WEST VIRGINIA CHILDREN WITH SERIOUS EMOTIONAL DISORDER (CSED) WAIVER
WRAPAROUND FACILITATION HOME VISIT FORM

Name/Record ID# of Person Who Receives Services:		**Service Date:** _____
Travel to Start Time:	**Travel to End Time:**	**Service Code: T1016HA** _____
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	**Home:** ☐ **NF** ☐ **Foster Home**	**Total Time (including travel time):**
	Out of home: ☐ **Telehealth** ☐ **Telephone**	_____

Medicaid Card Verification*: ☐ **YES** ☐ **NO**
*WF 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 WF should complete and submit a WV-BMS-CSED-12 to request an eligibility extension/hold.

WF OBSERVATION

Describe the appearance of the person who receives services (e.g., safe, neat, clean) and the condition of the home (e.g., safe, is there food, do they have access to water). Look for presence of dangerous items, including unsecured medications. Ensure safety check for foster homes. Is the individual's privacy maintained (locks on the inside of bath and bedrooms)? Were any needs observed? Locks on outside of bedroom doors should be questioned. Wraparound Facilitator should observe sleeping arrangement, number of individuals residing in the home, signs/symptoms of abuse, if anything is questionable please talk to the child alone. Look to see if the service location is integrated and not isolated.

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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 sleeping or appetite issues? Any incidents to communicate to the therapist? Are there any environmental or equipment needs? Are there any problems or issues with support staff? Has mobile response been utilized since previous the home visit? Has there been involvement with CPS, Department of Justice, or local law enforcement? (Truancy, elopement, etc.) Do you have access to your Member Handbook (online or hardcopy)? Are you aware of how to report incidents that occur and if not, do you know where to find that process? Discuss school progression/regression, IEP, 504, and conduct. Have there been any community activities such as school clubs, church, boy & girls club, sports, 4-H or hobbies engaged in within the last month? Any maladaptive behavior concerns? Do you feel safe?

NOTE: Medication changes

MEDICATION NAME	DOSE/METHOD	FREQUENCY	PRESCRIBING PHYSICIAN

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THERAPY/GOALS
Therapy habilitation and/or support activity progression/regression noted/reported. Are any changes to transition and/or discharge plans needed? Goals and objectives in Plan of Care being met (progress/regression)? Items to communicate to the therapist (e.g., program change ideas/problems). Is there need for adaptive equipment/specialized therapy, or peer parent support?
INCIDENTS
Have there been any incidents during the past month? If yes, describe the incidents and necessary follow-up ☐ **YES** ☐ **NO**
WF FOLLOW UP/ACTION
Status of previous requests, new request, unmet needs:

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

WF Signature/Credentials: **Date:**

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

Parent/Legal Rep./Title: **Date:**