Out-of-State TBI Rehabilitation Services Request Form

Last Name: ________________ _______________________________

First Name: ____

Medicaid ID Number: ____________________________

LTC Score: _______ + TBI Addendum Score: ________ = ________ TOTAL OF SCORES

Date of most current TBI-UAI: ____________________________

Out-of-state provider: ____

Date of Admission: _________ __ ___________

TCM Name: ____

TCM Agency: ____

1) Please attach letters of denial from all approved in-state facilities stating the specific reasons for the denial of service.

2) Please substantiate in writing why the HCBS/TBI waiver cannot meet the consumer's needs in the community:

Send to TBI Program Manager:

Michael F. Deegan
SRS/HCP/CSS
DSOB 9th Fl. East
915 Harrison
Topeka, KS 66612

Phone: (785) 296-3561
Fax: (785) 296-0557
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