WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

West Virginia (WV) Children with Serious Emotional Disorders (CSED) Waiver Home Visit Form

If you are completing a home visit, please only complete this form and not a separate service note.

Member Information

First Name, MI, Last Name		Medicaid ID Number	
Medicaid Card Verification *WF must verify by calling 888-483-0793. Eligibility must be verified monthly*.		Yes ☐	No ☐
Has the individual received Direct Care Services during the month? *If no, the WF should complete and submit a WV-BMS-CSED-12 to request an eligibility extension/hold.*		Yes ☐	No ☐

Home Visit Information

Service Date		Travel to Start Time	
Service Code		Travel to End Time	
Service Start Time		Travel from Start Time	
Service End Time		Travel to End Time	
Total Service Time		Total Travel Time	

Location Visited

Natural Family ☐	Telehealth ☐	Foster Home ☐	Community ☐

WF Observation

Describe the appearance of the person and the condition of the home. Ensure safety and privacy in the home and/or presence of dangerous items. Observe sleeping arrangement, number of individuals residing in the home, and signs/symptoms of abuse. If anything is questionable, please talk to the child alone.
Interview: *Include qestions, comments, concerns, and activities for the past month. Were there any health/safety issues and/or recent medical appointment outcomes? Are there any upcoming appointments? Are there any sleeping or appetite issues? Are there any incidents to communicate to the therapist? Are there any environmental or equipment needs? Are there any problems or issues with support staff? Has there been involvement with CPS, Department of Justice, or local law enforcement? Does the member have access to the Member Handbook (online or hardcopy)? Is the member aware of how to report incidents that occur and if not, know where to find that process? Discuss school progression/regression, IEP, 504, and conduct. Have there been any community activities such as school clubs, church, boy & girls club, sports, 4-H, or hobbies engaged in within the last month? Are there any maladaptive behavior concerns? Does the child feel safe?*

NOTE: Medication Changes

Medication Name	Dose/Method	Frequency	Prescribing Physician

Therapy/Goals

Are there therapy habilitation and/or support activity progress/regression noted/reported? Are any changes to transition and/or discharge plans needed? Are goals and objectives in Plan of Care being met (progress/regression)? Are there items to communicate to the therapist (e.g., program change ideas/problems). Is there need for adaptive equipment/specialized therapy, or peer parent support?

Incidents

Have there been any incidents during the past month? If yes, describe the incidents and necessary follow-up.	**Yes**	☐	**No**	☐
Was it a critical incident?	**Yes**	☐	**No**	☐
Follow up:				

Additional WF Follow Up

Status of previous requests, new request, unmet needs:

Signatures

	WF Initial	I certify that I have physically seen the person who receives services on this date.		
	WF Initial	I certify that this visit took place in the residence of the person who receives services.		
WF Signature/Credential			**Date**	
Member Signature			**Date**	
Parent/Legal Guardian Signature			**Date**	