WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES

TRAUMATIC BRAIN INJURY WAIVER PROGRAM
INTERIM SERVICE PLAN

(Initial Service Plan **must** be completed in 21 calendar days from Program Enrollment)
Date of Program Enrollment __/__/____
Date Interim Service Plan was developed __/__/____

Last Name	First Name	Medicaid #
Case Manager Name: Case Management Provider:		Phone Number:
Personal Attendant Name: Personal Attendant Provider:		Phone Number:

I Prefer These Activities, on These Days, During These Times: (bathing, dressing, grooming, etc.)

Day	Activity	Strategies/Interventions needed during the activity	Time (in minutes)	Formal	Informal
MON					
TUES					
WED					
THUR					

Day	Activity	Strategies/Interventions needed during the activity	Time (in minutes)	Formal	Informal
FRI					
SAT					
SUN					

WHAT SERVICES AND RESOURCES DO I NEED?

Service Type or Resource	Provider	Amount/Frequency

Service Type or Resource	Provider	Amount/Frequency

Document any current identified risk to health and safety? _____

Personal Attendant Services will begin on __/__/____ (3 business days of plan development)

_____ _____ _____ _____

Participant/Legal Representative Signature Date Case Manager Signature Date

Start Time_____ Stop Time_____

Date copy of interim service plan send to Personal Attendant Services Agency ___/___/_____

Date copy of interim service plan send to Participant/Legal Representative ___/___/_____