

**WEST VIRGINIA CHILDREN WITH SERIOUS EMOTIONAL DISORDER (CSED) WAIVER
CASE MANAGEMENT HOME VISIT FORM**

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:	
		Total Travel Time Duration:
Location Visited (✓): Home: <input type="checkbox"/> NF <input type="checkbox"/> Foster Home *HV every month Out of home: <input type="checkbox"/> Telehealth <input type="checkbox"/> Telephone		Total Time (including 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

Describe the appearance of the person who receives services (e.g., safe, neat, clean) and the condition of the 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.

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THERAPY/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 FOLLOW UP/ACTION

Status of previous requests, new request, unmet needs:

_____(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:

Date:

Signature of Person Who Receives Services:

Date:

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Parent/Legal Rep./Title:

Date: