MAP 24B (Rev. 1/99)

CABINET FOR HEALTH SERVICES
COMMONWEALTH OF KENTUCKY
FRANKFORT, 40621-0001

DEPARTMENT FOR MEDICAID SERVICES
"An Equal Opportunity Employer M/F/D"

TO: _____ County Office
Department for Community Based Services

FROM: (1) _____
Department for Mental Health/Mental Retardation

DATE: (2) _____

SUBJECT: Brain Injury Waiver Admission/Discharge

(3) _____ _____ _____ _____
(last name) (first name) (mi) (social security number)

(4) _____ _____ KY _____ _____
(address) (city) (zip) (phone #)

(5) Was admitted/discharged to the Brain Injury Waiver Program on _____.
(date)

(6) The case manager is _____ _____ _____ _____
(name) (phone #) (Provider #) (cost)

(7) _____ _____ KY _____
(address) (city) (zip)

(8) Primary Provider: _____ _____ _____ _____
(name) (phone) (provider #) (cost)

(9) _____ _____ KY _____
(address) (city) (zip)

(10) _____ _____ _____ _____
(name) (phone #) (provider #) (monthly cost)

(11) _____ _____ _____ _____
(name) (phone #) (provider #) (monthly cost)

(12) _____ _____ _____ _____
(name) (phone #) (provider #) (monthly cost)

(13) _____ _____ _____ _____
(name) (phone #) (provider #) (monthly cost)

EDUCATION PAYS

Procedural Instructions for MAP 24B

Upon discharge of an individual from the Acquired Brain Injury Waiver Program, the case manager shall forward a MAP-24B form to the local office, Department for Community Based Services and the Department for Mental Health/Mental Retardation Services. The case manager shall complete the form through line seven (7).

This form is also to be used by the Department for Mental Health/Mental Retardation Services to notify the Department for Community Based Services when a Medicaid applicant/recipient is admitted to or discharged from the Acquired Brain Injury Waiver Program. These forms should be mailed to the local Department for Community Based Services office where the family or interested party of the applicant/recipient resides. A copy of the MAP 24B form should be mailed to the case manager

Use the following instructions to fill in the blanks on the MAP 24B.

Line One (1): List name of Department for Mental Health/Mental Retardation staff person who completed the MAP 24B form.

Line Two(2): List the date the form was prepared.

Line Three (3): List the last name, middle initial and social security number of the recipient/applicant.

Line Four (4): List the complete address and telephone number of the recipient/applicant.

Line Five (5): Circle admitted or discharged as appropriate and list date applicant/recipient was admitted/discharged to the brain injury program. If the provider changes, submit a MAP 24B form for the discharge and another MAP 24B form for the admission.

Line Six (6): List the name, phone number, case management agency, provider number of the case manager and the monthly case management cost of the case manager.

Line Seven (7): List the complete address of the case manager.

Line Eight (8): List the name, phone number, provider number and the monthly cost of the services to be provided by the primary provider. This should be the provider with the highest anticipated monthly costs.

Line Nine (9): List the complete address of the primary provider.

Line Ten (10), Eleven (11), Twelve (12) and Thirteen (13): List the name, phone number, provider number and monthly costs for each additional provider.