Chapter 513 IDD Waiver Forms

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WEST VIRGINIA I/DD WAIVER
APPLICATION

1. _____/_____/_____ **2.** _____/_____/_____
Applicant First Name / Last Name / M — Date of Birth

3. _____/_____/_____/_____/_____
Street/Apt#/Address / City / State / Zip Code / County

4. (_____)_____ **5.** _____/_____/_____ **6.** _____ **7.** Gender: ☐ Male ☐ Female
Telephone Number — Social Security Number — Medicaid Number

8. Does the applicant have a legal guardian or legal representative? ☐ YES ☐ NO

9. Check if legal guardian/representative is: ☐ PARENT/RELATIVE ☐ NON-RELATIVE ☐ STATE/COUNTY

10. _____/_____ **11.** (_____)_____
Legal Representative's First Name / Legal Representative's Last Name — Legal Representative's Phone Number

12. _____/_____/_____/_____/_____
Legal Representative's Street/Apt#/Address / City / State / Zip Code / County

13. Additional Information: Include Medical Power of Attorney or non-legal representative name, address, and phone number, if applicable:

Name:_____ Relationship to Applicant:_____

Address:_____

Telephone Number: ( )

14. I certify the above information is accurate and complete to the best of my knowledge. I understand the information provided in this document will be treated confidentially.

_____
Printed Name of Applicant or Legal Representative — Date

_____
Signature of Applicant or Legal Representative — Date

DO NOT WRITE BELOW THIS LINE

Mail or fax I/DD-1 to:
APS Healthcare, Inc.-WV
100 Capitol Street, Suite 600
Charleston, WV 25301
(866)521-6881

Received by the Administrative Service Organization (Date/Signature): _____

WEST VIRGINIA I/DD WAIVER
FREEDOM OF CHOICE
(Must be completed annually)

Member Name: _____Date:_____

Home/Community-Based or ICF/MR	If you qualify for the level of care provided in an Intermediate Care Facility for those with Mental Retardation or Developmental Disabilities (ICF/MR) you have the right to choose between receiving support in an ICF/MR or your home and/or community. The WV I/DD Waiver program provides services and support in your home/community.
	Please check the option that applies to your choice: □ I choose to receive support in my home and community through the WV I/DD Waiver program. I will have the following rights: • The right to choose among qualified providers, • The right to choose a different provider if I prefer, • The right to a fair hearing through the Bureau for Medical Services if I am not given choice. □ I choose to receive support in an ICF/MR.
SC Agency	You have the right to choose among qualified providers in your area. All enrolled agencies that provide Service Coordination in your catchment area have been discussed with you.
	The agency that I choose to provide Service Coordination is:
Service Delivery Model	West Virginia has several options available for the delivery of certain services. Person-centered Supports, Goods and Services, Respite Care and Transportation are the only services with the option to self-direct. Self-directed options allow you, as the member in services, to determine the level of budget and employer authority you wish to exercise. These options have been discussed with you during your individual budget assessment. All other I/DD Waiver services may only be delivered through the Traditional agency model.
	I choose to receive supports through the following model of service delivery (check all that apply): □ Traditional: Services are provided through the agency. □ Traditional and Agency with Choice: The agency and I (or my representative) co-manage my support staff. The agency serves as the FMS. □ Traditional and Fiscal/Employment Agent: I (or my representative) am responsible to manage my support staff. WV's chosen Fiscal/Employment Agent serves as the FMS.

_____ _____
Member Signature and Date Legal Representative Signature and Date

_____ _____
ASO Representative Signature and Date SC Agency Representative Signature and Date

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

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

SC OBSERVATION
Medicaid Card Verification : ☐ **YES** ☐ **NO** ☐ **N/A (for Day Visit)**
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?

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

Member Name:	Service Date:

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 Signature/Credentials: **Date:**

Member Signature: **Date:**

Staff/Worker Signature/Title: **Date:**

WEST VIRGINIA I/DD WAIVER
INITIAL INDIVIDUALIZED PROGRAM PLAN
(Must be completed within seven days of intake)

Member Name: _____APSID#_____ Date of Enrollment: _____

Upon eligibility determination (medical, financial and slot allocation) the following goal/objectives will be implemented in order to initiate I/DD Waiver Services (use additional pages as necessary):

Goal #1: Service Coordinator will provide linkage/referral to facilitate member's access to I/DD Waiver Services.

Objective 1: The Service Coordinator will schedule, coordinate and facilitate the 7-day Person Centered Program Plan and the full IDT meeting to develop the Annual IPP.

Objective 2: _____

_____

Objective 3: _____

_____

Objective 4: _____

_____

Goal #2:

_____

_____

_____

Goal #3:

_____

_____

_____

_____ _____
Member Signature/Date Legal Representative Signature/Date

_____ _____
Service Coordinator Signature/Date Other/Date

WEST VIRGINIA I/DD WAIVER
INDIVIDUALIZED PROGRAM PLAN (IPP)

IPP Start Date:_____ **Date this Plan will be Reviewed:_____**

Type of IDT Meeting:

☐Annual ☐3-month ☐6-month ☐9-month ☐Critical Juncture ☐Transfer ☐Discharge

Demographics

Member Name:

Address:

Phone Number:

Date of Birth:

Additional Insurance:

Date of Financial Eligibility:

Date of Medical Eligibility:

Legal Representative: ☐Yes ☐No

If "Yes" ☐ Full ☐ Limited

Name:

Address:

Phone:

Health Care Surrogate:

☐ Yes ☐ No

Name:

Address:

Phone:

Medical Power of Attorney:

☐ Yes ☐ No

Name:

Address:

Phone::

Payee: ☐ Yes ☐ No

Name:

Address:

Phone #:

Conservator:☐Yes☐No

Name:

Address:

Phone#:

Behavioral Interventions (May be N/A)

Date of Functional Assessment:_____

Date of Positive Behavior Support Plan or Protocol:_____

Date of HRC Approval:_____

Service Coordination

SC Name:

SC Provider Agency:

SC Telephone #, ext:

SC e-mail:

Attachments:

☐Crisis Plan (required for Annual and 6-month IPPs)

☐Positive Behavior Support Plan/Protocol (required, if applicable, for Annual and 6-month IPPs)

☐Budget from CareConnection® (required)

I/DD Waiver Budget Information:

Assessed Individualized Budget Amount:

$_____

Cost of I/DD Waiver Services Annually:

$_____

Service Delivery Option:

☐Traditional: Services are provided through the agency.

☐Traditional and Agency with Choice: The agency and I (or my representative) co-manage my support staff. The agency serves as the FMS.

☐Traditional and Fiscal/Employment Agent: I (or my representative) am responsible to manage my support staff. WV's chosen Fiscal/Employment Agent serves as the FMS.

Meeting Minutes (Use additional pages, as necessary)	
Who attended this meeting? Did any team members attend by phone, and why?	
Summary of what was discussed during this meeting:	
Meeting Minutes Submitted By	

Circle of Support
Intimacy: Who can I count on
Friendship: Who is a good friend?
Participation: List people, organizations, or networks you are involved with:
Exchange: People who are paid to be in my life (staff):
Who I would like to participate in developing my plan?

Goals and Dreams (Use additional space, as necessary)
What are my short-term and long-term goals and dreams? Goals should be positive and possible. (Where do you want to live? Ideal job? Who do you want to live with? Dream vacation? What do you want to learn?) Who is going to help me achieve these goals/dreams?
Short-term goals: **Long-term goals:**
What do I expect to be different as a result of receiving services and supports? What outcomes do I expect to accomplish with the help of supports?
What are things that I like and dislike? What things do I consider pleasant and important? What do I like to do during my leisure time? What community activities do I enjoy?
What are my strengths? What am I good at?

Evaluation	Date of Evaluation	Summary of Assessment/Evaluations Results and Recommendations as a Result (List all assessments used to develop the service and habilitation plan):
Person-Centered Assessment		
ICAP		
ABAS:II		
Health & Safety Issues Identified		
Psychological/ Psychiatric		If applicable
Medical		List all physicians, date of last appointment, and recommendations
Therapy (PT, OT, ST, etc.)		If applicable
Other		
Other		
Other		

Medications that I take (use additional rows, as necessary)	Dosage	Frequency	Reason for taking this medication (applicable diagnosis)	Who will administer? (agency name and staff title)

I/DD Waiver Services Needed to Support Me
Individual Services Plan

Service Code	Service Description	Provider	Is the service available?
			☐ Yes ☐ No
Amount/Frequency: Service should average ____ units per month and should not exceed ____ units per year			
Duration of Service: This should service should begin on ______ and end on _______			
Plan of Action/Scope of Work to be done to support me. What, specifically, will the provider do to support my needs? What has changed since the last time my IDT met?			
Service Code	**Service Description**	**Provider**	**Is the service available?**
			☐ Yes ☐ No
Amount/Frequency: Service should average ____ units per month and should not exceed ____ units per year			
Duration of Service: This should service should begin on ______ and end on _______			
Plan of Action/Scope of Work to be done to support me. What, specifically, will the provider do to support my needs? What has changed since the last time my IDT met?			
Service Code	**Service Description**	**Provider**	**Is the service available?**
			☐ Yes ☐ No
Amount/Frequency: Service should average ____ units per month and should not exceed ____ units per year			
Duration of Service: This should service should begin on ______ and end on _______			
Plan of Action/Scope of Work to be done to support me. What, specifically, will the provider do to support my needs? What has changed since the last time my IDT met?			
Service Code	**Service Description**	**Provider**	**Is the service available?**

			☐ Yes ☐ No

Amount/Frequency: Service should average ____ units per month and should not exceed ____ units per year

Duration of Service: This should service should begin on ______ and end on _______

Plan of Action/Scope of Work to be done to support me. What, specifically, will the provider do to support my needs? What has changed since the last time my IDT met?

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			☐ Yes ☐ No

Amount/Frequency: Service should average ____ units per month and should not exceed ____ units per year

Duration of Service: This should service should begin on ______ and end on _______

Plan of Action/Scope of Work to be done to support me. What, specifically, will the provider do to support my needs? What has changed since the last time my IDT met?

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			☐ Yes ☐ No

Amount/Frequency: Service should average ____ units per month and should not exceed ____ units per year

Duration of Service: This should service should begin on ______ and end on _______

Plan of Action/Scope of Work to be done to support me. What, specifically, will the provider do to support my needs? What has changed since the last time my IDT met?

Service Code	Service Description	Provider	Is the service available?
			☐ Yes ☐ No

Amount/Frequency: Service should average ____ units per month and should not exceed ____ units per year			
Duration of Service: This should service should begin on _____ and end on _____			
Plan of Action/Scope of Work to be done to support me. What, specifically, will the provider do to support my needs? What has changed since the last time my IDT met?			
Service Code	**Service Description**	**Provider**	**Is the service available?**
			☐ Yes ☐ No
Amount/Frequency: Service should average ____ units per month and should not exceed ____ units per year			
Duration of Service: This should service should begin on _____ and end on _____			
Plan of Action/Scope of Work to be done to support me. What, specifically, will the provider do to support my needs? What has changed since the last time my IDT met?			
Service Code	**Service Description**	**Provider**	**Is the service available?**
			☐ Yes ☐ No
Amount/Frequency: Service should average ____ units per month and should not exceed ____ units per year			
Duration of Service: This should service should begin on _____ and end on _____			
Plan of Action/Scope of Work to be done to support me. What, specifically, will the provider do to support my needs? What has changed since the last time my IDT met?			

Non-I/DD Waiver and Natural Supports (Volunteer groups, clubs, churches, schools, etc.)	
Support	**Who Provides This Support?**
Frequency of Support:	

Duration of Support: This support should begin on _____ and end on _____	
Plan of Action/Scope of Work to be done to support me:	
Support	**Who Provides This Support?**
Frequency of Support:	
Duration of Support: This support should begin on _____ and end on _____	
Plan of Action/Scope of Work to be done to support me:	
Support	**Who Provides This Support?**
Frequency of Support:	
Duration of Support: This support should begin on _____ and end on _____	
Plan of Action/Scope of Work to be done to support me:	
Support	**Who Provides This Support?**
Frequency of Support:	
Duration of Support: This support should begin on _____ and end on _____	
Plan of Action/Scope of Work to be done to support me:	

I/DD Waiver Individual Habilitation Plan and Task Analysis							
Member Name:		**Program #**		**Date Established**		**Target Date**	
Responsible Agency and Staff:				**Date Revised/Discontinued:**			
My Skill or Goal Area:							

My Instructional Objective:					
Instructional Methods/ Special Instructions to staff (include possible prompting levels)					
What materials are needed?					
In what setting will this take place?		**How frequently will this activity occur?**		**Miles needed to achieve this goal?**	
How often will data be collected?		**What type of reinforcement will I receive?**			
What criteria is needed for me to move on to the next step?					
Possible Prompt Levels (specific to my needs):					

Task Analysis

In this example, only step 1 is scored (4 trials per day). Make the following chart applicable to the specific member's needs, # of trials and hab/training objectives.

	Month/ Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
1	***Name* goes to sink (Trial 1)**																															
	Trial 2																															
	Trial 3																															
	Trial 4																															
2	*Name* turns on water																															
3	*Name* wets hands																															
4	*Name* applies soap																															
5	*Name* washes hands																															
6	*Name* rinses hands																															
7	*Name* turns off water																															
8	*Name* dries hands																															
9	*Name* applies lotion																															
	Staff Initials																															

TC/BSP Signature and Credentials: _____

My Tentative Schedule Is:

LIST: MULTIPLE SERVICE PROVIDERS; WHEN THE PROVIDER PROVIDES THE SERVICE; AND/OR TIME-FRAMES FOR PLANNED ACTIVITIES NEEDED FOR IMPLEMENTATION OF THE PLAN. ENSURE MEMBER HAS VOICED THEIR CHOICE OF ACTIVITIES AND SCHEDULE IS PERSON-CENTERED.

Projected Time Range	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

Interdisciplinary Team Signature Sheet

Member Name:_____Date of Meeting:_____

Type of IDT Meeting:

☐Annual ☐3-month ☐6-month ☐9-month ☐Critical Juncture ☐Transfer ☐Discharge

Relationship	Signature and Credentials	Time Spent in Meeting	Agree	Disagree	Date this IPP was sent out
Member					
Parent/Legal Representative					
Service Coordinator					
Other Relationship:					
Other Relationship:					
Other Relationship:					
Other Relationship:					
Other Relationship:					
Other Relationship:					

IDT member has disagreed with the plan. The rationale is attached.

Rationale for Disagreement with the Plan

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature:_____Date:_____

WEST VIRGINIA I/DD WAIVER
CERTIFICATE OF TRAINING

Member Name		Date of Training	
Name of Trainer		Trainer's Agency	
Training is valid from:		Training is valid until:	
Location of Training	□ Member's Home □ Facility DH □ Agency Office □ Supported Employment □ Community □ Other (describe):_____		

Trained on the following items listed below. Specific procedure/techniques/methods may be found attached to the Individual Program Plan.

1		11	
2		12	
3		13	
4		14	
5		15	
6		16	
7		17	
8		18	
9		19	
10		20	

I certify that I have received training on the items listed above. I will contact the Trainer if additional training is needed or for any questions.

Printed Name of Person Trained	Signature of Person Trained	Title of Person Trained

Signature and Credentials of Trainer		Date	

WEST VIRGINIA I/DD WAIVER
DIRECT SUPPORT SERVICE LOG

Member Name		**Service Coordination Agency**	
Month of Service		**Year of Service**	

Service Name	Service Code	Identifier (ID)	Total Time Per Service For This Page
		1	
		2	

If training was provided, Task Analysis 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 I/DD WAIVER
REQUEST FOR ENVIRONMENTAL ACCESSIBILITY ADAPTATION (EAA)
And/or GOODS AND SERVICES (G&S)
(To be completed by the Service Coordinator)

Member Name		**Date**		
Medicaid Number		**Type of Residence (✓)**		Natural Family
SC Agency				SFCH
Name of SC				ISS
EAA/G&S Requested for (✓): ☐EAA for Home ☐EAA for Vehicle ☐Goods and Services				Group Home
Brief description of the EAA or G&S Needed (Detailed invoice must be attached):				
Total Amount Requested EAA or G&S			**$**	

Vendor Information

Vendor Name	
Vendor Address	
Vendor Phone #	
Vendor Qualifications	

A copy of the following documentation must be attached for processing and determination:

- ☐ **IPP recommendations detailing need for this EAA or G&S**
- ☐ **The invoice detailing costs and description for the EAA or G&S**
- ☐ **If approved, receipts for the EAA or G&S must accompany this form in the member's clinical record.**

Member Signature/Name		**Date**	
Representative Signature		**Date**	
Service Coordinator Signature		**Date**	

DIRECT SUPPORT PROGRESS NOTE

(To be used if something out of the ordinary occurs while providing services)

Member Name		Service Coordination Agency	
Month of Service		Year of Service	

Date		Time	AM PM	Provider/Staff Initials	

Were there any parts of the goal in which the member did especially well or poor? Did anything out of the ordinary occur (such as illness, behaviors, etc.)? Did the member require more support than usual?

Date		Time	AM PM	Provider/Staff Initials	

Date		Time	AM PM	Provider/Staff Initials	

Date		Time	AM PM	Provider/Staff Initials	

Date		Time	AM PM	Provider/Staff Initials	

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

Service Code: ☐ **A0160HI (Miles)** ☐ **A0121HI (Trip)**

Member Name		**Service Coordination Agency**	
Month of Service		**Year of Service**	

Date	Travel From (starting location)	Travel To (end location)	Reason for Travel (must correspond to an objective on the member's IPP)	Total Miles	Provider/Staff Initials
			Total Miles for This Page		

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

Page____of____

WEST VIRGINIA I/DD WAIVER
REQUEST FOR ENVIRONMENTAL ACCESSIBILITY ADAPTATION (EAA)
And/or GOODS AND SERVICES (G&S)
(To be completed by the Service Coordinator)

Member Name		**Date**		
Medicaid Number		**Type of Residence (✓)**		Natural Family
SC Agency				SFCH
Name of SC				ISS
EAA/G&S Requested for (✓): ☐EAA for Home ☐EAA for Vehicle ☐Goods and Services				Group Home
Brief description of the EAA or G&S Needed (Detailed invoice must be attached):				
Total Amount Requested EAA or G&S			**$**	

Vendor Information

Vendor Name	
Vendor Address	
Vendor Phone #	
Vendor Qualifications	

A copy of the following documentation must be attached for processing and determination:

- ☐ **IPP recommendations detailing need for this EAA or G&S**
- ☐ **The invoice detailing costs and description for the EAA or G&S**
- ☐ **If approved, receipts for the EAA or G&S must accompany this form in the member's clinical record.**

Member Signature/Name		**Date**	
Representative Signature		**Date**	
Service Coordinator Signature		**Date**	

WEST VIRGINIA I/DD WAIVER PROGRAM
REQUEST FOR NURSING SERVICES

TO BE COMPLETED BY SERVICE COORDINATOR:

Member Name_____Date of Birth_____

WV Medicaid Recipient #_____ Service Coordinator Name:_____

Living Arrangement (✓): ☐ NF/SFCH ☐ ISS ☐ Group Home ☐ Other_____

Agency Name_____Agency Phone #_____

Agency Address_____

Principal Diagnosis_____

Has there been a change in this member's condition during the last year (✓)? ☐ Yes ☐ No
If Yes, please describe:_____

_____

TO BE COMPLETED BY THE ATTENDING PHYSICIAN:

Brief description of member's medical status:_____
_____
_____
_____
_____

Has family/caregiver been trained to adequately care for member (✓)? ☐ Yes ☐ No
List/Describe exactly what procedures this member requires that must be performed by a licensed nurse:
_____
_____
_____
_____
_____
_____

List all medications and treatment orders:_____
_____
_____
_____
_____

RX:
I certify that this patient is in need of skilled nursing services @ _____ hours per day/_____days per week. The patient is under my care and requires the skilled procedures as listed above. Unless otherwise indicated this authorization covers a one year period, unless there is a change in the patient's condition.

Physician's Signature:_____ Date:_____

WEST VIRGINIA I/DD WAIVER
MEMBER TRANSFER/DISCHARGE

Must be received by the ASO **within seven (7) days** of the Member's transfer/discharge.
Fax form to #866.521.6882

Member Name		**Date**	
SC Agency		**APSID #**	

Transfer: From one Service Coordination agency to another.
An overlap of Service Coordination (up to 30-days) may occur for active participants.

Transfer From (Agency)		**Final Access Date** (last date of service provision for Transfer From agency-n/a if on the Wait List)	
Transfer To (Agency)		**Effective Date of Transfer**	

Reason For Transfer (✓)		Participant requests new SC provider
		Participant moved to a new geographic location
		Provider no longer offers Service Coordination
		Provider initiated transfer

Additional comments:

Discharge: Permanently exiting the program

Effective Date of Discharge		**Final Access Date** (n/a if on the Wait List)	

Please check **(✓)** if discharge refers to: ☐Active Participant ☐Participant on Wait List

Reason for Discharge (✓)		No longer a WV resident
		Deceased
		No longer eligible for I/DD Waiver
		Voluntarily declines the I/DD Waiver program
		Decided to receive support through an ICF/MR

Additional Comments:

Signature of Person Completing this Form		**Date**	
Member Signature		**Date**	
Legal Representative Signature		**Date**	
Witness Signature		**Date**	

WEST VIRGINIA I/DD WAIVER
NOTIFICATION OF MEMBER DEATH

(This form is only used to report the death of a member who resides in a 24-hour staffed setting.)

TO: **IRG d/b/a APS Healthcare-WV**
I/DD Waiver Program
100 Capitol Street, Suite 600
Charleston, WV 25301
Fax: 866.521.6882

FROM: _____

_____

_____

INFORMATION ON THE DECEASED:

Name_____**Gender**_____**Age**_____

Date of Birth___/___/_____**Address**_____

City_____**APSID#**_____

DIAGNOSIS AND MEDICAL CONDITION:

Axis I

Axis II

Axis III

Medications: (Use additional paper if necessary)
List all current medications prescribed and non-prescribed.

Medication	Dosage/Frequency	Purpose of Medication

Date of Death____/____/____ **Time of Death**_____**a.m./p.m.** **Location of Death**_____

Cause of Death_____

_____

WEST VIRGINIA I/DD WAIVER
REQUEST TO CONTINUE SERVICES

Submit by fax (866-521-6882) or email to wvmrddwaiver@apshealthcare.com

Date Request is Submitted: _____
Name of Person Submitting Request: _____
Provider Agency (Please Include location if applicable): _____
Contact Information: Phone # Ext. _____
Email Address: _____
Member Name: _____ Member APSID#: _____

Type of Request (check ☑ applicable):

☐Eligibility extension request	Elig Exp. Date: _____	# days requested for extension: _____
☐Exception to monthly home visit request	Date of last home visit: _____	Time period requested for extension: _____
☐Exception to bi-monthly day visit request	Date of last day visit: _____	Time period requested for extension: _____
☐Exception to interdisciplinary team meeting (IPP) request ☐To hold meeting without member present ☐To hold meeting outside mandated timelines ☐To hold meeting without legal representative	IPP Fixed Date: _____ Date of last Annual IPP: _____ Date of last 6-mo. IPP: _____	Date the IDT meeting is expected to be held: _____

Briefly describe the reason for the special request

Please do not write below line. For APS Healthcare Use Only

☐ Approved – Date extension expires: _____
☐ Not Approved
☐ Requested Additional Documentation (see notes section for more information)
Name of ASO staff reviewing request:_____ Email Address: _____

Notes