MAP-621 (2/14) Cabinet for Health and Family Services
Department for Medicaid Services

APPLICATION FOR MPW WAIVER WAITING LIST

Section 1

DO NOT leave any information blank in section 1. Applications will be returned if left blank.

Name - Legibly print first, middle and last name of applicant
Sex - Check whether the applicant is male or female
SS# - Be sure the social security number has 9 numbers
Medical Assistance Number - This is the # on the MEDICAID card (10 numbers) If applicant has not applied for Medicaid then enter N/A
DOB - example: 08/18/1966
Phone Number - Always include area code. If no phone, please write "no phone"
Current Address - Please print legibly.

Name: _____ _____ _____ Sex: ☐M ☐F
First Middle Last
Social Security Number: _____ Medical Assistance Number: _____
Date of Birth: _____ Phone: _____
Month, Day Year
Current Address: _____

_____ _____ _____ _____
City County State Zip Code

Section 2

Complete this section only if there is a LEGAL representative or guardian
If the applicant is a minor, there **must** be a legal guardian.

Legal Representative/Guardian: _____
Address _____

_____ _____ _____ _____
City County State Zip Code
Phone: _____ Relationship to Applicant: _____
Email: _____ Ex: mother, father, friend

DSM Diagnosis

Axis I – DO NOT LEAVE BLANK - write "none" on the line if there is no diagnosis
Axis II - DO NOT LEAVE BLANK - write "none" on the line if there is no diagnosis
Axis III - DO NOT LEAVE BLANK - write "none" on the line if there is no diagnosis

Age disability identified is the age the applicant was diagnosed with an intellectual or developmental disability (Ex: birth, 1 yr old, etc.). Intellectual disability must be present prior to age 18. Developmental disability must be present prior to age 22.

DSM Diagnosis:
Axis I (Mental Health): _____
Axis II (Intellectual/Developmental Disability): _____
Axis III (Physical Health): _____
Age Disability Identified: _____

SERVICES THE INDIVIDUAL CURRENTLY RECEIVES (Check **ALL THAT APPLY**)

- ☐ Acquired Brain Injury
- ☐ Behavior Support
- ☐ Case Management
- ☐ Day Program
- ☐ EPSDT (if under 21)
- ☐ Hart Supported Living
- ☐ Home & Community Based Waiver
- ☐ Other Medicaid Services: _____
- ☐ Home Health
- ☐ Mental Health Counseling/Medication
- ☐ Supported Employment
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Residential
- ☐ Respite
- ☐ School Services
- ☐ Speech Therapy

Other: _____

Mail or Fax to:

Carewise Health
9200 Shelbyville Road. Suite 800
Louisville, KY 40222
Fax: 1-800-807-7840