WEST VIRGINIA I/DD WAIVER
CASE MANAGEMENT HOME/DAY VISIT

Name/Record ID# of Person Who Receives Services:	**Date:**

Type of Contact: ☐ **Face-to-Face** ☐ **Remote**

Travel To Start Time (or N/A):	**Travel To End Time (or N/A):**	**Service Time Duration:**
Service Start Time:	**Service Stop Time:**	**Total Travel Time Duration (or N/A):**
Travel From Start Time (or N/A):	**Travel From End Time (or N/A):**	**Total Time (including travel time):**

Service Code (✓): ☐ **G9002 U3** ☐ **G9002 U4**

Location (✓): **Home:** ☐ **Natural Family** ☐ **SFCH** ☐ **Waiver Group Home**
*HV every month ☐ **Unlicensed Residential**

*DV/PV every quarter **Day:** ☐ **FBDH** ☐ **Pre-Vocational** ☐ **Supported Employment**
*SE *only* when clinically warranted ☐ **Job Development**

Medicaid Card Verification*: ☐ **YES** ☐ **NO** ☐ **N/A (for Day Visit)**
*CM must verify by calling 888-483-0793. Eligibility must be verified monthly.

Has the individual received Direct Care Services during the month? ☐ **YES** ☐ **NO***
*If no, the CM should complete and submit a DD-12 to request an eligibility extension/hold.

Has the CM discussed WV ABLE accounts with the member/representative this month? ☐ **YES** ☐ **NO**

CM ASSESSMENT OF NEEDS/OBSERVATION

Topics for discussion as appropriate: *Are all the member's needs currently met? Does he/she have needed food, medication, and toiletries? Is the crisis plan up-to-date? How are member-specific needs such as behavior supports being addressed, if applicable? Describe the appearance of the person who receives services (e.g., safe, neat, clean) and the condition of the home or facility (e.g., safe and clean). Is the person's privacy maintained (locks on bath and bedrooms)? Were any needs observed? Is the service location integrated (not isolated)?* ***If SE is observed****, how many members were being served?*

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INTERVIEW
Include questions, comments, concerns, and activities for the past month. Were there any health/safety issues, recent medical appointment outcomes? Are there any upcoming appointments? Are there any medication changes, sleeping or appetite issues, or items to communicate to the RN or BSP? Are there any environmental or equipment needs? Are there any problems or issues with staffing or staff attendance? Have there been any critical and/or A/N/E incidents during the past month? If so, what is the status of those, including entry and follow up in IMS?

HABILITATION
Training documentation up to date, habilitation and/or support activity progression/regression noted/reported, staff issues, items to communicate to the BSP (e.g., program change ideas/problems):

CM FOLLOW UP/ACTION
Status of previous requests, new request, unmet needs:

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ELECTRONIC MONITORING ☐ **N/A** (if service is not utilized or if conducting a Day Visit)

Have there been any problems or incidents during the past month while the person was receiving assistance through the Electronic Monitoring service? ☐ *Yes* ☐ *No*

If Yes, describe the problems or incidents and necessary follow-up.

Is all the equipment related to the Electronic Monitoring service in good working order? ☐ *Yes* ☐ *No*

If No, describe any equipment problems and required follow-up.

Complete only if contact was made by phone or other non-face-to-face means, due to COVID-19 precautions:

_____ (CM initial) I certify that I have made contact with the person who receives services and/or their Direct Care Provider/Legal Representative on this date.

_____ (CM initial) I certify that this contact occurred by phone, or by other non-face-to-face means, due to COVID-19 precautions.

Complete only if contact was made through face-to-face contact:

_____ (CM initial) I certify that I have physically seen the person who receives services on this date.

_____ (CM initial) I certify that this visit took place in the residence of the person who receives services (only applies to HV).

_____ (CM initial) I certify that this visit took place in the community or day facility of the person who receives service (only applies to DHV).

CM Signature/Credentials: **Date:**

Signature of Person Who Receives Services: **Date:**

Direct Care Provider/Legal Rep./Title: **Date:**