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.

WEST END ADULT DAY HEALTHCARE
(Requestor's Name)

3847 CANE RUN ROAD Fax: 502 305 6590
(Address)

LOUISVILLE **KY** 40211 502 653 7220
(City) **(Zip)** **(Phone)**

PHYSICIAN'S RECOMMENDATION

I recommend Waiver services for:

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

_____
(Address)

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

DIAGNOSIS (ES):
ICD 10 CODES _____

Recommended Waiver Program:

- [x] 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)