Occupational Therapy: ________________________
☐ Personal Assistance/Companion Services/Personal Care:___________
☐ Physical Therapy:________________________
☐ Residential: __________________________
☐ Respite:________________________
☐ Speech Therapy: ____________________________
☐ Supported Employment:_______________________
☐ None
☐ Other:

59A.*What Program?

1. Acquired Brain Injury Waiver (ABI)
2. Acquired Brain Injury-Long Term Care Waiver (ABI-LTC)
3. Community Mental Health Center Programs (CMHC)
4. Durable Medical Equipment (DME)
5. Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) (if under 21)
6. First Steps
7. Health Access Nurturing Development Services (HANDS)
8. Hart Supported Living Program
9. Home Health Services (HHS)
10. Home and Community Based Waiver Program (HCB)
11. Hospice
12. Hospital Inpatient
13. Hospital Outpatient
14. IMPACT
15. Modell II (Ventilator) Waiver (MIIW)
16. Kentucky Children's Health Insurance Program (KY CHIP)
17. Michelle P. Waiver (MPW)
18. Money Follows the Person (MFP)
19. Personal Care Attendant Program (PCAP)
20. Private Paid Service
21. School Based Services
22. State Supplementation
23. Supports for Community Living Waiver (SCL)
24. Transportation
25. Traumatic Brain Injury Trust Fund
26. Vocational Rehabilitation (OVR)
27. Other

60.*Please list services needed, whether you get them now or not: (check all the services you need)

☐ Attendant Care Services
☐ Behavior Support
☐ Case Management
☐ Community Access/Community Living Support
☐ Day Program/Day Training
☐ Homemaking
☐ Mental Health Counseling/Medication/Psychological Services
☐ Nursing
☐ Occupational Therapy
☐ Personal Assistance/Companion Services/Personal Care
☐ Physical Therapy
☐ Residential
☐ Respite
☐ Speech Therapy
☐ Supported Employment
☐ Other: ____

61.*How soon are the services needed?

☐ Immediately (Health and Safety)
☐ Within 1 Year
☐ More Than 1 Year

62.*Describe why the services are needed in the time-frame chosen? Note: Provide thorough information so the reviewer can make an appropriate determination.

____
____
____

Clinical Information

63.*Are you currently on a waiting list for any of these Medicaid waiver programs? ☐ Yes ☐ No (If "Yes", what list(s) are you on? (check all that apply)

☐ Acquired Brain Injury Waiver (ABI)
☐ Acquired Brain Injury-Long Term Care Waiver (ABI-LTC)
☐ Home & Community Based Waiver (HCB)
☐ Model II Waiver (MIIW)
☐ Michelle P. Waiver (MPW)
☐ Supports for Community Living Waiver (SCL)

64.*Do you have a physically disability? ☐ Yes ☐ No

65.*What kind of disability do you have?

☐ Intellectual Disability:

In order to make a determination regarding eligibility for a waiver related to intellectual disability, a full thorough psychological evaluation including adaptive behavior analysis is required. Intellectual disability is recorded on a psychological evaluation. Please refer to the psychological evaluation for a determination regarding disability and age of onset. Intellectual disability is a disability characterized by significant limitations in both intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. This disability originates before the age of 18. Definition: http://aaidd.org/intellectual-disability/definition#

* Was the onset prior to age 18? ☐ Yes ☐ No

What is the individual's IQ score: _________________ (Optional)

IQ score is recorded on the psychological evaluation. Please refer to the document and record the score here.

☐ Developmental Disability

Developmental disability is recorded on a psychological evaluation. Please refer to the psychological evaluation for a determination regarding disability and age of onset. Developmental Disability is an umbrella term that includes intellectual disability, but also includes other disabilities that are apparent during childhood. Developmental disability is a diverse group of chronic conditions due to impairments that are present at birth or occur during the developmental years. Developmental disabilities cause individuals living with them many difficulties in areas of life, especially in language, mobility, learning, self-help, and independent living. Developmental disabilities can be detected early on, and persist throughout an individual's life.

http://www.gpo.gov/fdsys/pkg/CFR-2002-title45-vol4/xml/CFR-2002-title45-vol4-sec1385-3.xml

* Was the onset prior to age 22? ☐ Yes ☐ No

☐ Both intellectual and developmental disability:

Developmental and intellectual disabilities are recorded on a psychological evaluation. Please refer to the psychological evaluation for a determination regarding disability and age of onset.

* Was the onset prior to age 18? ☐ Yes ☐ No (If 'No' answer the next question)
* Was the onset prior to age 22? ☐ Yes ☐ No

What is the individual's IQ score: _________________ (Optional)

66.*Do you have an Acquired Brain Injury? ☐ Yes ☐ No (If "Yes," answer question # 67)

Acquired brain injury is brain damage caused by events after birth including

a. An injury from physical trauma;
b. Damage from anoxia or from a hypoxic episode; or
c. Damage from an allergic condition, toxic substance, or another acute medical incident;

http://biau.org/types-and-levels-of-brain-injury/

67.*Do you have an Acquired Brain Injury of the following nature? (check all that apply; if you 'check' any of the following, answer # 68 - # 70)

☐ Injury from physical trauma
☐ Damage from anoxia or from hypoxic episode
☐ Damage from allergic condition, toxic substance, or other acute medical incident
☐ A stroke treatable in a nursing facility providing routine rehabilitation services
☐ A spinal cord injury for which there is no known or obvious injury to the intracranial central nervous system
☐ Progressive dementia or another condition related to mental impairment that is of a chronic degenerative nature, including senile dementia, organic brain disorder, Alzheimer's disease, alcoholism or another addiction
☐ A depression or a psychiatric disorder in which there is no known or obvious central nervous system damage
☐ A birth defect
☐ Mental retardation without an etiology to an acquired brain injury
☐ A condition which causes an Individual to pose a level of danger or an aggression which is unable to be managed and treated in the community
☐ Determination that the recipient has met his or her maximum rehabilitation potential
☐ Unknown

68.*Do you have an Acquired Brain Injury that requires any of the following? (check all that apply)

☐ Supervision
☐ Long term supports
☐ Intensive rehab services

☐ Therapy to maintain current level of functioning

69.*What problems has the Acquired Brain Injury caused? (check all that apply)
☐ Cognition
☐ Behavior
☐ Motor Skills
☐ Sensory
☐ May need step-by-step instructions to initiate or complete tasks; (high noise levels) or to complete activities that involve many steps
☐ Short-term memory deficits
☐ Changes in cognition involving executive functions such as problem solving, impulse control, self-monitoring, attention, short-term memory and learning, speed of information processing and speech and language functions
☐ Lack of awareness of illness and/or need of medical attention or lack of awareness of deficits and/or loss of abilities; (dressing, eating, hygiene, grooming)
☐ Information processing (speed of ability to take in information - auditorily or graphically, ability to assign meaning to information - make choices) - may affect: safety, cooking, dressing, eating
☐ Expressive/receptive language deficits (wording finding difficulties, comprehension deficits, communication of wants and needs, reading and writing difficulties) – may affect: safety, medication management, cooking
☐ Visual-spatial skills (inability to judge distance, place of object in space, depth perception) - may affect: grooming, cooking, hygiene, safety.

70.*What is the date of the Acquired Brain Injury? (MM/DD/YYYY)
______/____/_____

71.*Is the Individual dependent on a ventilator? ☐Yes ☐ No (This excludes CPAP and BiPAP machines settings) (If "Yes" please answer questions # 72 and # 73)
A **ventilator** is a machine designed to mechanically move breathable air into and out of the lungs, to provide the mechanism of breathing for a person who is physically unable to breathe, or who breathes insufficiently.

72.*Does the ventilator stimulate respirations? ☐ Yes ☐ No

73.*Is the ventilator used for more than 12 hours per day? ☐Yes ☐ No

74.*Do you have a permanent tracheostomy? ☐Yes ☐ No

75.*Do you require 24 hours of daily high-intensity nursing care? ☐Yes ☐ No (If 'Yes' answer # 76)

76.*List the needs for requiring high intensity nursing care: (check all that apply)
☐ Intravenous, intramuscular, or subcutaneous injections and hypodermoclysis or intravenous feeding
☐ Bladder irrigations in relation to previously indicated stipulation
☐ Nasogastric or gastrostomy tube feedings
☐ Special vital signs evaluation necessary in the management of related conditions
☐ Nasopharyngeal and tracheotomy aspiration
☐ Changes in bed position to maintain proper body alignment, for individual who are unable to self-position related to physical conditions such, but not limited to, a comatose state or a minimally conscious state, paralysis, locked-in syndrome, etc.
☐ Recent or complicated ostomy requiring extensive care and self-help training
☐ In-dwelling catheter for therapeutic management of a urinary tract condition
☐ Treatment of extensive decubitus ulcers or other widespread skin disorders
☐ Receiving medication recently initiated, which requires high-intensity observation to determine desired or adverse effects or frequent adjustment of dosage
☐ Sterile dressings

Living Situation

77. *Where do you live?
☐ Living with family/relatives
☐ Living in own home or apartment
☐ Foster Care
☐ Group Home
☐ Personal Care Home
☐ Nursing Home
☐ Psychiatric Facility
☐ Nursing Home
☐ Psychiatric Facility
☐ Intermediate Care Facility (ICF/IDD)
☐ Living with a friend
☐ Jail
☐ Homeless shelter
☐ Staffer Home
☐ *Other (If selected, answer # 78)

78.*Explain your living situation: Note: Provide thorough information so the reviewer can make an appropriate determination.

____
____
____

Caregiver Status

79.*Is the living situation working? ☐ Yes ☐ No (if "No" answer question # 80)

80.*Where do you prefer to live?
☐ Where you are currently living
☐ At home with family member with someone to come in and help
☐ In your own home with support
☐ In residential services in the community, living with a family
☐ In residential services in a community home, with staff
☐ *Other (If selected, please answer # 81)

81.*Explain where you prefer to live: Note: Provide thorough information so the reviewer can make an appropriate determination.

____
____
____

82.*Do you have a Main Caregiver? ☐ Yes ☐ No (if "Yes" answer questions # 83 - # 88)

83.*Is the Main Caregiver also your Legal Guardian? ☐ Yes ☐ No

84.*Name of Main Caregiver:
First Name:_________________ Middle Initial: ______ Last Name:___________________ Suffix:___

85.*How would the Main Caregiver like to be contacted? ☐ Phone ☐ Email ☐ Mail

86.*Is the Main Caregiver related to you? ☐ Yes ☐ No (If "Yes" explain the Main Caregiver's relationship with the Individual. If "No", explain who the Main Caregiver is)

____
____

87.*What is the Main Caregiver's age?
☐ Less than 30 years old
☐ 31-50 years old
☐ 51-60 years old
☐ 61-70 years old
☐ 71-80 years old
☐ Over 80 years old

88.*What is the Main Caregiver's health status?
☐ Poor
☐ Good

89.*Do you have another caregiver? ☐ Yes ☐ No (If "Yes" answer questions # 90 - # 95)

90.*Is the other caregiver also your Legal Guardian? ☐ Yes ☐ No

91.*Name of other caregiver:
First Name:_________________ Middle Initial: ______ Last Name:___________________ Suffix:___

92.*How would the other caregiver like to be contacted? ☐ Phone ☐ Email ☐ Mail

93.*Is the other caregiver related to you? ☐ Yes ☐ No (If "Yes", explain the Other Caregiver's relationship with the Individual. If "No", explain who the Other Caregiver is)

____
____
____

94.*What is the other caregiver's age?
☐ Less than 30 years old
☐ 31-50 years old
☐ 51-60 years old
☐ 61-70 years old
☐ 71-80 years old
☐ Over 80 years old

95.*What is the other caregiver's health status?
☐ Poor
☐ Good

96.*Do you have family that is or could be involved in your life? ☐ Yes ☐ No (If "Yes" answer # 97)

97.*Is the family member available to provide care? ☐ Yes ☐ No (If "Yes" answer # 98)

98.*Please discuss the care provided by this family member: Note: Provide thorough information so the

reviewer can make an appropriate determination.

____
____
____

Current Conditions

99.*How are you able to get around?

☐ Walk independently
☐ Use wheelchair & need help
☐ Walk with supportive devices
☐ Use wheelchair operated by self
☐ Total assistance is needed with help from one person
☐ Total assistance is needed with help from two or more people

100.*How much assistance is needed for daily living tasks?

☐ None
☐ Monitoring
☐ Verbal/gestural prompting
☐ Partial physical assistance
☐ Full physical assistance

101.*How do you communicate?

☐ Use verbal communication
☐ Use communication board or device
☐ Use gestures
☐ Use sign language
☐ Use an interpreter
☐ Needs time to process questions/commands

102.*Check each of the challenges you have:

☐ Self-Injury
☐ Property destruction
☐ Physically/verbally aggressive towards others
☐ Inappropriate sexual behavior
☐ Inappropriate social behavior/lack of emotional control
☐ Life threatening (threat of death or severe injury to self or others)
☐ Committed a crime and been arrested
☐ Elopement/runs away
☐ Resistive behaviors
☐ None

103.*How much time is needed to make sure you are safe?

☐ Requires less than 24 hours
☐ Requires 9-16 hours on a day average
☐ Requires 24hrs (does not require an awake person overnight)
☐ Requires 24hrs (with an awake person overnight)
☐ Extreme Needs: Require 24 hours awake person trained to meet individual's particular needs; continuous monitoring

104.*Explain the time needed to make sure you are safe: Note: Provide thorough information so the reviewer can make an appropriate determination.

____
____

105.*Have you been abused, neglected or taken advantage of? ☐Yes ☐ No (If "Yes" answer # 107 and #

108)

106.*What was the outcome?

____
____
____

107.*What was the protective service worker's name?

____

108. You may add other comments here:

____
____
____
____

Note: It is important to be VERY thorough in your responses so that reviewers have as much information as possible to make appropriate determinations. Complete documents must accompany the application.

Application Confirmation

☐ **I consent that I have the authority to apply on behalf of the person**

☐ **I certify the information contained above is accurate and correct to the best of my knowledge**

First Name: _________________________ Middle Initial: ______ Last Name:_______________________________________
Signature:____