WEST VIRGINIA I/DD WAIVER
INTRODUCTORY INDIVIDUALIZED PROGRAM PLAN
(Must be completed within seven days of intake for NEW slots only)

Name of Person Who Receives Services: _____Date of I/DD Waiver Enrollment: _____
(date slot received)

Upon eligibility determination (medical, financial and slot allocation) the following will be implemented in order to initiate I/DD Waiver Services (use additional pages as necessary):

Service Code:
Service Description: Case Management: Traditional Option
Provider:
Accessible/Available: Yes or No
Duration:
Amount/Frequency:
Plan of Action/Scope of Work: My Case Manager (CM) will provide linkage/referral to facilitate access to I/DD Waiver Services. My CM will help me establish life-long, goal-oriented processes for coordinating my natural and paid supports, range of services, and instruction and assistance that is specific to my needs, wishes, desires and goals. My CM will provide service planning, advocacy, etc. as outlined in the I/DD Waiver Manual.

Service Code:
Service Description:
Provider:
Accessible/Available: Yes or No
Duration:
Amount/Frequency:
Plan of Action/Scope of Work:

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_____ _____
Signature of Person Who Receives Services/Date Legal Representative Signature/Date

_____ _____
Case Manager Signature/Date Other/Date