TRAUMATIC BRAIN INJURY WAIVER
PERSON-CENTERED SERVICE PLAN ADDENDUM

Last Name:	**First Name:**	**Medicaid #:**
Case Management Agency:		**Dual Services: Yes ☐ No ☐**
CHANGE IN NEED ☐ **TRANSFER ☐**	**DATE:**	

Complete this section for change in the member's need and/or member transfer.	
Describe how the participant's needs have changed.	
Describe any changes in services.	
Responsibility Agreement in place	Include the signed Responsibility Agreement with the addendum
Other	

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

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Case Manager Signature	Date	Member/Legal Representative Signature	Date

04/2021
Revised V2 8/2023
Revised V3 3/2024

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