

**APPLICATION FOR PARTICIPATION
HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVERS
TRAUMATIC BRAIN INJURY (TBI)**

Applicant Name	CIN
Current Residence	Telephone
Telephone	Date of Birth

- Not enrolled in Medicaid
- Medicaid application is pending

I am requesting participation in a TBI Home and Community Based Services Medicaid Waiver. I understand that approval to participate in the waiver is based on documentation of the following:

- Nursing home level of care
- Medical documentation of a brain injury
- Eligibility and authorization for Medicaid coverage for Community Based Long Term Care Services
- Being able to live in the community with the needed assistance of available informal supports; or non Medicaid supports; or Medicaid State Plan Services; and at least one waiver service
- Age of at least eighteen (18) years at the time of approval for the waiver
- Age of not older than sixty-four (64) at the time of application

Applicant Signature _____ Date _____

Legal Guardian (as applicable) Signature Telephone Date

Authorized Representative (as applicable) Signature Telephone Date

Regional Resource Development Specialist Signature _____ Date _____