

**WEST VIRGINIA I/DD WAIVER  
SERVICE COORDINATION HOME/DAY VISIT**

<b>Member Name:</b>	<b>APS ID:</b>	<b>Service Code:</b> T1016HI
<b>Service Date:</b>	<b>Service Start Time:</b>	<b>Service Time Duration:</b>
	am/pm	<b>Travel Time Duration:</b>
<b>Location Visited (✓):</b>	<b>Home:</b> <input type="checkbox"/> NF <input type="checkbox"/> SFCH <input type="checkbox"/> Waiver Group Home <input type="checkbox"/> ISS	<b>Total Time (including travel time):</b>
*HV Every month	<b>Day:</b> <input type="checkbox"/> DH Facility <input type="checkbox"/> SE <input type="checkbox"/> Community	
*DV Every other month		

**SC OBSERVATION**

**Medicaid Card Verification :**  YES  NO  N/A (for Day Visit)  
 \*SC may verify by viewing Medicaid card during home visit or by calling 888-483-0793. Eligibility must be verified monthly.

*Describe the member's appearance (e.g., safe, neat, clean) and the condition of the home or facility (e.g., safe and clean). Were any needs observed?*


**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? Have there been any medication changes, sleeping or appetite issues, or items to communicate to the RN, TC or Behavior Support Professional? Are there any environmental/equipment needs? Are there any problems or issues with staffing or staff attendance?*


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Member Name:	Service Date:
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**HABILITATION**

*Training documentation up to date, habilitation progression/regression noted/reported, staff issues, items to communicate to TC (e.g., program change ideas/problems):*


**SC FOLLOW UP/ACTION**

*Status of previous requests, new request, unmet needs:*


**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 member 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.*


\_\_\_\_\_(SC initial) I certify that I have physically seen the member on this date  
 \_\_\_\_\_(SC initial) I certify that this visit took place in the member's place of residence (Only applicable for HV)

**SC Signature/Credentials:**

**Date:**

**Member Signature:**

**Date:**

**Staff/Worker Signature/Title:**

**Date:**