

**WEST VIRGINIA CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE (CSED) WAIVER  
REQUEST FOR SPECIALIZED THERAPY AND/OR ADAPTIVE EQUIPMENT  
(To be completed by the Case Manager)**

<b>Name of Person Who Receives Services</b>		<b>Date</b>	
<b>Medicaid Number</b>		<b>Type of Residence (✓)</b>	<input type="checkbox"/> Natural Family
<b>CM Agency</b>			<input type="checkbox"/> Foster Care Family
<b>CM Name</b>			<b>CM Signature</b>
<b>CM Phone #</b>			

**Specialized Therapy/Adaptive Equipment Requested for (✓):**

Specialized Therapy (Must be prior authorized by MCO)

Type of Therapy Requested: \_\_\_\_\_

Adaptive Equipment (Must be prior authorized by MCO)

Type of Equipment or Service Requested:

\_\_\_\_\_

Did the CM ensure request meets service description in the Policy Manual? *(Check credentials of the Specialized Therapist according to the policy manual. Is the Adaptive Equipment requested listed in the policy manual as acceptable)?*

Yes  No

**Brief description of Specialized Therapy/ Adaptive Equipment requested (Invoice including itemization of materials and services on contractor letterhead must be attached):**

**Total Amount Requested Specialized Therapy/Adaptive Equipment combined cannot exceed \$500.00 per service year** \$

**Vendor Information**

Vendor Name:	
Vendor Address:	
Vendor Phone #:	
Vendor Qualifications:	

**A copy of the following documentation must be sent to the MCO for processing and determination:**

- PCSP recommendations detailing need for the ST and/or AE
- The invoice detailing costs and description of the ST and/or AE
- If approved, receipts for the ST and/or AE must accompany this form and be sent to the MCO.

<b>Signature/Name of Person Who Receives Services</b>		<b>Date</b>	
<b>Representative Signature</b>		<b>Date</b>	
<b>Case Manager Signature</b>		<b>Date</b>	