

## HCBS/TBI Waiver Notice of Action Instructions

- This form is to be filled out by the TBI-TCM or agency providing the services. This form is to be received by the consumer of HCBS services and any effected providers.
- This form serves as a notice of changes in HCBS/TBI services. Please complete all sections of this form.

### **Definitions:**

**Date of Notice** - The date this form is being completed.

**To** - The name of the consumer receiving the services.

**From** - The case manager or agency, name, address and phone number.

**Medicaid ID** - Consumers Medicaid number.

**Service & Procedure Code** - List the name of the service and the corresponding procedure code.

**Provider name** - The name of the person or agency providing the above service.

**Dates of Service** - The date the services began until the anticipated date that the services ends. If this is a notice regarding the ending of services be sure and include the last date services will be provided.

**I, D, C** - Designates whether the services have been implemented, changed, or discontinued. Please choose on to specify the designation.

**Client Obligation** - If client obligation amount is known, please place here.

**Comments, Messages or Explanation of Action** - Please fill in the date that the change will become effective. Under "reason" you must state the reason why services are changing. For example: The occupational therapy services you are currently receiving through the HCBS/TBI wavier are being discontinued for calendar year 2003-04. You have received the maximum number of units allowed for therapy.

**Regulatory Reference(s)** - Refer to policy & procedure manual, or if applicable, the KEESM manual.

**Case Manager** - Name of case manager on most recent plan of care.