Kansas Department for Aging and Disability Services

Kansas Traumatic Brain Injury Rehabilitation Facility (TBIRF) Referral Form

Rev. 8-22-16

☐Acute Care Referral ☐TBI Rehabilitation Facility Request

I. CONSUMER INFORMATION

Name: _____ Medicaid ID #: _____

Address: _____

Phone: _____ SSN: _____ Date of Birth: _____

Responsible Person/Contact: _____ Phone: _____

Address: _____

I attest that I choose to discharge to:

☐Community (HCBS-TBI)

☐Nursing Facility (NF)

☐Rehabilitation Facility (TBIRF)

Current KanCare Health Plan: _____

Signature Date

Person Responsible for Signing Consent: ☐Consumer ☐DPOA/Guardian ☐Other

NOTE: Information provided in this packet may be disclosed with other health care entities for the purposes of treatment approval and activities. These health care entities include: Kansas Department for Children and Families (DCF), Kansas Department for Aging and Disability Services (KDADS), and contracted entities with a business agreement with KDADS.

II. ADMISSION FACILITY

1. Does the person demonstrate medical necessity for inpatient rehabilitation services? ☐Yes ☐No
2. Is the request for admission less than 6 months following the qualifying TBI? ☐Yes ☐No
3. Has guardianship or DPOA been requested or activated for this person? ☐Yes ☐No *Submit documentation with packet.*

COMPLETED DOCUMENTATION:

☐**TBI Diagnosis/Supporting Documentation**
☐**PMDT/SSA Documents**
☐**Guardian/DPOA Paperwork, if applicable**

Person Completing Section: _____ Office Phone: _____

Organization: _____

Comments: _____

_____

Signature Date Sent to KDADS

***Email completed documents and checklist to TBI Program Manager (use "Acute TBI Referral" in subject line).**

III. KDADS

TBI Program Manager Decision :

Determination:
☐Approved
☐Denied

Action:
☐FAI Reviewed
☐NOA Sent
☐Referral Form Sent to TBIRF
☐3160/PMDT/SSA documents sent to KDHE

Comments: _____

Signature Date Returned to TBIRF