MR/DD WAIVER PROGRAM
PARTICIPANT MONITORING STATUS REPORT

L This form is being submitted: 9 To **update** previously submitted information 9 As part of an **full application packet**
L **Highlight** the areas below that have been changed since the last DD-1 was submitted.

Participants Name____ Date:_______________
First *Last* *Middle Initial*

Service Coordination Agency_________________________________ SS#_______________________

Medicaid #____________________________ DOB_____________________ Sex: 9 Male 9 Female

Mental Diagnosis Code(s)______________________ Physical Diagnosis Code(s) ___________________

Residential Provider____ Phone_________________

Address____ County DHHR_______________

Type of Residence: 9 NF 9 SFCH 9 GH 9 ISS 9 Other ______________________

Date of Residential Placement______________________ Prior Institutionalization 9 Yes 9 No

Name of Last Facility ____

Legal Representative____
Address ____

Phone_________________________ Relationship to Participant________________________________

Financial Resources: 9 Trust 9 Medicaid 9 Medicare 9 Private Pay Insurance 9 SSI
9 SSDI 9 SSA 9 Handicapped Children Services 9 Other

Monthly Average Income $___________ Permission to Exceed Monthly Cost: 9 Yes 9 No

Does the DD6 estimate include: 9 Supported Employment (WO230 and/or WO232)
9 Prevocational Training (WO229 and/or WO231)

Medley Class Member: 9 Yes 9 No

Service Coordinator______________________________________ Phone_____________________

Regional Advocate_______________________________________ Phone_____________________

Representative Payee_____________________________________ Phone_____________________

N COMPLETE THIS SECTION ONLY IF SUBMITTING A FULL APPLICATION PACKET N

_____ Client Needs Summary for ICF/MR Waiver
_____ DD1 (see top right corner)
_____ DD2A (see physician's signature, page 4)
_____ DD3 (actual date testing conducted)
_____ DD4 (see top right corner, page 1)
_____ DD5 (see top right corner, page 1)
_____ DD6 (see top right corner, page 1)
_____ DD-7 (see date signed #1/#2)
_____ DD-7A (see date signed #1/#2)
_____ DD13 (see top right corner, page 1)

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
ANNUAL MEDICAL EVALUATION

Participant Name: ____ Birthdate:___________________________

Name of Behavioral Health Center: _______________________________ Date: __________________________

Address of BHC: ____ SS#: __________________________

Location of Physical Exam: __________________________________Medicaid #: __________________________

* **Illness/Accidents since Last Examination (Give dates and summarize):**

* **Allergies:**

* **CURRENT MEDICATIONS:**

Name of Medication	Date Started	Dosage	Frequency

* **LIST ANY PREVIOUS MEDICATIONS THAT COULD MOCK SYMPTOMS OR MIMIC MENTAL ILLNESS:**

Name of Medication	Date Started	Date Stopped	Dosage	Frequency

* **LIST ANY OTHER MEDICATIONS THE PARTICIPANT IS USING OR USES FREQUENTLY (OVER THE COUNTER AND PRESCRIPTION):**

Name of Medication	Reason for Taking

*** NUTRITIONAL STATUS SUMMARY:**

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

COMPREHENSIVE PSYCHOLOGICAL EVALUATION (TRIENNIAL)

NAME:__________________________________ EVALUATION DATE:____/____/___

BIRTHDATE: ___/____/____ AGENCY/FACILITY: _____________________________

REASON FOR EVALUATION:____

I. RELEVANT HISTORY:

A. Prior Hospitalization/Institutionalization

B. Prior Psychological Testing

C. Behavioral History

DD-3
New - July, 1985
Revised - June 2001

II. CURRENT STATUS:

A. Physical/Sensory Deficits

B. Medications (Type, frequency and dosage)

C. Current Behaviors

1. Psychomotor

2. Self-help

3. Language

4. Affective

5. Mental Status

6. Others (Social interaction, use of time, leisure activities)

III. CURRENT EVALUATION

A. Intellectual/Cognitive:

1. Instruments used:

2. Results:

3. Discussion:

B. Adaptive Behavior:

1. Instruments used: ABS I & II Others (list)

2. Results:

3. Discussion:

C. Other:

1. Instruments used:

2. Results:

3. Discussion:

D. Indicate the individual's level of acquisition of these skills commonly associated with need for active treatment.

1. Able to take care of most personal care needs. yes G no G
2. Able to understand simple commands. yes G no G
3. Able to communicate basic needs and wants. yes G no G
4. Able to be employed at a productive wage level without systematic long term supervision or support. yes G no G
5. Able to learn new skills without aggressive and consistent training. yes G no G
6. Able to apply skills learned in a training situation to other environments or settings without aggressive and consistent training. yes G no G
7. Able to demonstrate behavior appropriate to the time, situation or place without direct supervision. yes G no G
8. Demonstrates severe maladaptive behavior(s) which place the person or others in jeopardy to health and safety. yes G no G
9. Able to make decisions requiring informed consent without extreme difficulty. yes G no G
10. Identify other skill deficits or specialized training needs which necessitates the availability of trained MR personnel, 24 hours per day, to teach the person to learn functional skills. ___________________________________

E. Developmental Findings/Conclusions

IV. RECOMMENDATIONS:

A. Training

B. Activities

C. Therapy/Counseling/Behavioral Intervention

V. DIAGNOSIS:

VI. PROGNOSIS:

VII. PLACEMENT RECOMMENDATIONS:

Signature of Supervised Psychologist	Signature of Licensed Psychologist
Title	License #/Title
Date	Date

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
SOCIAL HISTORY

PARTICIPANT NAME:_________________________________ DATE:__________________

I. DEVELOPMENTAL HISTORY: Provide information summarizing personal growth from infancy through adolescence with attention to the development of his/her physical, social, and emotional competencies. As outlined below, if development is delayed, describe the circumstances or conditions associated with the delay and date of onset. If more space is needed, use back of this sheet and identify information by Roman Numeral and Letter.

a) Physical

b) Social

c) Emotional

II. FAMILY: List parents, spouse, children, siblings, significant others, and type of relationships, i.e., are they an available source of support and/or resources. Include description of family's socio-economic circumstances, and family composition. Past and current living arrangements, special problems, such as alcohol, substance abuse, and mental illness should be included.

III. EDUCATION/TRAINING: Describe education and training experiences, identify schools and programs attended, relationships with peers and teachers, any adjustment problems, levels of accomplishment and any other pertinent information.

IV. FUNCTIONAL STATUS: Describe levels of functioning relating to employment capabilities, work-related experiences, and assessment of skills relevant to the activities of daily living and self-care skills. Is applicant/participant now, or ever been gainfully employed? Indicate level of care recommendation.

V. RECREATION/LEISURE ACTIVITIES: Identify and describe recreational and leisure time activities, frequencies, accessibility, and degree of involvement.

VI. HOSPITALIZATIONS: List medical and psychiatric hospital dates and reason for admissions.

VII. FAMILY MEDICAL HISTORY (Identify relationship to the participant):

___________	MR/DD	___________	Heart Disease	___________	Cerebral Palsy
___________	Autism	___________	Diabetes	___________	Tuberculosis
___________	Hepatitis	___________	Mental Illness	___________	Kidney Disease
___________	Cancer	___________	Hypertension	___________	Metabolic Disease
___________	Allergies	___________	Thyroid Disease	___________	Muscular Dystrophy
___________	Epilepsy	___________	Other	___________	Other

Deceased Siblings (Cause of Death) ____

VIII. LEGAL STATUS: (Guardianship, committee, custody).

IX. OTHER RELEVANT INFORMATION: (Family medical history; applicant/participant military service; religious preference; or significant events or circumstances not covered in other sections).

______________________________	______________________________
DATE	DATE
______________________________	______________________________
SIGNATURE OF TEMPORARY LSW	SIGNATURE/CO-SIGN OF DEGREED/LSW
______________________________	______________________________
LICENSE #/DEGREE	LICENSE #/DEGREE

CONFIDENTIAL

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

INDIVIDUAL PROGRAM PLAN

________________________ ________________________ ___/___/___
PARTICIPANT AGENCY/FACILITY DATE

I. Evaluations and Assessments Performed: List the Dates Assessments Completed

Medical/ Nursing	Initial Medical Examination ___/___/___ Dental Exam ___/___/___ Neurological Exam ___/___/___ Nutrition ___/___/___ Motor ___/___/___ Speech ___/___/___ Nursing ___/___/___ Hearing ___/___/___ Vision ___/___/___ Language ___/___/___ Other ________
Psychological	ABS ___/___/___ WAIS ___/___/___ CIIS ___/___/___ WISC-R ___/___/___ Other ________ ___/___/___
Habilitative/ Social	Social History ___/___/___ Training/Education ___/___/___ Recreation/Leisure ___/___/___ Other ________ ___/___/___ Habilitation - WVATTS ___/___/___ Brigance ___/___/___ L.A.P. ___/___/___

II Evaluation and Assessment Summary: (List Strengths/Needs in all Areas)

A. Medical/Health:	
Strengths	Needs

New - July, 1985
Current - September,1993

CONFIDENTIAL

NAME ____________________________ DATE ____/____/____

II. (cont'd)

B. Psychological Strengths	Needs
C. Social Strengths	Needs

DD-5

CONFIDENTIAL

NAME ________________________________ DATE ____/____/____

II. (cont'd)

D. Habilitation Strengths	 Needs
C. Other Strengths	 Needs

F. Projected Date of Community Placement: ____/____/____

DD-5

CONFIDENTIAL

DATE ___/___/___

NAME ______________________________ ____ of ____ Page

III. Individual Service Plan (Staff Actions Based on Assessment Results)

Area	Service Needs	Availability Accessibility	Provider

Frequency Days/Hours	Duration	Plan of Action	Responsible Person

DD-5

CONFIDENTIAL

DATE ____/____/____

NAME ________________________________ ____ of _____

III. Individual Service Plan (Staff Actions Based on Assessment Results)

Area	Service Needs	Availability Accessibility	Provider

Frequency Days/Hours	Duration	Plan of Action	Responsible Person

REEVALUATION DATE ______________ 9 3 MOS. 9 6 MOS. 9 9 MOS. 9 12 MOS.

________________________ ___/___/___ ________________________ ___/___/___

PARTICIPANT DATE SERVICE COORDINATOR DATE

________________________ ___/___/___ ________________________ ___/___/___PARENT/LEGAL

REPRESENTATIVE DATE SERVICE COORDINATOR DATE

CONFIDENTIAL

DATE ___/___/____

NAME ____ _____ of _____

IV. Individual Habilitation Plan

#	Goal/Need	#	Behavioral Objective	Barriers

Activities and Methods	Date Initiated	Date Completed	Responsible Person

#	Goal/Need	#	Behavioral Objective	Barriers

Activities and Methods	Date Initiated	Date Completed	Responsible Person

DD-5

CONFIDENTIAL

DATE ___/___/___

NAME ______________________________ ____ of ____

IV Individual Habilitation Plan

#	Goal/Need	#	Behavioral Objective	Barriers

Activities and Methods	Date Initiated	Date Completed	Responsible Person

REEVALUATION DATE ________ 90 DAYS ________ 180 DAYS ________ ANNUAL ________

______________________ ___/___/___ ______________________ ___/___/___
PARTICIPANT DATE SERVICE COORDINATOR DATE

______________________ ___/___/___ ______________________ ___/___/___
PARENT/LEGAL REPRESENTATIVE DATE SERVICE COORDINATOR SUPERVISOR DATE

DD-5

<u>**CONFIDENTIAL**</u>

NAME:_________________________________ DATE:_____/_____/___PAGE:____OF_____

V. Signatures:

Participant's Printed Name/Role	**Signature**	**Agency**	**Agree**	**Disagree ***	**Time Spent**
Individual					
Parent/Legal Rep.					
Service Coordinator					
Physician/RN					
Psychologist					
Social Worker					
Advocate					
Day Program Supervisor					
QMRP					

*** IDT Member has disagreed with the IPP; rationale for disagreement is attached.**

CONFIDENTIAL

NAME:_____________________________________ DATE:______/______/___PAGE:_____OF______

V. Signatures:

Participant's Printed Name/Role	Signature	Agency	Agree	Disagree *	Time Spent

*** IDT Member has disagreed with the IPP; rationale for disagreement is attached.**

CONFIDENTIAL

NAME:______________________________________ DATE:______/______/______ PAGE:_____OF______

VI. RATIONALE FOR DISAGREEMENT WITH IPP:

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Signature

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
MR/DD Waiver Program Services Cost Estimate Worksheet

Participant's Name_______________________________ Date____________________

Medicaid #_______________________________ Social Security # _______________________________

Service Coordination Agency_______________________________ Phone____________________

Name of Service Coordinator _______________________________

Procedure Code	Unit Cost	MONTH:		MONTH:		MONTH:	
		# Units	Mo. Costs	# Units	Mo. Costs	# Units	Mo. Costs
MONTHLY TOTALS				+		+	

Procedure Code	Unit Cost	MONTH:		MONTH:		MONTH:	
		# Units	Mo. Costs	# Units	Mo. Costs	# Units	Mo. Costs
MONTHLY TOTALS				+		+	

= SIX MONTHS' TOTAL $_______________________________

A = AVERAGE WAIVER MONTHLY COST

$ _______________________________

B = AVERAGE ICF/MR MONTHLY COST

$ _______________________________

If A is less than B, plan is cost effective.

DD-6
New - July, 1985
Revised - June 2001

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

INFORMED CONSENT
TO A CHOICE OF
ALTERNATIVES BETWEEN INSTITUTIONAL
AND WAIVER HOME AND COMMUNITY-BASED SERVICES

NAME:____________________________________ **AGENCY/FACILITY**____________________________

___________**1.** The findings and results of the evaluations and needs have been discussed with the participant and/or family or legal representative.

___________**2.** Alternative plans for providing services to meet the participant's needs have been discussed and a choice of services between ICF/MR and community-based MR/DD Waiver services has been presented to the participant and/or family or legal representative.

___________**3.** The participant and/or family or legal representative have chosen ______________________________ _________ as described by the Interdisciplinary Team.

___________**4.** The participant and/ or family or legal representative have requested that an Individual Program Plan be developed for their approval.

___________**5.** The right to a fair hearing and the agency and state appeal process have been discussed with the participant and/or family or legal representative.

___________**6.** A copy of the MR/DD Waiver Handbook has been offered to the participant and/or family or legal representative and he/she has _________________ accepted ____________ refused the copy of the handbook.

A. ___________________________ ___________
Participant Date
OR

B.___________________________ __________
Service Coordinator Date

C. ___________________________ __________
Parent or Legal Representative Date

D.___________________________ __________
Service Coordinator Supervisor Date

E.____
Relationship to Participant

F.___________________________ __________
Witness Date

DD-7
Revised June 2001

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

INFORMED CONSENT
TO A CHOICE OF
MR/DD WAIVER PROVIDERS AND MR/DD WAIVER SERVICES

NAME:___________________________________ **AGENCY/FACILITY**___________________________

__________**1.** The right to choose among all qualified providers has been discussed with the participant and/or family or legal representative.

__________**2.** All enrolled service coordination agencies in the participant's catchment area have been discussed with the participant, family and/or legal representative.

__________**3.** The participant and/or family or legal representative have chosen _________________________ ________ as their service coordination agency.

__________**4.** The right to choose among all available MR/DD Waiver services to meet the participant's needs have been discussed with the participant and/or family or legal representative.

__________**5.** The participant, family and/or legal representative has been informed of their right to a fair hearing if denied service(s) and the provider(s) of their choice.

__________**6.** A copy of the MR/DD Waiver Reference Guide to Providers has been offered to the participant, family and/or legal representative have _____________________ accepted _________________________ refused a copy of the Reference Guide.

A. ______________________________ ____________
Participant Date
OR

B. ______________________________ ____________
Service Coordinator Date

C. ______________________________ ____________
Parent or Legal Representative Date

D. ______________________________ ____________
Service Coordinator Supervisor Date

E. ____
Relationship to Participant

F. ______________________________ ____________
Witness Date

MR/DD WAIVER PROGRAM
RESIDENTIAL HABILITATION TRACKING FORM

Participant Name ______________________ Service Coordination Agency ______________________

Provider Name ______________________ Service Coordinator Name ______________________

Provider Address ______________________

TYPE OF RESIDENCE: 9 Natural Family 9 Specialized Family Care Home 9 Group Home 9 ISS

In the spaces below, write in number of hours under the date that the participant received residential habilitation and/or related transportation services.

THIS REPORT IS FOR THE MONTH OF ________________________________, 2____________.

Code	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

ABSENCE CODES

Hospitalization	H
Home Visit	HV
Respite Care	RC
Illness	I
Other (Specify under comments)	O

COMMENTS: ____

____

____

____

I certify that the above documented services were delivered for the participant in accordance with the Individual's Program Plan (DD-5) and the regulations governing the Title XIX MR/DD Waiver Program. No services are claimed that were not provided to the participant.

Provider Signature ______________________ Date Completed ______________________

Service Coordinator Signature ______________________ Date Reviewed ______________________

DD-8
Revised June 2001

MR/DD WAIVER
MONTHLY HOME VISIT REPORT

____ ____
Participant Name Service Coordination Agency

____ ____
Participant Address Service Coordinator's Name

TYPE OF RESIDENCE: 9 Natural Family 9 Specialized Family Care Home
9 Group Home 9 ISS

Areas of Discussion	Comments
Progress/problems in meeting objectives outlined in the IHP	
Progress/problems in meeting the service needs in the ISP	
Identification of any new service requests or unmet needs	
Progress/problems identified behavior support plan	
Medical appointment results and upcoming appointments	
Unusual changes in mood, appetite, or behavior	
Opportunity for community integration and recreational activities	
Any other applicable information	

I certify the above service was delivered at the time of the monthly home visit in accordance with regulations governing the Title XIX MR/DD Waiver Program. No services have been claimed that were not provided to the participant.

____________________________________ _____________________________ __________________________
Date of the Home Visit Time Home Visit Initiated Time Home Visit Ended

____
Service Coordinator Signature Date

____
Participant, Legal Representative or Provider Signature Date

MR/DD WAIVER
DAY HABILITATION VISIT REPORT (EVERY OTHER MONTH)

____ ____
Participant Name Service Coordination Agency

____ ____
Day Service Address Service Coordinator's Name

TYPE OF DAY SERVICE: 9 Day Program 9 Community Day Habilitation
9 Pre-Vocational Training 9 Supported Employment

Areas of Discussion	Comments
Progress/problems in meeting objectives outlined in the IHP	
Progress/problems in meeting the service needs in the ISP	
Identification of any new service requests or unmet needs	
Progress/problems identified behavior support plan	
Medical appointment results and upcoming appointments	
Unusual changes in mood, appetite, or behavior	
Opportunity for community integration and recreational activities	
Any other applicable information	

I certify the above service was delivered at the time of the monthly home visit in accordance with regulations governing the Title XIX MR/DD Waiver Program. No services have been claimed that were not provided to the participant.

_____________________________________ ______________________________ __________________________
Date of the Day Visit Time Day Visit Initiated Time Day Visit Ended

____
Service Coordinator Signature Date

____
Participant, Legal Representative or Provider Signature Date

DD-9A
New June 2001

MR/DD WAIVER PROGRAM
ADULT COMPANION SERVICES TRACKING FORM

______________________________ Participant Name

______________________________ Service Coordination Agency

______________________________ Provider Name

______________________________ Service Coordinator Name

______________________________ Provider Address

TYPE OF RESIDENCE: 9 Natural Family 9 Specialized Family Care Home 9 Group Home 9 ISS

In the spaces below, write in number of hours under the date that the participant received adult companion services and/or related transportation services.

THIS REPORT IS FOR THE MONTH OF ______________________________, 2___________.

Code	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**

ABSENCE CODES

Hospitalization	H
Home Visit	HV
Respite Care	RC
Illness	I
Other (Specify under comments)	O

COMMENTS: ____

____

____

____

I certify that the above documented services were delivered for the participant in accordance with the Individual's Program Plan (DD-5) and the regulations governing the Title XIX MR/DD Waiver Program. No services are claimed that were not provided to the participant.

______________________________ Provider Signature

______________________________ Date Completed

______________________________ Service Coordinator Signature

______________________________ Date Reviewed

DD-10
New June 2001

MR/DD WAIVER PROGRAM
RESPITE TRACKING FORM

Participant Name ______________________ Service Coordination Agency ______________________

Provider Name ______________________ Service Coordinator Name ______________________

Provider Address ______________________

TYPE OF RESPITE CARE: 9 W0106 9 W0107

If respite care was provided during the month by more than one provider, a separate DD-11 for each provider is requested.

In the spaces below, write in number of hours under the date that the participant received respite care services and transportation related to respite if applicable.

THIS REPORT IS FOR THE MONTH OF ______________________, 2__________.

Code	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

REASON FOR RESPITE CARE: ______________________

I certify that the above documented services were delivered for the participant in accordance with the Individual's Program Plan (DD-5) and the regulations governing the Title XIX MR/DD Waiver Program. No services are claimed that were not provided to the participant.

Provider Signature ______________________ Date Completed ______________________

Service Coordinator Signature ______________________ Date Reviewed ______________________

DD-11
Revised June 2001

MONTHLY PROGRESS SUMMARY

PARTICIPANT'S NAME: ______________________________

MONTH/YEAR: ______________________________

PROVIDER'S NAME: ______________________________

Training Objectives	Summarize progress/regression noted during the month
Communication	
Self-Help Skills	
Social Development	
Mobility Skills	
Fine/Gross Motor Skills Development	
Behavior	
Daily Living	
Leisure Time & Recreational Activities	
Community Activities	
Other	

______________________________ ______________________________

Provider's Signature Date Service Coordinator's Signature Date

DD-12
Revised June 2001

MR/DD WAIVER PROGRAM
CERTIFICATION OF TRAINING FOR HABILITATION PROVIDERS

Name of Participant: ______________________________ Date: ______________________

Service Coordination Agency: ____

Name of Subcontracting Agency (If applicable): ____________________________________

Name of Location: 9 GH 9 ISS/Semi-I/Apt 9 Day Pro 9 SFCH 9 NF Home

Period for Which Training is Valid: From ___________________ To ___________________

Trained on the Following Program Objectives:

1. ________________________________ 9. ________________________________
2. ________________________________ 10. ________________________________
3. ________________________________ 11. ________________________________
4. ________________________________ 12. ________________________________
5. ________________________________ 13. ________________________________
6. ________________________________ 14. ________________________________
7. ________________________________ 15. ________________________________
8. ________________________________ 16. ________________________________

* Note: Specific procedure/techniques/methods may be found attached to the program plan. Amount of time spent training is documented in the QMRP case notes.

I certify that I have received training on the program objectives listed above. I will contact the service coordinator or QMRP if additional training is needed.

___________________________________ ___________________________________
Signature of Person Trained/Title Signature of Person Trained/Title

___________________________________ ___________________________________
Signature of Person Trained/Title Signature of Person Trained/Title

___________________________________ ___________________________________
Signature of Person Trained/Title Signature of Person Trained/Title

___________________________________ ___________________________________
Signature of Person Trained/Title Signature of Person Trained/Title

___________________________________ ___________________________________
Signature of Person Trained/Title Signature of Person Trained/Title

____ _______________________
Signature and Credentials of Trainer Date

WEST VIRGINIA MR/DD WAIVER PROGRAM
APPLICATION FORM (DD-14)

1 ________________________/___________________________________/______ 2 DOB _______/_________/________
First Name Last Name M Month Day Year

3 _______________________________________/_____________________________/_____/______________/_____________
Street/Apt# Address City State Zip Code County

4 Telephone #(_____)_________________ 5 Social Security #_____________________ 6 Medicaid #_________________

7 Parent's Name____________________/___________________________/___ 8 Parent's Phone #(_____)_____________
First Name Last Name M

9 Parent's Address_____________________________/_______________________/_____/___________/_________________
Street/Apt# City State Zip Code County

10 Does the applicant have a legal guardian or legal representative? 9YES 9NO

11 Guardian's Name's___________________/_____________________/___ 12 Guardian's Phone #(_____)___________
First Name Last Name M

13 Guardian Address_____________________________/_______________________/____/___________/________________
Street/Apt# City State Zip Code County

14 Service Coordination Agency Name____/______________________
Phone Number

15 Please indicate anticipated time frame the applicant requires MR/DD Waiver Services to begin?
90 - 90 Days (APPLICATION) 991 Days or Greater (STATEMENT OF INTEREST)

16 If "91 Days or Greater was checked in #15, please indicate the anticipated month and year the applicant requires MR/DD Waiver Services to begin:____________________________________/_______________________.
Month Year

17 I certify the above information is accurate and complete to the best of my knowledge. I authorize the West Virginia State MR/DD Waiver Office to review and release the above information to the Service Coordination Agency I have selected on this application. I understand the information provided in this document will be treated confidentially.

____
Print Name of Applicant or Legal Representative

____ ____________________________
Signature of Applicant or Legal Representative ***Date***

DO NOT WRITE BELOW THIS LINE

Received by the Local Behavioral Health Center (Date/Signature): ____

Received by the Local DHHR Office (Date/Signature): ____

Date Received by the State MR/DD Waiver Office (Date/Signature): ____

White - State MR/DD Waiver Office **Yellow - Applicant** **Pink - Selected Service Coordination Agency**

MR/DD WAIVER PROGRAM
PARTICIPANT EXIT/TRANSFER FORM

(This form should be completed and received at the MR/DD Waiver office **within seven days** of the participant's exit/transfer from the center)

NAME OF CENTER ______________________________ DATE__________________

NAME OF PARTICIPANT ____

DATE OF EXIT OR TRANSFER FROM THE PROGRAM _________________________

REASON FOR EXITING THE PROGRAM:

9 OPTED OFF THE MR/DD WAIVER PROGRAM.
Reason ____

Date of Transitional IPP Meeting ____________________________________

Participant and/or Legal Representative _____ agreed or _____ refused to participant in the transitional IPP meeting.

9 DECEASED

9 PARTICIPANT IS NO LONGER MEDICALLY ELIGIBLE FOR AN ICF/MR LEVEL OF CARE

9 PARTICIPANT IS NO LONGER FINANCIALLY ELIGIBLE FOR THE MR/DD WAIVER PROGRAM

9 PARTICIPANT IS NO LONGER ELIGIBLE FOR AN ICF/MR LEVEL OF CARE

9 STILL ON THE WAIVER PROGRAM; TRANSFERRED TO ANOTHER AGENCY
Transferred to: ____

9 OTHER ____

NAME OF PERSON COMPLETING THIS FORM: ________________________________

DD-16
Revised June 2001

QMRP CREDENTIALING FORM (DD-17)

Name of QMRP ______________________________ Date ____________________

Service Coordination Agency ______________________________

Name of Subcontracting Agency (If applicable) ______________________________

r Highest level of QMRP approved to bill: 9 QMRP I 9 QMRP II 9 QMRP III

r QMRP is: 9 An employee of the service coordination agency
9 Subcontracting with the service coordination agency through another licensed B
9 Privately Subcontracting with the service coordination agency (community provider)

r Bachelor's degree obtained: 9 Yes 9 N/A In what area? ____________________
Is a copy on file: 9 Yes 9 N/A

r Master's degree obtained: 9 Yes 9 N/A In what area? ____________________
Is a copy on file: 9 Yes 9 N/A

r Doctoral degree obtained: 9 Yes 9 N/A In what area? ____________________
Is a copy on file: 9 Yes 9 N/A

r Current license/certification verifying registration as a medical therapist: 9 Yes 9 N/A
In what area? ____________________ Is a copy on file: 9 Yes 9 N/A

r Outline the years/months of experience with MR/DD individuals (previous employment, training, paid internship etc.). Include dates, names of agencies/institutions and any other specific details of the experiences (***This section is not applicable for licensed QMRP III's***):

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(If you need more space write on the back or attach a blank sheet)

r Based on the information outlined I certify that ____________________ is qualified to provide QMRP services as defined in the MR/DD Waiver manual:

______________________________ ______________________________

Agency Representative Signature/title **MR/DD Waiver Office Representative (*only applicable when submitting for optional prior approval*)**

MR/DD WAIVER PROGRAM
REQUEST FOR ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS

TO BE COMPLETED BY THE SERVICE COORDINATOR:

Date______________________________

Participant Name__________ ____

Medicaid Recipient #__________ ____

Living Situation: 9Natural Family 9SFCP 9ISS 9Group Home

Service Coordination Agency__________ ____

Service Coordination Agency Address__________ ______________________________

Service Coordination Phone Number__________ ________________________________

Service Coordinator Name__________ ____

Brief Description of the Environmental Accessibility Adaptation Needed:__________ __________

____

____

____

____

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____

____

____

____

____

____

Total Cost of the Environmental Accessibility Adaptation: $______________________

Has the Participant utilized this service in the current calendar year? 9YES 9NO

If yes, what is the total amount of funding utilized in the current calendar year? $__________

ATTACH THE FOLLOWING DOCUMENTATION:

- **IPP recommendations**
- **Documentation of denials or exhaustion of non-Medical and non-family resources**
- **Purchase order detailing costs and description for the Environmental Accessibility Adaptations.**

Service Coordinator Signature/Date____

Agency Contact Person Signature/Date ______________________________________

****All Original Documentation (form and attachments) must be maintained in the participant's file. A copy of this form must be maintained in a single file by the Agency Contact Person.****

DD-19
New June 2001

MR/DD WAIVER NOTIFICATION OF PARTICIPANT DEATH
(This form is only used to report deaths of participants who reside in a 24 hour staffed setting.)

TO: Office of Behavioral Health Services
MR/DD Waiver Program
350 Capitol Street, Room 350
Charleston, West Virginia 25301-3702

FROM: ____

____

____

INFORMATION ON THE DECEASED:

Name____ Gender________ Age_____

Date of Birth____' _____' _____ Address_________________ ____

City____ Medicaid Number________________________________

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. (Circle One)

Location of Death ____

History of Most Recent Illness or Incident resulting in the Death:(Attach Additional Sheets as Needed):

INFORMATION OF PERSON COMPLETING THIS FORM:

Name and Position/Title:____

Agency:____

Signature: _______________________________ **Date**:_________________

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
RESIDENTIAL HABILITATION SPECIAL PROJECT APPLICATION

9 New Application
9 Re-Certification

I. GENERAL INFORMATION

Applicant ____ Date: ________________________
First *Last* *M*

Social Security Number________________________________ Medicaid Number________________________________

Is the applicant currently approved for the MR/DD Waiver Program? 9YES 9NO

If no, has a Full Application Packet been submitted? 9YES 9NO Date Submitted ____________________

Current Residence (Address, City, State, Zip Code) ____

____

Current Residence Type: 9ISS 9ICF/MR 9SFC 9Natural Family 9Nursing Facility 9State Facility

9Other ____

Service Coordination Agency ____

Service Coordinator____ Phone___________________________

Residential Provider____ Phone___________________________

Special Project Residence (if different from current address) ____

____

Special Project Home Size (# of Participants, including non-special project participants) _________________________

Primary Need: 9BEHAVIORAL 9MEDICAL 9BOTH

II. STAFFING PATTERNS (Please indicate all nursing and direct care staff hours the applicant will require)

POSITION	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
1.							
2.							
3.							
4.							
5.							
6.							

7.							
8.							

III. DIAGNOSIS INFORMATION

AXIS I	AXIS III
1.	8.
2.	9.
3.	10.
4.	11.
AXIS II	12.
5.	13.
6.	14.
7.	15.

IV. MEDICAL NEEDS

#	MEDICAL NEEDS	CHECK OR COMPLETE ALL THAT APPLY
1.	Current Level of RN Supervision	_______________ (#) of hours per day.
2.	Current Level of LPN Supervision	_______________ (#) of hours per day.
3.	G-Tube Care	G YES G NO
4.	Colostomy Care	G YES G NO
5.	Seizure Care	G Emergency/ Extensive G Oxygen G IM Medication G Rectal Medication
6.	Injectable Medications	G Insulin Treatment G Allergy Injections G PRN Orders
7.	Suctioning Care	G YES G NO
8.	Sterile Dressing with Prescriptions Medication	G YES G NO
9.	Oxygen Therapy	G YES G NO

10.	Medical Hospitalizations	_______________ (#) of hospitalizations in the past 12 months.

V. BEHAVIORAL NEEDS

#	BEHAVIORAL NEEDS	CHECK OR COMPLETE ALL THAT APPLY
1.	Current Staff Level or Ratio	G 1:1 (24 hours per day) G 1:1 (16 hours per day) G 2:1 (24 hours per day) G 2:1 (16 hours per day)
2.	Imminent Danger to Self: G Historically G Currently	G Suicidal G Tissue Damage requiring Medical Treatment G Self-Mutilation G Life Threatening PICA G Life Threatening Elopement
3.	Imminent Danger to Others: G Historically G Currently	Physical harm to other requiring medical treatment” G Daily G Once per week G Once per month G 3-4 times per year
4.	Severe Property Destruction: G Historically G Currently	Public or Private Property Destruction: G Daily G Once per week G Once per month G 3-4 times per year
5.	Criminal Behavioral Against Others: G Historically G Currently	G Sexual Offenses G Arson Offenses G Assault Offenses
6.	Sexually Inappropriate Behavior: G Historically G Currently	G Inappropriate Touching of Others G Predatory Behavior G Removal of Clothing in Public
7.	Psychiatric Hospitalizations	_________ (#) of hospitalizations in past 12 months.
8.	Emergency Procedures	_________ (#) of emergency procedures used in the past 12 months.

If sections V. or VI do not accurately describe the applicants medical or behavioral needs please attach copies

of assessments or program plans as appropriate.

VI. ATTACHMENTS

(The following attachments are required for the application to be process without unnecessary delay.)

G Current Annual Medical Evaluation (DD-2A)
G Current Psychological Evaluation (DD-3)
G IPP (DD-5)
G Cost Estimate Worksheet (DD-6)
G Current ABS-RC:2 Assessment Summary Report (Standard Scores)

VII. PROFESSIONAL CERTIFICATION:

Please following the following instructions for certification of the application.

- Applications for medical level of care needs to be signed by the physician.
- Applications for behavioral level of care needs to be signed by the licensed psychologist.
- Applications for both medical and behavioral level of care needs to be signed by both the physician and the licensed psychologist.

I certify that to the best of my knowledge all the information on this form is true and accurate. A also certify that this information represents the needed supports and services of the individual.

Signature (Physician)	*License #*	*Date*
Signature (Licensed Psychologist)	*License #*	*Date*

VIII. AGENCY CERTIFICATION

I certify that to the best of my knowledge all the information on this form is true and accurate. I also certify that this information represents supports and services identified on the applicants Individual Program Plan.

Signature (Service Coordinator)	*Date*
Signature (Residential Program Supervisor)	*Date*

DO NOT WRITE BELOW THIS LINE

Residential Habilitation Special Project
Change in Approved Participants Form (DD-22)

Last Name ______________________ First Name ______________________ Middle Initial __________

Social Security #________________ Medicaid #________________ Provider #________________

Name of Residential Provider ____

Name of Service Coordination Agency ____

Home Name ____

Home Address(Street/City) ____

Check one of the following:

9 Request to discontinue participation in the special project.

9 Approved Special Project participant deceased. Date of Death__________________

9 Individual utilizing fee-for-service moving out of the above special project home.

9 Individual utilizing fee-for-service moving into the above special project home.

9 Approved Special Project participant moving into another special project home.

Name of New Home______________________________________ Provider #________________

New Home Address (Street/City)____ ____

Date the change will take place: ____

Name of Person Completing Form: ____

Phone # ____

______________________ ______________________
Residential Provider Signature Date Completed

______________________ ______________________
Service Coordinator Signature Date Reviewed

______________________ ______________________
Waiver Contact Person Signature Date Reviewed

DD-22
Revised November 2001

RESIDENTIAL HABILITATION SPECIAL PROJECT
PARTICIPANT/RESIDENTIAL TRACKING FORM
Quarterly Report

______________________________ ______________________________ ______________________________
Last Name First Name Middle Initial

Social Security #______________________________ Medicaid #__________________________ Provider #__________________

Name of Residential Provider ____

Name of Service Coordination Agency ____

Home Name ____

Home Address(Street/City) ____

Please check one of the following: 9 Special Project Participant 9 Fee-For-Service Participant 9 OTHER

Total # of People Residing in the Home:________________ **# of Special Project Participants:**_______________

In the spaces below, put an **"X"** under the date to identify if services were provided under the special project. If the person was in the hospital, please put an "H" in the space provided.

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	

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	

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	

______________________________ ______________________________
Residential Provider Signature Date Completed

______________________________ ______________________________
Service Coordinator Signature Date Reviewed

______________________________ ______________________________
Waiver Contact Person Signature Date Reviewed