



**West Virginia (WV) Children with Serious Emotional Disorders (CSED) Waiver  
Request Form for Specialized Therapy and/or Adaptive Equipment**

*To be completed by the Wraparound Facilitator (WF)*

**Member Information**

First Name, MI, Last Name			
Medicaid Number			
WF First Name, Last Name			
WF Agency			
WF Phone Number		Date of Form Completion	

**Member Residence**

Natural Family	Foster Care Family	Other
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**Specialized Therapy/Adaptive Equipment Requested for:**

Type of Specialized Therapy or Adaptive Equipment Requested		
Were Community Resources Researched or Attempted?	Yes	No
If Yes, please list in detail the resources researched:		
Did the WF ensure the request meets the service description in the Policy Manual?	Yes	No

**Service or Equipment Information**

Please provide a brief description of the specialized therapy/adaptive equipment requested:



What **therapy goal** is linked with the service or equipment?

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Is this something the family can sustain/continue after services end?	Yes	No
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If yes, what resources were considered?	
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If no, what efforts will be taken to make the services sustainable?	
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**Please note: The invoice including itemization of materials and services on contractor letterhead must be attached.**

Cost of Service/Adaptive Equipment	\$
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**Vendor/Provider for Therapy or Equipment Information**

Vendor Name	
Vendor Address	
Vendor Phone Number	
Vendor Qualifications	

**A copy of the following documentation must be sent to the MCO for processing and determination**

	Plan of Care (POC) recommendations detailing the need for the specialized therapy and/or adaptive equipment.
	The invoice detailing costs and description of the specialized therapy and/or adaptive equipment.
	If approved, receipts for the specialized therapy and/or adaptive equipment must accompany this form and be sent to the MCO.



**Signatures**

Signature/Name of the Member		Date	
Legal Representative Signature		Date	
WF Signature		Date	

**Approval Status**

	Approved
	Denied
	More Information Needed

**MCO Certification**

	MCO has reviewed the request and the member's plan of care (POC).
	MCO has certified that the service or equipment was provided.
	MCO has certified that the invoice was received.