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Steven Stack, MD
SECRETARY

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TO: Home and Community Based (HCB) Waiver Providers
Michelle P. Waiver (MPW) Providers

FROM: Carmen Hancock, Director
Division of Long-Term Services and Supports

Crystal Adams, Director
Department for Behavioral Health, Developmental and Intellectual Disabilities
Division of Developmental and Intellectual Disabilities

Marnie Mountjoy, Director
Department for Aging and Independent Living
Division of Quality Living

DATE: July 24, 2026

RE: Kentucky Michelle P. (MPW) and Home and Community Based (HCB) Waiver Waitlist Verification

Dear Kentucky Waiver Providers,

Kentucky House Bill (HB) 2, signed into law in April 2026, establishes new requirements related to the management of waitlists for certain Medicaid 1915(c) Home and Community Based Services (HCBS) programs.

How does this affect you?

As required under state law, individuals currently on the waitlist for the Michelle P. Waiver or the Home and Community Based (HCB) Waiver who wish to remain on the waitlist must submit a completed Provider Attestation by January 31, 2027.

The Provider Attestation must include:

- The individual's primary diagnosis
- Waiver services required
- A signature from an approved provider

Per HB 2, an approved provider is defined as:

- A physician or physician assistant licensed under KRS Chapter 311
- An advanced practice registered nurse licensed under KRS Chapter 314
- A licensed psychologist licensed under KRS Chapter 319

Individuals affected by this requirement are being notified directly and may contact your office for assistance in completing the documentation. For your reference, the required Provider Attestation Form is attached to this correspondence.

Your timely assistance in completing the documentation requested is greatly appreciated and will help ensure individuals can maintain their placement on the waiver waitlist. Failure to submit required documentation by the deadline will result in removal from the waitlist.

Important Information to Share with Participants and Families

As a provider, you play an instrumental role in helping individuals and families engaged with Kentucky Medicaid waiver programs understand this process.

Please help reinforce the following key points with individuals and families:

- **Current waiver recipients are not impacted.**
  Individuals currently enrolled in and receiving 1915(c) waiver services will continue receiving services without interruption. This verification process applies only to individuals currently on a waiver waitlist.

- **The process includes multiple outreach attempts.**
  No individual will be removed from the waitlist without documented outreach efforts. Individuals subject to removal for non-response will receive at least three documented contact attempts over a minimum 90-day period, followed by a final 60-day notice.

The Cabinet for Health and Family Services recognizes the important role providers play in supporting individuals and families navigating Kentucky's Medicaid waiver programs and appreciates your support during implementation of these new requirements.

If you have questions regarding this process involving the Michelle P. Waiver (MPW), please contact:
Department for Behavioral Health, Developmental and Intellectual Disabilities
(502) 564-7700
DDID.Info@ky.gov

If you have questions regarding this process involving the Home and Community Based (HCB) Waiver, please contact:
Department for Aging and Independent Living
(877) 315-0589
DAILHCBWaiverParticipantInquiries@ky.gov

Thank you for your continued support and collaboration.

Commonwealth of Kentucky Cabinet for
Health and Family Services
Department for Medicaid Services

1915(c) WAIVER SERVICES
PROVIDER ATTESTATION & RECOMMENDATION

Member Name _____ **Medicaid Member ID #** _____ **Member DOB** _____

The member listed above authorizes the provider listed below to provide the information requested on this form to the Kentucky Cabinet for Health and Family Services for waiver application review tasks. Further, the member authorizes the provider to respond to any requests for clarification or additional information related to this request. This authorization expires one year from the date signed.

Signature _____ **Date** _____ **Printed Name and Relationship if Signed by Parent/Guardian** _____

I attest that the member listed above has the following diagnosis(es):

_____
List all diagnosis(es)

I attest that the member listed above needs the following waiver services and, without these services, institutional placement in a Nursing Facility (NF), Inpatient Psychiatric Hospital for Youth under the age of 21 or Intermediate Care Facility for Individuals with an Intellectual Disability shall be appropriate for this member. (Select all that apply)

- ☐ Supervised Residential Services
- ☐ In-Home Support Services (Assistance with ADL's, IADL's or respite for primary caregiver)
- ☐ Skilled Nursing for Ventilator Dependency (12+ hours per day)
- ☐ Community Living or Community Access Supports (Facilitate community involvement for those residing in their own homes)
- ☐ Rehabilitation/Training for Acquired Brain Injury
- ☐ Home Modifications for Safety or Accessibility
- ☐ Adult Day Health Care or Adult Day Training
- ☐ Clinical or Therapeutic Services
- ☐ Behavioral Supports
- ☐ Other: _____

Provider Information

Provider name:	NPI #:
Provider type (MD, DO, APRN, Psychologist):	
Address:	Length of time providing service to applicant:
Phone:	Email:

Provider Signature _____ **Date** _____