WEST VIRGINIA CHILDREN WITH SERIOUS EMOTIONAL DISORDER (CSED) WAIVER
INITIAL PLAN OF CARE
(Must be completed within seven days of intake)

WEST VIRGINIA CHILDREN WITH SERIOUS EMOTIONAL DISORDER (CSED) WAIVER PLAN OF CARE		
PLAN OF CARE SERVICE YEAR: *mm/dd/yr – mm/dd/yr*	**DATE OF MEETING:** Click here to enter a date.	**DATE OF MASTER PLAN OF CARE DEVELOPMENT:** Click here to enter a date.
DEMOGRAPHICS		
Member Name: **Address:** **Phone Number:** **Date of Birth:**		**Additional Insurance (if applicable):** **Date of Financial Eligibility:** **Date of Medical Eligibility:** **Anchor Date:**
Legal Representative: Yes ☐ No ☐ If "Yes" Full ☐ Limited ☐ Name: Address: Phone:		**Medical Power of Attorney:** Yes ☐ No ☐ Name: Address: Phone:
Wraparound Facilitation: WF Name: WF Provider Agency: WF Telephone #, ext.: WF e-mail:		**Non-CSED Waiver State Plan (Medicaid) Services:** (Describe all services the member is receiving not covered under the waiver)

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Upon eligibility determination (medical, financial and slot allocation) the following will be implemented in order to initiate CSED Waiver Services (use additional pages as necessary):

Service Code: T1016HA
Service Description: Wraparound Facilitation
Provider:
Accessible/Available: Yes or No
Duration:
Amount/Frequency:
Plan of Action/Scope of Work: My Wraparound Facilitator (WF) will provide linkage/referral to facilitate access to CSED Waiver Services. My WF will help me establish life-long, goal-oriented processes for coordinating my natural and paid supports, range of services, and instruction and assistance that is specific to my needs, wishes, desires and goals. My WF will provide service planning, advocacy, etc. as outlined in the CSED Waiver Manual.

Service Code:
Service Description:
Provider:
Accessible/Available: Yes or No
Duration:
Amount/Frequency:
Plan of Action/Scope of Work:

Service Code:
Service Description:
Provider:
Accessible/Available: Yes or No
Duration:
Amount/Frequency:
Plan of Action/Scope of Work:

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MEETING MINUTES	
Who attended this meeting? Did any team members attend by phone, and why?	
Summary of what was discussed during this meeting *(describe specific details including, but not limited to, person-centered items, current events, concerns, anticipated/upcoming changes, unmet needs, current placement concerns, current maladaptive behaviors, date to complete CANS, etc.)*	
Meeting Minutes Completed By	

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Initial Plan of Care – Child and Family Team Signature Sheet					
Participant Name:		**Date of Meeting:** Click here to enter a date.		**DATE UPLOADED TO MCO:** Click here to enter a date.	
Relationship	**Signature and Credentials**	**Time Spent in Meeting** **(start/stop times)*	**Agree**	***Disagree**	**Date this Plan of Care was sent out**
Waiver Participant					
Parent/Legal Representative					
Wraparound Facilitator					
Other Relationship:					
Other Relationship:					
Other Relationship:					