

**WEST VIRGINIA I/DD WAIVER
CASE MANAGEMENT HOME/DAY VISIT**

Name/Record ID# of Person Who Receives Services:	Date:
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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? Have there been any critical and/or A/N/E incidents during the past month? If so, what is the status of those, including entry and follow up in IMS?

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):

CM FOLLOW UP/ACTION

Status of previous requests, new request, unmet needs:

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HCBS MONTHLY RESIDENTIAL OBSERVATIONS

Answer the following questions as observed each month. "Setting" refers to the home where the member lives. Note that answers of "no" should be addressed by the IDT.

1. The individual is not isolated from individuals not receiving Medicaid HCBS in the broader community. Yes No
2. The individual does not live and receive services in a different area of the setting separate from individuals not receiving HCBS. Yes No
3. The setting is in the community among other private residences and retail businesses. Yes No
4. Bus and other public transportation schedules and telephone numbers are posted in a convenient location. (n/a in Natural Family settings) Yes No N/A
5. The individual has access to materials to become aware of activities occurring outside the setting. Yes No
6. The setting affords the individual with the opportunity to participate in meaningful non-work activities in integrated community settings in a manner consistent with the individual's needs and preferences. Yes No
7. The setting is an environment that supports individual comfort, independence, and preferences. Yes No
8. The individual has full access to facilities in the home such as a kitchen with cooking facilities, dining area, laundry, and comfortable seating in shared areas. Yes No
9. Assistance is provided in private, as appropriate, when needed. Yes No
10. The individual has unrestricted access in the setting. Yes No
11. The physical environment meets the needs of the individual, such as grab bars, seats in the bathroom, ramps for wheelchairs, accessible appliances. Yes No N/A
12. The individual has access to public transportation. (n/a in Natural Family settings) Yes No N/A
13. An accessible van is available to transport the individual to appointments, shopping, etc. (n/a in Natural Family settings) Yes No N/A
14. The individual has access to make private telephone calls/text/email at the individual's preference and convenience. Yes No
15. The individual is free from coercion. Yes No
16. The individuals in the setting have different haircut/hairstyle, and hair color. (n/a in Natural Family settings) Yes No N/A
17. The individual's right to dignity and privacy is respected. Schedules of PT, OT, medications, restricted diet, etc. are not posted in general open areas for all to view. (n/a for Natural Family) Yes No N/A
18. Staff communicates with the individual in a dignified manner. Yes No
19. The individual has privacy in their sleeping space and toileting facility. Yes No N/A
20. The individual can close and lock his/her bedroom door. The individual can close and lock the bathroom door. Yes No
21. The individual has privacy in his/her living space. Yes No
22. The individual has a comfortable place for private visits with family and friends (n/a in Natural Family settings) Yes No N/A
23. The individual is not required to adhere to a set schedule for waking, bathing, eating, and exercising activities. Yes No
24. Requests for services and supports are accommodated as opposed to ignored or denied. Yes No

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ELECTRONIC MONITORING <input type="checkbox"/> N/A (if service is not utilized or if conducting a Day Visit)
<i>Have there been any problems or incidents during the past month while the person was receiving assistance through the Electronic Monitoring service?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If Yes, describe the problems or incidents and necessary follow-up.</i>
<i>Is all the equipment related to the Electronic Monitoring service in good working order?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If No, describe any equipment problems and required follow-up.</i>
Complete only if contact was made by phone or other non-face-to-face means, due to COVID-19 precautions: ____ (CM initial) I certify that I have made contact with the person who receives services and/or their Direct Care Provider/Legal Representative on this date. ____ (CM initial) I certify that this contact occurred by phone, or by other non-face-to-face means, due to COVID-19 precautions.
Complete only if contact was made through face-to-face contact: ____ (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 (only applies to HV). ____ (CM initial) I certify that this visit took place in the community or day facility of the person who receives service (only applies to DHV).
CM Signature/Credentials: Date:
Signature of Person Who Receives Services: Date:
Direct Care Provider/Legal Rep./Title: Date: