

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

Name/APS ID# of Person Who Receives Services:		Service Date:
Travel To Start Time:	Travel To End Time:	Service Code: T1016HI
Service Start Time:	Service Stop Time:	Service Time Duration:
Travel From Start Time:	Travel From End Time:	
Location Visited (✓): *HV every month Home: <input type="checkbox"/> NF <input type="checkbox"/> SFCH <input type="checkbox"/> Waiver Group Home *DV every other month <input type="checkbox"/> Unlicensed Res. *PE/SE <i>only</i> when clinically warranted Day: <input type="checkbox"/> DH Facility <input type="checkbox"/> Pre-Vocational <input type="checkbox"/> SE		Total Travel Time Duration: Total Time (including travel time):
Medicaid Card Verification* : <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A (for Day Visit) <small>*SC must verify by calling 888-483-0793. Eligibility must be verified monthly.</small>		
SC OBSERVATION		

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). 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? 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?

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HABILITATION
<i>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):</i>

SC FOLLOW UP/ACTION
<i>Status of previous requests, new request, unmet needs:</i>

ELECTRONIC MONITORING <input type="checkbox"/> N/A (if service is not utilized or if conducting a Day Visit)
<i>Have there been any problems or incidents during the past month while the person was receiving assistance through the Electronic Monitoring service? <input type="checkbox"/> Yes <input type="checkbox"/> No</i>
<i>If Yes, describe the problems or incidents and necessary follow-up.</i>
<i>Is all the equipment related to the Electronic Monitoring service in good working order? <input type="checkbox"/> Yes <input type="checkbox"/> No</i>
<i>If No, describe any equipment problems and required follow-up.</i>

_____(SC initial) I certify that I have physically seen the person who receives services on this date.	
_____(SC initial) I certify that this visit took place in the residence of the person who receives services (only applicable for HV).	
SC Signature/Credentials:	Date:
Signature of Person Who Receives Services:	Date:
Direct Care Provider/Legal Rep./Title:	Date: