

# ACQUIRED BRAIN INJURY (ABI)

NEUROPSYCHOLOGIST/PHYSIATRIST CHECKLIST  
FOR NURSING FACILITY ACQUIRED BRAIN INJURY SERVICES



**IF YOU NEED ASSISTANCE, PLEASE CALL GOULD HEALTH SYSTEMS AT 1-800-609-7893.**

**FAX THIS FORM TO GOULD HEALTH SYSTEMS ALONG WITH THE SIGNED PLAN OF CARE, INCLUDING TYPES AND FREQUENCIES OF THERAPIES, EXPECTED OUTCOMES, AND TIMEFRAMES.**

**ALL SUBMITTED PAGES MUST INCLUDE THE INDIVIDUAL'S NAME AND A NEUROPSYCHOLOGIST/PHYSIATRIST SIGNATURE.**

SUBMITTING FACILITY INFORMATION				
FACILITY NAME		CURRENT DATE	ADMISSION DATE	
FAX NUMBER		PHONE NUMBER		
PRINT NAME/LICENSURE/TITLE OF PERSON COMPLETING FORM				
CONSUMER INFORMATION				
LAST NAME	FIRST NAME	M.INT.	DATE OF BIRTH	MAINECARE NUMBER
ABI POLICY CHECKLIST				
In order for services to be covered under the ABI rate of reimbursement, the assessment as described in 67.02-5(B) must be completed and a rehabilitation plan of care based upon the findings of the assessment must be in place. An assessment conducted up to <b>no more than three (3) months prior to admission</b> will be accepted.				
1	THE INDIVIDUAL HAS A DIAGNOSIS OF ACQUIRED BRAIN INJURY			Y <input type="checkbox"/> N <input type="checkbox"/>
2	THE INDIVIDUAL HAS RECEIVED AN ASSESSMENT BY A QUALIFIED NEUROPSYCHOLOGIST AND/OR LICENSED PHYSICIAN WHO IS BOARD CERTIFIED, OR OTHERWISE BOARD ELIGIBLE IN PHYSICAL MEDICINE AND REHABILITATION. <b>PLEASE ATTACH ASSESSMENT.</b>			Y <input type="checkbox"/> N <input type="checkbox"/>
3	THE INDIVIDUAL IS NOT IN A PERSISTENT VEGETATIVE STATE			Y <input type="checkbox"/> N <input type="checkbox"/>
4	THE ASSESSMENT POSITIVELY INDICATES THAT THE INDIVIDUAL IS ABLE TO DEMONSTRATE POTENTIAL FOR:			
CHECK ALL THAT APPLY	Physical Rehabilitation			Y <input type="checkbox"/> N <input type="checkbox"/>
	Behavioral Rehabilitation			Y <input type="checkbox"/> N <input type="checkbox"/>
	Cognitive Rehabilitation			Y <input type="checkbox"/> N <input type="checkbox"/>
5	THE ASSESSMENT POSITIVELY INDICATES THAT THE INDIVIDUAL SHOWS EVIDENCE OF:			
CHECK ALL THAT APPLY	Moderate to Severe Behavioral Disability			Y <input type="checkbox"/> N <input type="checkbox"/>
	Cognitive Disability			Y <input type="checkbox"/> N <input type="checkbox"/>
	Functional Disability			Y <input type="checkbox"/> N <input type="checkbox"/>
6	THE ASSESSMENT AT LEAST RESULTS IN SPECIFIC REHABILITATION GOALS, BASED UPON THE FINDINGS OF THE ASSESSMENT, DESCRIBING TYPES AND FREQUENCIES OF THERAPIES AND EXPECTED OUTCOMES AND TIMEFRAMES. <b>PLEASE ATTACH THERAPY EVALUATIONS &amp; RECENT PROGRESS NOTES.</b>			Y <input type="checkbox"/> N <input type="checkbox"/>
ATTESTATION				
NEUROPSYCHOLOGIST/PHYSIATRIST SIGNATURE (REQUIRED):				