Map 10
(Rev 06/15)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
WAIVER SERVICES
PHYSICIAN'S RECOMMENDATION

PLEASE RETURN TO THE REQUESTOR LISTED BELOW.

_____
(Requestor's Name)

_____
(Address)

_____ **KY** _____ _____
(City) **(Zip)** **(Phone)**

PHYSICIAN'S RECOMMENDATION

I recommend Waiver services for:

_____ _____
(Member) **(Medicaid Member ID #)**

_____
(Address)

_____ **KY** _____ _____
(City) **(Zip)** **(Phone)**

DIAGNOSIS (ES):

_____

Recommended Waiver Program:

- ☐ HCBW (APRN, PA or Physician signature)
- ☐ ABI Waiver – Services to adults with a **primary** diagnosis of an acquired brain injury (18 yrs and older) with a potential for rehabilitation and retraining (**Physician signature**)
- ☐ ABI Long Term Care Waiver – Services to adults (18 yrs and older) with a **primary** diagnosis of an acquired brain injury who has reached a plateau in their rehabilitation level and require maintenance services. (**Physician signature**)
- ☐ SCL Waiver (SCL IDP or Physician signature)
- ☐ Michelle P. Waiver – Non-residential Services to children and adults **with intellectual or developmental disabilities. (APRN, IDP, PA or Physician signature**)

I certify that if Waiver services were not available, institutional placement in a Nursing Facility (NF) or Intermediate Care Facility for Individuals with an Intellectual Disability shall be appropriate for this member.

_____ _____
(Authorized Signature) **(NPI #)**

_____
(Address)

_____ **KY** _____ _____
(City) **(Zip)** **(Phone)**

_____
(Date)

TEAM KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES