Innovative Resource Group d/b/a
APS Healthcare

TRAUMATIC BRAIN INJURY (TBI)
CASE MANAGEMENT MONTHLY REPORT

The report must be submitted to APS Healthcare, Inc. by every Case Management Agency by the 6th business day of every month. It can be submitted in the following ways:

By Mail: **APS Healthcare, Inc.**
100 Capitol Street, Suite 600
Charleston, WV 25301

By Fax: **1.866.607.9903**

To Complete this Form:

1. Complete the top section of the form with the current month, year, provider name, provider number, phone number, agency address, and the name of the person submitting the form.
2. If you have had no new members open for the reporting month, no members transferred to or from your agency during the reporting month or no closures from the TBI Waiver Program for the reporting month - mark No Activity this month.
3. If you have had new members open, members transfer or members close from the TBI Waiver Program for the reporting month, you will need to fill out the member information section for each of these.
4. New TBI Member Enrollments – these are individuals opened by your agency that are new to the TBI program. The Enrollment Date is the Anchor date on the Member Enrollment Confirmation Letter you received from APS Healthcare, Inc. for each member.
5. Transfers Received From – If you received a transfer from another agency during the month, complete the agency's name you received the transfer from and the date you received the transfer.
6. Transferred To – If you had a member transfer from your agency to another agency – complete agency's name they transferred to and the date they were transferred.
7. Closures – These are individuals that have closed from the TBI program. List the reason they were closed – these reasons must be consistent with policy and accurate. Ex. 180 days without service, unsafe environment, and member no longer desires services, death, moved out of state, loss of financial eligibility, loss of medical eligibility.
8. Comment Section – list any additional information APS Healthcare may need to know.

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CASE MANAGEMENT MONTHLY REPORT

Month: Year:

Provider Name:	Provider Number:		Phone:
Address:	City:	Zip:	☐ No activity this month
Submitted by:			

MEMBER INFORMATION

Member:__________ Address: __________ __________ County: ______ Birth date: ___/___/______ Medicaid#: __ __ __ __ __ __ __ __ __ __ __ __ New TBI Member Enrollment Date: ___/___/______ Transfer Received From: __________ (Agency Name) Date: ___/___/______ Transferred To: __________ (Agency Name) Date: ___/___/______ Date Closed___/___/______ Reason______ Comments: __________ __________	Member:__________ Address: __________ __________ County: ______ Birth date: ___/___/______ Medicaid#: __ __ __ __ __ __ __ __ __ __ __ __ New TBI Member Enrollment Date: ___/___/______ Transfer Received From: __________ (Agency Name) Date: ___/___/______ Transferred To: __________ (Agency Name) Date: ___/___/______ Date Closed___/___/______ Reason______ Comments: __________ __________
Member:__________ Address: __________ __________ County: ______ Birth date: ___/___/______ Medicaid#: __ __ __ __ __ __ __ __ __ __ __ __ New TBI Member Enrollment Date: ___/___/______ Transfer Received From: __________ (Agency Name) Date: ___/___/______ Transferred To: __________ (Agency Name) Date: ___/___/______ Date Closed___/___/______ Reason______ Comments: __________ __________	Member:__________ Address: __________ __________ County: ______ Birth date: ___/___/______ Medicaid#: __ __ __ __ __ __ __ __ __ __ __ __ New TBI Member Enrollment Date: ___/___/______ Transfer Received From: __________ (Agency Name) Date: ___/___/______ Transferred To: __________ (Agency Name) Date: ___/___/______ Date Closed___/___/______ Reason______ Comments: __________ __________
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