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**

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

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

1. MEMBER NAME: ______________________ ______________ ___ Sex: ☐ MALE ☐ FEMALE
Last First MI

2. MEDICAID MEMBER ID #: ____________________________ 3. DOB: ____________________

4. ADDRESS: ____
Street

______________ ____ ______ ________ 5. HOME PHONE:______________
City State Zip County

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

______________ ____ ______ ________ 11. PHONE:__________________
City State Zip County

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

13. LOC CERTIFICATION DATES: FROM: _____________ TO: __________________

14. PRIMARY CAREGIVER: ____________________________________ ______________
Relationship

15. ADDRESS: ____
Street

______________ ____ ______ ________ 16. PHONE:__________________
City State Zip County

TEAM KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES

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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