Map 109
(Rev 07/08)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
PLAN OF CARE/PRIOR AUTHORIZATION FOR WAIVER SERVICES

- ☐ **Initial**
- ☐ **30 Day**
- ☐ **Annual**
- ☐ **Modification**

Residential Status
- ☐ **In Home**
- ☐ **Family Home Provider**
- ☐ **Adult Foster Care Provider**
- ☐ **Staffed Residence**
- ☐ **Group Home**

Type of Waiver Program
- ☐ **SCL**
- ☐ **HCB**
- ☐ **MP**
- ☐ **ABI**
- ☐ **Traditional**
- ☐ **CDO**
- ☐ **Blended (CDO/Traditional)**

1. MEMBER NAME: _____ (Last) _____ (First) ___ (MI) Sex: ☐ MALE ☐ FEMALE

2. MEDICAID MEMBER ID #: _____ 3. DOB: _____

4. ADDRESS: _____ (Street)

_____ (City) ____ (State) _____ (Zip) _____ (County) 5. HOME PHONE: _____

6. CASE MANAGEMENT/SUPPORT BROKER AGENCY (CDO): _____ _____ (Phone)

7. GUARDIAN NAME: _____ _____ (Relationship:) _____ (Phone)

8. POWER OF ATTORNEY: _____ _____ (Relationship:) _____ (Phone)

9. REPRESENTATIVE NAME (CDO ONLY): _____: _____ (Relationship)

10. ADDRESS: _____ (Street)

_____ (City) ____ (State) _____ (Zip) _____ (County) 11. PHONE: _____

12. LEVEL OF CARE (LOC) CERTIFICATION NUMBER: _____

13. LOC CERTIFICATION DATES: FROM: _____ TO: _____

14. PRIMARY CAREGIVER: _____ _____ (Relationship)

15. ADDRESS: _____ (Street)

_____ (City) ____ (State) _____ (Zip) _____ (County) 16. PHONE: _____

TEAM KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
PLAN OF CARE/PRIOR AUTHORIZATION FOR WAIVER SERVICES

Member Name: _____ **Medicaid Member ID#**:_____

Identification of Needs/Outcomes/Services/Providers

NEED(S)	OUTCOMES/GOAL(S)	OBJECTIVES/INTERVENTION(S)	SERVICE CODE	PROVIDER NAME/#

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Member Name: _____ **Medicaid Member ID#:** _____ **Date Services Start:** _____

Support Spending Plan

Traditional Waiver Services

Service Code A	Provider Name and Number B	Units per Week C	Units per Month D	Cost per Unit E	Cost per Week (Column CxE) F	Total Cost Monthly (4.6xColumn F) G
					$0.00	$0.00
					$0.00	$0.00
					$0.00	$0.00
					$0.00	$0.00
					$0.00	$0.00
					$0.00	$0.00
						Total Cost per Month $ 0.00

Consumer Directed Services

Service Code A	Description of Service B	Employee Providing the Service C	Units per week D	Units per Month (Column D x 4.6) E	Hourly Wage F	Number of Hours per Month G	Sum of Wages Times Hours H	Administrative Costs I	Total Monthly Amount J
									Total Cost Per Month $ 0.00

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Member Name: _____ **Medicaid Member ID #:** _____

List each provider/employee name, address and telephone number:

Provider/Employee Name	Provider Number	Address	Phone Number

Clinical Summary:

_____
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Member Name: _____ Medicaid Member ID #: _____

Emergency Back-up Plan (CDO only)

_____

_____

_____

_____

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_____

_____

I certify the information contained above is accurate and that I have made an informed choice when selecting the providers/employees to provide each service.

_____ _____
Member/Guardian Signature Date

_____ _____
Case Manager/Support Broker Signature Date

_____ _____
Representative Signature (CDO) Date

Plan of Care/Support Spending Plan ☐ **Approved** ☐ **Denied**

_____ _____
QIO Signature/Title **Date**

Clear Form