

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

<b>Name/Record ID# of Person Who Receives Services:</b>	<b>Date:</b>
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<b>Type of Contact:</b> <input type="checkbox"/> Face-to-Face <input type="checkbox"/> Remote		
<b>Travel To Start Time (or N/A):</b>	<b>Travel To End Time (or N/A):</b>	<b>Service Time Duration:</b>
<b>Service Start Time:</b>	<b>Service Stop Time:</b>	<b>Total Travel Time Duration (or N/A):</b>
<b>Travel From Start Time (or N/A):</b>	<b>Travel From End Time (or N/A):</b>	<b>Total Time (including travel time):</b>
<b>Service Code (✓):</b> <input type="checkbox"/> G9002 U3 <input type="checkbox"/> G9002 U4		
<b>Home Location (✓):</b> *NF/SFCH; one face-to-face and two phone contact HV's every month: <input type="checkbox"/> Natural Family <input type="checkbox"/> SFCH *GH/UR; Face-to-face HV's required every month: <input type="checkbox"/> Waiver Group Home <input type="checkbox"/> Unlicensed Residential		
<b>Day Location (✓):</b> *DV/PV every quarter: <input type="checkbox"/> FBDH <input type="checkbox"/> Pre-Vocational *SE only when clinically warranted: <input type="checkbox"/> Supported Employment		
<b>Medicaid Card Verification*:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A (for Day Visit) *CM must verify by calling 888-483-0793. Eligibility must be verified monthly.		
<b>Has the individual received Direct Care Services during the month?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO* *If no, the CM should complete and submit a DD-12 to request an eligibility extension/hold.		
<b>Has the CM discussed WV ABLE accounts with the member/representative this month?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		

CM ASSESSMENT OF NEEDS/OBSERVATION
<b><u>Topics for discussion as appropriate:</u></b> Are all the member's needs currently met? Does he/she have needed food, medication, and toiletries? Is the crisis plan up-to-date? How are member-specific needs such as behavior supports being addressed, if applicable? Describe the appearance of the person who receives services (e.g., safe, neat, clean) and the condition of the home or facility (e.g., safe and clean). Is the person's privacy maintained (locks on bath and bedrooms)? Were any needs observed? Is the service location integrated (not isolated)? <b>If SE is observed</b> , how many members were being served?

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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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<b>ELECTRONIC MONITORING</b> <input type="checkbox"/> <b>N/A</b> (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>

<b>Complete only if contact was made by phone or other non-face-to-face means:</b>	
____ (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.	
<b>Complete only if contact was made through face-to-face contact:</b>	
____ (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).	
<b>CM Signature/Credentials:</b> _____	<b>Date:</b> _____
<b>Signature of Person Who Receives Services:</b> _____	<b>Date:</b> _____
<b>Direct Care Provider/Legal Rep./Title:</b> _____	<b>Date:</b> _____