WEST VIRGINIA I/DD WAIVER
SERVICE COORDINATION HOME/DAY VISIT

Name/Record ID# of Person Who Receives Services:		**Service Date:** _____
Travel To Start Time:	**Travel To End Time:**	**Service Code: T1016HI** _____
Service Start Time:	**Service Stop Time:**	**Service Time Duration:** _____
Travel From Start Time:	**Travel From End Time:**	**Total Travel Time Duration:** _____

Location Visited (✓):
*HV every month
*DV/PV every other month
*SE *only* when clinically warranted

Home: ☐ **NF** ☐ **SFCH** ☐ **Waiver Group Home** ☐ **Unlicensed Res.**

Day: ☐ **DH Facility** ☐ **Pre-Vocational** ☐ **SE**

Total Time (including travel time): _____

Medicaid Card Verification* : ☐ **YES** ☐ **NO** ☐ **N/A (for Day Visit)**
*SC 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 SC should complete and submit a DD-12 to request an eligibility extension/hold.

SC OBSERVATION

Describe the appearance of the person who receives services (e.g., safe, neat, clean) and the condition of the home or facility (e.g., safe and clean). Were any needs observed?

INTERVIEW

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 medication changes, sleeping or appetite issues, or items to communicate to the RN or BSP? Are there any environmental or equipment needs? Are there any problems or issues with staffing or staff attendance?

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HABILITATION
Training documentation up to date, habilitation and/or support activity progression/regression noted/reported, staff issues, items to communicate to the BSP (e.g., program change ideas/problems):

SC FOLLOW UP/ACTION
Status of previous requests, new request, unmet needs:

ELECTRONIC MONITORING ☐ **N/A** (if service is not utilized or if conducting a Day Visit)
Have there been any problems or incidents during the past month while the person was receiving assistance through the Electronic Monitoring service? ☐ *Yes* ☐ *No*
If Yes, describe the problems or incidents and necessary follow-up.
Is all the equipment related to the Electronic Monitoring service in good working order? ☐ *Yes* ☐ *No*
If No, describe any equipment problems and required follow-up.

_____(SC initial) I certify that I have physically seen the person who receives services on this date.
_____(SC initial) I certify that this visit took place in the residence of the person who receives services (only applicable for HV).

SC Signature/Credentials: **Date:**

Signature of Person Who Receives Services: **Date:**

Direct Care Provider/Legal Rep./Title: **Date:**