WEST VIRGINIA CHILDREN WITH SERIOUS EMOTIONAL DISORDER (CSED) WAIVER
CASE MANAGEMENT SERVICE LOG

Name of Person Who Receives Services		Case Manager Name	
Date of Service		Provider Agency	

Service Name	Service Code	Service Location	Total Time Per Service for This Page
CASE MANAGEMENT	T1016-HA	01	
CASE MANAGEMENT (TELEHEALTH)	T1016-HA	02	

Telehealth is available with 02 service location only when due to inclement weather and excluding the monthly face-to-face contact. Telehealth justification must be provided in the service note

Date	Service Location	Start Time am/pm	Stop Time am/pm	Total Time	Case Manager Initials

Case Manager Name	Case Manager Signature	Date

WEST VIRGINIA CHILDREN WITH SERIOUS MOTIONAL DISORDER (CSED) WAIVER
CASE MANAGEMENT PROGRESS NOTE

Name of Person Who Receives Services		Name of Case Manager	
Date of Service		Provider Agency	

Date		Time	AM PM	Case Manager Initials	

Identify the coordination of supports, resources, and strategies for the members treatment including family input. Are other service providers ensuring services and clinical treatment modalities augment each other for optimal outcomes? Has a transition plan been developed? Have the persons strengths and needs been identified and integrated into treatment? Has there been any changes to medications or an increase in incidents that may require an adjustment of treatment? Is communication maintained among all team members including family members? Has discharge planning been discussed and documented? Has a transition plan been developed for individuals who are coming up on the waiver's maximum age limit?

Case Manager Name	Case Manager Signature	Date

WEST VIRGINIA CHILDREN WITH SERIOUS EMOTIONAL DISORDER (CSED) WAIVER
IN- HOME FAMILY THERAPY SERVICE LOG

Name of Person Who Receives Services		Name of In-Home Family Therapist	
Date of Service		Provider Agency	

Service Name	Service Code	Service Location	Total Time Per Service for This Page
IN-HOME FAMILY THERAPY	H0004-HO-HA	01	
IN-HOME FAMILY THERAPY (TELEHEALTH)	H0004-HO-HA	02	

Telehealth is available with 02 service location and telehealth justification must be provided within the service note

If training was provided, WV-BMS-CSED-6 must be completed

Date	Service Location	Start Time am/pm	Stop Time am/pm	Total Time	Was training provided? (Y/N)	Therapist Initials

Therapist Name	Therapist Signature	Date

WEST VIRGINIA CHILDREN WITH SERIOUS MOTIONAL DISORDER (CSED) WAIVER
IN-HOME FAMILY THERAPY PROGRESS NOTE

Name of Person Who Receives Services		Name of In-Home Family Therapist	
Date of Service		Provider Agency	

Date		Time	AM PM	Therapist Initials	

Identify therapy techniques, goals and objectives discussed during session. Did the person require more support than usual? Have any incidents or trauma occurred since previous session? How did the person respond to support and services provided? Has crisis response been utilized? What is the plan, goals, and objectives for follow up session?

Therapist Name	Therapist Signature	Date

WEST VIRGINIA CHILDREN WITH SERIOUS EMOTIONAL DISORDER (CSED) WAIVER
IN-HOME FAMILY SUPPORT SERVICE LOG

Name of Person Who Receives Services		**Name of In-Home Family Support Worker**	
Date of Service		**Provider Agency**	

Service Name	Service Code	Service Location	Total Time Per Service for This Page
IN-HOME FAMILY SUPPORT	H0004-HA	01	
IN-HOME FAMILY SUPPORT (TELEHEALTH)	H0004-HA	02	

Telehealth is available with 02 service location and telehealth justification must be provided within the service note

If training was provided, WV-BMS-CSED-6 must be completed

Date	**Service Location**	**Start Time** am/pm	**Stop Time** am/pm	**Total Time**	**Was training provided?** (Y/N)	**In-Home Support Worker Initials**

Support Worker Name	**Support Worker Signature**	**Date**

WEST VIRGINIA CHILDREN WITH SERIOUS MOTIONAL DISORDER (CSED) WAIVER
IN-HOME FAMILY SUPPORT PROGRESS NOTE

Name of Person Who Receives Services		Name of In-Home Family Support Worker	
Date of Service		Provider Agency	

Date		Time	AM PM	In-Home Family Support Initials	

Identify therapy techniques, goals and objectives discussed during session. Did the person require more support than usual? Have any incidents or trauma occurred since previous session? How did the person respond to support and services provided? Has crisis response been utilized? What is the plan, goals, and objectives for follow up session?

Support Worker Name	Support Worker Signature	Date

WEST VIRGINIA CHILDREN WITH SERIOUS EMOTIONAL DISORDER (CSED) WAIVER
MOBILE RESPONSE SERVICE LOG

Name of Person Who Receives Services		Name of Mobile Response Worker	
Date of Service		Provider Agency	

Service Name	Service Code	Service Location	Total Time Per Service for This Page
MOBILE RESPONSE	H2017-HA	01	
MOBILE RESPONSE (TELEHEALTH)	H2017-HA	02	

Telehealth is available with 02 service location, only when distance does not permit staff to reach the person receiving services within one hour. Telehealth justification must be provided within the service note

Date	Service Location	Start Time am/pm	Stop Time am/pm	Total Time	Mobile Response Worker Initials

Mobile Response Name	Mobile Response Signature	Date

WEST VIRGINIA CHILDREN WITH SERIOUS MOTIONAL DISORDER (CSED) WAIVER
MOBILE RESPONSE PROGRESS NOTE

Name of Person Who Receives Services		Name of Mobile Response Worker	
Date of Service		Provider Agency	

Date		Time	AM PM	Mobile Response Worker Initials	

What was the presenting issue? What de-escalation techniques were used in this situation? What other issue resolution support was provided? What other services and resources will you link the person receiving services and their family with as a result of the issue? What will be communicated to the in-home family therapist and in-home family support worker about the events that transpired? Service must result in the development of a stabilization plan for any additional services that are needed to resolve the immediate situation and follow-up communication must occur with the in-home family therapist. Follow-up must also be made with the individual's case manager to ensure consistency and treatment congruency among all services.

Mobile Response Name	Mobile Response Signature	Date

WEST VIRGINIA CHILDREN WITH SERIOUS EMOTIONAL DISORDER (CSED) WAIVER
PEER PARENT SUPPORT SERVICE LOG

Name of Person Who Receives Services		**Name of Peer Parent**	
Date of Service		**Provider Agency**	

Service Name	Service Code	Service Location	Total Time Per Service for This Page
PEER PARENT SUPPORT	H0038-HA	01	
PEER PARENT SUPPORT (TELEHEALTH)	HOO38-HA	02	

Telehealth is available with 02 service location and telehealth justification must be provided within the service note

Date	Service Location	Start Time am/pm	Stop Time am/pm	Total Time	Peer Parent Initials

Peer Parent Name	Peer Parent Signature	Date

Name of Person Who Receives Services		Name of Peer Parent	
Date of Service		Provider Agency	

Date		Time	AM PM	Peer Parent Initials	

What was the presenting issue? What community services, programs and strategies have been discussed? What connections and relationships have been built to assist the parents/caretakers of the child? What are some successful strategies of treatment have worked? What strategies and treatments have not worked?

Peer Parent Name	Peer Parent Signature	Date

WEST VIRGINIA CHILDREN WITH SERIOUS EMOTIONAL DISORDER (CSED) WAIVER
DIRECT SUPPORT SERVICE LOG

Name of Person Who Receives Services		Name of Direct Support Provider	
Date of Service		Provider Agency	

Service Name	Service Code	Identifier (ID)	Total Time Per Service for This Page
INDEPENDENT LIVING/SKILLS BUILDING (DAY HABILITATION)	H2033-HA	1	
JOB DEVELOPMENT	T2021-HA	1	
SUPPORTED EMPLOYMENT, INDIVIDUAL	T2019-HA	1	
RESPITE, IN-HOME	T1005-HA	1	
RESPITE, OUT-OF-HOME	T1005-HA-HE	1	

If training was provided, WV-BMS-CSED-6 must be completed

Date	ID	Start Time am/pm	Stop Time am/pm	Total Time	Was training provided? (Y/N)	Provider/Staff Initials

Provider/Staff Name	Provider/Staff Signature	Provider/Staff Name	Provider/Staff Signature

WEST VIRGINIA CHILDREN WITH SERIOUS EMOTIONAL DISORDER (CSED) WAIVER
TRANSPORTATION LOG
Service Code: A0160-HA

Name of Person Who Receives Services		Provider Agency	
Month of Service		Year of Service	

Date	Travel From (starting address)	Travel To (end address)	Reason for Travel (must correspond to an objective on the PCSP)	Starting Odometer Reading	Ending Odometer Reading	Total Miles or Trips	Provider Initials
			Total Miles for This Page				

Provider/Staff Name	Provider/Staff Signature	Provider/Staff Name	Provider/Staff Signature