

## 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
- Respite Care Services
- Companion Care Services
- Adult Day Training
- Supported Employment Services
- Behavior Programming
- Psychological Rehab Services
- Therapeutic Activities/Occupational Therapy
- Speech, Hearing and Language Services
- Durable Medical/Specialized Medical Equipment
- Home Modification/Environmental Modification
- Supervised Residential Care
- Assessment & Re-Assessment

#### ABI LONG TERM CARE WAIVER

- Case Management
- Community Living Supports
- Respite Care Service
- Adult Day Health Care
- Adult Day Training
- Supported Employment Services
- Behavior Programming
- Psychological Rehab Services
- Therapeutic Activities/Occupational Therapy
- Speech, Hearing and Language Services
- Durable Medical/Specialized Medical Equipment
- Home Modification/Environmental Modification
- 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 (907 KAR 3:090) and/or the Acquired Brain Injury Long Term Care Waiver Services regulation (907 KAR 3:210). 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**