

MAP 10  
(Rev-7/97)

**KENTUCKY MEDICAID PROGRAM**  
Home and Community Based Services Waiver

TO:

AGENCY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
PHONE: \_\_\_\_\_

**PHYSICIAN'S RECOMMENDATION**

I recommend the Home and Community Based Waiver Program for:

Client:

\_\_\_\_\_

Address: \_\_\_\_\_  
PHONE: \_\_\_\_\_

SOCIAL SECURITY# \_\_\_\_\_ MAID# \_\_\_\_\_

DIAGNOSIS (ES) \_\_\_\_\_  
\_\_\_\_\_

I understand that the Home and Community Based Services Waiver Program includes the following services, provided as needed; assessment/care planning, reassessment, case management, personal care, homemaker, attendant care, respite, minor home adaptations, and adult day health care services.

I certify that if Home and Community Based Waiver Services were not available, nursing facility placement shall be appropriate for this individual in the near future.

PHYSICIAN'S NAME: \_\_\_\_\_ UPIN# \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
PHONE: \_\_\_\_\_

\_\_\_\_\_  
Signature Date