Map – 24C
(Rev. 07/2008)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
Admittance, Discharge or Transfer of an Individual in the ABI/SCL Program

TO: **(1)** ________________________________ County Office
Department for Community Based Services

(2) Quality Improvement Organization (QIO)

(3) Department for Mental Health, Developmental Disabilities and Addiction Services for SCL Waiver **or** Department for Medicaid Services/Acquired Brain Injury Branch for ABI Waiver

FROM: **(4)** ________________________________
Case Management Agency/Support Broker

DATE: **(5)** ________________________________

(A) MEDICAID WAIVER PROGRAM

(Check program)
☐ ABI ☐ SCL ☐ MP

(Check type of action)
☐ Admission ☐ Discharge
☐ Temporary Discharge ☐ Readmit from Temporary Discharge
☐ Change in Case Management Company ☐ Change in Primary provider
☐ Change of client address ☐ Facility / Hospital Admission/Discharge

Date of above action: ________________________________

(B) CLIENT INFORMATION:

(Last Name) (First Name) (MI) (Social Security Number)

(Address)

(City) KY (Zip) (Phone number)

(C) CASE MANAGEMENT AGENCY/SUPPORT BROKER INFORMATION

(Name) (Provider #)

(Address)

(City) KY (Zip) (Phone number)

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Re: CLIENT NAME: ___________________________________ **SS#:** ____________________

(D) PRIMARY PROVIDER INFORMATION

(1) Primary Provider

____ ______________________________
(Provider Name) (Provider #)

____
(Address)

___________________________________ KY _________ ______________________________
(City) (Zip) (Phone)

Monthly Cost: ____

(E) FACILITY/HOSPITAL INFORMATION

Admission Date: _____________________ **Discharge Date:** _________________________

(1) Facility/Hospital Name: ____

____
(Address)

___________________________________ KY _________ ______________________________
(City) (Zip) (Phone)

(2) Reason for Admission

____
____
____

(3) Discharge Outcome

____
____
____

(F) WAIVER PROGRAM DISCHARGE

Voluntary: ☐ **Involuntary:** ☐

(1) Reason for Program Discharge

____
____
____

**IF DISCHARGE IS VOLUNTARY, SUBMISSION OF DOCUMENTATION SIGNED BY THE GUARDIAN/LEGAL REPRESENTATIVE IS REQUIRED CONFIRMING INTENT TO DISCONTINUE SERVICES.