West Virginia (WV) Children with Serious Emotional Disorders (CSED) Waiver Progress Note Form

Progress notes for services are required, this form is an optional template for provider use only.

Wraparound Facilitation (WF)

WF First Name, Last Name		Provider Agency	

Service Name	WF (In-Home)	WF (Telehealth)	WF (Community)
Service Location	01 ☐	02 ☐	03 ☐
Service Codes	T1016-HA	T1016-HA	T1016-HA

***Refer to the policy manual for more details regarding telehealth service requirements.**

Date of Service	Start Time	End Time	Total Time Spent

Progress Note

Identify the coordination of supports, resources, and strategies for the members treatment including family input.

Wraparound Facilitator Name	Wraparound Facilitator Signature	Date

Therapy

Therapist First Name, Last Name		Provider Agency	

Service Name	Family Therapy (In-Home)	Family Therapy (Telehealth) 02	Family Therapy (In-Office)	Specialized Therapy
Service Location	01 ☐	02 ☐	03 ☐	04 ☐
Service Codes	H0004-HO-HA	H0004-HO-HA	H0004-HO-HA	G0176-HA

***Refer to the policy manual for more details regarding telehealth service requirements.**

Date of Service	Start Time	End Time	Total Time Spent

Progress Note

Identify therapy techniques, goals, and objectives discussed during session.		
Therapist Name	**Therapist Signature**	**Date**

Family Support Service

In-Home Family Support Worker First Name, Last Name		Provider Agency	

Service Name	Family Support (In-Home)	Family Support (Telehealth)
Service Location	01 ☐	02 ☐
Service Codes	H0004-HA	H0004-HA

Refer to the policy manual for more details regarding telehealth service requirements.

Date of Service	**Start Time**	**End Time**	**Total Time Spent**

Progress Note

In-Home Family Support Worker Name	**In-Home Family Support Worker Signature**	**Date**

Peer Parent Support Service

Peer Parent First Name, Last Name		Provider Agency	

Service Name	Peer Parent Support (In-Home)	Peer Parent Support (Telehealth)
Service Location	01 ☐	02 ☐
Service Codes	H0038-HA	H0038-HA

Refer to the policy manual for more details regarding telehealth service requirements.

Date of Service	**Start Time**	**End Time**	**Total Time Spent**

Progress Note

What was the presenting issue? What community services, programs and strategies have been discussed?		
Peer Parent Name	**Peer Parent Signature**	**Date**

Direct Support Service

Direct Support Staff First Name, Last Name		Provider Agency	

Service Name	Independent Living/Skills Building (Day Habilitation)	Job Development	Supported Employment, Individual	Respite, In-Home	Respite, Out-of-Home
Service Location	01 ☐	02 ☐	03 ☐	04 ☐	05 ☐
Service Codes	H2033-HA	T2021-HA	T2019-HA	T1005-HA	T1005-HA-HE

Refer to the policy manual for more details regarding telehealth service requirements.

Date of Service	**Start Time**	**End Time**	**Total Time Spent**

Progress Note

Identify what services were provided during the session. Did the member require more support than usual? How did the person respond to support and services provided? Are there any follow-up requests or information to communicate to the team?

Staff Name	**Staff Signature**	**Date**

Transportation Log – A0160-HA

Date	**Travel From** (starting address)	**Travel To** (end address)	**Reason for Travel**	**Total Miles**