

Brain Injury Waiver Application

Date: _____

1. Participant Information					
Name:					
Date of Birth:		Medicaid #:		Medicare #:	
Male or Female		Marital Status:			

2. Current Residential Information					
Facility Name: <small>(if applicable)</small>					
Street Address:					
Mailing address, if different:					
City:		County:		State:	ME
Social Worker/Discharge Planner's Name:		Zip:			
Phone #:		Fax #:			
Email address:					
Admission date: (mm/dd/yyyy):					
Current (MED Assessed) level of care:					

3. Person and Agency (if applicable) Making Referral					
Name of Person and Agency(if Applicable):					
Street Address:					
City:		County:		State:	ME
Phone #:		Fax #:		Zip:	
Email address:					

4. Legal Representative, Guardian, Power of Attorney (Provide a copy of paperwork to OADS with this application)					
Name:					
Street Address:					
City:		County:		State:	ME
Phone #:		Alternate Phone #:		Zip:	
Relationship to Client:					

5. Emergency Contact (i.e., Guardian, closest family member)

Name:							
Street Address:							
City:		County:		State:	ME	Zip:	
Phone #:		Alternate Phone #:					
Relationship to Client:							

6. Preferred Living Arrangements

Is assistance needed to find housing?	___ Yes ___ No		
Living Preference:	Consumer's Choice	Guardian's Choice <small>(if applicable)</small>	Comments
With relatives/caregiver in their residence	<input type="checkbox"/>	<input type="checkbox"/>	
-Relative's Name: _____ Phone: _____			
-Address: _____			
Alone in apartment	<input type="checkbox"/>	<input type="checkbox"/>	
Alone in own home	<input type="checkbox"/>	<input type="checkbox"/>	
In 8-bed or less group home (8 unrelated individuals)	<input type="checkbox"/>	<input type="checkbox"/>	
Nursing Facility	<input type="checkbox"/>	<input type="checkbox"/>	

7. Information about Brain Injury and Diagnosis

Date of Injury:		Age at time of Injury:	
Description of Event that Led to Injury:			
Description of How the Injury has Impact Daily Life and Current Needs:			
Current Diagnosis:	Axis I:		
	Axis II:		
	Axis III:		
	Axis IV:		
	Axis V (GAF):		

8. Areas of Support Needed (check all that apply)

Part A. Risks/Challenging Behaviors/Critical Support Needs

- | | | |
|--|---|--|
| <input type="checkbox"/> Lack of orientation to:
<input type="checkbox"/> self
<input type="checkbox"/> time
<input type="checkbox"/> place | <input type="checkbox"/> Ineffective/unsafe response in emergency
<input type="checkbox"/> Falls
<input type="checkbox"/> Medication/treatment non-compliance
<input type="checkbox"/> Difficulty with Memory
<input type="checkbox"/> Short Term Memory
<input type="checkbox"/> Long Term Memory
<input type="checkbox"/> Impacts Daily Tasks | <input type="checkbox"/> Wanders – without clear direction of where he/she is going
<input type="checkbox"/> Elopes – purposely tried to leave unnoticed
<input type="checkbox"/> Unaware of personal boundaries
<input type="checkbox"/> Unaware of social cues
<input type="checkbox"/> Intrusive to others space
<input type="checkbox"/> Unable to manage interpersonal conflict
<input type="checkbox"/> Verbally abusive
<input type="checkbox"/> Taking others property
<input type="checkbox"/> Property destruction
<input type="checkbox"/> Physical assaults
<input type="checkbox"/> Lethal threats to self
<input type="checkbox"/> Lethal threats to others |
| <input type="checkbox"/> Difficulty navigating inside residence
<input type="checkbox"/> Disorientated outside residence
<input type="checkbox"/> Unsafe in the residence
<input type="checkbox"/> Unsafe in the kitchen
<input type="checkbox"/> Unsafe in the community
<input type="checkbox"/> Traffic/Pedestrian
<input type="checkbox"/> Unable to safely occupy own time
<input type="checkbox"/> less than one hour
<input type="checkbox"/> less than three hours
<input type="checkbox"/> less than 8 hours | <input type="checkbox"/> Difficulty with Expressive language
<input type="checkbox"/> Difficulty with Receptive language
<input type="checkbox"/> Unable to control eating
<input type="checkbox"/> Inappropriate dress
<input type="checkbox"/> Significant lack of motivation/initiation
<input type="checkbox"/> Impulsive consumption/collection | |

Describe above checked items:

Part B. Health & ADL/IADL Support Needs		
<input type="checkbox"/> INCONTINENCE <input type="checkbox"/> bladder <input type="checkbox"/> bowel <input type="checkbox"/> requires direct support for toileting <input type="checkbox"/> requires cueing/monitoring for toileting	<input type="checkbox"/> EATING <input type="checkbox"/> swallowing issues <input type="checkbox"/> special diet <input type="checkbox"/> requires direct support for eating <input type="checkbox"/> requires cueing/monitoring	<input type="checkbox"/> MOBILITY <input type="checkbox"/> uses wheelchair <input type="checkbox"/> uses walker <input type="checkbox"/> uses cane <input type="checkbox"/> requires direct support for moving <input type="checkbox"/> requires cueing/monitoring for moving
<input type="checkbox"/> BATHING AND DRESSING <input type="checkbox"/> requires direct support for bathing <input type="checkbox"/> requires cueing/monitoring for bathing <input type="checkbox"/> requires direct support for dressing <input type="checkbox"/> requires cueing/monitoring for dressing	<input type="checkbox"/> SLEEP <input type="checkbox"/> awake at night <input type="checkbox"/> sleeps less than 6 consecutive hours at night <input type="checkbox"/> CPAP <input type="checkbox"/> BIPAP	<input type="checkbox"/> List any Specialized Nursing Care Issues <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> IADLs (check item if help needed with this task) <input type="checkbox"/> household chores <input type="checkbox"/> money management <input type="checkbox"/> laundry <input type="checkbox"/> shopping <input type="checkbox"/> cooking	Comments:	

9. Medications		
Name of Medication	Reason Prescribed	Dosing Amount and Directions

Complete this application and fax along with all items listed below to:

Brain Injury Services @ (fax) 207-287-9229

- Brain Injury Waiver Application
- Release of Information
- Neuropsychological Assessment
- Documentation from a physician that the services are medically necessary
- Power of Attorney, Representative Payee, or Guardianship Documents (if applicable)