*To be completed by Case Manager
** To be completed by Case Manager Supervisor

Member Name:___________________________
Review Date: ___________________________

TRAUMATIC BRAIN INJURY WAIVER RISKS TO SERVICE PLAN MAPPING CHECKLIST							
Assessed Risk	**Identified Risk(s)**	***Identified Risk Reduction Strengths/Assets** (✓ = Yes ✗ = No)	***Additional Supports for Identified Risk Reduction** (✓ = Yes ✗ = No)	***Formal Supports Identified** (✓ = Yes ✗ = No)	****All Identified Risks Included on Service Plan?** (✓ = Yes ✗ = No)	****Are All Service Plan Components Completed?** (✓ = Yes ✗ = No)	****Do Components Include an Appropriate Response to Identified Risk?** (✓ = Yes ✗ = No)
Medical Risk (e.g. disease management, medication management, requiring physical repositioning, inability to evacuate home, obesity, oxygen use, seizures)							
Behavioral/Mental Health Risk (e.g. easily agitated, resistant to care, sexually inappropriate, mood swings, hallucinations, delusions)							
Fall/Mobility Risk (e.g. stairs, rugs, use of prosthetics, history of falls, numbness)							
Safety/Substance Abuse Risk (e.g. fall risk, physically dangerous to oneself if alone, alcohol and substance abuse)							
Environmental Risk (e.g. uneven flooring, poor lighting, unsafe living space, needed home repairs, need accessibility modifications)							
Nutritional Risk (e.g. poor nutrition due to inability to feed oneself, diabetic, feeding tube)							
Cognitive Risk (e.g. cannot communicate basic needs, impaired judgement and decision-making abilities, unable to follow commands or cooperate with treatment efforts, inattention, absent short-term memory, inability to retain information)							

The purpose of this document is to verify that Service Plans adequately address identified health and safety risks with appropriate responses and documentation.

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Case Manager Notes:

Case Manager Supervisor Notes:

The purpose of this document is to verify that Service Plans adequately addresses identified health and safety risks with appropriate responses and documentation

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Case Manager Supervisor Review

- **Service Plan Reviewed By:** ____________________________________
- **Date of Review:** _______________________
- **Overall Compliance:** ☐ Fully Compliant ☐ Partially Compliant ☐ Non-Compliant
- **Follow-Up Actions Required:**

The purpose of this document is to verify that Service Plans adequately addresses identified health and safety risks with appropriate responses and documentation