



Community Services and
Programs Commission

Technology-Assisted Waiver

KanCare HCBS Waiver
KDADS

Presented by: Children's Resource Connection

TA Waiver Mission

- Provide hospital-level of care in an in-home setting so children can remain with their family instead of a hospital or institution.
- Provide the necessary in-home nursing services that can maintain or actually improve the child's medical status, as well as educate parents in child's care.
- Provide care support for families to allow parents to seek and/or maintain employment to help support the family unit.
- Services individuals age 0 thru 21 years of age.

TA Waiver

Definition of Technology Assisted and Medically Fragile

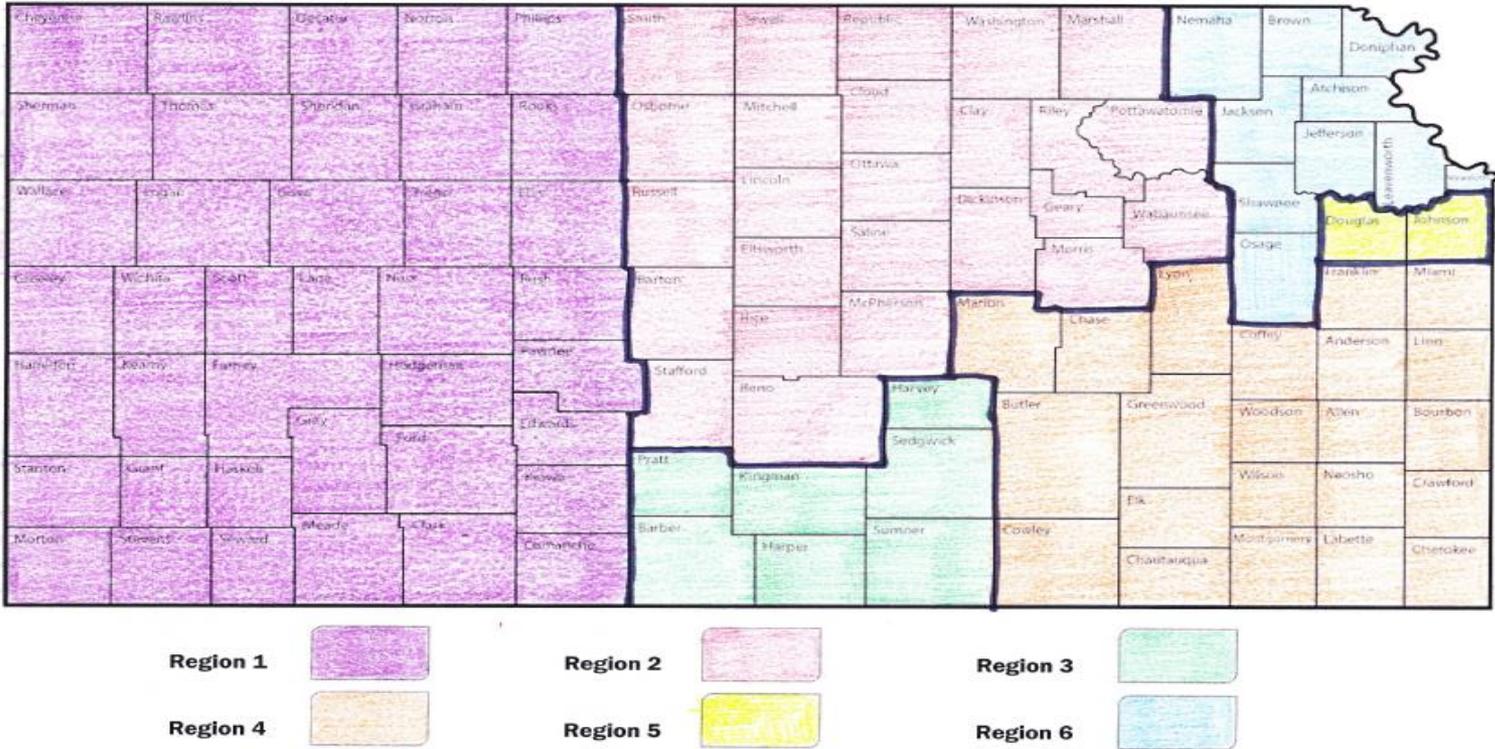
● Technology Assisted

- Dependent on an eligible medical device to compensate for loss of vital body function.
- Require substantial and ongoing daily care by a nurse comparable to the level of care provided in a hospital setting, to avert death or further disability.
- In the absence of home care, illness or disability would require admission to, or prolonged stay in a hospital.

TA Waiver Overview

- MATLOC assessment tool evaluates the type of medical technology dependency and level of medical fragility of the individual.
- Administered by a trained and State certified RN or APRN.
- MES brings years of experience working with disabled children, as well as families and trauma situations. There are 4 assessors that cover the entire State of Kansas, with the State divided into 6 regions.

TA WAIVER MES REGIONS



MATLOC Eligibility Specialists

Monique Barnes, RN, MSN, APRN
Toby Leavendusky, RN, BSN

Kipp Wilhoit, RN, BSN
Susan Hellman, RN, BSN –
Children’s Choice

TA Waiver Eligible Technologies

- Total or Intermittent Ventilator dependent
- Tracheostomy
- Bi-Pap or C-Pap
- Oxygen – continuous greater than 8 hrs
- Oximetry or Apnea Monitor – continuous greater than 8 hrs and in conjunction with the oxygen technology requirement
- Gastro tube feeding – either continuous or bolus, providing majority of nutritional intake, not supplemental
- Total Parental Nutrition (TPN) – continuous greater than 6 hrs
- Intravenous (IV) Therapy – continuous greater than 6 hrs
- Home Dialysis (must be administered in the home)

TA Waiver

Additional Eligibility Criteria

- In addition to meeting definition of “technology assisted”, the individual must also meet the following criteria:
 - Require daily use of eligible technology device and meet the minimum technology points requirement.
 - Meet the level of care (LOC) minimum nursing acuity threshold for the specific age group.
 - Must be a Kansas resident and provide proof of US citizenship.
 - Be determined eligible for Medicaid.

TA Waiver

Referral Process

- Children's Resource Connection
 - The one-stop referral center for TA Waiver.
 - Communications with hospitals all over Kansas, as well as DCF offices, providers, Infant-Toddler services, as well as hospitals out of state that handle our demographics.
 - Good communications with all 3 MCOs.
 - Experienced in working with the TA population.

TA Waiver

Referral Process

● New Referrals

- After initial screening, if child meets the technology requirements, the case is assigned to the MATLOC Eligibility Specialist (MES) who covers the region where they live.
- MES contacts family within 24 business hours and arranges a time to conduct the initial assessment.
- Assessment to be conducted within 5 to 10 days of referral, if possible. Can be done as early as 14 days before hospital discharge.

TA Waiver

Referral Process

- New Referrals

- If child is found eligible, CRC processes the assessment done by MES and submits it to the KAMIS database. TA Waiver does not need Program Manager approval as assessment tool is the medical technology and acuity indicator and there is no wait list for the TA Waiver.
- CRC notifies the assigned MCO of TA eligibility through Notice of Action. Follows up on child's coding status to make sure the 3160 form is processed and required documentation is submitted by family.
- If child is not active in KanCare, coding status is followed up with DCF to make sure required documentation has been received and MCO notified once coding is complete.

TA Waiver

Required Eligibility Reassessments

● 6-mo Reassessments

- Eligibility reassessments are conducted on active TA Waiver children every 6-months.
- If a child is found to no longer be eligible, but still has qualifying technology, a period of 45 days is given before eligibility ends. MCO should assist with either transition to another waiver or locate community services.
- If a child loses eligible technology at any time, a period of 10 days is give before TA eligibility ends.

MATLOC Eligibility Assessment Tool

Medical Assistive Technology Level of Care

Section: I (Child's Demographics Information)

Last Name: _____		First Name: _____		Medicaid #: _____	
				DOB: _____	
Parent or Guardian: _____			Last KBH: _____	SS#: _____	
Address: _____		City: _____	State: KS	Zip: _____	County: _____
Home Phone: _____		Work Phone: _____		Cell Phone: _____	
Primary Insurance: _____		Group#: _____	Effective Date: _____		Decline Date: _____

Alternative Mailing Address

Foster Home Placement: N/A	Address: _____	City: _____	State: KS	Zip: _____
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Personal Information

Gender: Unknown		Primary Language: Unknown		Specify Other: _____	
Referral Agency: N/A		Date: _____	Hometown: N/A	Attends School? N/A	Ethnicity: Other

Assessment Completion

Type of Assessment	<input type="checkbox"/> New (initial LOC assessment)	<input type="checkbox"/> Modified	<input type="checkbox"/> Reassessment (every 6 mos. or as needed)
Date of Assessment	_____	_____	_____

Diagnosis

Primary Diagnosis	Diagnosis Code	Secondary Diagnosis	Diagnosis Code
_____	_____	_____	_____
_____	_____	_____	_____

(Level of Care Eligibility Assessment)

CURRENT MEDICAL TECHNOLOGY	POINT VALUE	REFERRAL FOR WAIVER SERVICE (MATLOC ELIGIBILITY SPECIALIST SECTION)
Ventilator: Intermittent <input type="checkbox"/>	<input type="checkbox"/> 40	KanCare Health Plan of Choice: _____ Level of Care Requested <input type="checkbox"/> LPN <input type="checkbox"/> RN <input type="checkbox"/> Personal Service Attendant <input type="checkbox"/> Medical Service Technician
Ventilator: Total <input type="checkbox"/>	<input type="checkbox"/> 50	
Tracheostomy <input type="checkbox"/> (do not check if total vent is selected)	<input type="checkbox"/> 40	
C-Pap <input type="checkbox"/> Bi-Pap <input type="checkbox"/>	<input type="checkbox"/> 25	
O2(cont. over 8hrs.): _____ (required for apnea monitor and/or oximetry points)	<input type="checkbox"/> 20	
Oximetry(cont over 8hrs.) <input type="checkbox"/> Apnea Monitor(cont over 8hrs.) <input type="checkbox"/>	<input type="checkbox"/> 10	
Gastro-tube cont. <input type="checkbox"/> bolus <input type="checkbox"/>	<input type="checkbox"/> 35	
(TPN) or (IV) Therapy (cont. over 6 hrs.) <input type="checkbox"/>	<input type="checkbox"/> 40	
Home Dialysis* (see qualifier)	<input type="checkbox"/> 40	
*** Special Treatments (provided at min. 4x daily) <input type="checkbox"/> Specify: _____	<input type="checkbox"/> 10	
Level of Care assessment indicates the individual is determined functionally: <input type="checkbox"/> eligible <input type="checkbox"/> not eligible		Nursing acuity points: _____ Technology points: _____ Total eligible support hrs: _____ per week

*Special Treatments: (i.e. but not limited to; nebulizer tx, suction, sterile dressing)

*Level of Care assessment: Demonstrates an individual's level of care based on the combined medical technology and nursing acuity.

*Nursing Acuity points: Represents the amount of time for each care element per week.

* Number of eligible formal support: Calculation (total nursing acuity points/7x31= eligible formal support per month).

MATLOC Eligibility Specialist's Information

Name	Title	Agency	Provider Number	Phone
_____	_____	_____	_____	_____
Date of application submission: _____		DCF Worker: _____		

Section: II (Nursing Acuity Scale I)

Last Name: <input style="width: 90%;" type="text"/>	First Name: <input style="width: 90%;" type="text"/>	DOB: <input style="width: 90%;" type="text"/>	Medicaid#: <input style="width: 90%;" type="text"/>
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Point	Care Element	Point	Care Element	Point	Care Element
	Weight .5 <input type="checkbox"/> < 65lbs. no or partial lift 1 <input type="checkbox"/> > 65lbs. no or partial lift 1 <input type="checkbox"/> < 55lbs. total lift 2 <input type="checkbox"/> > 55lbs. total lift 2.5 <input type="checkbox"/> > 125lbs. partial or total lift		Mobility 1 <input type="checkbox"/> Back brace 1.5 <input type="checkbox"/> Fracture or cast- UE 2 <input type="checkbox"/> Fracture or cast- LE 2 <input type="checkbox"/> Body cast 1.5 <input type="checkbox"/> Missing limb 1.5 <input type="checkbox"/> Short/dysfunctional limb .5 <input type="checkbox"/> AFOs/ splints/ orthotics 1 <input type="checkbox"/> OT/PT daily regimen 2 <input type="checkbox"/> Walker/WC/Crutch dep. 1 <input type="checkbox"/> ROM 1.5 <input type="checkbox"/> Turn q 2h 1 <input type="checkbox"/> Lift device .5 <input type="checkbox"/> Special positioning		Elimination .5 <input type="checkbox"/> Incont. stool occasionally 1.5 <input type="checkbox"/> Incont. stool daily .5 <input type="checkbox"/> Incont. urine occasionally .5 <input type="checkbox"/> Incont. urine daily 1 <input type="checkbox"/> Trip training bowel/bladder 2 <input type="checkbox"/> Total assist perineal care 1 <input type="checkbox"/> Urinary catheter indwelling 1 <input type="checkbox"/> Ileostomy/Colostomy 1.5 <input type="checkbox"/> Straight catheter 10 <input type="checkbox"/> Home Dialysis*
	Nutrition 1 <input type="checkbox"/> Special diet or prolonged oral feeding 1.5 <input type="checkbox"/> Reflux/ dysphagia 1.5 <input type="checkbox"/> NG-tube 1 <input type="checkbox"/> G-tube 1 <input type="checkbox"/> Enteral pump .5 <input type="checkbox"/> Gravity		Neurologic (seizures) 1 <input type="checkbox"/> Mild, min. management 1.5 <input type="checkbox"/> Mod., medication admin 1 <input type="checkbox"/> Intervene > 3x/wk 1.5 <input type="checkbox"/> Intervene daily 2 <input type="checkbox"/> Severe, meds/airway/injury 1 <input type="checkbox"/> VNS > 3x/wk		Sleep .5 <input type="checkbox"/> Sleep < 8hrs/noc 1 <input type="checkbox"/> Sleep < 6hrs/noc 1.5 <input type="checkbox"/> Sleep < 4hrs/noc 2 <input type="checkbox"/> Sleep < 2hrs/noc
	Integumentary 1 <input type="checkbox"/> Stoma/ ostomy care 1.5 <input type="checkbox"/> Wound care general 2 <input type="checkbox"/> Decubitus care 2 <input type="checkbox"/> Burn care 2 <input type="checkbox"/> Complex dressing 1 <input type="checkbox"/> Skin treatment > q4h		MES Comments: <input style="width: 100%;" type="text"/>		
	Communication (see last page for more) 1.5 <input type="checkbox"/> Communication limited (difficulty communicating needs), is expressive/receptive/ augmented 2 <input type="checkbox"/> Non-verbal (unable to communicate)				
Total points : <input style="width: 100%;" type="text"/>					

Click on the boxes in front of the applicable care element, tabulate and assign points.

Section II: (Nursing Acuity Scale II)

Last Name: _____ First Name: _____ DOB: _____ Medicaid#: _____

Point	Care Element	Point	Care Element	Point	Care Element
	<p>Hydration/ Specialty Care</p> <p>2 <input type="checkbox"/> IV therapy<q4h 1.5 <input type="checkbox"/> IV therapy>q4h 2 <input type="checkbox"/> IV therapy cont> 6 hrs 1.5 <input type="checkbox"/> IV therapy intermittent 2.5 <input type="checkbox"/> TPN central line 2 <input type="checkbox"/> Central line care 1 <input type="checkbox"/> Blood product admin q month 2 <input type="checkbox"/> IV pain control 1 <input type="checkbox"/> Lab draw each peripheral 1.5 <input type="checkbox"/> Lab draw each central 2 <input type="checkbox"/> Chemotherapy IV or injection .5 <input type="checkbox"/> Maintain infusion port .5 <input type="checkbox"/> Finger sticks</p>		<p>Airway Management</p> <p>1 <input type="checkbox"/> Tracheostomy 1 <input type="checkbox"/> Oxygen, continuous .5 <input type="checkbox"/> Oxygen, intermittent .5 <input type="checkbox"/> Oxygen prn .5 <input type="checkbox"/> Humidification .5 <input type="checkbox"/> Intermit. oronasal suctioning 1 <input type="checkbox"/> Occasional tracheal suctioning 1.5 <input type="checkbox"/> Tracheal suctioning >q3hrs. 2 <input type="checkbox"/> Bi-Pap or C-pap 3.5 <input type="checkbox"/> Ventilator 10 <input type="checkbox"/> Respiratory effort absent 2 <input type="checkbox"/> SIMV<10hrs/day 3 <input type="checkbox"/> SIMV>10hrs/day 1 <input type="checkbox"/> Vent on standby 2 <input type="checkbox"/> Respiratory assist mode 1 <input type="checkbox"/> Aspiration precaution 1.5 <input type="checkbox"/> Apnea 1 <input type="checkbox"/> Cont. apnea/oximetry monitor 1 <input type="checkbox"/> Cough assist/percussion daily .5 <input type="checkbox"/> Nebulizer>q4h</p>		<p>Orientation/Behaviors/ Cognition</p> <p>.5 <input type="checkbox"/> Oriented<X3 1 <input type="checkbox"/> Confused 2 <input type="checkbox"/> Cognitive impaired-dependent/ Uncooperative 1.5 <input type="checkbox"/> Cognitive impaired-ADL interference 1.5 <input type="checkbox"/> Combative .5 <input type="checkbox"/> Requires occasional redirection 1 <input type="checkbox"/> Requires frequent redirection 1 <input type="checkbox"/> Self-abusive behavior, mild-no injury. 1.5 <input type="checkbox"/> Self-abusive behavior, moderate injury 2 <input type="checkbox"/> Self-abusive behavior, Severe</p>
	<p>Assessments</p> <p>1 <input type="checkbox"/> General assessment q shift 1.5 <input type="checkbox"/> Intermittent assess (mod) 2 <input type="checkbox"/> Continual assess. Line of sight 1 <input type="checkbox"/> Min. 3hrs/wk RN manager intervention (Lab, MD contact, care planning) 2 <input type="checkbox"/> >3hr/wk RN manager intervention .5 <input type="checkbox"/> Assess VS/neuro/resp/GI q8h 1 <input type="checkbox"/> Assess VS/neuro/resp/GI q4h 1.5 <input type="checkbox"/> Assess VS/neuro/resp/GI q2h or less</p>		<p>Sensory Deficits</p> <p>.5 <input type="checkbox"/> Visual .5 <input type="checkbox"/> Auditory .5 <input type="checkbox"/> Tactile</p>		<p>Medication Administration</p> <p>1 <input type="checkbox"/> Injectable med<1x wk 1.5 <input type="checkbox"/> Injectable med>1xwk 1.5 <input type="checkbox"/> Complex med admin, and/or RX>q2hr intervals 1 <input type="checkbox"/> Routine Medication Admin.</p>
	<p>Development</p> <p>.5 <input type="checkbox"/> Development delay<5yrs. 1 <input type="checkbox"/> Developmental disability 5+ years old(biological age)</p>				
	<p>Acute Care Episodes (select one only)</p> <p>1.5 <input type="checkbox"/> Acute hospitalization> 7 days 2.5 <input type="checkbox"/> New trach within 30 days 1.5 <input type="checkbox"/> Abdominal surgery within 45 days 1.5 <input type="checkbox"/> Bone surgery within 45days 2.5 <input type="checkbox"/> Ventricular shunt new or revised within 30 days.</p>		<p>MES Comments: _____</p>		
<p>Total points (add rows): _____</p>					

Section II: (Nursing Acuity Scale III)

Last Name: []	First Name: []	DOB: []	Medicaid#: []
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<p>Communication Level (If eligible, 2 points total awarded)</p> <p>Hearing</p> <p><input type="checkbox"/> 0- Hears adequately <input type="checkbox"/> 1- Minimal difficulty <input type="checkbox"/> 2- Hears in special situation only <input type="checkbox"/> 3- Highly impaired/absence of useful hearing</p> <p>Making Self Understood</p> <p><input type="checkbox"/> 0- Understand <input type="checkbox"/> 1- Usually understood- difficulty finding words or finishing thoughts <input type="checkbox"/> 2- Sometimes understood- ability is limited to making concrete requests <input type="checkbox"/> 3- Rarely/never understood</p> <p>Speech Clarity</p> <p><input type="checkbox"/> 0- Clear speech <input type="checkbox"/> 1- Unclear speech-slurred mumbled words <input type="checkbox"/> 2- No speech- absence of spoken words <input type="checkbox"/> 3- Unable to make needs know by any means</p> <p>Ability to Understand</p> <p><input type="checkbox"/> 0- Understands <input type="checkbox"/> 1- Usually understands-may miss some part/intent of message <input type="checkbox"/> 2- Sometimes understands- responds adequately to simple, direct communication <input type="checkbox"/> 3- Rarely/ never understands</p> <p>Total additional points: []</p>	<p>Modes of Expression (Indicate which one)</p> <p><input type="checkbox"/> Speech <input type="checkbox"/> Signs/gesture/sounds <input type="checkbox"/> Writing <input type="checkbox"/> Communication board <input type="checkbox"/> American Sign Language or Braille <input type="checkbox"/> Dynavox or other device</p> <p>Communication Devices/ Techniques</p> <p><input type="checkbox"/> Hearing aid <input type="checkbox"/> Other receptive techniques used(e.g. lip reading)</p> <p>Mood (indicate which one)</p> <p><input type="checkbox"/> Positive <input type="checkbox"/> Calm <input type="checkbox"/> Anxious <input type="checkbox"/> Tearful <input type="checkbox"/> Depressed <input type="checkbox"/> Suicidal</p> <p><i>*Click on the boxes in front of the applicable level of communication.</i></p> <p><i>* If rated 3 or more in any of the levels of communication category, add 2 points to the grand total</i></p>
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Total points Acuity Scale I	Total points Acuity Scale II	Total points Acuity Scale III	Total eligible service hours based on medical needs assessment
[] hours	[] hours	N/A hours	[] hours per month

***The total number of nursing acuity points assessed for each acuity scale section represents the number of eligible service hours for the care element selected in the corresponding category.*

My signature acknowledges and confirms the accuracy of the Medical Assistive Technology Level of Care assessment, including my choice of KanCare Health Plan as indicated on page 1 of this assessment. I agree the assessment is current and true as of date.

Child/Parent/Guardian Signature: [] Original on file Date: []

MATLOC Eligibility Specialist (MES) Signature/ Title: [] Original on file Date: []

My signature confirms the individual being assessed is under my care; and the medical technology needs and care elements identified in this assessment is accurate and true to the best of my knowledge.

Medical Provider Signature: [] Original on file Date: []
 (Attending Physician, PA, ARNP)

Kansas Department for Aging and Disability Services
Community Services and Programs
HCBS-Technology Assisted Waiver
Participant Service Plan of Care (PSPOC)



Name: <input type="text"/>	DOB: <input type="text"/>	Medicaid#: <input type="text"/>
Level of Care Assessment: <input type="checkbox"/> Initial <input type="checkbox"/> Modified <input type="checkbox"/> Reassessment	Date of assessment: <input type="text"/>	Assessment period: <input type="text"/> - <input type="text"/>
Type of Service Plan: <input type="checkbox"/> Expedited (check for initial LOC assessment only) <input type="checkbox"/> Estimated Service Plan (check for initial and LOC reassessment)		

In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act. All individual determined level of care eligible for the waiver may choose any or all services offered under the waiver. All service(s) requested will be considered based on individual and family medical needs, requested services requires prior authorization and are subject to approval by the participant's KanCare Health Plan of choice.

Section I: Service Delivery History

Current KanCare Health Plan Provider	What type of service does the participant currently receive? (check all that applies)	Consideration for additional support beyond assessed medical needs:
<input type="checkbox"/> Amerigroup <input type="checkbox"/> Sunflower State Health Plan <input type="checkbox"/> United Healthcare <input type="checkbox"/> New to KanCare	<input type="checkbox"/> Interm. Intensive Medical Care (IIMC) <input type="checkbox"/> Specialized Medical Care (SMC) <input type="checkbox"/> Agency (MST) <input type="checkbox"/> Self-directed (PSA) <input type="checkbox"/> Medical Respite (MR-SMC) <input type="checkbox"/> Health Maintenance Monitoring (HMM) <input type="checkbox"/> Home Modification Services (HMS)	<input type="text"/>

Section II: Risk Factors: *Calculation (risk factor total= x31 days= /mo.)

<input type="checkbox"/> 3 Single parent working outside home <input type="checkbox"/> 1 One parent work outside home <input type="checkbox"/> 2 Two parent work outside home <input type="checkbox"/> 3 Other special needs/TA child in home, how many? <input type="text"/> <input type="checkbox"/> 2 Current or recent problems within the last month of neglect, abuse, or exploitation experience <input type="checkbox"/> 2 Parent of 2 or more non-school age child(ren) <input type="checkbox"/> 1 Lives in rural demographic region <input type="checkbox"/> 1 Cultural/ language barriers	Total Eligible Support <hr/> A. Total eligible formal support hrs based on nursing acuity needs: <input type="text"/> /mo. <hr/> B. Total eligible risk factors hrs: <input type="text"/> /mo. <hr/> C. Expedited Care (six weeks)- do not complete section III (1-6) of this form <input type="checkbox"/> 24hr/day X 7 days (week 1) <input type="checkbox"/> 18 hr/day X 7 days (week 4) <input type="checkbox"/> 22hr/day X 7 days (week 2) <input type="checkbox"/> 16hr/day X 14 days (week 5&6) <input type="checkbox"/> 20hr/day X 14 days (week 3)
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Note** Section II-C (Expedited Care is available to post-hospital discharge at initial level of care assessment only)

Section III: Proposed Service Plan (Include formal and informal support)

1) Type of service	2) Total formal support	3) Time of day	4) Total hours per day of informal and formal supports						
Level of care needs/ Current provider or agency of choice	Hrs/mo	Start-End Time	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
N/A- <input type="text"/>	/mo <input type="text"/>	-							
N/A- <input type="text"/>	/mo <input type="text"/>	-							
N/A- <input type="text"/>	/mo <input type="text"/>	-							
N/A- <input type="text"/>	/mo <input type="text"/>	-							
5) Total formal support hours requested: <input type="text"/> /mo		* Support hours calculation= # eligible hours/31 days= daily averages. *Do not include respite							
6) Total formal support units requested: <input type="text"/> /mo									

1) Indicate type of support /Name of provider or Agency of choice(s). 2) Indicate total eligible formal support requested for each waiver service per month. 3) Indicate when formal/informal support will be delivered. 4) Total formal/informal support hours per day. 5) Total eligible formal hours of service requested per month. 6) Total eligible formal units requested per month.

I, on behalf of have chosen to participate in Home and Community Based- TA Waiver Program as an alternative to hospitalization. I participated in the development of this service plan and I understand my KanCare Health Plan will assist me with access to needed waiver service(s) and service provider(s). My signature acknowledges my authorization and agreement with the information provided and submitted on this service plan.

Participant/Parent/Legal Representative Signature: , Date: Original on file

MATLOC Eligibility Specialist Signature/Title: , Date: Original on file

TA Waiver Population

- As of 12/31/14, there were 427 children actively receiving TA Waiver services.
- The TA Waiver averages over 15 new referrals every month with 170 new children added in 2014.
- Adding in new referrals and children found ineligible for services, or who expired, approximately 620 children were evaluated and/or received services in 2014.
- Total assessments (initial and 6-mo) conducted in 2014 were 1016.

TA Waiver

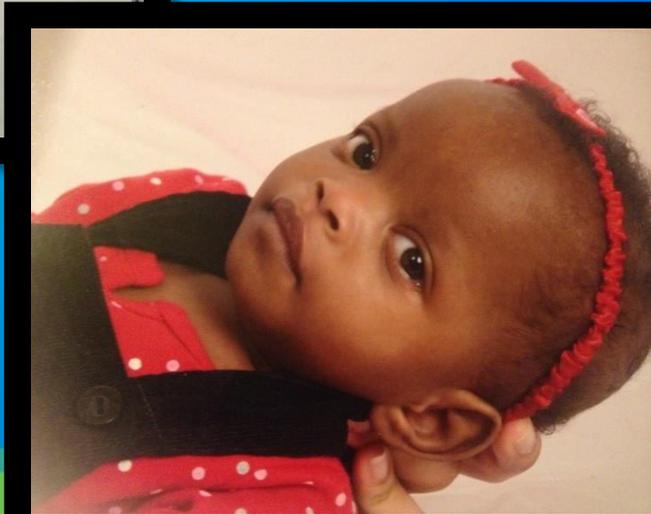
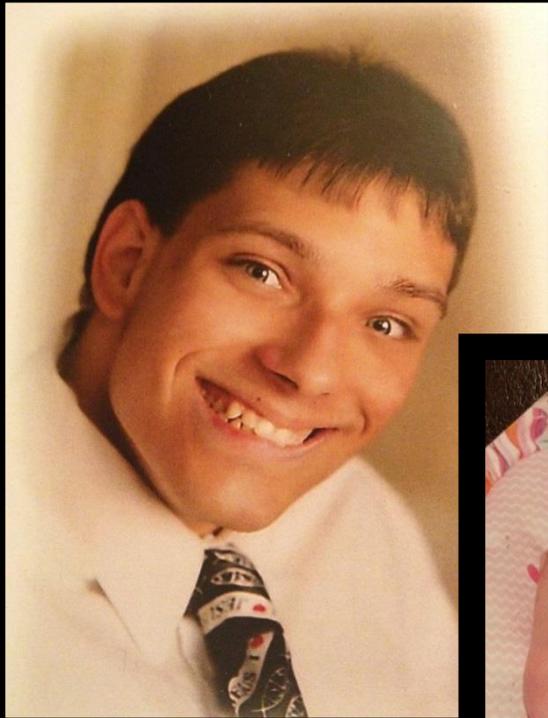
- CRC and the MES are committed to ensuring that children meet the eligibility requirements set out by the State of Kansas before being placed on or remaining on the TA Waiver and receive in-home nursing and/or attendant care.
- A success story for a child on the TA Waiver is to be able to transition off services (either to another waiver or community services) because as a result of having in-home nursing care, and the parental education and training of care, their medical status has improved to where there are no longer considered to be medically fragile and have declined in their medical acuity needs, or are no longer dependent on technology.

TA Waiver

- CRC and the eligibility assessors have no connection to any MCO or service provider, thus providing a conflict-free environment when completing eligibility assessments.
- It is advantageous to the integrity of the TA Waiver, being a medical waiver, that all assessments are conducted by a RN or APRN who is knowledgeable about medical equipment, needs, medications, conditions, etc., so that appropriate medical evaluations of needs are accomplished.

KDADS Home and
Community Based Services

*Technology
Assisted Waiver*



TA Waiver
Kids

Technology Assisted (TA) Resource Guide

Link to Technology Assisted "Full TA Resource Guide:
<http://childrensresourceconnection.com/index.html>