MAP-4100A

ACQUIRED BRAIN INJURY WAIVER PROGRAM PROVIDER INFORMATION AND SERVICES

PROVIDER NUMBER _____

NPI (National Provider Identifier) Number _____

AGENCY NAME _____

AGENCY ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

COVERED SERVICES (Check all that apply)

ABI WAIVER

- ☐ Case Management
- ☐ Personal Care Services
- ☐ Companion Services
- ☐ Respite Care
- ☐ Environmental Modifications
- ☐ Behavior Programming
- ☐ Counseling and Training
- ☐ Structured Day Program
- ☐ Specialized Medical Equipment and Supplies
- ☐ Prevocational Services
- ☐ Supported Employment Services
- ☐ Community-Residential Services
- ☐ Occupational Therapy
- ☐ Speech, Hearing and Language Services

ABI LONG TERM CARE WAIVER

- ☐ Support Coordination
- ☐ Community Living Supports
- ☐ Respite Care Service
- ☐ Adult Day Heath Care
- ☐ Supported Employment
- ☐ Behavior Programming
- ☐ Psychological Rehab
- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Specialized Medical Equipment and supplies
- ☐ Environmental Modifications
- ☐ Supervised Residential Care
- ☐ Nursing Supports
- ☐ Family Training
- ☐ Physical Therapy
- ☐ Assessment & Re-Assessment

By signing below I, _____ , certify that this agency is capable of and agrees to comply with the conditions for participation established in the Acquired Brain Injury Services Regulation. In addition, I certify that all staff shall meet all training requirements prior to the provision of services.

_____

Signature of Authorized Representative

_____ _____

Title Date

Please return forms to:
KY Medicaid Provider Enrollment
P.O. Box 2110
Frankfort, KY 40602-2110