

Open Enrollment Period Acquired Brain Injury Waiver, May 1-21, 2012

What is the Acquired Brain Injury (ABI) Waiver Program?

The ABI Waiver Program enables eligible brain injury survivors to move from nursing homes, chronic care or rehabilitation hospitals into the community. MassHealth and the Massachusetts Rehabilitation Commission (MRC) have contracted with the BIA-MA to develop an outreach strategy to share information about the Acquired Brain Injury Waiver Program.

What are the two waivers offered?

- ABI-Non-Residential Habilitation waiver (ABI-N) which provides community supports only to individuals living in their own home or apartment or the residence of another person, who do not require 24 hour services.
- Beginning May 1, 2012, ABI-N applications will be accepted on an ongoing basis.
- ABI-Residential Habilitation (ABI-RH) which provides supervision and staffing 24 hours a day, 7 days a week through a qualified residential provider agency.

What are the eligibility requirements?

- Experienced a brain injury at age 22 or older.
- Causes of brain injury include strokes, brain tumors, infection, anoxia, car crashes, falls, and other brain traumas.
- Must live in a nursing facility, chronic or rehabilitation hospital for at least 90 consecutive days.
- Eligible for MassHealth (Medicaid) if the individual were to move out of the facility.
- The expected services needed for the individual to safely live in the community must not exceed certain cost limits::

For the ABI-RH Waiver, the maximum is \$194, 186 per year.

For the ABI-N Waiver, the maximum cost is \$99,890 per year.

The University of Massachusetts Medical School ABI Waiver Unit is responsible for screening all applications for clinical eligibility, which includes the projected cost of services each person will need to live safely in the community.

What services/supports are provided?

- An Individual Service Plan (ISP) will be created for each person accepted into the program.
- Person-centered planning ensures that each participant or guardian drives his or her own ISP; he or she can choose others to participate in the planning process.
- A Case Manager is assigned to each individual. They assist with transition planning to enable someone to move from the facility to the community. This will include referral and linkages to community services and coordination and monitoring of these services on an ongoing basis.
- Waiver services may include day programs, rehabilitation therapies, 24/7 group homes, supported employment, homemaker, personal care, medical equipment, adult companion, transitional assistance services and transportation to name a few.

Questions? Need help? Call 800-242-0030 or visit www.biama.org