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

Name of Person Who Receives Services		**Date**	
Medicaid Number		**Type of Residence (✓)**	☐ Natural Family
WF Agency			☐ Foster Care Family
WF Name			**WF Signature**
WF Phone #			

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 WF 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:

☐ Plan of Care 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.

Signature/Name of Person Who Receives Services		**Date**	
Representative Signature		**Date**	
Wraparound Facilitator Signature		**Date**	