WEST VIRGINIA CHILDREN WITH SERIOUS EMOTIONAL DISORDER (CSED) WAIVER
WRAPAROUND FACILITATION SERVICE LOG

Name of Person Who Receives Services		**Wraparound Facilitator Name**	
Date of Service		**Provider Agency**	

Service Name	Service Code	Service Location	Total Time Per Service for This Page
WRAPAROUND FACILITATION	T1016-HA	01	
WRAPAROUND FACILITATION (TELEHEALTH)	T1016-HA	02	

Telehealth is available with 02 service location only when due to inclement weather and excluding the monthly face-to-face contact. Telehealth justification must be provided in the service note

Date	Service Location	Start Time am/pm	Stop Time am/pm	Total Time	Wraparound Facilitator Initials

Wraparound Facilitator Name	Wraparound Facilitator Signature	Date

WEST VIRGINIA CHILDREN WITH SERIOUS EMOTIONAL DISORDER (CSED) WAIVER
WRAPAROUND FACILITATION PROGRESS NOTE

Name of Person Who Receives Services		**Name of Wraparound Facilitator**	
Date of Service		**Provider Agency**	

Date		**Time**	**AM PM**	**Wraparound Facilitator Initials**	

Identify the coordination of supports, resources, and strategies for the members treatment including family input. Are other service providers ensuring services and clinical treatment modalities augment each other for optimal outcomes? Has a transition plan been developed? Have the persons strengths and needs been identified and integrated into treatment? Has there been any changes to medications or an increase in incidents that may require an adjustment of treatment? Is communication maintained among all team members including family members? Has discharge planning been discussed and documented? Has a transition plan been developed for individuals who are coming up on the waiver's maximum age limit?

Wraparound Facilitator Name	**Wraparound Facilitator Signature**	**Date**

WEST VIRGINIA CHILDREN WITH SERIOUS EMOTIONAL DISORDER (CSED) WAIVER
IN- HOME FAMILY THERAPY SERVICE LOG

Name of Person Who Receives Services		**Name of In-Home Family Therapist**	
Date of Service		**Provider Agency**	

Service Name	Service Code	Service Location	Total Time Per Service for This Page
IN-HOME FAMILY THERAPY	H0004-HO-HA	01	
IN-HOME FAMILY THERAPY (TELEHEALTH)	H0004-HO-HA	02	
SPECIALIZED THERAPY	G0176-HA	03	

Telehealth is available with 02 service location and telehealth justification must be provided within the service note

If training was provided, WV-BMS-CSED-6 must be completed

Date	**Service Location**	**Start Time** am/pm	**Stop Time** am/pm	**Total Time**	**Was training provided?** (Y/N)	**Therapist Initials**

Therapist Name	**Therapist Signature**	**Date**

WEST VIRGINIA CHILDREN WITH SERIOUS EMOTIONAL DISORDER (CSED) WAIVER
IN-HOME FAMILY THERAPY PROGRESS NOTE

Name of Person Who Receives Services		**Name of In-Home Family Therapist**	
Date of Service		**Provider Agency**	

Date		**Time**	**AM** **PM**	**Therapist Initials**	

Identify therapy techniques, goals and objectives discussed during session. Did the person require more support than usual? Have any incidents or trauma occurred since previous session? How did the person respond to support and services provided? Has crisis response been utilized? What is the plan, goals, and objectives for follow up session?

Therapist Name	**Therapist Signature**	**Date**

WEST VIRGINIA CHILDREN WITH SERIOUS EMOTIONAL DISORDER (CSED) WAIVER
IN-HOME FAMILY SUPPORT SERVICE LOG

Name of Person Who Receives Services		**Name of In-Home Family Support Worker**	
Date of Service		**Provider Agency**	

Service Name	Service Code	Service Location	Total Time Per Service for This Page
IN-HOME FAMILY SUPPORT	H0004-HA	01	
IN-HOME FAMILY SUPPORT (TELEHEALTH)	H0004-HA	02	

Telehealth is available with 02 service location and telehealth justification must be provided within the service note

If training was provided, WV-BMS-CSED-6 must be completed

Date	**Service Location**	**Start Time** am/pm	**Stop Time** am/pm	**Total Time**	**Was training provided?** (Y/N)	**In-Home Support Worker Initials**

Support Worker Name	**Support Worker Signature**	**Date**

WEST VIRGINIA CHILDREN WITH SERIOUS EMOTIONAL DISORDER (CSED) WAIVER
IN-HOME FAMILY SUPPORT PROGRESS NOTE

Name of Person Who Receives Services		**Name of In-Home Family Support Worker**	
Date of Service		**Provider Agency**	

Date		**Time**	**AM PM**	**In-Home Family Support Initials**	

Identify therapy techniques, goals and objectives discussed during session. Did the person require more support than usual? Have any incidents or trauma occurred since previous session? How did the person respond to support and services provided? Has crisis response been utilized? What is the plan, goals, and objectives for follow up session?

Support Worker Name	**Support Worker Signature**	**Date**

WEST VIRGINIA CHILDREN WITH SERIOUS EMOTIONAL DISORDER (CSED) WAIVER
MOBILE RESPONSE SERVICE LOG

Name of Person Who Receives Services		**Name of Mobile Response Worker**	
Date of Service		**Provider Agency**	

Service Name	Service Code	Service Location	Total Time Per Service for This Page
MOBILE RESPONSE	H2017-HA	01	
MOBILE RESPONSE (TELEHEALTH)	H2017-HA	02	

Telehealth is available with 02 service location, only when distance does not permit staff to reach the person receiving services within one hour. Telehealth justification must be provided within the service note

Date	Service Location	Start Time am/pm	Stop Time am/pm	Total Time	Mobile Response Worker Initials

Mobile Response Name	Mobile Response Signature	Date

WEST VIRGINIA CHILDREN WITH SERIOUS EMOTIONAL DISORDER (CSED) WAIVER
MOBILE RESPONSE PROGRESS NOTE

Name of Person Who Receives Services		**Name of Mobile Response Worker**	
Date of Service		**Provider Agency**	

Date		**Time**	**AM PM**	**Mobile Response Worker Initials**	

What was the presenting issue? What de-escalation techniques were used in this situation? What other issue resolution support was provided? What other services and resources will you link the person receiving services and their family with as a result of the issue? What will be communicated to the in-home family therapist and in-home family support worker about the events that transpired? Service must result in the development of a stabilization plan for any additional services that are needed to resolve the immediate situation and follow-up communication must occur with the in-home family therapist. Follow-up must also be made with the individual's Wraparound Facilitator to ensure consistency and treatment congruency among all services.

Mobile Response Name	**Mobile Response Signature**	**Date**

WEST VIRGINIA CHILDREN WITH SERIOUS EMOTIONAL DISORDER (CSED) WAIVER
PEER PARENT SUPPORT SERVICE LOG

Name of Person Who Receives Services		**Name of Peer Parent**	
Date of Service		**Provider Agency**	

Service Name	Service Code	Service Location	Total Time Per Service for This Page
PEER PARENT SUPPORT	H0038-HA	01	
PEER PARENT SUPPORT (TELEHEALTH)	HOO38-HA	02	

Telehealth is available with 02 service location and telehealth justification must be provided within the service note

Date	Service Location	Start Time am/pm	Stop Time am/pm	Total Time	Peer Parent Initials

Peer Parent Name	Peer Parent Signature	Date

WEST VIRGINIA CHILDREN WITH SERIOUS EMOTIONAL DISORDER (CSED) WAIVER
PEER PARENT SUPPORT PROGRESS NOTE

Name of Person Who Receives Services		**Name of Peer Parent**	
Date of Service		**Provider Agency**	

Date		**Time**	**AM PM**	**Peer Parent Initials**	

What was the presenting issue? What community services, programs and strategies have been discussed? What connections and relationships have been built to assist the parents/caretakers of the child? What are some successful strategies of treatment have worked? What strategies and treatments have not worked?

Peer Parent Name	**Peer Parent Signature**	**Date**

WEST VIRGINIA CHILDREN WITH SERIOUS EMOTIONAL DISORDER (CSED) WAIVER
DIRECT SUPPORT SERVICE LOG

Name of Person Who Receives Services		**Name of Direct Support Provider**	
Date of Service		**Provider Agency**	

Service Name	Service Code	Identifier (ID)	Total Time Per Service for This Page
INDEPENDENT LIVING/SKILLS BUILDING (DAY HABILITATION)	H2033-HA	01	
JOB DEVELOPMENT	T2021-HA	02	
SUPPORTED EMPLOYMENT, INDIVIDUAL	T2019-HA	03	
RESPITE, IN-HOME	T1005-HA	04	
RESPITE, OUT-OF-HOME	T1005-HA-HE	05	

If training was provided, WV-BMS-CSED-6 must be completed

Date	**ID**	**Start Time** am/pm	**Stop Time** am/pm	**Total Time**	**Was training provided?** (Y/N)	**Provider/Staff Initials**

Provider/Staff Name	**Provider/Staff Signature**	**Provider/Staff Name**	**Provider/Staff Signature**

WEST VIRGINIA CHILDREN WITH SERIOUS EMOTIONAL DISORDER (CSED) WAIVER
TRANSPORTATION LOG
Service Code: A0160-HA

Name of Person Who Receives Services		**Provider Agency**	
Month of Service		**Year of Service**	

Date	Travel From (starting address)	Travel To (end address)	Reason for Travel (must correspond to an objective on the Plan of Care)	Starting Odometer Reading	Ending Odometer Reading	Total Miles or Trips	Provider Initials
			Total Miles for This Page				

Provider/Staff Name	Provider/Staff Signature	Provider/Staff Name	Provider/Staff Signature