Name/Record ID# of Person Who Receives Services:		Service Date:		
Travel to Start Time:	Travel to End Time:	Service Code: T1016HA		
Service Start Time:	Service Stop Time:	Service Time Duration:		
Travel from Start Time:	Travel from End Time:			
Location Visited (√): *HV every month	Home: NF Foster Home	Total Travel Time Duration: Total Time (including		
The every month	Out of home: Telehealth Telephone	travel time):		
Medicaid Card Verification*: YES NO *CM must verify by calling 888-483-0793. Eligibility must be verified monthly.				
Has the individual received Direct Care Services during the month? YES NO*  *If no, the CM should complete and submit a WV-BMS-CSED-12 to request an eligibility extension/hold.				
	CM OBSERVATION			
home (e.g., safe, is there food, do they have access to water). Look for presence of dangerous items, including unsecured medications. ENSURE SAFETY CHECK for FOSTER Homes. Is the individual's privacy maintained (locks on the inside of bath and bedrooms)? Were any needs observed? Locks on outside of bedroom doors should be questioned. Case Manager should observe sleeping arrangement, number of individuals residing in the home, signs/symptoms of abuse, if anything is questionable please talk to the child alone. Look to see if the service location is integrated and not isolated.				

	IN	TERVIEW			
Include questions, comments, concerns, and activities for the past month. Were there any health/safety issues, recent medical appointment outcomes? Are there any upcoming appointments? Are there any sleeping or appetite issues? Any incidents to communicate to the therapist? Are there any environmental or equipment needs? Are there any problems or issues with support staff? Has mobile response been utilized since previous the home visit? Has there been involvement with CPS, Department of Justice, or local law enforcement? (Truancy, elopement, etc.) Do you have access to your Member Handbook (online or hardcopy)? Are you aware of how to report incidents that occur and if not, do you know where to find that process? Discuss school					
progression/regression, IEP, 504, and conduct. Have there been any community activities such as school clubs, church, boy & girls club, sports, 4-H or hobbies engaged in within the last month? Any maladaptive behavior concerns? Do you feel safe?					
NOTE: Medication changes					
MEDICATION NAME	DOSE/METHOD	FREQUENCY	PRESCRIBING PHYSICIAN		

	THE	PADV/GOALS		
Therapy habilitation and/or support activity progression/regression noted/reported. Are any changes to transition and/or discharge plans needed? Goals and objectives in PCSP being met (progress/regression)? Items to communicate to the therapist (e.g., program change ideas/problems). Is there need for adaptive equipment/specialized therapy, or peer parent support?				
INCIDENTS				
Have there been any incidents during the past month? If yes, describe the incidents and necessary follow-up  YES NO				
	CM FOLL	OW UP/ACTION		
Status of previous requests, new req	uest, unmet nee	ds:		
	<u> </u>			
(CM initial) I certify that I have	e nhysically seen	the nerson who receives s	envices on this date	
(CM initial) I certify that I have physically seen the person who receives services on this date(CM initial) I certify that this visit took place in the residence of the person who receives services				
CM Signature/Credentials:	risit took place	Title residence of the parts	Date:	
5.5. a.a.a. 5, 5. c.a.a			2010.	
Signature of Person Who Receives S	Sarvicas		Date:	
Signature of Ferson with Neccives	sei vices.		Date.	

Parent/Legal Rep./Title:	Date: